



Progress reports

Report by the Secretariat

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A. POLIOMYELITIS: MECHANISM FOR MANAGEMENT OF POTENTIAL RISKS TO ERADICATION (resolution WHA61.1)

1. In 1988, the Health Assembly adopted resolution WHA41.28 on global eradication of poliomyelitis by the year 2000. By 2008, all but four countries had interrupted indigenous transmission of wild polioviruses (Afghanistan, India, Nigeria and Pakistan), and the annual number of cases had declined by more than 99% since 1988. However, case numbers were still fluctuating between 1000 and 2000 per year and 12 to 23 additional countries were experiencing cases of poliomyelitis due to imported polioviruses each year.¹ In at least two of these latter countries (Angola and Chad) and possibly the Democratic Republic of the Congo and Sudan, the imported virus persisted for more than 12 months and led to further international spread. In 2008, the Health Assembly in resolution WHA61.1 called for a new strategy to eradicate poliomyelitis from the remaining affected countries. The Programme of Work 2009 of the Global Polio Eradication Initiative was constructed in order to inform this new strategy by evaluating new tactical innovations in each disease-endemic area,² conducting clinical trials of new oral poliovirus vaccine formulations and facilitating an independent evaluation of major barriers to interrupting poliovirus transmission.

2. In India, new tactics increased oral poliovirus vaccination campaign coverage in 2009 among migrant and mobile populations and enhanced campaign operations being undertaken in the disease-endemic districts of central Bihar and western Uttar Pradesh, raising the proportion of very young children with antibodies to type 1 poliovirus in the latter area from 85% in late 2007 to 96% in late 2009.³ In Nigeria, comparing the last six months (May–October 2009) with the same period in 2008, the proportion of children who had never been immunized in the 10 endemic northern states (high-risk states) fell from close to 20% (19.5%) to less than 10% (9.6%) in 2009,⁴ after state governors signed the Abuja Commitments to Polio Eradication in February 2009 and traditional leaders formed a polio eradication committee in June 2009. Both of these actions have resulted in greater accountability at the local level for the performance of the poliomyelitis campaigns. In Pakistan, the Prime Minister launched a Polio Action Plan in February 2009 that enhanced multisectoral support for the oral poliovirus vaccination campaigns in many areas, although coverage remained less than 80% in the disease-endemic districts in the north of both the North West Frontier Province and the Federally Administered Tribal Areas, Baluchistan and the greater Karachi area of Sindh. In the two remaining disease-endemic provinces in Afghanistan (Kandahar and Helmand in the Southern Region), access to children improved in key security-compromised districts during recent oral poliovirus vaccination campaigns through the use of new tactics, which included an enhanced role for nongovernmental organizations, the recruitment of local “access negotiators”, and negotiations with the International Security Assistance Force and the Taliban for days of tranquillity. Although access in the Southern Region continues to fluctuate, the proportion of inaccessible children was reduced for the first time to

¹ Poliomyelitis case numbers available at www.polioeradication.org/casecount.asp.

² Areas where indigenous transmission of wild poliovirus has never been interrupted.

³ Data from a seroprevalence study in Moradabad (India) among 1002 six- to nine-month-old children, April–May 2009; data available in WHO headquarters.

⁴ Analysis of immunization profile of reported cases of non-poliomyelitis acute flaccid paralysis; data available in WHO headquarters.

5% during the oral poliovirus vaccination campaigns in July and September 2009, down from more than 20% at the start of the year.¹

3. To improve the efficiency and impact of oral poliovirus vaccination campaigns against the last two remaining serotypes of wild poliovirus, clinical trial lots of a bivalent oral poliovirus vaccine, containing type 1 and type 3 viruses, were produced. In 2009, the results of the clinical trial demonstrated that the protection conferred against disease due to both serotypes by this bivalent vaccine was superior to that provided by the trivalent oral poliovirus vaccine and “non-inferior” to the respective monovalent oral poliovirus vaccines.² The Advisory Committee on Poliomyelitis Eradication concluded that “the use of bivalent oral poliovirus vaccine in supplementary immunization activities constitutes an important new tool for the Global Polio Eradication Initiative” and made recommendations for its use.² This bivalent oral poliovirus vaccine was subsequently used for the first time in the Global Polio Eradication Initiative in December 2009 in Afghanistan, and in India, Nigeria and Pakistan in the first quarter of 2010. It is expected that a sufficient supply of the vaccine will be available to meet full demand by mid-2010.

4. An independent evaluation of major barriers to interrupting poliovirus transmission was chaired by Dr A.J. Mohamed (Oman), a vice-chairman of the Executive Board, and comprised five subteams with a total of 28 experts in relevant disciplines including public health, immunization programmes, vaccinology, social mobilization and security. These subteams collectively spent 24 person-months working on the evaluation in Afghanistan, Angola, India, Nigeria, Pakistan, Sudan, the WHO regional offices for Africa and the Eastern Mediterranean and WHO headquarters, with wide consultation with Global Polio Eradication Initiative partners and stakeholders in each country. The evaluation team submitted its report to the Director-General on 22 October 2009, and its progress report to the Executive Board at its 126th session in January 2010.³

5. In India, the evaluation team verified very high coverage during oral poliovirus vaccination campaigns and recommended an aggressive research agenda and multipronged approach to overcome the unique challenge posed by incomplete gut mucosal immunity to polioviruses in the setting of northern India. In Nigeria, the team recommended building on the improvements in oral poliovirus vaccination campaign coverage made in 2009, in particular by establishing specific mechanisms to hold leaders of local government areas accountable for programme performance as management issues at this level were now the most critical barriers to success. Finding that insecurity is now one of the most significant barriers to eradication in Afghanistan and Pakistan, the team highlighted the need for plans and solutions specific to districts and subdistricts in such areas, based on the local culture, local partners and the nature of the civil conflict. In Pakistan, the team also recommended monitoring the coverage achieved through the oral poliovirus vaccination campaign at the subdistrict level in order to be able to rectify the “non-accountability and political interference” of local district leaders, especially in the infected areas of Sindh and Baluchistan.⁴

¹ Independent monitoring reports of the supplementary immunization activities undertaken in July and September 2009; data available in WHO headquarters.

² Advisory Committee on Poliomyelitis Eradication: recommendations on the use of bivalent oral poliovirus vaccine types 1 and 3. *Weekly Epidemiological Record*, 2009, **29**(84):289–300.

³ Document EB126/38 Add.1, section A.

⁴ Independent evaluation of major barriers to interrupting poliovirus transmission – Executive Summary. 20 October 2009; available at http://www.polioeradication.org/content/general/Polio_Evaluation_CON.pdf (accessed 26 November 2009).

6. The evaluation team found that the persistent transmission of imported polioviruses in Angola and Chad, and possibly in the Democratic Republic of the Congo and Sudan, was the result of incomplete implementation of guidelines on the responses to poliomyelitis outbreaks. The team recommended that poliovirus transmission be considered to have been re-established in such areas, reflecting the increased risk they pose to the global eradication effort. To limit further international spread of polioviruses, the evaluation team urged a bolstering of routine oral poliovirus vaccination coverage in districts neighbouring poliomyelitis-affected areas and the focusing of such vaccination campaigns on areas where the virus had been reintroduced and routine oral poliovirus vaccination coverage was poor. The team recommended the vaccination of travellers at land crossing points between poliomyelitis-affected and poliomyelitis-free countries in sub-Saharan Africa, and supported the vaccination of other travellers, wherever appropriate, in order to reduce further the risk of international spread, as has been implemented during the hajj.

