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Family and community health

Annual progress report on achievements in the year 2000

Gender and Women's Health (GWH)[1]

1. WHO is mindful of the complex interaction between poverty, gender-based inequities, and violations of human rights, which continue to have negative impacts on women's health and complicate efforts to improve the health of women. In addition, while reproductive health continues to be central to the health of women for a considerable part of their lives – especially where HIV/AIDS is highly prevalent – global changes such as increasing life expectancy, reduced fertility, expanding economic opportunity and epidemiological shifts call for a broadening of the women's health agenda to incorporate issues of importance throughout a woman's life. Responding to this challenge, the objectives for the biennium 2000-2001 are:

- to frame a comprehensive policy on women's health;
- to generate and disseminate evidence on women's health issues, addressing neglected areas and emerging issues;
- to translate the evidence from research into a basis for action and advocate the incorporation of women's health concerns into national and international policies and programmes.

[1] Known as Women's Health until 22 December 2000.

2. Accordingly, the programme of work in women's health for the biennium 2000-2001 can be summarized under three headings:

Policy development

Study and systematic reviews of selected emerging and neglected issues

Translation of evidence into action and advocacy.

POLICY DEVELOPMENT

3. In the course of 2000, WHO worked to formulate a policy statement on women's health. This necessitated consultation with partners, including WHO's regions and other programmes. Discussions were held in the course of visits to regional offices, and a consultation was organized with regional advisers/focal points on women's health in October 2000. These efforts led to a draft policy document delineating key issues, identifying major challenges, providing data on the distinctive nature of women's health problems throughout the lifespan; the document seeks to formulate principles of work, and to generate a strategy for women's health. A key element in this policy is the inclusion of gender analysis focusing on the health of both women and men.

STUDY AND SYSTEMATIC REVIEWS OF SELECTED EMERGING AND NEGOTIATED ISSUES

4. Activities dealing with research and evidence have been guided by the need to address topics that are relevant to international discussions of women's health and interventions to improve it, and that complement ongoing work at WHO, either by providing a women's health perspective to activities and projects in other areas of work, or by dealing with important topics not covered elsewhere. During 2000, WHO undertook systematic reviews in the following areas:

(a) patterns in use of medications by men and women;

(b) women's health across the life span, with special attention to women's reported health at different ages and in comparison with men's reported health;

(c) access to and utilization of health care, and women's perceptions of health services;

(d) identification of indicators for monitoring women's health.

5. Work on these four issues is at different stages of progress. The project on patterns in use of medication is the most advanced. A study proposal has been prepared, partner institutions have been identified for the pilot phase (University of Massachusetts and University of Amsterdam), and research instruments have been developed and are being tested. During 2001 the study is being undertaken in four settings; preliminary findings should be available before the end of the year, and will be used to develop a protocol for a large comparative study in countries of both North and South.

6. A review of evidence related to women's health across the life span has been carried out. In order to complement work done in different WHO areas of work on adolescence, ageing and the life cycle, an

exploratory study of transition to adulthood in Africa has been undertaken; it is designed to identify the connections between health and other aspects of the life of adolescents, and to develop ways to incorporate local ideas into work on gender, adolescence and health.

7. Other activities are under way, to define the content of women-friendly health services; and to identify appropriate indicators of women's health. Regional inputs are important in view of the influence of locally defined factors on the construction of gender and on women's expression of health problems and their ability to take action to protect or advance their own health. A number of regional offices have carried out work on indicators and their experiences are being incorporated into plans of work.

8. Work has continued on the multicountry study on violence against women, which aims to build the knowledge base for policy and action. The project provides data on prevalence, determinants and related risk and protective factors and health consequences from a diverse group of countries. Work during 2000 included finalization of a core questionnaire, development of field manuals and data entry system and completion of training and data collection in Brazil, Japan, Peru, Samoa and Thailand. Formative research, translation and testing are under way in Bangladesh, Namibia and the United Republic of Tanzania. The second meeting of the expert steering committee of the multicountry study on violence against women, which was held in Geneva from 4 to 6 December 2000, reviewed progress of the study and agreed on recommendations for analysis, interpretation and dissemination of materials to ensure effective use of the findings. The yearly meeting of the country research teams documented and shared lessons learned and began work on analysis and preparation of country reports.

9. Research is also under way to measure the obstetric sequelae of female genital mutilation. A study has been initiated in six countries in Africa (Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan). The pilot phase is nearly completed and preliminary results are forthcoming.

