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1. NUMBER OF WORK-RELATED ACCIDENTS AND ILLNESSES CONTINUES TO INCREASE

WHO and ILO join in call for prevention strategies

Faced with a rising toll of occupational-related death, injury and sickness, the World Health Organization (WHO) and the International Labour Office (ILO) marked April 28, 2005, as the World Day for Safety and Health at Work by highlighting the need for a preventative safety culture worldwide.

According to new estimates by the ILO, the number of job-related accidents and illnesses, which annually claim more than two million lives, appears to be rising because of rapid industrialization in some developing countries.

A new assessment of workplace accidents and illness indicates that the risk of occupational disease has become by far the most prevalent danger faced by people at their jobs - accounting for 1.7 million annual work-related deaths and outpacing fatal accidents by four to one.

In its latest estimates, the ILO found that in addition to job-related deaths, each year there are some 268 million non-fatal workplace accidents in which the victims miss at least three days of work as a result, as well as 160 million new cases of work-related illness. The ILO has previously estimated that workplace accidents and illness are responsible for the loss of some 4% of the world's GDP in compensation and absence from work.

Broken down by region, the figures indicate that workplace accidents have levelled off in many

industrialized and newly-industrialized countries, while some countries now undergoing rapid development in Asia and Latin America are experiencing increases. For example, the ILO analysis showed that while the number of fatal and non-fatal workplace accidents held steady or declined in most regions, in China the estimated number of fatal accidents rose from 73,500 in 1998 to 90,500 in 2001, while accidents causing three or more days absence from work increased from 56 million to 69 million. Meanwhile, in Latin America, a rise in the total number of persons employed and growth in the construction sector, particularly in Brazil and Mexico, appear to have led to an annual increase in fatal accidents from 29,500 to 39,500 over the same time period.

"This is happening because in the newly developing countries workers are often coming out of the rural areas, with few skills and very little training in safe work practices," says Jukka Takala, Director of the ILO's Safework Programme. "Most have never worked with heavy machinery, and some have little or no experience with industrial hazards such as electricity, so they don't know how dangerous these things can be. Yet these are elements of the kinds of jobs that are available for low-skilled workers in rapidly industrializing countries."

"Once countries reach a more mature stage of development, there is a shift from construction to less dangerous service jobs and the accident rates begin to level off. We are seeing this now in the Republic of Korea, for example," Takala added.

The most common workplace illnesses are

cancers from exposure to hazardous substances, musculoskeletal diseases, respiratory diseases, hearing loss, circulatory diseases and communicable diseases caused by exposure to pathogens. In many industrialized countries, where the number of deaths from work-related accidents has been falling, deaths from occupational disease, notably asbestosis, is on the rise. Globally, asbestos alone is responsible for 100,000 occupational deaths per year. Meanwhile, in the agricultural sector, which employs half the world's workforce and is predominant in most underdeveloped countries, the use of pesticides causes some 70,000 poisoning deaths each year, and at least seven million cases of acute and long-term non-fatal illnesses, as stated in the assessment.

Improving the health of workers has led the ILO and WHO to cooperate closely on occupational safety and health issues. WHO helps countries to implement preventive strategies with a network of 70 Collaborating Centres, based on its Global Strategy on Occupational Health for All.

"Despite significant improvements in health and safety in many parts of the world over the past several decades, the global challenge of providing for worker health and safety is ever greater today," said Dr Kerstin Leitner, Assistant Director-General for Healthy Environments and Sustainable Development at WHO. "Significant and more long-lasting health gains could be achieved if greater emphasis were placed on effective policies and programmes for primary prevention. In many locations, particularly in developing countries, these are weak or virtually non-existent. From a public health perspective, prevention through safety measures is better and also less expensive not only to workers individually, but to the society at large."

The three cornerstones of WHO's occupational health work focus on supporting the development and implementation of occupational health policies and action plans to countries in strengthening surveillance, estimating the occupational health burden and in developing "basic" national occupational health profiles. Another key role is to build capacity through a network of WHO Collaboration Centres in Occupational Health making current information on various risk factors (chemical, physical, ergonomic, psychosocial, biological, accidents) widely available. Finally, WHO defines a minimum package of occupational health services that each country should establish with a focus on primary prevention.

