



World Health Organization

WHO/FRH/97.4
Distr.: Limited

Family and Reproductive Health

"A partnership of programmes"

Report of the Second Meeting of Interested Parties
Geneva, 17-18 June 1996



FRH
Family and Reproductive Health

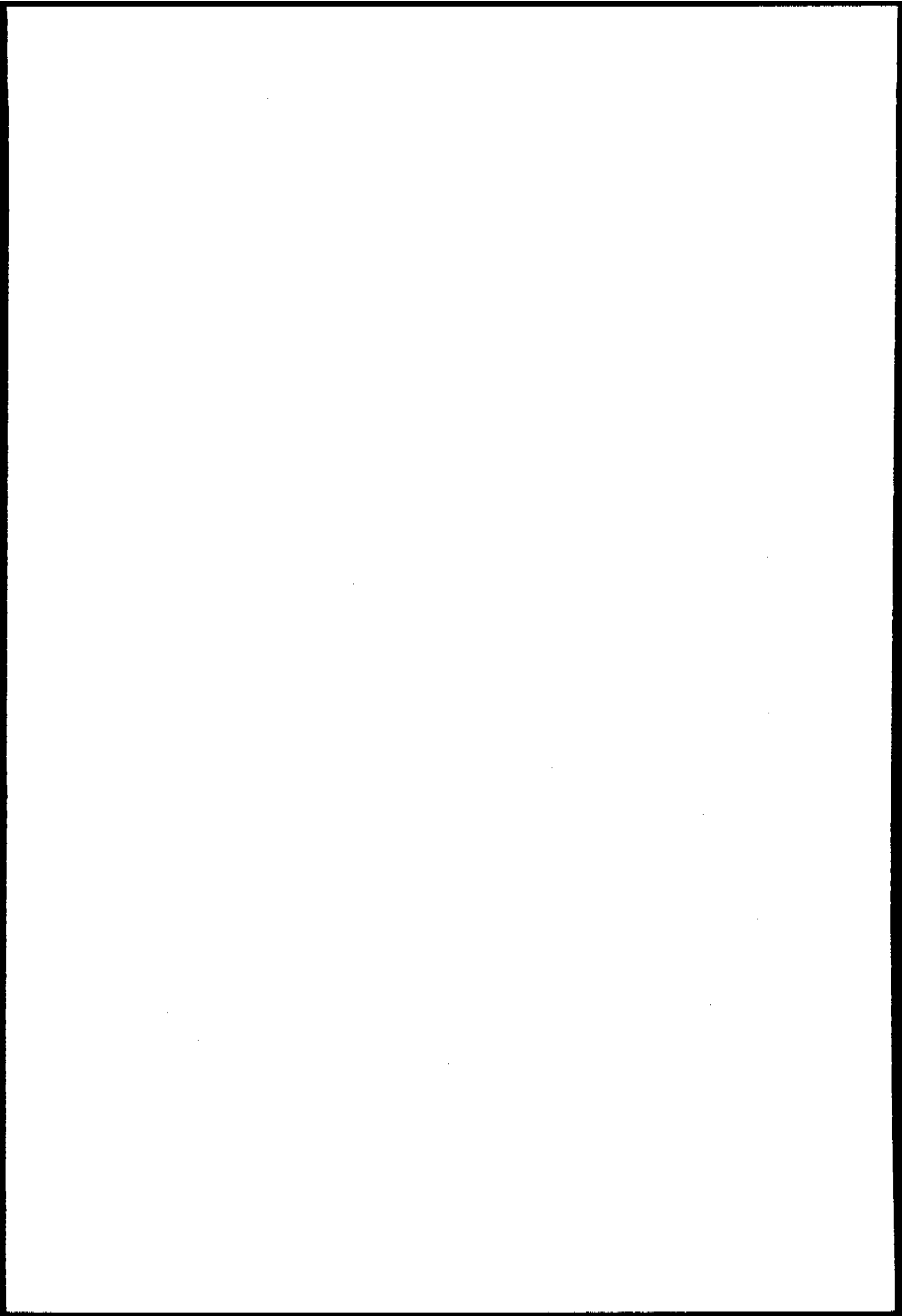
© World Health Organization

This document is not issued to the general public, and all rights are reserved by the World Health Organization (WHO). The document may not be reviewed, abstracted, quoted, reproduced or translated, in part or in whole, without the prior written permission of WHO. No part of this document may be stored in a retrieval system or transmitted in any form or by any means - electronic, mechanical or other - without the prior written permission of WHO.