TRANSLATION OF EVIDENCE INTO ACTION AND ADVOCACY

10. During 2000, a number of advocacy and public education activities took place. Several events were centred on combating female genital mutilation in the European setting, focusing on immigrant communities, and presenting examples of integrated and comprehensive approaches that bring together legal, health, and social strategies. This included a meeting organized by the European Parliament to raise awareness of female genital mutilation, promote its elimination and improve health care for women who have undergone female genital mutilation.

11. The main opportunity for diversified advocacy and education on women's health was in connection with the June 2000 United Nations General Assembly Special Session on Beijing +5 (UNGASS). During the preparatory meetings in March held by the Commission on the Status of Women and UNGASS in June, women's health and various other programmes from headquarters as well as the WHO focal points/regional advisers on women's health from three regions supported panels, workshops, and special events on topics such as women's mental health, women's health in rural development, violence against women, women and autoimmune diseases. WHO prepared 17 fact sheets in two languages on issues in women's health for distribution and discussion.

12. Efforts were directed towards the application of knowledge and evidence related to neglected or emerging issues in women's health. Building on past work, the activities on female genital mutilation were carried to the health sector and to the public through promotion and dissemination of technical and advocacy materials. The joint project with Reproductive health and research on deriving and disseminating

best practices for the prevention of female genital mutilation in Nigeria, Kenya, Burkina Faso, Ghana and Cameroon, which commenced in 1999, continued to evolve. A teachers' guide, a student manual and policy guidelines for integration of female genital mutilation content into nursing and midwifery curricula were field tested in Eritrea and Nigeria. A video "The road to change" was widely distributed to policy-makers, nongovernmental organizations and institutions especially in countries where female genital mutilation is still practised. The Regional Office for the Eastern Mediterranean received support for a workshop (Egypt, 6 to 9 March 2000) to assess the extent of activities to eliminate female genital mutilation in the Region and to identify the feasibility of integrating such activities into reproductive and family health programmes.

13. A number of collaborative activities bringing together regions and headquarters continued during 2000 and will serve as the basis for further efforts. These included work on the health impact of functional literacy and economic empowerment activities (multiregion case studies); work by the Regional Office for Europe on the health of minority women in Europe; preparation of a multiyear strategic action plan for the health of women in Europe and a study of women and tobacco in the developing world prepared by the University of Witwatersrand, South Africa.

14. In consultation with the committee for the Convention on the Elimination of All Forms of Discrimination Against Women, WHO is moving forward with formulation of guidelines for field staff working with Member States on preparation of information about women's health as input for the State Party report to the Committee. In November, working with UNAIDS and the United Nations Division for the Advancement of Women, WHO co-sponsored an expert group meeting on the HIV/AIDS epidemic and its gender implications in Namibia.

CHILD AND ADOLESCENT HEALTH AND DEVELOPMENT (CAH)

15. Child and Adolescent Health and Development seeks to ensure healthy growth and development from 0-19 years of age, enabling the young to develop to their full potential. In 2000, CAH continued its efforts to realize this vision through support for high quality research and development, systematic planning and support for regional and country activities, and the effective use of monitoring and evaluation. CAH has one of the largest programmes of research within WHO and has established mechanisms for rapidly translating research results into policy and practice.

16. CAH continues to strengthen catalytic linkages within WHO, organizations of the United Nations system, bilateral agencies, nongovernmental organizations, and foundations. It is through these partnerships that CAH is able to build capacity and extend the application of Integrated Management of Childhood Illness (IMCI) and adolescent health and development interventions.

17. CAH is leading the Organization towards a unified approach to promote and protect the health of children and adolescents. During 2000, an initial draft of a WHO-wide strategy for child and adolescent health and development was prepared in collaboration with all WHO regional offices. CAH established an international forum to generate new thinking on the strategy development. The first step in this initiative was the meeting of *FutureThink* in Geneva in November 2000, bringing together 15 child and adolescent health experts from all WHO regions for a discussion on future challenges, new or neglected areas of child and adolescent health and on research needed on emerging health issues.

18. As WHO focal point for the United Nations General Assembly Special Session on Children, CAH chaired the WHO intercluster and regional working group for the preparation of all health-related inputs,

and coordinated a review of progress towards World Summit for Children goals. The special session, scheduled for September 2001, will agree on an agenda for children and adolescents for the next decade.

19. Efforts to use the Convention on the Rights of the Child as a mechanism for improving child health moved forward with the preparation of status reports on 12 countries, and capacity-building workshops for WHO staff in the South-East Asia and European regions.