The ILO also cited new data showing that in the construction industry, at least 60,000 fatal

workplace accidents occur each year worldwide - or about one death every ten minutes. About 17% of all fatal workplace accidents occur in this sector, while construction workers also face a number of health risks, including exposure to asbestos-laden dusts, silica and hazardous chemicals. In line with ILO conventions, recommendations and guidelines, the report pinpoints the need for better planning and coordination with regard to addressing safety and health issues on construction sites, as well as a greater focus on reducing work-related ill health and disease.

More generally, the ILO also predicted increases in the number of young people (age 15 to 24) and older people (age 60 and over) entering the workforce over the next 15 years, and warned that workers in these two age groups tend to suffer higher on-the-job accident rates. The report calls for the development of specially-tailored accident and disease prevention programmes for workers in these two age groups.

Special World Day commemorative activities and events are expected in more than 100 countries. Both the ILO and WHO are committed to promoting and strengthening increased cooperation at the national level between ministries of labor and ministries of health as well as businesses, workers' organizations and other civil society stakeholders.

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2. DAMAGE TO ECOSYSTEMS POSES GROWING THREAT TO HUMAN HEALTH

A new report shows that some 60% of the benefits that the global ecosystem provides to support life on Earth (such as fresh water, clean air and a relatively stable climate) are being degraded or used unsustainably. In the report, scientists working on the Millennium Ecosystem Assessment (MA) warn that harmful consequences of this degradation to human health are already being felt and could grow significantly worse over the next 50 years.

The Millennium Ecosystem Assessment (MA) synthesis report warns that the erosion of ecosystems could lead to an increase in existing

diseases such as malaria and cholera, as well as a rising risk of new diseases emerging. Worsening ecosystems will also affect the world's ability to meet the UN Millennium Development Goals (MDGs).

"Ecosystems are the planet's life-support system. They are fundamental to human health and indispensable to the well-being of all people everywhere in the world," said Dr Kerstin Leitner, World Health Organization (WHO) Assistant Director-General for Sustainable Development and Healthy Environments, and Member of the MA Board. "The work of the Millennium Ecosystem Assessment makes clear how ecosystems and human health are inter-twined - and further highlights how important it is that decisions related to economic development also protect the environment, in order to ultimately safeguard human health."

The links between environmental change and human health are complex because they are often indirect, displaced in space and time, and dependent on a number of modifying forces. There are two ways of avoiding disease and injury caused by ecosystem disruption. One is to prevent, limit or manage environmental damage; the other way is to find ways to protect individuals and populations from the consequences of ecosystem change.

"One of the striking and over-arching conclusions of this assessment lies in the fundamental need to ensure ecological sustainability to safeguard ecosystems and therefore protect human health in the long-term," said Dr Carlos Corvalan, a WHO scientist who contributed to the MA report. "Where ill-health is caused by excessive consumption of what the ecosystem provides such as water, food and energy, substantial reduction in consumption — and right of access to essential resources to marginalized communities — would have major health benefits."

The MA Synthesis Report is the first in a series of seven synthesis and summary reports and four technical volumes that assess the state of global ecosystems and their impact on human well-being. The study started in 2001 in response to a call by UN Secretary General Kofi Annan for global support of the MDGs. Some 1300 experts from 95 countries volunteered to conduct the study, while 900 served as reviewers and editors.

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3. MEASLES

Measles remains a leading cause of death among young children, despite the availability of a safe and effective vaccine for the past 40 years. More than half a million people, the majority of them children, died from measles in 2003 (the last year for which figures are available).

Measles is one of the most contagious diseases known. Almost all non-immune children contract measles, if exposed to the virus. Measles is an acute viral illness caused by a virus in the paramyxovirus family. As a respiratory disease, measles virus normally grows in the cells that line the back of the throat and in the cells that line the lungs. Measles is a human disease with no known animal reservoir.