The views expressed in documents by named authors are solely the responsibility of those authors.

CONTENTS

	Page
1. Welcome and opening of the meeting	1
2. Appointment of Chairman, Vice-Chairman, Rapporteur	1
2.1 Adoption of the Agenda	1
3. Report of the First Meeting of Interested Parties, 7-8 December 1995	1
4. An overview of the Family and Reproductive Health programme area	1
4.1 Discussion	4
5. Division of Child Health and Development	4
5.1 Introduction	4
5.2 Review of the Division's progress	4
5.3 Report of the first meeting of the CHD Technical Advisory Group (TAG)	9
5.4 Discussion	10
5.5 Financial report for 1994-1995	11
5.6 Revised programme budget for 1996-1997	12
6. Adolescent Health and Development programme	13
6.1 Introduction, objectives and accomplishments	13
6.2 Future directions	15
6.3 Proposed programme budget 1996-1997	16
6.4 Discussion	16
7. Women's Health and Development programme	18
7.1 Report on progress since December 1995	18
7.2 WHD's vision, aim and objectives and proposed activities	19
7.3 Staffing and budget	21
7.4 Discussion	22
8. Reproductive Health programme	23
8.1 Overview of WHO's Reproductive Health programme	24
8.2 Reproductive Health programme: proposed programme of work 1996-1997	25
8.3 Division of Reproductive Health (Technical Support): proposed programme budget 1996-1997	27
8.4 Special Programme of Research, Development and Research Training in Human Reproduction	28
8.5 Discussion	29
9. Discussion of the form, nature and responsibilities of the MIP	32
10. Concluding session	33
10.1 Concluding remarks	33
10.2 Closure	34



1. WELCOME AND OPENING OF THE MEETING

Dr Hu Ching-Li, Deputy Director-General ad interim, opened the meeting and welcomed all the participants on behalf of the Director-General, Dr Hiroshi Nakajima. He referred to the first Meeting of Interested Parties (MIP) held in December 1995. This had discussed an organizational change within WHO which would allow a more effective response to the needs of countries and to challenges in international health and development in the areas of reproductive health, child health, adolescent health and women's health. WHO's Executive Board of January 1996 and the World Health Assembly of May 1996 had endorsed the changes which involved bringing together and reorganizing, under an Executive Director for Family and Reproductive Health (FRH), three divisions dealing most directly with family and reproductive health. The resulting partnership of programmes would comprise a Reproductive Health programme with research and technical support components, a comprehensive Child Health and Development programme, an Adolescent Health and Development programme and a Women's Health and Development programme.

Since the MIP of December 1995 much progress has been made in learning to work together in developing and building upon collaboration among the programmes. MIP participants would be hearing of this during the meeting. WHO believed that the bringing together of divisions focused on the special health needs of children, adolescents and women, with a more comprehensive reproductive health programme which integrates research and action, would offer an unparalleled opportunity for targeted action at country level which would have cumulative benefits for people and health systems. The Organization looked forward to the continued support and collaboration of those countries and organizations represented at the MIP and invited comments on the programme plans that were to be presented in the coming two days.

2. APPOINTMENT OF CHAIRMAN, VICE-CHAIRMAN, RAPPORTEUR

Dr Fred Sai (Ghana) was appointed to the Chair, Ms Papineau-Salm (Netherlands) was appointed Vice Chairman and Dr Beryl Irons (Jamaica) was appointed Rapporteur. Participants are listed in Annex 1.

2.1 Adoption of the Agenda

The Agenda, which corresponds to the Table of Contents, was adopted without change.

3. REPORT OF THE FIRST MEETING OF INTERESTED PARTIES, 7-8 DECEMBER 1995

The report of the first Meeting of Interested Parties held 7-8 December 1995 was adopted.