7. In order to enhance the Global Polio Eradication Initiative's support to poliomyelitis-affected countries, the team recommended that research be continued and promising advances (such as bivalent oral poliovirus vaccine) be rapidly introduced and extended on a wider scale; that the level of technical assistance provided by the Global Polio Eradication Initiative in countries where poliovirus was persisting after importation be aligned with that in areas where the disease is endemic; and that the Global Polio Eradication Initiative's work be linked more closely with that on strengthening immunization systems. The evaluation team recommended the consideration of further mechanisms to address poorly performing local entities.

8. As at 16 February 2010, a total of 1595 cases of poliomyelitis had been reported from 23 countries in 2009: 1247 from the four countries where the disease remains endemic (Afghanistan, India, Nigeria and Pakistan); 142 from the four countries where poliovirus transmission was known or suspected to have been re-established (Angola, Chad, the Democratic Republic of the Congo, and Sudan); and 206 in a further 15 countries in western and central Africa and the Horn of Africa due to new importations.¹ In Nigeria, the improvements in oral poliovirus vaccination coverage contributed to a 50% decline in the overall number of poliomyelitis cases and a 90% decline in cases due to type 1 poliovirus compared with 2008. Although case numbers in India were similar to those of 2008, the new tactics that were introduced in 2009 reduced both the genetic diversity and geographical extent of the remaining viruses.² In Pakistan the overall number of cases was 25% lower than at the same time in 2008, with many being reported from, or genetically linked to, areas affected by insecurity. In Afghanistan, endemic poliomyelitis was primarily persisting in just 13 districts in the Southern Region, out of 329 districts in the country. By late 2009 no new case had been reported for more than three months in the Horn of Africa, although the outbreaks in Angola, Chad, central Africa and western Africa were continuing.

9. The results and impact of the Global Polio Eradication Initiative's Programme of Work 2009 were reviewed by WHO's Strategic Advisory Group of Experts on immunization on 29 October 2009, and by the Advisory Committee on Poliomyelitis Eradication on 18 and 19 November 2009 at a special consultation of this Group with polio-affected countries and Global Polio Management Team Partners. The Strategic Advisory Group of Experts on immunization urged the Global Polio Eradication Initiative rapidly to consider the findings of the independent evaluation; it also supported an enhanced research agenda and agreed that bivalent oral poliovirus vaccination constituted an

¹ Poliomyelitis case numbers are accessible at the following web site: www.polioeradication.org/casecount.asp.

² Twentieth Meeting of the India Expert Advisory Group for Polio Eradication: conclusions and recommendations (Delhi, India, 24–25 June 2009); available at www.polioeradication.org/content/meetings/IEAG_200906.report.pdf.

important new tool. The Group recommended that the Global Polio Eradication Initiative's major indicators be internationally monitored with influential oversight by senior management in partner agencies and polio-affected countries. The Advisory Committee on Poliomyelitis Eradication stated that the challenges faced by the Global Polio Eradication Initiative in 2009 should not be allowed to overshadow significant achievements, particularly in Afghanistan, India and Nigeria. Participants in the Advisory Committee on Poliomyelitis Eradication's consultation concurred that the Global Polio Eradication Initiative should establish, through a consultative process with countries and partners, a new three-year strategic plan that focuses on stopping transmission of wild poliovirus globally, and incorporates the findings and recommendations of the independent evaluation.

10. The Executive Board at its 126th session welcomed and strongly supported the proposal for a three-year strategic plan to interrupt all remaining wild poliovirus transmission globally, which should build on the main outcomes of the programme of work for 2009, including the rapid expansion of use of the new bivalent oral poliovirus vaccine, district-specific plans for security-compromised and other high-risk areas, strengthening of immunization systems in areas at highest risk of outbreaks and, potentially, enhanced vaccination of travellers in order to limit the international spread of poliovirus.¹ The Board also requested that clear milestones be established and progress monitored in order to ensure increased accountability for implementation of the new plan at national and international levels. It was agreed that the summary of the independent evaluation could include an amendment noting factual concerns raised by some Board members.

11. In response to the Health Assembly's resolution WHA61.1 and following the guidance of the Board at its 126th session, the Global Polio Eradication Initiative has formulated a new strategic plan for 2010–2012 with a corresponding budget, for consideration by the Sixty-third World Health Assembly. This new strategic plan proposes fundamental changes in strategy in two major areas in particular: achieving the population-immunity thresholds needed to stop wild poliovirus transmission in each of the remaining poliovirus-affected areas of Africa and Asia, and reducing the risks of international spread of poliovirus and re-infection in poliovirus-free areas. As at February 2010, the three-year budget for the new strategic plan stands at US\$ 2600 million, against which there is a global funding shortfall of US\$ 1400 million, including a US\$ 330 million shortfall for 2010. In order to facilitate national and international monitoring of progress and mid-course corrections if needed, the strategic plan for 2010–2012 outlines specific milestones, the progress towards which will be reviewed on a six-monthly basis by the Strategic Advisory Group of Experts on immunization, whose findings will be reported to the Executive Board and the Health Assembly through the Director-General.

B. CONTROL OF HUMAN AFRICAN TRYPANOSOMIASIS (resolution WHA57.2)

12. The chronic form of human African trypanosomiasis, caused by *Trypanosoma brucei gambiense*, is endemic in 24 countries. Between 2004 and 2008, the reported number of new cases fell by 40% to 10 235. Eleven countries (Benin, Burkina Faso, Gambia, Ghana, Guinea-Bissau, Liberia, Mali, Niger, Senegal, Sierra Leone and Togo) reported no case and six (Cameroon, Côte d'Ivoire, Equatorial Guinea, Gabon, Guinea and Nigeria) reported an average of less than 100 new cases annually. The Central African Republic, Chad, Congo and Uganda reported between 100 and 1000 new cases annually. Angola, Democratic Republic of the Congo and Sudan are the most affected countries, with each reporting an average of more than 1000 new cases each year.

¹ See document EB126/2010/REC/2, summary record of the thirteenth meeting, section 4.

13. During the same period, the number of newly reported cases of the acute form of human African trypanosomiasis, caused by *T. b. rhodesiense* which is endemic in 13 countries, fell by 56% to 259. Botswana, Burundi, Ethiopia, Namibia and Swaziland reported no case. Kenya, Mozambique, Rwanda and Zimbabwe reported sporadic cases; Malawi and Zambia reported fewer than 100 new cases each year; and Uganda and the United Republic of Tanzania reported between 100 and 1000 new cases annually.

14. Public–private partnerships have allowed countries in which human African trypanosomiasis is endemic to use the best available treatment options. In 2004 the proportion of cases of second-stage disease due to *T. b. gambiense* treated with the toxic melarsoprol was 86% whereas in 2008 this figure had been reduced to 51%; the remaining cases were treated with eflornithine, which is safer.

15. In response to resolution WHA50.36 on African trypanosomiasis, WHO signed a Memorandum of Understanding with the African Union Commission agreeing to join forces to fight African trypanosomiasis within the framework of the Pan African Tsetse and Trypanosomiasis Eradication Campaign. Also, with FAO, WHO has launched an initiative to map the distribution of the disease within the framework of the multi-institutional Programme Against African Trypanosomiasis.