Signs and symptoms

The first sign of infection is usually high fever, which begins approximately 10 to 12 days after exposure and lasts one to seven days. During this initial stage, the patient may develop coryza (runny nose), cough, red and watery eyes and small white spots inside the cheeks. After several days, a rash develops, usually on the face and upper neck. Over a period of about three days, the rash proceeds downward, eventually reaching the hands and feet. The rash lasts for five to six days, then fades. The rash occurs, on average, at day 14 after exposure to the virus, with a range of seven to 18 days.

Complications

Measles is often an unpleasant mild or moderately severe illness. Severe measles is particularly likely in poorly nourished young children, especially those who do not receive sufficient vitamin A, or whose immune systems have been weakened by HIV/AIDS or other diseases.

Children usually do not die directly of measles, but from its complications. Complications are more common in children under the age of five or adults over the age of 20.

The most serious complications include blindness, encephalitis (a dangerous infection of the brain causing inflammation), severe diarrhoea (possibly leading to dehydration), ear infections and severe respiratory infections such as pneumonia, which is the most common cause of death associated with measles. Encephalitis is estimated to occur in 1/1000 cases, while otitis media (middle ear infection) is reported in 5-15% of cases and pneumonia in 5-10% of cases. The case fatality rate in developing countries is generally in the range of 1 - 5%, but may be as high as 25% in populations with high levels of malnutrition and

poor access to health care. People who recover from measles are immune for the rest of their lives.

People most at risk

Un-immunized persons, especially young children, are at highest risk for measles and its complications, including death. Measles can also affect un-immunized older children, adolescents and young adults. All people who have not been immunized with vaccine or who have not acquired immunity through having experienced the disease can become infected.

Measles can be particularly deadly in countries experiencing or recovering from war, civil strife or natural disasters. Infection rates soar because damage to infrastructure and health services interrupts routine immunization and overcrowding in camps for refugees and internally displaced persons greatly increases the risk of infection.

Transmission

The highly contagious measles virus is spread by airborne droplets (circulating as a result of coughing and sneezing), close personal contact or direct contact with nasal or throat secretions of infected persons. Consequently, measles tends to occur as epidemics which may cause many deaths, especially among young malnourished children.

The virus remains active and contagious in the air or on infected surfaces for up to two hours. It can be transmitted by an infected individual from four days prior to the onset of the rash to four days after the onset. If one person has the disease, a high proportion of their susceptible close contacts will also become infected with the measles virus.

Treatment

Severe complications from measles can be avoided through proper clinical management. General nutritional support and the treatment of dehydration with oral rehydration solution are necessary. Antibiotics should be prescribed for treating eye and ear infections and pneumonia. To improve survival, it is important that children with measles receive adequate nutrition and fluids.

All children in developing countries diagnosed with measles should receive two doses of vitamin A supplements given 24 hours apart. Giving vitamin A at the time of diagnosis can help prevent eye damage and blindness. Moreover, vitamin A supplementation has been shown to reduce the number of deaths from measles by 50%.

Disease and mortality burden

While measles is now rare in many

industrialized countries, it remains a common illness in many developing countries. More than 30 million people are affected each year by measles. In 2003, it was estimated that there were 530 000 measles deaths globally; this translates to more than 1400 deaths every day; 60 people die every hour from measles. The overwhelming majority (> 95%) of measles deaths occur in countries with per capita Gross National Income of less than US \$1000. In countries where measles has been largely eliminated, cases imported from other countries remain an important source of infection.

Table 1

Estimated measles deaths, with uncertainty bounds*, by WHO Region (2003)

Africa Region	252 000 (48%)	[187 000 - 342 000]
South-East Asia Region	182 000 (34%)	[127 000 - 252 000]
Eastern Mediterranean Region	69 000 (13%)	[51 000 - 94 000]
Western Pacific Region	22 000 (4%)	[15 000 - 36 000]
European Region	5 000 (1%)	[3 000 - 7 000]
Americas Region	0 (0%)	[-]
TOTAL	530 000	[383 000 - 731 000]

*Based on Monte Carlo simulations that account for uncertainty in key input variables (i.e., vaccination coverage and case-fatality ratios)

The primary reason for continuing high childhood measles morbidity and mortality is the failure to deliver at least one dose of measles vaccine to all infants.