4. AN OVERVIEW OF THE FAMILY AND REPRODUCTIVE HEALTH PROGRAMME AREA

The Executive Director for Family and Reproductive Health, Dr Tomris Türmen, began by pointing out that this was the first opportunity for the programmes within FRH to present their work in a common forum and for MIP participants to be able to evaluate activities as a whole. This MIP had intentionally been arranged immediately prior to the Policy and Coordination Committee (PCC)

of the Special Programme of Research, Development and Research Training in Human Reproduction (HRP) in order to encourage information sharing between HRP's governing body and the MIP with regard to all reproductive health activities within FRH.

Dr Türmen set out the events that had led to WHO's decision to create the new programme area of Family and Reproductive Health. She provided the rationale for developing a partnership of programmes that would together address the lifelong developmental needs of the whole person, promoting healthy behaviours and equity in access to quality health services.

Dr Türmen recalled World Health Assembly Resolution WHA48/10 which requested the Director-General to develop a coherent programmatic approach for research and action in reproductive health. In the process of consultation that followed, countries had stressed that the concept of Maternal and Child Health (MCH) should be broadened to address the evolving agenda in reproductive health. This implied addressing a wider range of issues, for example integrating, where appropriate, the prevention and management of reproductive tract infections (RTIs), including sexually transmitted diseases (STDs), and maternal health care and family planning services, and linking the treatment of childhood diseases with elements of child growth and development. It also implied meeting the needs of a broader constituency including young people, the unmarried, men as well as women, older women and the most marginalized sectors of society.

FRH consists of four programmes: a Reproductive Health programme which brings together research and technical support in reproductive health; a comprehensive Child Health and Development programme (CHD) focusing on management of childhood illnesses and child growth and development; an Adolescent Health and Development programme (ADH) which focuses on promoting the healthy development of young people in all areas of their lives including in sexual and reproductive health; and a Women's Health and Development programme (WHD) which focuses on gender issues in health research, policies and services.

The rationale for bringing these programmes closer together includes the interrelatedness of the components and the synergistic effects of dealing with them in an integrated way; the cumulative benefits of addressing problems at earlier stages of life; and a common, people-centred approach that optimizes opportunities to offer a range of services to the child, the adolescent and the adult woman or man.

A review of the work and experience of the programmes over many years enabled the identification of a number of common themes including the importance of behaviours and relationships as determinants of health; the need to empower families to protect and promote the health of their members; the importance of well-being alongside survival; the importance of addressing health needs across the life span; the limits of technology-driven approaches; and the value of integrated responses to country and individual needs.

Dr Türmen described the advantages that will result from closer integration of these programmes, particularly in terms of the further development and implementation of cost-effective, feasible and integrated approaches to health and development needs. Such functional integration at the level of WHO will permit more comprehensive and effective responses to the needs of countries for technical support. It will also serve to stimulate countries themselves in responding to the needs of individuals, families and communities in a more comprehensive way.

Increased collaboration across programme areas that were previously viewed as separate will be a challenge. It will require new ways of working and have implications for the way district health systems function, for the financing of public health interventions and for the way the public sector interacts with the private sector. FRH will establish particularly close working relationships with the WHO programmes whose primary responsibilities lie in working to strengthen health systems. This will involve looking into the impact of health sector reform on the funding and implementation of integrated approaches; ensuring effective decentralization of skills and competencies of providers together with the necessary logistic and managerial support; working more closely with the private sector, bearing in mind the importance of regulatory frameworks needed to ensure adherence to agreed norms and standards; and working with health economists to develop innovative ways of financing essential public health interventions in the area of family and reproductive health.

Dr Türmen stressed that she will seek to build upon the achievements of the programmes within FRH, preserving and strengthening the best while allowing room for growth and innovation in response to continually evolving needs at national and international levels. ADH and WHD, less visible in the past, will be given the resources they need to come more fully to the forefront of international health and development. In order to facilitate closer collaboration Dr Türmen will serve in a catalytic, facilitating and enabling role. She will be responsible for maintaining close linkages between all FRH programmes with the object of ensuring coordinated output while maximizing expertise and resources across FRH as a whole. Each programme will retain its specificity in terms of technical focus. The Reproductive Health programme will focus on fertility regulation, maternal and newborn health and prevention and management of RTIs. CHD will concentrate on reduction of infant and child mortality and on healthy child development, ADH on adolescent health and development, particularly in relation to sexuality, and WHD on gender perspectives, female genital mutilation, violence, women's participation and quality of care.