20. There are three main areas of activity directly targeting poverty and equity issues in which CAH has been involved during 2000. First, the department contributed to the global initiative to stimulate a massive effort against diseases of poverty, in particular HIV/AIDS, tuberculosis, malaria, childhood illnesses, and maternal conditions. Second, IMCI is one of the core interventions to improve health outcomes of the poor to be reviewed in the scaling-up cost analysis carried out by the WHO Commission on Macroeconomics and Health, and the department provided technical input to this ongoing analysis. Third, CAH contributed to consultations on health and poverty reduction organized within WHO and by partners.

21. The home and community environments in which children live are crucial to their health, growth and development. As a child grows through infancy, childhood and adolescence, the relative importance of the family, health care, and physical and social environments evolves. In this area, WHO focused on breastfeeding, infant and young child feeding, micronutrient intake through supplementation, child and adolescent development, care seeking for children and for newborns, indoor air pollution, planning the community component of IMCI, and promoting safe and supportive communities for adolescents. In 2000, key activities included the following:

- Nutrition-related work included the completion of a draft of a paper on the composition of human milk, and how it differs from animal and artificial milks; the issue of a document on HIV and infant feeding counselling: a training course for health care providers dealing with infant feeding in situations of high risk of HIV transmission which is being used in four countries; new research findings from India showed that zinc supplementation reduces diarrhoea morbidity in children and that high levels of mothers' compliance with supplementation can be achieved.

- Research on family responses to illness and health concerns found that (1) interventions to improve care seeking for neonates can reduce mortality, but they also require significant investments to improve the quality of available health services; and (2) rates of return for recommended follow-up at IMCI health facilities in Sudan were high, and there was a perceived improvement in the quality of services after the introduction of IMCI; communities renovated their health facilities at their own expense.

- A process for planning interventions to improve family practices for child health was agreed among partners in an interagency working group on household and community IMCI. Thirty-eight countries in all six WHO regions are currently implementing community activities for child health as a part of IMCI.

- Work on safe and supportive communities for adolescents continued, in collaboration with UNICEF, with the introduction in the European Region, of a Rapid Assessment and Response Guide on Especially Vulnerable Young People. A similar approach is being developed for the prevention of tobacco use in young people. In addition, *What about boys?* a series of four publications describing neglected issues in adolescent boys' health and development, was published and disseminated.

22. IMCI remains WHO's principal strategy for reducing childhood illness and death. By the end of 2000, more than 80 countries were implementing or beginning to implement IMCI; of these, 22 are introducing the strategy, 40 are in early implementation, and 19 are expanding. In total, approximately 25 000 health workers have been trained in IMCI, more than 8000 of whom are also trained in breastfeeding counselling. In addition, regional and country initiatives broadened IMCI to address child growth and psychosocial development (in the Americas and European regions), child abuse and neglect (in the European Region), and neonatal care (in the Americas and European regions).

23. CAH works to improve the delivery of health services for children and adolescents by developing and reviewing case management guidelines for clinical practice (including projects on addressing antimicrobial resistance), means of helping health care providers improve their skills, strengthening health systems (including referral and emergency care), and strengthening linkages between health facilities and the communities they serve. In 2000:

- Clinical research findings included: the administration of reduced osmolarity ORS to children led to an improved clinical response (reduced stool output, less vomiting and fewer infusions are needed) compared to children receiving standard ORS. There was rapid expansion of the research programme to address antimicrobial resistance. Both amoxycillin and cotrimoxazole provide equally effective therapy for non-severe pneumonia – irrespective of the choice of antibiotic; good follow-up of children is essential to prevent worsening of illness.

- Developmental efforts included progress on the development of IMCI guidelines for the clinical management of children with HIV/AIDS. In addition, a comprehensive set of materials for IMCI preservice training is nearing completion, and has been informed by the experience of medical and nursing schools in developing countries. Guidelines for child care in small hospitals without specialized staff were completed and are being disseminated. A tool to estimate the costs involved in the implementation of IMCI in a country or district was completed and field tested, and capacity-building has begun.

- On health services for adolescents: preparatory work for the global consultation on adolescent friendly health services included a literature review, two regional consultations, analytical case studies of outstanding initiatives in developed countries, and an overview of lessons learned in other areas. Adolescent-specific technical content was incorporated in a range of WHO standards and guidelines, including those for the management of sexually transmitted infections.