16. Access of patients with human African trypanosomiasis to diagnosis and treatment has been facilitated by: the diminution of social upheavals; capacity building; increased technical and financial support for control and surveillance; and the free provision of diagnostic reagents and medicines for trypanosomiasis.

17. Despite progress, human African trypanosomiasis continues to be a threat in Africa, in particular in areas of the Central African Republic and Democratic Republic of the Congo where security constraints hamper control activities. Countries in which the disease is endemic should be supported to strengthen control and surveillance activities through identification of isolated pockets of disease transmission and improvement of reporting. The decrease in the number of cases detected has, unfortunately, lowered the priority given to control of the disease, mirroring the situation 50 years ago when it was believed that the disease had been eliminated. Subsequently, the awareness of human African trypanosomiasis declined and the setting of other public health priorities contributed to its neglect. To avoid a repeat of history, it is important to find cost-effective and sustainable means for surveillance and control of human African trypanosomiasis.

18. Sustainable control of human African trypanosomiasis is feasible only through an integrated approach whereby surveillance and control activities are undertaken within reinforced and operational health systems. The two main technical obstacles are: the unavailability of a sensitive and specific diagnostic test that is inexpensive, easy to perform in field conditions and acceptable for use at any level of the health system; and the lack of a new antitrypanosomal agent that is cheaper, safer, easier to administer than existing medicines and able to cure both forms of the disease.

19. The most immediate challenge is to expand and sustain current control and surveillance using the best tools available. Research into new tools should be accelerated. Awareness about the disease should be raised and priority-setting and fundraising advocated. WHO should continue to lead provision of support to countries and to coordinate the work of all parties concerned with control of, and research into, human African trypanosomiasis.

20. The Executive Board noted this progress report at its 126th session in January 2010.¹

C. REPRODUCTIVE HEALTH: STRATEGY TO ACCELERATE PROGRESS TOWARDS THE ATTAINMENT OF INTERNATIONAL DEVELOPMENT GOALS AND TARGETS (resolution WHA57.12)

21. Implementation of the strategy has been reinforced by the addition of a new target (5.B) for Millennium Development Goal 5: Achieve, by 2015, universal access to reproductive health. The Secretariat has continued to provide support to Member States in improving access to, and quality of, sexual and reproductive health care and accelerating attainment of universal access to appropriate services and commodities.

22. Regional activities, implemented in collaboration with partners, have included: adapting the strategy to regional contexts in order to respond best to local reproductive health needs; supporting the development of policies whose goal is universal access to reproductive health services and commodities; assessing the feasibility of measuring the indicators that are listed in the framework for implementing the strategy;² holding technical consultations on sociocultural approaches to accelerate achievement of Goals 4 and 5; and organizing workshops to strengthen national capacities for devising strategies and policies responsive to needs; and improving quality of care.

23. In 2009 the Secretariat assessed progress made by Member States in the five key action areas defined in the strategy. Responses to a questionnaire showed the following results:

- **Strengthening health systems capacity.** Strategies have been designed to expand reproductive health services and ensure the provision of basic emergency obstetric care in rural areas. Initiatives have been taken to attract health-care providers to work in hard-to-reach areas. Increased attention has been paid to preventive health care, and reproductive health commodities have been included in essential medicines lists.
- **Improving information for priority setting.** Questions about reproductive health matters have been incorporated into population surveys and censuses.
- **Mobilizing political will.** Workshops have been held for parliamentarians. Information has been disseminated to policy-makers, and the importance of reproductive health to development and attainment of the Millennium Development Goals has been advocated.
- **Creating supportive legislative and regulatory frameworks.** Legislation on the provision of reproductive health services and information has been enacted.
- **Strengthening monitoring, evaluation and accountability.** Reproductive health indicators have been included in national monitoring mechanisms, and maternal deaths have been reviewed.

¹ See document EB126/2010/REC/2, summary record of the thirteenth meeting, section 4.

² Document WHO/RHR/06.3.

24. The survey also indicated that Member States have identified various obstacles to the improvement of reproductive health services. These include: adverse sociocultural factors; armed conflict; poor reporting of all reproductive health indicators; poor access by vulnerable groups; shortage of equipment and care providers; unwillingness of providers to work in remote areas; lack of awareness about the range of family planning methods; and inadequate services for adolescents.

25. The application of key interventions developed by WHO to reduce maternal mortality and improve reproductive health has been reported. Of the 57 countries that responded to the survey, 48 (85%) from all regions reported that WHO's focused antenatal care approach is integrated in reproductive health programmes, and in more than 80% magnesium sulfate is registered for use in pre-eclampsia. Implementation of cervical cancer screening programmes, however, was reported to be limited, and emergency contraception as part of family planning method-mix was reported by slightly more than half the countries.

26. The latest available data indicate uneven progress in reduction of maternal mortality in the developing world. Statistics from the Millennium Development Goals' monitoring regions of Eastern Asia, North Africa and South-East Asia¹ showed declines of 30% or more in the number of maternal deaths per 100 000 live births between 1990 and 2005, and reports from southern Asia indicate a decline of more than 20% over the same period. In sub-Saharan Africa the risk of dying in pregnancy or childbirth remains high.² Unsafe abortion is estimated to have caused around 70 000 maternal deaths worldwide in 2005, and about 46% of those deaths occur in women younger than 25 years.³

27. Use of effective contraception by women who want to delay or stop child-bearing can prevent 32% of maternal deaths. Although globally more than 60% of women who are married or in union use contraceptives, marked differences in this percentage are seen across regions. Women in sub-Saharan Africa have the lowest levels of contraceptive use (22% in 2007). Unmet need for family planning changed little in least developed countries: from 26% in 1990 to 24% in 2007. In sub-Saharan Africa, every fourth woman who is married or in union has an unmet need for family planning. Unmet need for family planning was shown to be higher for poorer women than their richer counterparts (see Figure). Meeting family planning needs will also help to achieve other Goals than Goal 5. For instance, use of contraception to promote birth spacing is estimated to prevent 10% of infant deaths; it also contributes to women's empowerment and gender equality by enhancing opportunities for participation in societal and their own developmental activities.

28. Access to care during pregnancy and delivery is crucial for reducing maternal deaths and improving maternal health. The use of essential maternal health services has increased since the 1990s. The proportion of women giving birth with the help of a skilled health professional increased from 61% in the mid-1990s to 66% in the mid-2000s globally (see Table).⁴ Skilled attendance at birth varies according to women's socioeconomic and other characteristics. In developing countries, the median proportion of births attended by a skilled health professional is 50% in rural areas compared with 83%

¹ United Nations Millennium Development Goals (MDG) monitoring regions (<http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Data/RegionalGroupings.htm>).

² World Health Organization. *Maternal mortality in 2005: estimates developed by WHO, UNICEF, UNFPA and The World Bank*. Geneva, World Health Organization, 2007.

³ World Health Organization. *Unsafe abortion: global and regional estimates of incidence of unsafe abortion and associated mortality in 2003*, Fifth edition. Geneva, World Health Organization, 2007.