Dr Türmen presented suggestions for greater efficiency, such as grouping together some support functions common to all FRH programmes. These functions include advocacy; information dissemination, including document production and translation; and common clinical trials and informatics support.

She had presented the reorganization to the Technical Advisory Group of CHD and to the Scientific and Technical Advisory Group (STAG) of HRP. Both supported the approach taken by FRH. She would present FRH to HRP's PCC which would follow this meeting. Complementarity could be reinforced by bringing scientific and technical advisory groups closer together. One suggestion that would be presented to PCC was the possibility of having one STAG for the whole Reproductive Health programme.

Dr Türmen noted that FRH sees itself as a partner with a variety of multilateral and bilateral agencies, development banks and non-governmental organizations (NGOs) networking to provide better support to countries. A number of interagency mechanisms such as the United Nations Population Fund (UNFPA) Country Support Teams and the Inter Agency Task Force on follow-up to the International Conference on Population and Development (ICPD) already exist to strengthen such networking. FRH, a partner with technical expertise, would play its part in this web of country support.

Finally, Dr Türmen directed participants to the 3-page News Update which summarized the formal structure of FRH, the draft mission statement, guiding principles, objectives and anticipated outcomes. She welcomed inputs from participants.

4.1 Discussion

Meeting participants commended the Executive Director on the clear and informative presentation and referred to the high quality of background documents. Dr Türmen's aim of stimulating dialogue among FRH programmes, creating and building upon collaborative activities and making the best of existing strengths was viewed as of particular importance. Even if individual programmes are managed separately there is a need for integration at the operational level in order to have the desired impact in countries. Participants would therefore be looking for concrete examples of linkages and joint activities. Reference was made to difficulties that might arise in incorporating the delivery of comprehensive packages of reproductive health care in countries where there were currently several vertical programmes that may not easily become more integrated. MIP participants would also look for signs of programmes establishing clear priorities. They anticipated important discussions of the governance of the whole FRH area and the role and terms of reference of MIP. The plan to re-establish the steering committees specific to adolescent health and women's health issues was warmly welcomed.

Participants noted that much had been accomplished since the first MIP of December 1995 and especially welcomed the News Update which provided a clear and concise summary of the structure, vision and activities of FRH.

5. DIVISION OF CHILD HEALTH AND DEVELOPMENT

5.1 Introduction

The meeting considered:

- (a) a report of the progress of the Division on research, development, and implementation related to diarrhoeal diseases (CDD), acute respiratory infections (ARI), child growth and development, and the integrated management of childhood illness (IMCI), followed by the report of the first CHD Technical Advisory Group (TAG);
- (b) the financial report for 1994-1995;
- (c) the revised programme budget for 1996-1997.

5.2 Review of the Division's progress

Progress of the Division was presented by Dr Jim Tulloch, Director CHD. This presentation covered four main topics.

- i) Selected data on progress in reducing mortality among children under five years of age
 - The under-five mortality rate fell by 10%-60% in different regions of the developing world from 1980 to 1994. This demonstrates that progress has been made. But the progress has not

been uniform. Sixteen countries still had under-five mortality rates greater than 200 per 1000 live births in 1994; 15 were in Africa. While 36 countries in sub-Saharan Africa saw a decrease in under-five mortality rates between 1980 and 1994, in most cases this decrease was modest. Four countries actually saw an increase. Globally, forty-eight countries would need to increase more than three-fold (and half of these more than ten-fold) the rate of mortality reduction they have achieved since 1980 in order to achieve the World Summit for Children goals for the year 2000.