Prevention: a cost-effective, safe vaccine

Suffering, complications and death caused by measles can be easily prevented through immunization. The measles vaccine is safe, effective and inexpensive. It costs less than one US dollar (consisting of cost of vaccine, injection equipment and operational costs) to immunize a child against measles, making measles vaccination one of the most cost effective public health interventions available for preventing deaths. Measles immunization carries the highest health return for the money spent saving more lives per unit cost. The vaccine, which has been available for more than 40 years, costs about US \$0.30 per dose (\$0.15 for the vaccine itself and \$0.15 for the safe injection equipment) if procured through UNICEF (United Nations Children's Fund).

In many countries where the public health burden of rubella and/or mumps is considered to be important, measles vaccine is often incorporated with rubella and/or mumps vaccine as a combined, live, attenuated (weakened) Measles-Rubella (M-R) or Measles-Mumps-Rubella (M-M-R) vaccine. M-R

vaccine is about three times more expensive and M-M-R is about seven times the price of monovalent measles vaccine. Measles vaccine is equally effective whether in the monovalent or in the combined form.

Immunization coverage rates for measles vaccination vary significantly by region. The World Health Organization (WHO) and UNICEF estimate that the global average for routine measles immunization coverage was 77% in 2003. Lower measles vaccination coverage rates are reported from the African, South-East Asia and Eastern Mediterranean regions, those regions with the highest measles disease burden.

Global measles mortality reduction goals

In May 2003, the 56th World Health Assembly unanimously adopted a resolution (http://www.who.int/gb/EB_WHA/PDF/WHA56/ea56r20.pdf) to reduce measles deaths by 50% by the end of 2005 compared to 1999 levels. This goal was established a year earlier by the United Nations General Assembly Special Session on Children "World Fit for Children". The United Nations Millennium Declaration also set a child survival target: to reduce the under-five child mortality rate by two-thirds by the year 2015 compared with 1990 levels. Routine measles vaccination coverage is used as an indicator for this target.

WHO/UNICEF Comprehensive Strategy for Sustainable Measles Mortality Reduction

WHO and UNICEF have developed a joint Strategic Plan for Measles Mortality Reduction and Regional Elimination 2001-2005. The overriding goal of this Strategic Plan is to reduce the number of global measles deaths (from the 1999 level) by 50% by the end of 2005. The four-pronged Strategy for sustainable measles mortality reduction is based on providing all children with two opportunities for measles immunization during the first five years of life.

1. Strong routine immunization: The first dose of measles vaccine is given to children at the age of nine months or shortly thereafter through routine immunization services. This is the foundation of the sustainable measles mortality reduction strategy. At least 90% of children should be reached by routine immunization services every year, in every district.

2. A 'second opportunity' for measles immunization is provided to all children. This assures measles

immunity in children who failed to receive a previous dose of measles vaccine, as well as in those who were vaccinated but failed to develop immunity following vaccination (about 10 to 15% of those children vaccinated at nine months of age). The second opportunity prevents the accumulation of susceptible children to dangerous levels, since many older children have missed measles vaccination and have not been infected, so they are not immune. The second opportunity for measles immunization is given either through routine immunization services (if high coverage can be achieved and maintained over time) or through periodic supplementary immunization activities (SIAs). SIAs target large populations (entire nations or large regions) and aim to achieve immunization coverage of over 90%.

3. Surveillance Standard measles surveillance guidelines have been developed and implemented. Prompt recognition and investigation of measles outbreaks provide important information about program impact and assure the implementation of appropriate outbreak response activities.

4. Clinical management of measles cases is improved. This includes vitamin A supplementation and adequate treatment of complications, if needed, with antibiotics.

Priority countries

In their joint strategic plan for the period 2001-2005, WHO and UNICEF have identified 45 priority countries to target for implementation of accelerated sustainable measles mortality reduction activities. In 2000, these countries accounted for about 95% of global measles deaths; they are: African Region: Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, CTMte d'Ivoire, Democratic Republic of the Congo, Eritrea, Equatorial Guinea, Ethiopia, Gabon, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Mali, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, United Republic of Tanzania, Togo, Uganda and Zambia; Eastern Mediterranean Region: Afghanistan, Djibouti, Pakistan, Somalia and Sudan; South-East Asia Region: Bangladesh, India, Indonesia, Myanmar and Nepal; and Western Pacific Region: Cambodia, Lao People's Democratic Republic, Papua New Guinea and Viet Nam.