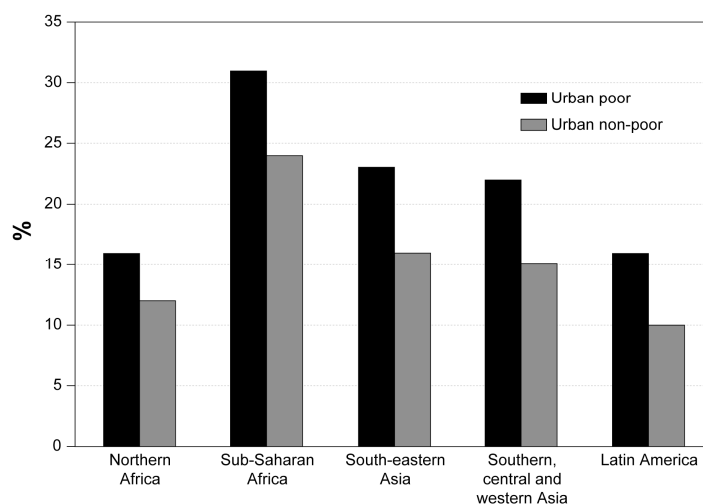
⁴ *World Health Statistics 2009*, Geneva, World Health Organization, 2009.

in urban areas.¹ Similarly, 43% of women in the poorest quintile received antenatal care at least four times, compared with 79% among the wealthiest quintile.

29. Reproductive health needs of boys and men require attention. Generally, less than 50% of young men aged 15–24 years reported using a condom even though they engaged in high-risk sexual behaviour.² Less than one third of men in many developing countries know that two ways of avoiding sexually transmitted infections are condom use and either abstinence or having only one uninfected partner. Sexuality education programmes were shown to have a significant effect on reducing risky sexual behaviours. WHO and its partners are conducting research and developing guidelines on men's sexual and reproductive health and their roles related to improving women's sexual and reproductive health. High priority topics include family planning, infertility, prevention and management of sexually transmitted infections including HIV infection, sexual health and human rights, maternal health, violence against women, female genital mutilation, reaching boys and young men with sexual and reproductive health information and services, and engaging boys and men to promote gender equity. Studies of interventions that have engaged men in the prevention of adverse sexual and reproductive health outcomes have shown positive results in terms of, for example, greater condom use (from 55% to 78%), more decision-making between partners about condom use (from 23% to 45%), higher uptake of voluntary counselling and testing for HIV infection, and fewer teenage pregnancies.

30. The Secretariat has noted the call made by the Executive Board³ to devote organizational resources in the area of sexual and reproductive health and is working in partnership towards securing sustainable resources. WHO and its partners, including health ministries, will continue to introduce effective interventions systematically using, among others, the WHO/UNFPA Strategic Partnership Programme to improve sexual and reproductive health.

Figure. Unmet need for family planning by married women (aged 25–29 years, in urban areas), broken down by socioeconomic status



Source: Montgomery MR et al (Eds). *Cities transformed: demographic change and its implication in the developing world*. Committee on Population, National Research Council of the National Academies. Washington DC, The National Academy Press, 2003.

WHO 10.8

¹ *World Health Statistics 2009*, Geneva, World Health Organization, 2009.

² The Millennium Development Goals Report 2009, Statistical Annex; Indicator 6.2.

³ Document EB126/2010/REC/2, summary record of the thirteenth meeting, section 4C.

Table. Proportion of deliveries attended by a skilled health worker: regional trends

	1991–1999	2000–2008
	%	%
WHO region		
African Region	48	46
Region of the Americas	87	92
South-East Asia Region	40	48
European Region	95	96
Eastern Mediterranean Region	42	59
Western Pacific Region	85	92
Income group		
Low-income	39	41
Lower middle-income	62	70
Upper middle-income	90	95
High-income	98	99
World total	61	65

Source: *World Health Statistics 2009*.

D RAPID SCALING UP OF HEALTH WORKFORCE PRODUCTION (resolution WHA59.23)

31. Several regions and countries have made commitments to augmenting the health workforce, and many have introduced innovative solutions. The need to expand the health workforce has also been recognized by multilateral and bilateral organizations, special initiatives, civil society, the private sector and philanthropic organizations.

32. The Secretariat is working to fulfil the Health Assembly's requests to the Director-General in the resolution at global, regional, and national levels. In the context of renewed focus on primary health care, it has identified three main strategic directions: providing strategic information on human resources for health; promoting strategic investments for developing human resources for health; and promoting innovative approaches to harmonize policies and programmes for providing health care to individuals throughout the life-course and to communities. The Secretariat has identified three main streams of work: advocacy; normative work; and capacity building in regions and countries.

33. Through advocacy, WHO has been working with major stakeholders to set goals for scaling up the workforce. For instance, the Japan International Cooperation Agency has committed itself to support the training of 100 000 new health workers in sub-Saharan Africa and the United States of America's President's Emergency Plan for AIDS Relief has made a similar commitment to train 140 000 new health workers. WHO has also advocated that health workforce production be a critical area for the High-Level Taskforce on Innovative Financing for Health Systems to invest in and has

provided support for estimating the costs of scaling up human resources for health. The need to scale up the health workforce towards the WHO threshold of 2.3 health workers per 1000 people was also recognized by the G8 members in 2008 and reinforced in the Summit Leaders declaration in 2009.¹

34. WHO co-organized with the Global Health Workforce Alliance the First Global Forum on Human Resources for Health (Kampala, Uganda, 2–7 March 2008), at which participants adopted the Kampala Declaration and Agenda for Global Action.²

35. In accordance with WHO's mandate, and pursuant to resolution WHA57.19 on international migration of health personnel, the Secretariat is working with Member States on a code of practice on the international recruitment of health personnel. Related to this, in July 2009, leaders of the G8 countries, in the Summit Leaders' declaration, called for WHO to complete the voluntary code of practice on ethical recruitment of health workers and for countries to endorse it.

36. The Secretariat has been working with global health initiatives, such as the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria, to develop recommendations, to support channelling as much funding as possible towards long-term and sustainable solutions for human resources for health.³

37. WHO, in collaboration with the President's Emergency Plan for AIDS Relief and UNAIDS, has issued global recommendations and guidelines on task shifting.⁴ These also cover the production of mid-level cadres and community health workers. The guidelines have now been implemented in 15 sub-Saharan African countries.

38. WHO and the President's Emergency Plan for AIDS Relief are partners in a new initiative to expand medical and nursing education in support of attaining sustainable human resources for health in countries.

39. The Secretariat is also contributing to work on increasing the number of midwives in order to make progress towards Millennium Development Goal 5 (Improve maternal health).

40. WHO, the Global Health Workforce Alliance, the United States Agency for International Development and other partners have collaboratively developed the Human Resources for Health Action Framework in order to streamline work at country level and to design operational tools for use by countries in scaling up the health workforce.

41. The Secretariat provides technical support to Member States for implementing the recommendations of the Global Health Workforce Alliance's Task Force for Scaling Up Education and Training for Health Workers, in the elaboration of which WHO participated.⁵ The

¹ http://www.g8italia2009.it/G8/Home/Summit/G8-G8_Layout_locale-1199882116809_Atti.htm.

² <http://www.who.int/workforcealliance/forum/2011/en/index.html>.

³ <http://www.who.int/healthsystems/publications/positivesynergiesdocs/en/index.html>.

⁴ WHO, President's Emergency Plan for AIDS Relief, UNAIDS. *Task shifting: rational redistribution of tasks among health workforce teams. Global recommendations and guidelines on task shifting*. Geneva, World Health Organization, 2008.

⁵ World Health Organization, Global Health Workforce Alliance. *Scaling Up, Saving Lives: summary and recommendations*. Task Force for Scaling Up Education and Training for Health Workers. Geneva, World Health Organization, 2008.

recommendations include the preparation of a 10-year plan to increase the production of health workers.