- Four diseases contribute to the majority of childhood deaths: acute respiratory infections, diarrhoea, malaria, and measles. When malnutrition is added to this list, these five conditions accounted in 1993 for 71% of all child deaths.
- ii) The overall objectives and priorities of CHD
- The primary objective of CHD is to reduce significantly mortality and morbidity among children. In order to do so, the Division gives priority to: diseases and determinants of ill-health causing the greatest burden in developing countries; interventions that directly affect health outcomes, that are cost-effective, and that are feasible on a large scale; and research and development to develop and test such interventions. The Division conducts research on interventions relevant to developing countries, develops practical guidelines and training materials, introduces and monitors the early use of these materials in countries, and evaluates their use and impact.
- iii) The progress of research and development in the 1994-1995 biennium, and of selected ongoing projects
- The biennial report of the former Division of Diarrhoeal and Acute Respiratory Disease Control (CDR) contains a 16-year retrospective account of research and development activities in CDD, ARI and IMCI. This report will soon be published as a separate document. In recent years, research and development have been coordinated by three working groups dealing, respectively, with case management in the home, case management outside the home and national programme management, and prevention. Since January 1996 there have been two working groups, one dealing with family and community practices, the other with health systems and programme management.
 - A meeting held jointly with the International Centre for Diarrhoeal Disease Research, Bangladesh in December 1994 concluded that use of reduced-osmolarity Oral Rehydration Salts (ORS) reduces stool output and the need for IV fluid. A multicentre study, jointly supported by the Applied Diarrhoeal Disease Research Project (ADDR), is now under way in six countries. This study will look at the benefit of reduced-osmolarity ORS in non-cholera diarrhoea in children, and the safety of its use in adults with cholera. The data collection will be completed in November 1996, with results to be available in 1997.
 - Also in collaboration with ADDR, the CDD programme has developed and tested an effective algorithm for the hospital management of persistent diarrhoea. This has now been adapted for outpatient use and is being tested; preliminary results show a 60% success rate after seven days. Two factors, poor compliance in taking micronutrients and fever, both increased treatment failure rate. The use of animal milk was not associated with increased risk of

treatment failure. A data analysis workshop will be held in November 1996 and results will be available in 1997.

- Research on ARI case management over recent years has focused on a few priority areas. A five-country study on the etiology and presentation of pneumonia, sepsis and meningitis in young infants has been completed, as have a study on the management of pneumonia in malnourished children and studies on oxygen delivery methods. Ongoing projects address the pharmacokinetics of antibiotics and alternative antibiotic regimes for the treatment of pneumonia. Antibiotic resistance is a major area of work and likely to continue to be so in the future.
- Work on the home case management of ARI continues to build on the use of the Focused Ethnographic Study and tools to test, adapt and apply the results. The tools developed will add to the range of materials available for the Behaviour Change Intervention Project being developed as part of IMCI.
- In addressing the prevention of disease, much of the Division's research has focused on improving nutrition, especially promoting breast-feeding and complementary feeding. Early work focused on descriptive studies; more recent research has been aimed at testing interventions. Examples from Guatemala and Peru show that factors leading to inadequate energy and nutrient intake were found to vary from one place to another, necessitating specially tailored interventions rather than standard approaches.
- A number of studies related to breast-feeding, carried out in Bangladesh, Guatemala, Pakistan and Peru reinforced the Division's commitment to breast-feeding counselling and enabled an improvement in these activities.
- In the area of micronutrient research, the Division's largest activity is a three-centre study examining vitamin A supplementation along with immunization to mothers, and to infants at 6, 10, and 14 weeks. In particular, the study looks at safety and the effect on diarrhoea and ARI incidence and severity, while sub-studies examine the effect on response to measles and polio immunization. Results will be available at the end of 1997. Other studies supported by the Division have examined the effect of vitamin A on diarrhoea and ARI in older infants. A 1990 study, reanalyzed in 1995, showed a significant impact, especially in non-breastfed infants, on both duration and severity of diarrhoea. Another area of micronutrient research is zinc supplementation. Preliminary results from a study in India show effects on severity and duration similar to those seen with vitamin A.
- Apart from research on nutrition, the Division's main area of interest in preventive interventions has been vaccines. A number of studies on rotavirus vaccine and various cholera vaccines are nearing completion.
- In the prevention of ARI, the most exciting news is the completion of the *Haemophilus influenzae* type b (Hib) vaccine trial in the Gambia. The vaccine was shown to have very high efficacy against proven Hib infection. Protection against definite Hib pneumonia in children who received two or three doses of vaccine was 100%, while protection against all invasive disease in children who received two or more doses was 93%. Other ARI prevention research includes a further review of the cost-effectiveness of pneumococcal and Hib vaccine,

preparation for a pneumococcal conjugate vaccine trial, and support to preparations for indoor air pollution intervention trials. Owing to budgetary constraints, the Division's support to this last item will be minimal.