- All WHO regional offices had developed specific plans of action on adolescent health and development. Five regional offices have already developed, or are developing, regional strategies to support countries in planning national adolescent health and development activities.

24. Work on monitoring and evaluation focused on four specific areas: expanding the epidemiological base; monitoring and evaluation at country level; strengthening the evidence base for strategies and interventions; and monitoring of, and advocacy for, global goals.

- Experience was gained with the IMCI health facility survey in three regions; the tool is now being finalized. IMCI indicators have been incorporated into all major population-based and health facility instruments used in developing countries, to help ensure that ministries of health will have consistent and useful data on child health.

- The multicountry evaluation of IMCI effectiveness, cost and impact expanded its scope to cover eight to 10 countries. Early results from the United Republic of Tanzania indicate significantly better quality of care in IMCI districts than in non-IMCI districts.

- The first phase of the measurement project for adolescent health and development was concluded, having defined and applied a programming and measurement framework, identified a core set of protective and risk factors and how they can be measured, and expanded capacity among a network of participating sites.

REPRODUCTIVE HEALTH AND RESEARCH (RHR)

25. In Reproductive Health and Research WHO has set itself the overall objective to strengthen the capacity of countries to enable people to promote and protect their own health and that of their partners as it relates to sexuality and reproduction and to have access to and receive quality reproductive health services when needed. The primary focus of the work is on the three key areas of fertility regulation, maternal and perinatal health, and reproductive tract and sexually transmitted infections (RTIs/STIs).

26. Highlights of the work during 2000 are summarized below; greater detail about these and other activities can be found in RHR's *Annual Technical Report 2000*.

Research towards better reproductive health

27. Through the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), a part of RHR, WHO is at the forefront of international research in reproductive health and of translating results of research into effective policies and programmes. In fertility regulation, findings from the large prospective Post-marketing Surveillance of Norplant® study (more than 16 000 women followed up over five years) provide reassurance to policy-makers about the safety and efficacy of this contraceptive implant. The pregnancy rate among Norplant® users was similar to sterilization (0.3 and 0.2 per 100 woman-years, respectively) and the incidence of major health problems was low.

28. Access to the HRP-developed levonorgestrel regimen for emergency contraception is expanding. The method is now registered in over 40 countries and registration is pending in several more. The finding that the earlier the treatment is given the more effective it is has led to easier access through over-the-counter availability in several countries. A multicentre study in three Latin American countries (Brazil, Chile and Mexico) showed that emergency contraception was acceptable to the majority of people interviewed and reinforced the call on policy-makers to consider introducing the method.

29. Progress has been made in the development of an injectable contraceptive for men. In a multicentre efficacy study of a six-weekly androgen-alone preparation in China, no pregnancies occurred among 308 couples followed over one year. A 10-centre Phase III study involving 1000 couples is now being planned.

30. Several multinational trials in maternal and perinatal health have provided new information to policy-makers and programme planners. For instance, a randomized trial (about 24 000 women in Argentina, Cuba, Saudi Arabia and Thailand) evaluated a new antenatal care model which emphasizes effective tests, clinical procedures and follow-up activities distributed over four visits compared to the

"western" standard model. Providing routine antenatal care following the new model produced similar maternal and perinatal outcomes and may reduce cost.

31. Findings from a multicentre evaluation (18 000 women) of misoprostol for the prevention of postpartum haemorrhage led to the conclusion that systemic administration of oxytocin (10 IU) is to be preferred to 600 µg misoprostol (orally) in hospital settings where the active management of the third stage of labour is the norm. Further research is planned to investigate the use of misoprostol and/or oxytocin in non-hospital settings and of misoprostol for the treatment of postpartum haemorrhage.

32. A randomized trial in five Latin American countries evaluated a strategy to reduce unnecessary, non-emergency Caesarean section through the introduction of mandatory second opinion before the operation. The strategy contributed to a modest reduction of caesarean section in the 34 participating hospitals but not to the extent identified as of major clinical significance before the trial.

33. Research relevant to reproductive tract infections and sexually transmitted infections including HIV/AIDS continued to expand during the year. Condom acceptability was a central theme in several projects. In an initiative involving six southern and eastern African countries findings already available from one site (Kenya) affirm that effective condom use continues to be inhibited by: (i) its association with mistrust and "promiscuity"; (ii) conflict generated by religious messages opposing its use; and (iii) sexual norms, gender power imbalances, and women's reduced ability to negotiate protection.