42. The Secretariat provided support to countries in developing proposals for the Global Fund to Fight AIDS, Tuberculosis and Malaria that included interventions to scale up the health workforce. The Global Fund allocated 23% of the overall funding to human resources for health in Global Fund Round 2–7 proposals.

43. The Secretariat provided support to two educational networks in Africa in order to establish academic programmes focused on health workforce development and is the lead moderator on an online forum of more than 500 interested parties to exchange information for expanding the health workforce.

44. Several countries have expanded the health workforce with technical support from WHO and partners. Brazil trained and deployed 30 000 family health teams which, by 2008, had reached 70% of the population. In the past three years Ethiopia has trained and deployed more than 25 000 health extension workers, with some 6800 more in training; intake of medical students was increased from 200 per year in 2006 to 1500 in 2008, and a strategy for four-year innovative medical education is being explored. In Malawi, output of medical doctors from training institutions increased from 17 in 2002 to 59 in 2008; clinical officers from 66 to 103; medical assistants from none to 192; and nurses and midwives from 168 to 322.

45. The Executive Board noted this progress report at its 126th session in January 2010.¹

E. STRENGTHENING NURSING AND MIDWIFERY (resolution WHA59.27)

46. In response to resolution WHA59.27, the Secretariat, in collaboration with international, regional and national partners, is working with Member States at regional level in order to strengthen national capacities for nursing and midwifery. This report highlights progress made in the areas of developing human resources for health, strengthening health systems within the context of primary health care and optimizing the contribution of nurses and midwives to the achievement of the health-related Millennium Development Goals.

Developing human resources for health

47. In collaboration with 45 bodies representing health professionals, WHO has developed a framework for interprofessional collaboration in education and practice, as a strategy for effective health workforce utilization. The framework is currently being piloted in two countries in the Caribbean region.

48. In 2008, a global programme of work, supported by dedicated tools and standards, was developed by the Secretariat in collaboration with partners and representative Member States.² In line with the global programme, one country in each of the six WHO regions is implementing the

¹ See document EB126/2010/REC/2, summary record of the thirteenth meeting, section 4.

² *Scaling up the capacity of nursing and midwifery services to contribute to the Millennium Development Goals: Programme of Work, 2008–2009*. Geneva, World Health Organization, 2008.

following activities: strengthening education in nursing and midwifery, improving health service provision, promoting supportive workplace environments, building capacity for leadership and management, and enhancing partnerships.

49. The Regional Office for the Western Pacific has developed a model with 15 baseline indicators for projecting needs in the area of human resources for health. Five countries from three WHO regions are using the model to inform their health workforce planning in order to maintain adequate numbers of competent nursing and midwifery personnel.

Strengthening health systems within the context of primary health care

50. All WHO regions have begun reorienting nursing and midwifery programmes to support the renewal of primary health care. In 2009, the Regional Office for the Eastern Mediterranean began supporting the establishment of national family health nursing programmes. An evaluation report on the applicability of the programmes to current population health needs was produced by the Regional Office for Europe.

51. WHO and key partners have been advocating for regulatory reform to support health system strengthening. Twenty countries in the Region of the Americas are updating nursing regulations based on the findings of a study carried out by the Regional Office for the Americas. In 2009, eight francophone countries in the African Region assessed the roles and functions of regulatory bodies, and 21 countries developed national action plans.

52. A compendium has been issued of 38 case studies of successful primary health care models, involving 29 countries.¹ Lessons learnt will be used to strengthen the role of nurses and midwives in efforts to renew primary health care.

Optimizing the contribution of nurses and midwives

53. In 2008, policy advice issued by the Global Advisory Group on Nursing and Midwifery Development covered, inter alia, the establishment of a multidisciplinary high-level group on the renewal of primary health care. WHO is providing technical support to the work of the group in reviewing related policies and health care models.

54. WHO has drafted a strategy for accelerating work in the area of human resources for health in support of the achievement by 2015 of Millennium Development Goal 5 (Improve maternal health). The Regional Office for South-East Asia is supporting Member States in strengthening educational programmes and in reforming pre- and in-service education on maternal and child health.

55. As part of the continuing collaboration between the Secretariat and different stakeholders, two capacity-building workshops were conducted using the training package on infection prevention and control of acute respiratory disease;² an article on the contribution of nurses and midwives in the

¹ *Now more than ever: the contribution of nurses and midwives to primary health care. A compendium of primary care case studies.* Geneva, World Health Organization, 2009 (document WHO/HRH/HPN/09.2).

² *Infection prevention and control of epidemic- and pandemic-prone acute respiratory diseases in health care. WHO interim guidelines.* Geneva, World Health Organization, 2007 (document WHO/CDS/EPR/2007.6).

eradication of poliomyelitis and the control of measles was also published;¹ and an Asia–Pacific network in disaster preparedness and management came into operation in response to the recommendation of the global consultation meeting on nursing and midwifery, held in Geneva in 2008.

56. WHO has supported 14 countries in the Region of the Americas in mounting hepatitis B vaccination campaigns in order to tackle occupational transmission of bloodborne pathogens among health workers; 500 000 health workers have been vaccinated as a result. A new global workplan on occupational health has been developed for the period 2009–2012. In addition, agreement was reached on recommendations and policy options for health workers' access to services for HIV and tuberculosis at a WHO-organized international consultation (Geneva, 14–16 September 2009).

Future directions for strengthening nursing and midwifery

57. The publication *Strategic directions for strengthening nursing and midwifery services (2002–2008)* is being updated in line with current global health priorities and the Eleventh General Programme of Work.

58. WHO will continue to work towards increased investment in the nursing and midwifery workforce at all levels and will strive to enhance interprofessional collaboration for the achievement of the Millennium Development Goals and the renewal of primary health care.

59. The Executive Board noted this progress report at its 126th session in January 2010.²

F. SUSTAINING THE ELIMINATION OF IODINE DEFICIENCY DISORDERS (resolution WHA60.21)

60. Iodine deficiency disorders are an important cause of preventable cognitive impairment. In resolution WHA43.2 the Health Assembly decided that WHO should aim at eliminating them as a public health problem and reaffirmed that goal in resolution WHA49.13. In subsequent resolutions it has urged greater efforts towards strengthening commitments to the sustained elimination of these disorders and increasing efforts in reaching those not yet protected from them.³ An earlier version of this report, which describes progress over the past three years towards their elimination, was noted by the Executive Board at its 126th session in January 2010.²

61. Population iodine status has been mapped through the measurement of iodine excretion in school-age children.⁴ Within the five-year period 2004–2008, only 37 of WHO's 193 Member States reported national data on urinary iodine concentrations for school-age children, covering 36.3% of the world's school-age population. These data show that nine countries had a prevalence of low iodine

¹ Nkwane A et al., The role of nurses and midwives in polio eradication and measles control activities: a survey in Sudan and Zambia. *Human Resources for Health*, 2009, 7:78.

² See document EB126/2010/REC/2, summary record of the thirteenth meeting, section 4.

³ Resolutions WHA58.24 and WHA60.21.