- The Report of the Ad hoc Committee on Health Research and Development included an important figure which graphically represents the monumental mismatch between the disease burden and research spending for the two largest killers of children, diarrhoea and ARI. Taken together, these two represent 15.7% of the global burden of disease, whereas research on these conditions receives only 0.2% of the total health research spending.
 - By far the major undertaking of the Division in the past few years has been the development of an integrated approach to the management of childhood illness (IMCI). This activity has been a collaborative effort within WHO, with major contributions made by the Special Programme for Research and Training in Tropical Diseases, the Global Programme for Vaccines and Immunization, and the units of Nutrition and of Maternal and Newborn Health/Safe Motherhood. A number of other programmes also participated.
 - Through this collaboration, a pretest of the draft IMCI training materials was made possible in 1994, and the development of complementary materials was initiated. In 1995 a full field test of the IMCI training course for first-level health workers was conducted in Arusha, Tanzania, and the course was subsequently revised and finalized. This year the course is being introduced in selected countries, while a substantial research and development programme continues.
 - Other IMCI-related tools under development include guidelines for country-specific adaptation of the training course, guidelines for a workshop and on-the-job training on drug management in health facilities, guidelines and training materials for referral-level IMCI, a planning guide for interventions to change family behaviours in relation to child health, and guidelines for a health facility quality review.
 - With the evolution of CDR to CHD earlier in 1996, the newest area of research and development is child growth and development. An interdivisional task force on this topic was formed to outline future work in this area. A first step is a formal review of all existing information on interventions that affect growth and development. The terms of reference for this review have been defined, and the review should be completed in 1996.
- iv) Progress in the 1994-1995 biennium, and current and planned technical support to countries to assist them in implementing CDD, ARI and IMCI activities
- In 1994-1995 the Division's technical support to countries was oriented towards strengthened collaboration between CDD and ARI programmes and country-specific problem solving (leading to improving the quality of activities carried out). Attention was focused on countries with the greatest potential for mortality reduction. In addition, planning for early use and monitoring of IMCI in selected countries was started in collaboration with WHO partners such as UNICEF and the USAID project, Basic Support for Institutionalizing Child Survival (BASICS).

- Strong emphasis continues to be placed on training, particularly improving the quality of training, better training plans and supportive supervision. Preservice training and combined ARI/CDD training are being encouraged. Serious attempts are being made to monitor the quality of training. With quite stringent criteria, including adequate training duration, adequate practice, and an instructor-participant ratio of 1:4, many deficiencies have been reported. The Division will continue to explore ways to solve problems identified. Efforts to improve the teaching of CDD in medical schools has now involved 152 schools in 35 countries. This experience is currently being evaluated in three countries.
- Another dimension of technical support to countries is training in breast-feeding counselling, jointly developed with UNICEF. This course was used in 1994-1995 in 11 countries with the Division's support, and at least six other countries. Evaluation of the course is under way in Brazil.
- Communication skills are included in all diarrhoea, ARI and IMCI case management courses. The Division's guide to the effective use of radio was completed with UNICEF and USAID in 1994. In 1995 a group of consultants was trained in its use. Technical support to communication activities based on the use of WHO tools continues in a selected number of countries.
- Health facility survey results related to diarrhoea case management show an important increase from 1990 to 1995 in the proportion of cases correctly assessed and advised, reflecting training emphases by the Division.
- Twelve household surveys on the home management of diarrhoea and ARI show that, although a high proportion of diarrhoea cases receive increased fluids (62%), and even more receive continued feeding (76%), only about one-third of cases surveyed received both fluids and food. For ARI, although only 40% of caretakers could correctly state the reasons for seeking care for a child with an acute respiratory infection needing assessment, 75% reported taking appropriate action. The proportion of children receiving inappropriate or harmful drugs appears low (16%), however in absolute numbers this is still an alarming number of children receiving these drugs.
- Although changes in childhood mortality rates have been reported from many countries, few provide disease-specific data. A recent report from Bolivia shows that, with an overall reduction of 24% in under-five mortality from 1984 to 1994, the reductions were greatest for diarrhoea (37%) and ARI (26%), for which there have been the most active control programmes.
- IMCI technical support to countries for 1996-1997 will take place at three levels: first, full support for adapting, initial training, and monitoring of IMCI in six "early use" countries; second, the introduction of IMCI in large-scale health projects, such as those supported by the World Bank and regional development banks; and third, support to other interested countries by training consultants or national staff. Some countries will receive technical support from other sources, such as the USAID BASICS project. So far, 17 countries are preparing for the introduction of IMCI training. Many more have expressed interest.