34. Meanwhile, acceptability research in Thailand as part of new condom development suggests that the standard-sized non-latex condom was preferred to both the baggy non-latex condom and a standard latex condom. Experiments on the structural integrity of female condoms subjected to an *in vitro* disinfection, washing and relubrication protocol have shown that the devices were able to withstand the chemical challenges. However, there was evidence of a small increase in the number of condoms with holes. Additional research is under way to assess whether and under what conditions it is safe to reuse the polyurethane female condom.

Development of norms, tools, standards and interventions

35. Results of research supported by HRP and others, together with direct programmatic experience, form the basis of the normative materials and guidance developed for use by countries in their programmes and services. The document *Improving access to quality care in family planning – Medical eligibility criteria for contraceptive use* was revised to incorporate the latest scientific evidence on the appropriateness of contraceptive method use by women with selected conditions, and published in 2001. The first edition (1996), distributed in all six official WHO languages as well as Indonesian and Vietnamese, has been used by more than 50 countries in the preparation and revision of national service delivery guidelines for family planning.

36. Guidelines were developed to support the Integrated Management of Pregnancy and Childbirth (IMPAC). Particularly noteworthy in this context are *Managing complications in pregnancy and childbirth: A guide for doctors and midwives* (published in early 2001), and the *Essential care practice guide for pregnancy, childbirth and newborn care*, which was made ready for field testing.

37. In collaboration with UNAIDS the document *The female condom: A guide to planning and programming* was produced. Collaboration also continued with the Organization of International Standardization, Technical Working Group for Mechanical Contraceptives on the revision of the *International standard for male latex condom 4074*.

38. Together with several other areas of work and UNHCR, RHR developed *Reproductive health during conflict and displacement: A guide for programme managers*, a manual providing details on the programmatic issues that managers must address to assess and respond to changing reproductive health needs during each phase of conflict and displacement.

39. Two technical consultations were convened to provide guidance to policy-makers on the use of antiretroviral regimens for the prevention of mother-to-child transmission of HIV. A consultation to develop technical and policy guidance for health systems on the provision of safe abortion was also held.

Technical cooperation with countries

40. RHR has continued to refine its strategic approach to broadening choice and improving quality of care in fertility regulation and other reproductive health services. The strategic approach has three stages. Stage I focuses on interaction between users of services, available technologies and the service delivery system. In Stage II, research is conducted to test the recommendations of Stage I, aiming at improving the quality of care in service delivery. Stage III applies and disseminates the research findings generated in Stage II into policy development and planning for wider implementation.

41. In China, a Stage I assessment was carried out at the request of the State Family Planning Commission. Key themes that emerged from the assessment included, among others, the need to: (a) strengthen providers' capacity to provide all contraceptive methods available in the national family planning programme with improved quality of care; (b) reduce the number of different IUDs provided in the programme and improve aspects of care related to both their insertion and removal; and (c) strengthen the diagnosis and management of reproductive tract infections.

42. Stage II activities were completed in Bolivia and South Africa and continued in Myanmar and Zambia, while substantial progress was made with the development of Stage II action research in Ethiopia and the Lao People's Democratic Republic. In Bolivia, as a result of the Stage II work, family planning services have become more accessible and the number of new acceptors is markedly higher in participating health centres as compared to those not involved in the project. Major accomplishments of the Stage II project in South Africa include the inclusion of emergency contraception in the national programme and the development of a national family planning policy and service delivery guidelines, with the latter based on RHR's seminal publication, *Improving access to quality care in family planning – Medical eligibility criteria for contraceptive use* (see above).

43. Brazil represents the first country where the use of the strategic approach has progressed through all three stages. Initial interventions consisted, among others, in training and restructuring the roles of health providers, creating a referral centre for reproductive health, introducing depot-medroxyprogesterone acetate, instituting a new management information system and a system of supportive supervision, and developing community women's groups to participate in the planning and management of reproductive health services. In subsequent years, vasectomy and related reproductive health services for men were added and a reproductive health centre for adolescents was created. Although funding has ceased, many of the project initiatives and changes in service delivery continue. Because of the success of the interventions a number of states and municipalities have requested technical assistance to implement this approach in their locations.

Monitoring and evaluation

44. RHR has continued to provide leadership in the definition of reproductive health indicators, and has maintained global databases for several indicators, monitored progress towards internationally agreed goals, and developed estimates of the global burden of reproductive ill-health.

