49. National data on coverage levels often hide important disparities among population subgroups, including issues such as gender, urban versus rural residence, income and ethnicity. Countries with similar levels of overall national coverage of interventions may differ substantially in terms of equity of coverage among population groups. Generally, intervention coverage is substantially higher among households with higher incomes. Countries that are bridging this equity gap include Bangladesh, Brazil, Egypt, Swaziland and Zambia.

50. Too few countries have adopted recent evidence-based policies to increase access to essential reproductive, maternal, newborn and child health interventions. Enhancing access to such health interventions has been challenged by limitations on the scope of health worker responsibilities in some countries. Among the 68 "countdown countries" (that is, those countries bearing the highest burden), for example, in only 26 countries were midwives performing seven life-saving tasks and in only 29 countries were community health workers identifying and treating children who showed signs of pneumonia. Twenty-two countries had adopted the International Code of Marketing of Breast-milk Substitutes[1] and 41 countries reported having a national plan with costings for maternal, newborn and child health. These data make clear the need for strengthening national policies and programmes in order to accelerate action for reproductive, maternal, newborn and child health.

51. The United Nations Secretary-General's *Global strategy for women's and children's health*,[2] endorsed by world leaders in September 2010, provides a platform for joint action to make the continuum of care for reproductive, maternal, newborn and child health a reality. The Strategy highlights relevant aspects of all health-related Millennium Development Goals. It recognizes the special vulnerability of pregnant women, newborn infants and adolescents. It calls for unity in support of country-led health plans for increased investment along with greater efficiency. Accountability is an important aspect of the strategy in which all partners have a role to play.

52. The Executive Board at its 128th session in January 2011 noted the present progress report.[3]

G. FEMALE GENITAL MUTILATION (resolution WHA61.16)

53. In response to resolution WHA61.16, the Secretariat is working with Member States, in collaboration with international, regional and national partners, towards the elimination of the practice of female genital mutilation. This report highlights progress since 2008, and the Executive Board noted this progress report at its 128th session.[3]

54. The Secretariat supported studies in several countries[4] on the practice of female genital mutilation, the aim of which was to collect information that would contribute to improving efforts to eliminate the practice. In addition, the studies provided information about the care for those girls and

[1] International Code of Marketing of Breast-milk Substitutes. Geneva, World Health Organization, 1981.

[2] United Nations Secretary-General Ban Ki-moon, *Global strategy for women's and children's health*. New York, United Nations, 2010.

[3] See document EB128/2011/REC/2, summary record of the twelfth meeting, section 4.

[4] Burkina Faso, Egypt, Gambia, Ghana, Kenya, Nigeria, Senegal, Sierra Leone and Sudan.

women who have undergone the practice. In eight countries across Africa and Asia, education and information initiatives targeted special groups at the community level and through the mass media.[1]

55. As at November 2010, laws criminalizing the practice of female genital mutilation exist in 20 African countries, and in several states of two additional countries.[2] Three countries have enacted such laws since May 2008: Egypt (in 2008), Uganda (in 2009), and Sudan. Egypt and Djibouti have strengthened existing laws and cases have been brought to court in several countries.[3] Furthermore, 13 countries that receive immigrants from communities where female genital mutilation is practised have introduced legislation against that practice.

56. Four countries in Africa launched national plans of action against the practice of female genital mutilation. Other governments issued public statements and improved the coordination of the response to the practice. Furthermore, nine European countries have developed plans of action. The European Parliament has adopted four resolutions on combating female genital mutilation, and in 2009 the European Union launched the "End Female Genital Mutilations" campaign.

57. Community interventions were carried out in 16 countries by nongovernmental organizations, governments and religious leaders, resulting in hundreds of communities publicly declaring their intention to discontinue the practice.

58. Intersectoral collaboration has increased. In 2008, the Regional Office for Africa conducted a mid-term review of the regional plan of action (for the period 1996–2015) on the elimination of the practice.[4] Collaborative programmes and funding partnerships were formed between key stakeholders, including organizations in the United Nations system, government ministries, nongovernmental organizations, safe-motherhood projects, community and faith-based organizations, and religious leaders. New cross-cutting collaborations were established in four countries: in Burkina Faso and Sudan legal and human rights issues were the focus; and in Ethiopia and Guinea the focus was regional networks with local governments, nongovernmental organizations and civil society institutions.