⁴ Median urinary iodine concentration (UI) is an indicator of iodine intake. Countries are divided into three groups of iodine intake: "adequate" (100 µg/l < UI < 199 µg/l), "above recommended nutrient intakes" (200 µg/l < UI < 299 µg/l) and "excessive" (UI > 300 µg/l), that is, in excess of the amount required to prevent and control iodine deficiency disorders.

status that was considered to be of public health significance,¹ 17 countries had iodine intakes that were adequate, and eight had iodine intakes that were excessive. Three countries had a documented increased risk of thyroid disorders in susceptible groups of people. With only 37 Member States reporting national urinary iodine data for school-age children between 2004 and 2008, it is difficult to generate a global estimate of iodine deficiency based on national data alone. When all reports from various administrative levels between 1993 and 2007 are considered, the number of countries having a public health problem of iodine deficiency disorders fell by more than half, from 110 to 47. This year, the Secretariat will launch a global analysis on progress towards eliminating these disorders.

62. The number of countries that provided data on the population iodine status for input into WHO's Vitamin and Mineral Nutrition Information System declined from 47 in 1993–2003 to 37 in 2004–2008. More data on women of reproductive age need to be generated, as they are an important target of public health programmes.

Strategy for control of iodine deficiency disorders

63. The preferred strategy for control of iodine deficiency disorders remains universal salt iodization. Salt has been chosen as a vehicle for fortification because its consumption is fairly stable throughout the year; iodization technology is inexpensive and the procedure is easy to implement. Additionally, the concentration of iodine in salt can easily be adjusted to meet policies aimed at reducing human consumption of salt in order to prevent chronic diseases.² Salt iodization is more effective when established by law.

64. Iodine supplementation is also recommended, especially for susceptible groups such as pregnant women and young children living in high-risk communities that are unlikely to have access to iodized salt³ or as a temporary strategy when salt iodization is not successfully implemented. The number of countries with at least 90% of households consuming adequately iodized salt is now 36,⁴ compared to 33 in 2006⁵ and 28 in 2004.⁶ Worldwide, 70% of households are still estimated to have access to iodized salt.

65. An Expert Consultation in 2007 on salt as a vehicle for fortification² concluded that policies for salt iodization are compatible with those for reduction of salt consumption aimed at preventing cardiovascular diseases. The current recommendation that salt be fortified with iodine at 20–40 ppm needs to be adjusted by national authorities in light of their own data on dietary salt intake and the median level of urinary iodine of the population. The Secretariat is currently reviewing its guidelines on the use of salt as a vehicle for iodine fortification and is aiming to produce recommendations for the adjustment of the concentration of iodine in fortified salt according to the dietary salt intake of the population.

¹ Urinary iodine concentration in school-age children of <100 µg/l.

² World Health Organization. *Salt as a vehicle for fortification. Report of a WHO Expert Consultation, Luxembourg, 21–22 March 2007*. Geneva, World Health Organization, 2008.

³ World Health Organization, United Nations Children's Fund. *Joint Statement: Reaching optimal iodine nutrition in pregnant and lactating women and young children*. Geneva, World Health Organization, 2007.

⁴ UNICEF. *State of the World's Children*. New York, UNICEF, 2010.

⁵ UNICEF. *State of the World's Children*. New York, UNICEF, 2007.

⁶ UNICEF. *State of the World's Children*. New York, UNICEF, 2004.

Monitoring and evaluation

66. Monitoring and evaluation of the impact of programmes to control iodine deficiency disorders are crucial in order to ensure that interventions are both effective and safe. It is currently recommended that countries conduct a national survey on the iodine status of the population every three to five years. Revised guidelines on indicators to assess and monitor these control programmes were published in 2007 by WHO, UNICEF and the International Council for the Control of Iodine Deficiency Disorders. A joint statement by WHO and UNICEF on reaching optimal levels of iodine nutrition in pregnant and lactating women and young children was issued in 2007.¹

67. WHO will convene a technical consultation in 2010 in collaboration with the Centers for Disease Control and Prevention (Georgia, Atlanta, United States of America) in order to discuss possible methods for generating regional and global estimates of iodine deficiency and of other vitamin and mineral deficiencies, especially in situations where country data are lacking.

Advocacy

68. The Network for Sustainable Elimination of Iodine Deficiency supports national efforts to accelerate elimination of iodine deficiency disorders by promoting collaboration among public and private sectors and among scientific and civic organizations. The Network has drawn up a communication plan in order to mobilize decision-makers and public health authorities on the importance of iodine deficiency.

G. MULTILINGUALISM: IMPLEMENTATION OF ACTION PLAN (resolution WHA61.12)

69. Implementation of the plan of action on multilingualism is overseen by a special coordinator for the promotion of multilingualism,² who works with focal points in headquarters³ and regional offices to promote respect for linguistic diversity and enhance WHO's multilingual output.

70. Under the guidance of the special coordinator, an electronic platform known as "e-Pub" has been established to facilitate **translation priority setting**. WHO regional offices have also made progress in setting translation priorities with Member States through informal consultations to identify topics and titles of major importance. For example, the Regional Office for the Eastern Mediterranean conducted a survey to identify the technical topics and titles most valued by Member States for publication in their national languages. In the Regional Office for the Western Pacific meetings in the first half of 2010 are being planned with Member States to set priorities for translation into Chinese and Vietnamese.

71. In an effort to use new technologies to rationalize multilingual workflow, the Secretariat has successfully piloted new software for publishing multilingual versions from a single source. The

¹ World Health Organization, United Nations Children's Fund. *Joint Statement: Reaching optimal iodine nutrition in pregnant and lactating women and young children*. Geneva, World Health Organization, 2007.

² See document EB121/6.

³ In particular, those working on translation, publishing, the web site and the library.

software, which maximizes production accuracy and efficiency, is being applied in the production of the *Bulletin of the World Health Organization*, including the abstracts of all articles in six languages.

72. Work to ensure that WHO's **information products are available in official and non-official languages** has continued. The Regional Office for Europe granted 70 requests for translation rights in 2009, while the Regional Office for the Americas translated 12 publications. In 2009, the Regional Office for the Eastern Mediterranean translated 52 publications into Arabic and granted 54 translation requests for non-official languages such as Farsi and Urdu. Last year, with the collaboration of external partners from 40 Member States, WHO headquarters produced 192 publications in multilingual format, covering a total of 41 languages.

73. There has been a visible increase in **multilingual technical content on the WHO headquarters web site**; information on over 35 essential health topics is now available in all official languages. In 2009, more than 1700 pages in each official language were added to WHO's governance subsite. In addition, in the same year, between 500 and 700 pages of content in each language were added to the WHO corporate web site. Pages were selected according to priority topics for each language – as identified by web statistics and WHO strategic objectives – and in response to health crises and emergencies. Awareness has been raised about the importance of multilingualism on the Internet; as a result, technical units have increased their demand for multilingual web sites. Last year, 10 technical web sites were made fully available in all official languages. WHO has also developed its first **multilingual web style guide** with the aim of standardizing language usage and controlling quality on the Organization's web site.¹

74. The Regional Office for Europe published 465 non-English web pages on its web site in 2009 and 47% of the documents uploaded to the online document archive were in French, German or Russian. In 2009, the Regional Office for the Eastern Mediterranean added 450 Arabic pages to its web site, translated the full-text versions of the *Bulletin of the World Health Organization* into Arabic, and made them available on the WHO web site.

75. The plan of action proposed that a **global institutional repository** should be established to collect and store WHO's intellectual output in digital form. Following an extensive evaluation process, an electronic platform that uses open source software was selected, in part, for its ability to support a very large amount of multilingual content.² The platform will be customized to permit optimal navigation, browsing, searching and retrieving in all official languages and an implementation plan has been prepared for its deployment.