45. In July 2000, WHO convened the Second Interagency Meeting on Reproductive Health Indicators for Global Monitoring. Participants agreed that two HIV/AIDS indicators should be added to the existing shortlist of 15 global indicators for reproductive health monitoring. Since then, the available data have been compiled on the global datasets of the 17 indicators maintained by various organizations, and a "WHO toolkit" for collecting and using the indicators will be published in 2001. WHO continued to maintain databases of several key indicators. Jointly with UNICEF and UNFPA, global, regional and country estimates for 1995 were produced for the number of maternal deaths, maternal mortality ratios, and lifetime risk of death due to pregnancy.

46. The *Mapping best reproductive health practices* initiative, now in its fifth year, has continued to contribute to the pool of evidence on the effectiveness of reproductive health interventions. The *WHO Reproductive Health Library* (RHL), an annually updated, electronic review journal published by RHR is the main dissemination tool for this activity. In 2000, RHL No. 3 was produced in English and, for the first time, also in Spanish.

Reproductive health and human rights

47. The promotion of a rights-based approach to reproductive health at country level was launched through a pilot project as part of the Making Pregnancy Safer initiative in Mozambique. The review of health system requirements and clinical standards used in maternal and newborn health care provision is being reinforced by a human rights analysis involving mapping of laws and policies related to care, and attention to the human rights principles of equity, access and participation.

48. Data on key reproductive health indicators, such as maternal mortality and coverage of maternity care, were made available to the United Nations Human Rights Treaty Bodies which monitor countries' fulfilment of their human rights obligations. An analysis of indicators was also provided to guide the Committees' discussions on reproductive and sexual health.

Making Pregnancy Safer (MPS)

49. MPS represents WHO's contribution to the global safe motherhood initiative. The initiative operates at global, regional and country levels, working through national and international partners**.** The initiative focuses on health outcomes and on improving health systems in order to attain long-term, sustainable and affordable results in safe motherhood. This is dependent on the availability, accessibility and quality of maternal and neonatal care services. Therefore, efforts must be focused on strengthening the health system at all levels, including primary and first referral levels, and ensuring links between them.

50. Implementing the MPS strategy requires collaboration with other health programmes involved in various areas of work highly relevant to maternal health (e.g. HIV/AIDS; Roll Back Malaria (RBM); Nutrition; Child and Adolescent Health and Development; Blood Safety and Clinical Technology; Stop TB; etc.). MPS works with partners across sectors to build capacity and extend the application of key technical and health systems interventions necessary to improve maternal and newborn health.

51. MPS is an integral part of the scaling-up action against the diseases of poverty which has identified seven effective tools to control diseases in poor countries: DOTS, IMCI, RBM, Extended programme on immunization, IMPAC/MPS, and social marketing of condoms. It provides input to the ongoing analysis of the core set of interventions to improve health outcomes of the poor conducted by the WHO Commission on Macroeconomics and Health. The initiative will further focus on research and guidance to countries on ways to target resources for sustainable provision of priority maternal and newborn health interventions for the poorer and disadvantaged segments of the population.

52. The development of technical tools for maternal and newborn health is a critical component in the work of MPS at country level. The IMPAC guidelines continued to be developed and refined during the year. The document *Managing Complications in Pregnancy and Childbirth – A guide for midwives and doctors* was issued in a joint effort with the Maternal and Neonatal Health Project (JHPIEGO) and is endorsed by the World Bank, UNICEF, UNFPA, the Federation of Gynecologists and Obstetricians (FIGO), and the International Confederation of Midwives. The *Essential care practice guide for pregnancy, childbirth and newborn care* was made ready for field testing and *Midwifery modules* for teaching trainers essential midwifery skills was revised. Work also continued on a manual for newborn care. The IMPAC guidelines should assist with the establishment of evidence-based interventions necessary for the delivery of quality maternal and newborn care at different levels of the health care system. A planning guide to assist health care providers to improve their skills, strengthen health systems and ensure implementation of key maternal and newborn technical interventions is currently under development.

53. MPS advocates that additional resources must be secured for maternal and newborn health services at country level. The initiative fosters close partnerships at both global and national levels in building a consortium for reducing maternal and neonatal mortality. These efforts will strengthen involvement and coordination among partners in the implementation of national plans for maternal and newborn health. At the international level, contacts have been developed with a number of key partners in the field of safe motherhood, such as JHPIEGO, the averting maternal death and disability project (Columbia University), the Save the Mothers Fund project of FIGO, and the Saving Newborn Lives project (Save the Children). An international forum on maternal and newborn mortality reduction will be convened in 2001 in order to strengthen the international commitment and partnership for the Safe Motherhood Movement.