The Africa Measles Partnership

Launched in 2001, the Measles Initiative (www.measlesinitiative.org), is a long-term commitment to support governments of priority

African countries to reduce measles deaths in a sustainable manner. It focuses on providing life-saving measles vaccine to African children as part of global efforts to reduce child mortality. The core members of the partnership include the American Red Cross, the United Nations Foundation, the Centers for Disease Control and Prevention of the United States Health and Human Services Department, WHO and UNICEF. Each partner has a clearly defined role. WHO provides overall technical leadership and helps countries develop appropriate policies, strategies and plans for sustainable measles mortality reduction.

While the Measles Initiative is focused in Africa where the majority of measles-related deaths occur, partners also work on a wide-range of health initiatives around the world, including measles mortality reduction and strengthening vaccination services in other parts of the world.

Progress towards the 2005 measles mortality reduction goal

From 1999 to 2003, more than 350 million children globally received measles vaccine through SIAs. Moreover, improvements have been made in routine immunization over this period. These accelerated activities have resulted in a significant reduction in estimated global measles deaths. Overall, global measles mortality decreased by 39% between 1999 and 2003. The largest gains occurred in the African Region where measles deaths decreased by 46%. Given the progress made to date, it is expected that the 2005 global measles mortality reduction goal will be achieved.

Political commitment

Political commitment at all levels of government must be sustained if the measles mortality reduction goal is to be attained. WHO is supporting priority countries to fully implement the WHO/UNICEF recommended strategy for sustainable measles mortality reduction within their national immunization programmes. A district-level focus on achieving and maintaining high levels of vaccination coverage through routine services needs to be promoted in all countries. In addition, all children should be offered a second opportunity for measles immunization, either through routine immunizationservices or through periodic supplemental immunization activities.

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http://www.who.int/health_topics/measles/en/

4. ANIMAL TO HUMAN TRANSPLANTATION - FUTURE POTENTIAL, PRESENT RISKS

Transplantation of animal organs, living cells and tissues into humans is termed xenotransplantation. Recent experiments have shown that the transplantation of organs from genetically modified pigs into baboons can yield moderate to good results and this raises hopes for the future of organ transplantation from pigs to humans.

However these, along with existing claims of treatments for diabetes or neurodegenerative disorders such as Parkinson's disease, are still at a very embryonic phase. Apart from a few simple, established procedures such as the treatment of severe burns with human skin cells cultured with mouse cells, xenotransplantation today is only acceptable in very tightly controlled human trials.

An advisory group of international experts has recently met at the World Health Organization (WHO) to discuss progress made in xenotransplantation. The main objective of the meeting was to propose ways in which the health agency can assist countries to implement stronger policies to control the practice and enforce quality and safety measures while still promoting further research into its potential uses.

The main risk in xenotransplantation is the transmission of diseases. Many serious infections in human history have originated in animals. Once a new pathogen is introduced in one individual, it may spread to the larger population.

To manage that risk, several countries have developed rigorous guidelines and oversight procedures for the performance of xenotransplantation. However, xenotransplantation is also carried out in countries that lack such oversight and where materials and procedures used have not undergone any quality and safety controls. This means there is no proof of the quality of source animals and no monitoring of the recipient, leaving no guarantee of the safety of the procedures for the patient. The problem is globalized when individuals travel to a country where xenotransplantation has no adequate oversight. The WHO advisory group notes that any xenotransplantation performed in countries without adequate oversight poses unacceptable infectious public health risks and should be stopped.

International cooperation is clearly of paramount importance in the promotion of high standards for xenotransplantation across all regions. Without such oversight the efforts to minimize risks in some countries will be

undermined due to increasing numbers of people travelling to countries with less stringent laws.

The potential for such risks led the Member States of WHO to adopt a resolution addressing xenotransplantation in 2004. The resolution urges member States "to allow xenotransplantation only when effective national regulatory control and surveillance mechanisms overseen by National Health Authorities are in place."