- Of the six "early use" countries (Indonesia, Nepal, Peru, Philippines, Tanzania and Uganda), most have already held orientation meetings. All will hold their first training activities in 1996 or early 1997. Steps to introduce IMCI, exemplified by the process followed in Uganda, include an orientation workshop, the collection of outstanding data needed to inform policy, the adaptation of guidelines and training materials, and detailed planning of the first training course. The first course in Uganda is planned for August 1996; monitoring (including a health facility quality review) will be carried out over the next two years. The monitoring aims to obtain information on the IMCI course itself (to guide possible revisions), and on countries' experience in planning, adapting, and implementing the course. It will also serve as a basis for the development of programme management guidelines.
- Consultant training courses are being held in order to increase the capacity to support the introduction of IMCI training in countries. Two such courses have already been conducted. As in CDD and ARI training courses, IMCI training emphasizes individual feedback, active participation, practice with treating actual cases, and counselling.

5.3 Report of the first meeting of the CHD Technical Advisory Group (TAG)

Dr Alexander Muller (TAG Chairman) drew attention to some features of the discussions at the TAG, held in April 1996, and to the recommendations of the meeting. He noted that this TAG was made up of many members of the former CDR TAG, with the addition of two members representing the social sciences and child development. Emphasizing key recommendations, Dr Muller indicated that the TAG:

- was impressed by the quality of the biennial report 1994-1995, and complimented the Division on the outstanding accomplishments of 16 years of research and development work in child health. The TAG suggested that the review of this work should be published and distributed as a separate report, and a similar historical review should be carried out for implementation activities.
- recognized that IMCI is a much more complex approach than single disease programmes, and recommended that WHO endeavour to create the understanding among all partners involved that a long-term commitment is required to support the necessary research, development, and implementation efforts.
- was concerned about the lack of resources to support studies on indoor air pollution.
- supported the review of interventions affecting growth and development, and recommended that the bulk of the response to the new responsibilities in child health and development be focused on counselling activities to support and promote positive caregiver behaviour.
- congratulated the Division on its excellent record of achieving cooperation with other WHO programmes and recommended that these efforts continue.
- supported the development of the Health Facility Quality Review and recommended that the Division consider the possibility of devoting more attention to additional interventions that will contribute to health worker performance after training.

- supported the development of the Behaviour Change Intervention Project but deplored the lack of adequate resources to support this project.
- supported the initial implementation of IMCI in a limited number of countries, and urged the Division to caution countries against efforts that aim to achieve a rapid expansion of the approach without giving due consideration to requirements of creating national capacity for its implementation.

Dr Muller also informed the MIP of some more specific recommendations on research and development projects and on programme implementation. A full report of the TAG meeting was distributed to participants in the files for the MIP.

Dr Muller went on to report that the proposed budget for 1996-1997 represents a significant decline in funding levels and has compelled the Division to reduce its priority issues and activities. He expressed hope that the outcome of this MIP would lead to a more positive prospect for the future.