76. In the Regional Office for the Western Pacific, the official launch of the *Index Medicus* platform is planned for May 2010. The platform will provide access to medical journals in Chinese, Japanese, Korean, Mongolian and Vietnamese, with English abstracts. In the Regional Office for Africa, the *Index Medicus* database continues to collect and record data from English-, French- and Portuguese-speaking African countries.

¹ In addition, a terminology section and a terminologist position have been created within the Regional Office for Africa in order to harmonize style. In the Regional Office for Europe, a style guide is being adapted into French, German and Russian.

² A new public name has been selected for the institutional repository: IRIS (Institutional Repository for Information Sharing).

77. The **ePORTUGUÊSe** network is a platform to promote capacity building and strengthen collaboration among Portuguese-speaking countries. The network has contributed to the development of national Virtual Health Libraries in all Portuguese-speaking countries in Africa and in Timor-Leste in the South-East Asia Region.

78. In resolution WHA61.12 the Health Assembly requested the Director-General to ensure the establishment of a **database listing the official languages** in which staff members in the professional category were fluent. In response, a pilot survey has been undertaken in one department at headquarters.¹

79. **Language training** continues to be available to WHO staff members free of charge. In 2009 at WHO headquarters, 1050 staff members were enrolled in a language training course. Of these, 2% were studying Arabic, 2% Chinese, 12% English, 65% French, 2% Russian and 15% Spanish.

80. The Executive Board at its 126th session in January 2010 noted an earlier version of this report.²

H. HEALTH OF MIGRANTS (resolution WHA61.17)

81. Since the adoption of resolution WHA61.17 the global economic crisis has had a major impact on the migrant population, raising concerns about the effect on migrants' health of unemployment, falling wages and poorer working conditions. Unauthorized migration flows, mainly triggered by poverty and lack of employment, have continued to have considerable health consequences, with many migrants in an irregular situation lacking access to health services. In addition, natural disasters, armed conflict and food insecurity have generated millions of displaced people whose health is threatened as a result. The pandemic of influenza A (H1N1) 2009 has reemphasized the links between population mobility and the spread of disease; in response, universal access is needed to preventive measures and care irrespective of a person's migrant status.

82. In the area of forced population displacement, WHO has continued its work as lead agency for the Health Cluster, working with partners, governments and communities in order to reduce avoidable loss of life, burden of disease, and disability in countries affected by crises or vulnerable to them.

83. The Organization has mobilized resources to facilitate the access to health services of populations displaced or otherwise affected as a result of crises. The groups targeted include refugees, internally displaced people, returnees, and host communities, with the following countries particularly concerned: Afghanistan, Cameroon, Central African Republic, Chad, Colombia, Democratic Republic of the Congo, Jordan, Pakistan, Sudan, and Syrian Arab Republic. Efforts have also been made to integrate information concerning the health of displaced people into national health information systems.

84. WHO has provided support to Member States and partners in generating data on some hard-to-reach migrant groups, for instance those in southern Mexico and in the border provinces in Thailand. In such cases, the Organization's role has been to document migrants' health status and the barriers

¹ The results of the survey can be obtained from the special coordinator. Similar surveys will be conducted in other departments, followed by an Organization-wide survey.

² See document EB126/2010/REC/2, summary record of the thirteenth meeting, section 4.

impeding their access to health services. In the WHO European Region, research conducted among migrant women in support of promoting reproductive health rights has permitted the documentation of measures to improve health access and address the determinants of migrant health.

85. In the European Region a migrant health working group has mapped activities undertaken in the Region in respect of the health of migrants; the group shared information among country offices, and coordinated technical input into relevant processes. As part of the multi-stakeholder EU-level Consultation on Migrants Health – “Better Health for All” (Lisbon, 24 and 25 September 2009), WHO coauthored recommendations on moving towards a migrant-sensitive workforce.

86. In collaboration with partners, preventing the spread of infectious diseases and ensuring access to health services for migrant workers were central to various European based initiatives, supporting discussions between the Prime Minister of the Russian Federation and the Director-General held in June 2009.

87. WHO and the International Organization for Migration jointly promoted migrant health in several platforms: the 16th Migration Dialogue for Southern Africa; a Ministerial Roundtable Breakfast organized by the United Nations Economic and Social Council on migrant women’s health needs; and the 7th Global Conference on Health Promotion (Nairobi, 26–30 October 2009). Recommendations covered subjects including the need to reinforce the rights of migrants to access health and social services; multiregional and multisectoral collaboration; the integration of health into policy dialogues on migration, in particular the Global Forum on Migration and Development; and the integration of migration issues into debates on foreign policy and global health.

88. In 2009, in order to enhance their capacity in the domain of migration and health and improve joint programmes, the International Organization for Migration and WHO entered into a cooperation agreement, which included the secondment of a staff member to WHO as Senior Migrant Health Officer.

89. WHO took part in the 24th Meeting of the Programme Coordinating Board of UNAIDS, whose theme was “People on the move – forced displacement and migrant populations”; the Organization also participated in the International Task Team on HIV-related Travel Restrictions, which considered universal access and human rights issues.

90. In order to ensure that health systems in all regions offer equitable services that respond to today’s multiethnic societies, there is still a need for the following actions: the conducting of systematic analyses of migrants’ health, based on relevant disaggregated data and including gender and age; the fostering of multicountry and multisectoral cooperation; and the development of cohesive policies.

91. The Ministry of Health and Social Policy of the Government of Spain, WHO and the International Organization for Migration organized a global consultation on migrant health in March 2010. The consultation made it possible to review actions taken by Member States and stakeholders, reach consensus on strategies to improve migrant health, pursue the establishment of a cross-sectoral international technical network, and outline an operational framework to support Member States and stakeholders in their efforts to implement resolution WHA61.17. The operational framework incorporates the contributions made by Member States and stakeholders across sectors and takes into account experiences and accomplishments recorded in the application of existing policies and programmes. Political commitment and the concerted involvement of all stakeholders will be essential in order to ensure that the framework leads to the desired level of action, which should

encompass improved monitoring of migrant health, policy reorientation, effective use of legal instruments and the development of health systems reflective of the diversity of today's societies.

92. The Executive Board at its 126th session in January 2010 noted an earlier version of this progress report.¹

I. CLIMATE CHANGE AND HEALTH (resolution WHA61.19)

93. In January 2009 the Executive Board at its 124th session adopted resolution EB124.R5, which endorsed the Secretariat's workplan for climate change and health and requested the Director-General, *inter alia*, to implement the actions contained in the workplan. In May 2009 the Sixty-second World Health Assembly noted the resolution and workplan. An earlier version of the present report was noted by the Executive Board at its 126th session.¹ The relevant activities undertaken to date are presented according to the four objectives of the workplan.

94. **Advocacy and awareness raising.** A comprehensive toolkit of audiovisual material – including posters, slide shows, public service announcements, brochures and fact sheets – has been developed in order to provide support to countries and health professionals in responding to and preventing the health impacts of climate change. In May 2009, WHO and the nongovernmental organization Health Care Without Harm jointly prepared and issued a paper that begins to define a framework for analysing and dealing with the health sector's impact on the environment. WHO's climate and health web site has also been redesigned and updated.