54. During the first year of its existence MPS (headquarters and regional offices) has focused efforts on understanding how best to provide technical guidance and support to regional and country activities. This has led to the identification of priority areas of work in some regions. MPS began work in 10 countries (five countries in the African Region and one in each of the other five WHO regions) and will carefully document lessons learnt so that experiences can be introduced into other countries. The 10 "spotlight" countries (Bolivia, Ethiopia, Indonesia, Lao People's Democratic Republic, Mauritania, Moldova, Mozambique, Nigeria, Sudan and Uganda) were selected by the regions according to pre-established criteria, such as high maternal mortality ratios, number of deaths, population size, political support and commitment to health sector reform. The technical support provided to these 10 countries is intended to increase national capacity in improving quality of care, equitable access and use of maternal and newborn health services, as well as improving family and community practices for maternal and newborn health. MPS assisted several of these countries in the development and/or revision of maternal and newborn health plans, within the context of the current health situation and of existing national health policies, social, economic and institutional realities.

55. The establishment of MPS national task forces is under way together with the identification of a focal point in each country. The task forces are being established within the ministries of health and will

be responsible for the coordination of the MPS initiative, as well as the coordination of partnerships. Many of the task forces will be part of already existing safe motherhood committees, in an effort to strengthen ongoing mechanisms and avoid duplication. In some countries, draft plans of action have been prepared that build upon the work already done within the context of safe motherhood.

56. Links with other partners have been established in some countries and work on adapting global guidelines for national purposes has started. Efforts will be made to identify the health systems requirements and review the design, implementation and sustainability of the key interventions. Special attention will be given to advising countries on how to obtain resources and how to sustain provision of priority maternal and newborn interventions for the poorer and disadvantaged segments of the population. MPS acknowledges that, given the wide range of field realities, countries must adopt different strategies to achieve lower maternal and newborn mortality. One or more selected countries will receive assistance to use health systems data in analysing their laws and policies with regard to access, utilization and quality of maternal and newborn health care. Special attention will be given to marginalized groups and populations identified to be in greatest need. A guideline for this approach is being prepared and will be rigorously field tested before its dissemination. One of the initiative's responsibilities will be to start a global dialogue on how to establish guidance to policy-makers on the delegation of clinical responsibilities to different levels of health workers.

57. An essential component of the initiative will be to monitor and evaluate progress of MPS programmes in each of the 10 "spotlight" countries. To this end, the initiative will develop indicators, and assist countries to strengthen their health information systems by generating the information needed to improve programming. Development of a tool to investigate maternal deaths and severe complications of pregnancy and childbirth is nearing completion and countries will be encouraged to assess its usefulness to monitoring the quality of maternal health care services.

HIV/AIDS (HIV)

58. WHO is responsible within the UNAIDS framework for supporting countries to improve health system responses to the HIV/AIDS epidemic. HIV/AIDS coordinates all WHO's HIV/AIDS/STI-related activities at headquarters, regional and country level. It facilitated and supported the activities of 23 departments at headquarters as well as the regional counterparts in the following strategic areas: health systems evidence based prevention and care; surveillance and monitoring of the HIV/AIDS response.

59. The key achievements are outlined below.

Global health sector strategy

60. At the heart of WHO's commitment to the global response to HIV/AIDS is the objective of ensuring that the health sector – particularly in the worst affected countries – is technically and institutionally equipped to play an effective role in the society-wide response to the epidemic. At the request of the Health Assembly, through international consultation with all its partners, WHO developed a draft global health sector strategy covering determinants of the epidemic, challenges to the health sector, effective interventions, scaling up of the response, people-centred approaches, strengthening of local health systems and international support. Regional consultations to discuss and revise the draft document will shortly be held, to be followed by a global consultation to finalize the document, which will be presented to the Executive Board in January 2002.

Prevention and care of sexually transmitted infections

61. HIV/AIDS continued to develop and disseminate a large number of guidance materials for the control of sexually transmitted infections (STI). The Global Strategy for Prevention and Care of STI was finalized, field testing completed and a report is in preparation. The *STI Management Guidelines* including treatment and flowcharts were prepared and will go for translation and printing shortly. An intercountry workshop on STI case management was held in the Regional Office for Africa to support country implementation. The STI surveillance guidelines were developed ahead of the International AIDS Conference in Durban and are currently being translated into French and Spanish.