59. The Secretariat has updated its health-care guidelines for girls and women who have undergone female genital mutilation, and prepared multimedia material for the training of health providers.[5] Clinical guidelines have been adapted and used by five African countries. In-service training on the elimination of the practice and development of curricula for various health-care professionals on their role were reported from two African countries.

60. National helplines offering a support service to girls or women who have undergone female genital mutilation have been established in Egypt and are being set up in Djibouti.

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[1] Côte d'Ivoire, Djibouti, Eritrea, Ghana, Indonesia, Mauritania, Nigeria and Sudan.

[2] Benin, Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Kenya, Mauritania, Niger, Nigeria (13 states), Senegal, South Africa, Sudan (multiple states), Togo, Uganda, United Republic of Tanzania and Zambia.

[3] Including Burkina Faso, Djibouti, Egypt, Kenya, Senegal and Sierra Leone. Since 2008, new cases were brought before courts in the Netherlands and Switzerland.

[4] World Health Organization, *Regional plan of action to accelerate the elimination of female genital mutilation in Africa.* Brazzaville, WHO Regional Office Africa, 1997.

[5] *Female genital mutilation – mapping the evidence. Guidelines for health-care providers for curative and preventive work*. Geneva, World Health Organization, in press.

61. Furthermore, there is evidence that the proportion of cases of female genital mutilation being performed by health-care providers is increasing. A global strategy[1] to reverse this trend was developed by the United Nations family and intergovernmental and international professional associations.[2] The strategy is being promoted at regional and country levels. In addition, networks of physicians and professional organizations against female genital mutilation have been established in five countries.

H. STRATEGY FOR INTEGRATING GENDER ANALYSIS AND ACTIONS INTO THE WORK OF WHO (resolution WHA60.25)

62. The present report responds to the request in resolution WHA60.25 to report on progress in implementing the strategy for integrating gender analysis and actions, by providing an overview of the work of WHO since 2009.[3] An earlier version of this report was noted by the Executive Board at its 128th session in January 2011.[4]

63. A monitoring and evaluation framework was developed in response to the request to provide a biennial report on progress. Two stages of the framework, the baseline assessment[5] and the mid-term review,[6] were successfully implemented in 2008–2009 and in 2010, respectively. Results of the assessment and review are presented in this report, and reflect achievements in each strategic direction of the strategy for integrating gender analysis and actions into the work of WHO.[7]

PROGRESS BY STRATEGIC DIRECTION

Strategic direction 1: Building WHO capacity for gender analysis and planning

64. In terms of the Gender, Women and Health Network, progress includes an increase in the number of gender focal points in all WHO regions. Currently there are 112 such focal points.

65. The baseline assessment of the WHO gender strategy undertaken in 2008–2009 indicated that most (60%) WHO staff members who participated in the survey have a good knowledge of gender concepts. In contrast, almost 35% are applying gender analysis and actions to their work. WHO has

[1] *Global strategy to stop health-care providers from performing female genital mutilation*. Geneva, World Health Organization, 2010 and New York, United Nations Population Fund, 2010.

[2] The International Federation of Gynecology and Obstetrics, International Council of Nurses, International Organization for Migration, Medical Women's International Association, World Confederation for Physical Therapy, and the World Medical Association.

[3] For progress up to 2009, see document A62/23, section H.

[4] See document EB128/2011/REC/2, summary record of the twelfth meeting, section 4.

[5] *Gender mainstreaming in WHO: where are we now? Report of the baseline assessment of the WHO strategy 2010.* Geneva, World Health Organization, 2011.

[6] *The mid-term review of the strategy for integrating gender analysis and actions into the work of WHO.* Geneva, World Health Organization, in press.

[7] *Strategy for integrating gender analysis and actions into the work of WHO*. Geneva, World Health Organization, 2009.