The WHO advisory group and WHO experts have concluded that stronger measures need to be put in place by countries to stop the illegal performance of xenotransplantation and to promote harmonized quality and safety controls. To harness the real potential of this promising field, while minimizing the risks of unproven or misused practices, they have revised an action plan to assist Member States to implement the WHO resolution by:

- updating a compendium of guidelines and recommendations for national health authorities and regulatory bodies to deal with xenotransplantation;
 - o improving methods for the collection and dissemination of information on xenotransplantation practices - successes and potential risks;
 - o raising greater awareness among national health authorities and promoting high ethical standards and well regulated practices.

Guidance on xenotransplantation and its effective regulation is available from WHO at www.who.int/transplantation/xeno

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5. FIRST GLOBAL REPORT ON EFFORTS TO ROLL BACK MALARIA HIGHLIGHTS PROGRESS AND CHALLENGES

Burden of malaria still worst in Africa, but prevention and treatment reaching more people

More people are accessing prevention and treatment services for malaria, sparking hope that the number of people who become sick and die from malaria will begin to decline. However, challenges remain to reduce the burden of the disease which still kills one million people every year, most of those in Africa, according to the 2005 World Malaria Report.

The report released on 3 May 2005, by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), finds that

progress has been made in preventing and treating malaria since 2000. It finds that more countries are introducing the newest medicines to treat malaria, and that more people are receiving long-lasting insecticide-treated mosquito nets through innovative new programmes. The report analyzes malaria data collected through 2004 and represents the most comprehensive effort ever made to present the available evidence on malaria worldwide.

"Many countries are moving forward with malaria control programmes, and even those with limited resources and a heavy malaria burden now have a better opportunity to gain ground against this disease," said Dr LEE Jong-wook, Director-General of WHO. "However, proven interventions such as insecticide-treated nets, and the latest artemisinin-based combination therapies must reach many more people before we can have a real impact on malaria."

Due to the difficulties involved in gathering reliable information about malaria in most affected countries - and because those countries have intensified their efforts only in the past few years - it is too soon to measure the impact on illness and death of the recent expansion of malaria control strategies, the report states. A measurable effect should become apparent about three years after widespread implementation.

A number of countries are now engaged in intense antimalarial campaigns. In particular, more and more people are protected with insecticide-treated nets - a highly effective method of malaria prevention. In Africa, all countries reporting on nets collectively had a 10-fold increase in the number of insecticide-treated nets distributed over the last three years.

After a 2003 campaign to distribute treated nets in five districts of Zambia at least 80% of children under five were sleeping under the nets. A similar campaign across Togo in December 2004 succeeded in raising the overall percentage of households owning at least one treated net from 8% to 62%.

"At present malaria remains the infectious disease that takes more lives of children in Africa than any other - three times as many as HIV infection," said Ann M. Veneman, Executive Director of UNICEF. "If we are going to dramatically reduce child deaths in the next decade, we need to put more focus on combating malaria."

Countries where the former mainstays of malaria treatment, such as chloroquine, are no longer effective are also moving forward on new therapies. Since 2001, 42 malaria-endemic countries, 23 of them in Africa, have adopted artemisinin-based combination therapies recommended by WHO. These are the latest generation of

antimalarial medicines and the most effective treatment against falciparum malaria, the deadliest form of the disease. An additional 14 countries are in the process of changing their malaria treatment policy and 22 have embarked on home-care programmes which enable families and other caregivers to manage malaria.

The recent shortage of artemisinin-based combination therapies has hindered efforts to reduce the impact of the disease, but sufficient supplies to meet demand are expected to be available by the end of 2005, thanks to the combined efforts of UN agencies, other multilateral agencies, non-profit groups and corporations working together under the umbrella of the Roll Back Malaria Partnership.

The report finds that in 2003, some 350 to 500 million people worldwide became ill with malaria—a slight revision of the estimate of 300 to 500 million annual cases that WHO has used since 2000. The reasons for this difference are advances in data collection methods and increases in the world's population. Current methods do not allow for a more precise estimate, given that malaria is most often not diagnosed with certainty as well as the scarcity of reliable data from the communities where it occurs.