Prevention of mother-to-child transmission

62. WHO has continued to monitor the rapid scientific progress in this area and to provide guidance to Member States for the design and implementation of programmes to prevent mother-to-child transmission (MTCT) of HIV with respect to efficacy, safety, feasibility and cost of implementation. At a technical review convened by WHO, the implication of the emergence of drug resistance in some women exposed to a single dose of Nevirapine during labour was reviewed. A WHO technical consultation reviewed drug-resistance data which resulted in a revision of WHO policy guidelines on the use of antiretroviral drugs for MTCT-prevention. Policies on infant feeding were clarified, in order to provide guidance to countries considering implementing MTCT-prevention programmes. It was recommended that the prevention of MTCT should be included in the package of care for women known to be HIV infected, and for their infants.

63. Work is under way to identify gaps in knowledge and research on infant feeding which will lead to a research programme designed to address how to make breastfeeding safer by HIV-infected women.

64. WHO's responsibilities in the area of MTCT are being scaled up: to provide technical support to and identify gaps in the global research agenda and promote research to address them; to develop technical norms and standards; to provide technical support for local action and capacity-building; to promote integration within health systems of interventions to reduce MTCT; to provide technical support to monitoring and evaluation of MTCT interventions; to review and disseminate information on scientific advances related to MTCT; to strengthen global surveillance of MTCT-related HIV trends; and to update drug policies and strategies in order to promote access to HIV-related drugs and essential supplies.

Care for people living with HIV/AIDS

65. WHO continues to promote comprehensive, long-term care for people living with HIV/AIDS to increase length and quality of life and as an entry point and vital opportunity for prevention interventions. With UNAIDS, WHO is developing a comprehensive HIV/AIDS care strategy. The cornerstone of this strategy is the essential care and prevention package, which itself will be grounded upon effective utilization of antiretroviral therapy. It includes components on: voluntary counselling and testing, prevention of mother-to-child transmission, prevention and care of STI, management of opportunistic infections, in particular tuberculosis, pneumonia, diarrhoea and fungal infection, blood and blood product safety, palliative care and psychosocial support, universal precautions including safe injection practices and protection/care of healthy workers, and HIV/STI surveillance.

66. Much effort has been devoted to high level advocacy for establishment of voluntary counselling and testing services everywhere in order to substantially increase the number of people who know their HIV status. Keeping HIV-negative people uninfected, preventing further transmission by those who test

positive, and getting care and support to all in need are three vital outcomes of VCT programmes. *Voluntary counselling and testing for HIV infections in antenatal care: practical considerations for implementation* was finalized in 2000 and will be integrated into a comprehensive package for health care workers in maternity settings.

67. In the area of treatment of HIV-related illnesses, WHO developed updated guidance on safe and effective use of antiretroviral drugs in resource-poor settings; participated in the development of global mechanisms for monitoring emergence of drug resistance; reviewed evidence and issued policy guidance on the use of cotrimoxazole; and developed guidance on the integration of HIV care into tuberculosis community care.

Access to HIV-related drugs

68. WHO continued to promote rational selection and use, adequate financial resources, reasonable pricing, and minimum health services in order to increase access to HIV-related drugs. With UNAIDS, it participated in intense negotiations with industry and price reductions were achieved for drugs produced by some companies. In partnership with UNAIDS, WHO lent its support to mechanisms such as generic competition, bulk purchasing, compulsory licensing, and local production within the provisions of the Agreement on Trade-Related Aspects of Intellectual Property Rights.

Blood safety

69. Through advocacy, policy guidance, training workshops and dissemination of training materials, WHO promoted and provided technical support for a highly cost-effective intervention. In 2000, a major project to assure quality management in blood transfusion was launched in the African Region and learning materials on appropriate use of blood were developed to promote the use of alternatives to transfusion whenever possible.

Surveillance

70. With UNAIDS, WHO provided up-to-date information on the levels of HIV infection and trends in the epidemic (reports in June and December 2000), continued its work on improving surveillance methodology, and supported countries in their surveillance activities. Guidelines on second-generation surveillance were developed and published in collaboration with UNAIDS.

71. At the end of 2000, the Director-General created the Department of HIV/AIDS, which builds upon – and supersedes – the HIV/AIDS/STI Initiative and is designed to significantly strengthen WHO's efforts to combat the HIV/AIDS epidemic. This area of work will identify essential elements of HIV/AIDS prevention and care for adaptation to diverse settings and will enhance WHO's activities in the areas of strategy, advocacy and partnerships and global and interregional coordination.

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