95. **Partnerships with other organizations of the United Nations system and other sectors.** WHO has actively contributed to the United Nations System Chief Executives Board for Coordination (CEB) and related mechanisms. This has increased recognition of the health implications of climate change within the relevant United Nations documents, such as the Secretary General's report on climate change and its possible security implications,² which was considered by the General Assembly at its sixty-fourth session. WHO has also contributed to the negotiation process of the United Nations Framework Convention on Climate Change in support of a clear reference to the impact of climate change on health in the new climate agreement. WHO also participated actively in the 15th Conference of the Parties to the Framework Convention (Copenhagen, 7–18 December 2009). The Organization was involved in organizing events during the preparatory sessions for the Conference; and at the preparatory meetings held in Bangkok and Barcelona, WHO discussed with a number of Parties to the Framework Convention the best means of reflecting health concerns within the text of the new agreement. WHO also organized a side event on protecting health from climate change during the high-level segment of the 15th Conference of the Parties. Participants at the event included the health ministers of Bangladesh and Samoa, the Minister of State for Health and Family of the Republic of Maldives and high-level representatives from other countries. The Organization also participated in WHO's World Climate Conference-3 (Geneva, 31 August – 4 September 2009), leading the technical working session on climate and human health.

96. In response to the United Nations Secretary General's drive towards a "carbon neutral" United Nations system, a comprehensive analysis of the carbon footprint of WHO headquarters and other

¹ See document EB126/2010/REC/2, summary record of the thirteenth meeting, section 4.

² Document A/64/350.

offices has been carried out. The Secretariat is reviewing policy options and developing an action plan to reduce its emissions of carbon dioxide.

97. **Promote and support the generation of scientific evidence.** WHO has published the results of a global consultation to define an applied research agenda in this field. An international collaborative project to improve estimates of the global burden of disease attributable to climate change has also been initiated. In November 2009 an international consortium, including WHO, published a first assessment of the health implications of actions to reduce greenhouse gas emissions.¹ One example of these outcomes, which are generally positive, would be a reduction in the negative impact of air pollution on health. WHO has also reviewed and published the overall scientific evidence on the relationship between climate change and health that was distributed on the occasion of 15th Conference of the Parties to the Framework Convention.²

98. **Strengthen health systems to protect populations from the threats posed by climate change.** The activities in support of this objective are being integrated into the relevant regional policy frameworks, such as the Libreville Declaration on Health and Environment in Africa (2008).

99. Guidance for assessing the threat posed by climate change to the health of local populations and for selecting the necessary adaptation measures has been updated by the Regional Office for the Americas, and is now being piloted in several countries. In August 2009, the WHO Regional Office for South-East Asia issued a set of lectures to provide training on climate change and health. In September 2009, a technical meeting was held on improving early warning systems in support of malaria control. During 2009, WHO and national governments co-organized capacity-building workshops in Albania, Bhutan, Maldives, Oman, Russian Federation, the former Yugoslav Republic of Macedonia and Uzbekistan.

100. WHO has initiated country projects on climate change and health. The projects have involved seven countries in eastern Europe (with support received from the Government of Germany). Funding from the Global Environmental Facility was received in early 2010 for an additional seven-country global project to be undertaken in collaboration with UNDP, involving Barbados, Bhutan, China, Fiji, Jordan, Kenya and Uzbekistan. Funding for additional projects in China and Jordan has been received from Spain.

101. The present report concerns one year of activities to implement resolution WHA61.19. However, the Health Assembly may wish to consider a two-year reporting cycle as suggested during the relevant discussion at the Sixty-second World Health Assembly in May 2009.³

¹ Wilkinson P et al. Public health benefits of strategies to reduce greenhouse-gas emissions: household energy; and Woodcock J et al. Public health benefits of strategies to reduce greenhouse-gas emissions: urban land transport, *The Lancet*, 374 (5 December 2009): 1917–1943. Initially published online.

² *Protecting health from climate change: connecting science, policy and people*. Geneva, World Health Organization, 2009.

³ See document WHA62/2009/REC/3, summary record of the seventh meeting.

J. PRIMARY HEALTH CARE, INCLUDING HEALTH SYSTEM STRENGTHENING (resolution WHA62.12)

102. This report summarizes progress made with planning support for the renewal of primary health care, through the involvement of WHO's headquarters and regional and country offices.

103. Each region has reported numerous instances of countries engaging in often comprehensive reforms in order to renew primary health care, with universal coverage and people-centred primary care featuring prominently. The findings of the Commission on Social Determinants of Health are shaping efforts to establish multisectoral action as a central feature. Recurring themes include:

- moving towards universal coverage through efforts to extend the supply of services, remove barriers to access and extend social health protection through pooled prepayment mechanisms;
- transforming conventional health-care delivery into people-centred primary care networks, with frequent references to comprehensiveness, integration and continuity of care and a redistribution of roles between close-to-client primary care teams and hospitals;
- raising awareness about health inequalities, bolstering capacity for public health interventions and rapid responses, and introduction of health-in-all-policies approaches;
- policy dialogue on overarching national strategies for health development, and striving for a political consensus about the responsibilities and the level of engagement of the state in the health sector, with participation and involvement of civil society.

104. Each region is drawing up plans for supporting renewal of primary health care. In the African Region these are guided by the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa (2008); in the Region of the Americas by the amended Strategic Plan 2008–2012 for the Pan American Sanitary Bureau; in the South-East Asia Region by the strategic framework developed through the Regional Meeting on Health Care Reform (Bangkok, 20–22 October 2009); in the European Region by the Tallinn Charter: Health Systems for Health and Wealth (27 June 2008); and in the Eastern Mediterranean Region by the Doha Charter and Declaration on Primary Health Care (November 2008). The Western Pacific Region started planning its work, which focuses largely on universal coverage, at an intercountry Meeting on WHO Action in Primary Health Care and Health Systems Strengthening (Manila, 14–15 April 2009). Regional task forces and technical working groups are providing oversight and guidance to the translation of commitments into country cooperation strategy documents and the planning exercises for the biennium 2010–2011.

105. In order to ensure that the organizational efforts across all levels of the Organization contribute to the renewal of primary health care, the Secretariat has begun to provide support to Member States by:

- developing national health strategy and planning processes that respond to the country's health problems, health system challenges and expectations for renewal of primary health care;
- creating the institutional and managerial arrangements for implementing these strategies and plans;

-
- using these national strategies and plans as a base for negotiating adequate resources with country and global stakeholders.

106. WHO is reprioritizing its work accordingly, and:

- has started linking all its programmes and country-cooperation strategies to national planning and strategy-building processes; these processes tackle the impact of the renewal of primary health care for each of the health system's building blocks;
- is formulating a multiyear Organization-wide plan to bolster its capacities for supporting policy dialogue, at country and global levels, on the renewal of primary health care;
- has started using the preparation of *The world health report 2010* on financing for universal coverage and other corporate initiatives as a means to address issues that have previously received insufficient attention, such as investment in health-care infrastructure, including hospitals, and the inclusion of civil society in the policy dialogue on national health strategies and plans;
- is working towards creating a technical advisory committee on primary care and health systems strengthening;
- has stepped up its efforts to align global interventions with national health plans by, among other actions: providing, together with the World Bank, the secretariat functions of the International Health Partnership; facilitating the attempts of the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance and the World Bank to move towards more harmonized funding mechanisms; and intensifying collaboration with partners, particularly UNICEF.

107. The Executive Board noted this progress report at its 126th session in January 2010.¹

ACTION BY THE HEALTH ASSEMBLY

108. The Health Assembly is invited to note the above progress reports.

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¹ See document EB126/2010/REC/2, summary record of the thirteenth meeting, section 4.