Halting and reversing the incidence of malaria by 2015 is a target of the Millennium Development Goals. The more immediate goal of Roll Back Malaria is to halve the burden of malaria worldwide by 2010. A major obstacle to achieving that goal, the report explains, is a lack of funds. The report estimates that US\$ 3.2 billion per year is needed to effectively combat malaria in the 82 countries with the highest disease burden. This year, US\$ 600 million was made available for global malaria control. WHO and UNICEF welcome the recent World Bank announcement of its plan to commit US\$ 500 million to US\$ 1 billion over the next five years, which will help more people get access to essential malaria prevention and treatment.

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6. WHO REPORT CALLS FOR NEW APPROACH TO SAVE LIVES OF MOTHERS AND CHILDREN

10.6 million children die before age five, and half a million women die in childbirth

Hundreds of millions of women and children have no access to potentially life-saving care with often fatal results, the World Health Organization (WHO) says in a report published in April 2005. The report says the resulting death toll could be sharply reduced through wider use of key interventions and a “continuum of care” approach for mother and child that begins before pregnancy and extends through childbirth and into the baby's childhood.

About 530 000 women a year die in pregnancy or childbirth, more than three million babies are stillborn, more than four million newborns die within the first days or weeks of life, and altogether 10.6 million children a year die before their fifth birthday, according to WHO's latest figures.

In ‘The World Health Report 2005 - Make every mother and child count’, WHO estimates that out of a total of 136 million births a year worldwide, less than two thirds of women in less developed countries and only one third in the least developed countries have their babies delivered by a skilled attendant. The report says this can make the difference between life and death for mother and child if complications arise.

‘Make every mother and child count’ is being launched on World Health Day, which shares the report's main theme. The event is being marked in many countries, with a major launch in New Delhi, India.

According to the report, almost 90% of all deaths among children under five years of age are attributable to just six conditions. These are: acute neonatal conditions, mainly preterm birth, birth asphyxia and infections, which account for 37% of the total; lower respiratory infections, mostly pneumonia (19%); diarrhoea (18%); malaria (8%); measles (4%); and HIV/AIDS (3%). Most of these deaths are avoidable through existing interventions that are simple, affordable and effective. They include oral rehydration therapy, antibiotics, antimalarial drugs and insecticide-treated bednets, vitamin A and other micronutrients, promotion of breastfeeding, immunization, and skilled care during pregnancy and childbirth. To reduce the death toll, the report calls for much greater use of these interventions, and advocates a “continuum of care” approach for mother and child that begins before pregnancy and extends through childbirth and into the baby's childhood. This in turn requires a massive investment in health systems,

particularly the deployment of many more health professionals, including doctors, midwives and nurses. "For optimum safety, every woman, without exception, needs professional skilled care when giving birth," the report says, adding that continuity of care for the newborn in the following weeks is vital.

"This approach has the potential to transform the lives of millions of people," says Dr LEE Jong-wook, WHO Director-General. "Giving mothers, babies and children the care they need is an absolute imperative."

The report focuses on those developing countries where progress in maternal and child health is slow, stagnating or has even gone into reverse in recent years. Within such countries, less than half of mothers and newborns receive care, but by no means the full range of what they need. Make every mother and child count is a wide-ranging study of the obstacles to health facing women before and during pregnancy, in childbirth, and in the weeks, months and years that follow for them and their children. It pays particular attention to the plight of newborns, whose specific needs have "fallen between the cracks" separating maternal and child care programmes.

It is being published in the "report card year" of the United Nations' Millennium Development Goals (MDGs), two of which are to improve maternal and child health drastically by the year 2015. The latest available data show that total public health expenditure for the 75 countries with the biggest problems amounts to US\$ 97 billion per year. The report calculates that this amount needs to be increased by an average of US\$ 9 billion a year for each of the next ten years in order to increase access to care in those countries to a level that would permit them to move towards and even beyond the MDGs.

Exclusion from maternal, newborn and child health care is a key feature of inequity as well as a crucial obstacle to progress towards the MDGs, the report says. The health of mothers and children "is at the core of the struggle against poverty and inequality, as a matter of human rights".

Lack of access to skilled care and to major obstetric interventions is the prime reason why large numbers of mothers in rural areas are excluded from life-saving care at childbirth. For example, in a study of 2.7 million deliveries in seven developing countries, only 32% of women who needed a major life-saving intervention received it.

More than 18 million induced abortions each year are performed by people lacking the necessary skills or in an environment lacking the minimal medical standards, or both, and are therefore

unsafe. As a consequence, 68 000 women a year die.

In many countries, "numerous women and children are excluded from even the most basic health benefits: those that are important for mere survival". Some countries, often the poorest, show a pattern of massive deprivation, with only a small minority, usually the urban rich, enjoying reasonable access to health care, while an overwhelming majority is excluded.

Among those left out, women and their children suffer most. "Being poor or being a woman is often a reason for being discriminated against, and may result in abuse, neglect and poor treatment, poorly explained reasons for procedures, compounded by views sometimes held by health workers that women are ignorant. The care that women are offered may be untimely, ineffective, unresponsive or discriminatory," the report says

The report adds that putting in place the health workforce needed for scaling up maternal, newborn and child health services towards universal access is the first and most pressing task. The extra US\$ 9 billion a year that is required to scale up maternal, newborn and child health includes US\$ 3.5 billion in additional costs for human resources. Making up for the huge shortages and imbalances in the distribution of health workers in many countries will remain a major challenge for years to come. WHO is currently assessing the need for a massive scale-up in the numbers of health workers of all categories, not just maternal and child care, in the coming decade. The human resources crisis relates not just to shortages of people but also to issues such as pay and working conditions. WHO is developing a series of policy actions for each of the areas covered in the report and is encouraging governments and other stakeholders to introduce recommended interventions and scale up maternal, newborn and child health programmes. WHO will monitor and evaluate progress in these programmes.

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7. NEW WHO PUBLICATION ON RISK FACTORS FOR HEALTH

The World Health Organization (WHO) estimates that 20 major risk factors are responsible for almost half of the approximately 57 million deaths that occur each year. The effects of risk factors on people's health is examined in detail in

the newly published 'Comparative Quantification of Health Risks'. It estimates deaths and disability from preventable causes of major diseases and compares the impact of 26 major risk factors for disease and injury to help policymakers and researchers compare health risks around the world.

Of the preventable risks studied, the WHO publication lists the top ten globally as: childhood and maternal underweight; unsafe sex; high blood pressure; tobacco; alcohol; unsafe water, sanitation and hygiene; high cholesterol; indoor smoke from solid fuels; iron deficiency and overweight/obesity. Collectively, they account for over 40% of the 57 million deaths that occur worldwide annually and one-third of global loss of healthy life years.

The publication is based on the findings of the project on WHO's Comparative Risk Assessment, which involved more than 100 international scientists and many WHO experts. For four years, the group collected data on 26 major, preventable exposures known to cause poor health or disability. "This publication provides a comprehensive analysis of the evidence for these health risks. It illustrates the demography of these risks, and clearly shows how they are a growing concern for every region of the world, including the poorest," said Colin Mathers, WHO scientist responsible for ongoing WHO assessment of the global burden of disease.

The preliminary findings of 'Comparative Quantification of Health Risk's' were used as a basis for WHO's 'World Health Report 2002—Reducing Risks', 'Promoting Healthy Life' which announced that healthy life expectancy can be increased by as much as nine years worldwide if

governments and individuals make combined efforts against the major health risks. People in poor regions of the world could benefit most. 'Comparative Quantification of Health Risks' builds on those conclusions, providing more detailed explanations of the risk factors' analyses, the results for all regions of the world, and the researchers' conclusions.

One major finding is that three chronic disease risk factors, tobacco use, raised blood pressure and raised cholesterol, are among the top ten causes of disease in all regions, including Africa. The analysis of these risks to health is continuing within WHO, including the WHO Global InfoBase, a data warehouse for chronic disease related risk factor information, and the world report on chronic diseases, 'Chronic diseases: A vital investment', to be released in October 2005.

'Comparative Quantification of Health Risks', a two-volume set, is published by WHO. The project was funded by the US National Institute of Aging. A CD-ROM with detailed tables on aspects of disease burden caused by these risk factors accompanies the volumes.

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