5.4 Discussion

A number of meeting participants intervened with comments and questions following the presentations of Dr Tulloch and Dr Muller, who provided the following clarifications and responses to questions raised:

- In response to the participants' concern with linkages between the Division and other programmes, within and outside WHO, it was stressed that linkages represent additional work for an already-stretched staff. Nonetheless, there are some good examples of linkages already occurring. A working group has been created to deal with issues around the first seven days of life. Another working group on child health in the home has been proposed involving a number of WHO programmes. This would deal with the promotion of health and the prevention of illness as well as home case management and care seeking. The Behaviour Change Intervention Project under development by CHD, which is aimed at the family, starts by identifying behaviours to be modified. This may also create opportunities to address gender inequity.
- The Division does not "implement" programmes *per se*, but rather supplies technical support in the form of guidelines and training materials to national programmes. Technical advice is offered as needed to assist countries to plan and introduce new approaches, and evaluate their use.
- The Division agrees that it is essential to involve senior paediatricians in decisions to implement IMCI. This involvement is foreseen in the orientation meetings, as well as in the process to adapt materials in countries. Senior medical staff may also be interested in a textbook based on IMCI, soon to be published by Oxford University Press.
- The Division will continue to support presently-functioning national CDD and ARI programmes, and in particular will assist in making a smooth transition from these programmes to IMCI.

- The focus on implementation continues to be on those countries where the need is greatest, and where there is potential for success. This leads to an emphasis on African countries, but as can be seen from CHD documents, countries from all regions are involved in implementation activities.
- "Caretakers" is a broad term, most often used to refer to mothers. The involvement of fathers is not excluded. The specific roles that could be played by fathers are likely to be addressed by the Behaviour Change Intervention Project.
- In the area of breast-feeding, the Division has shown success in getting others to take up financing and in supporting particular implementation activities.
- The Division is working hard to ensure that IMCI is included in World Bank-supported health projects and has seconded a staff member to work with the Bank for this purpose. The Division would be pleased if more bilateral agencies and missions were to pick up IMCI activities.
- The impact of armed conflict on children and child health is an important issue. CHD participated, along with other WHO divisions, in a larger United Nations study on this topic.
- The Division is maintaining its focus on the major life-threatening diseases of children. It is the responsibility of the Division to see that child health remains visible and remains a priority for WHO and for the international community.
- Prioritization of research issues was discussed at length at the recent TAG meeting. As in 1994, a decision was made to keep giving highest priority to clinical management research; nonetheless, prevention issues remain a large part of the Division's research agenda.
- The Division's research agenda has always been dynamic. When a topic has been sufficiently investigated, attention has been turned to new areas. However, sometimes it is necessary to remain with one question over an extended period of time in order to achieve an outcome of practical value for programme implementation.

5.5 Financial report for 1994-1995

Mr Robert Hogan, Programme Management Officer CHD, presented this item drawing attention to several points.

In response to a request from the extrabudgetary financial contributors to all WHO programmes, a common format has been developed for financial reporting, standardising the subjects, sequence, and conventions that will be used.

Total resources available to the Division during 1994-1995 were US\$ 36.7 million, including a carryover of funds from the previous biennium, WHO Regular Budget, extrabudgetary contributions, and interest on unallotted funds. This represents a decrease of US\$ 2.8 million compared to total funds available in 1992-1993.

The Revised Budget for 1994-1995, US\$ 33 million, represents a decrease of US\$ 413 000 (1.2%) from the original budget for the biennium. This revision involved a decrease of 10.4% in Research and Development, an increase of 2.9% in Programme Implementation, and an increase of 9.1% in Programme Management and Support. The reasons for these changes were discussed at the previous MIP.

Obligations for Research and Development were 25.7% of total budget obligations; Programme Implementation represented 64% of the total, and Programme Management and Support was 10.3% of the total. All three Research and Development working groups obligated significantly less for research contracts and development projects than was projected in the original 1994-1995 budget. This was due to four reasons: an uncertain and uneven cash flow, the extension of some R and D work over a longer period of time, the identification of some alternative funding, and the unforeseen complexity of some of the work planned. Obligations for implementation work remained at approximately the same levels as planned. Five staff positions were abolished during the biennium, but consultant costs increased.

Since 1978, a total of 38 countries and agencies have contributed to the Division. Of the 22 countries that contributed in 1992-1993, 19 continued to contribute in 1994-1995, and there were three new contributors. Although extrabudgetary contributions decreased slightly in 1994-1995 as compared to 1992-1993, they were still greater than in any previous biennium. Regular Budget funding has steadily increased over the biennia.

Despite some decreases in extrabudgetary support, continuous cash flow problems and funding uncertainties, overall financial support for the Division's activities has remained high. Conservative financial management in the last half of 1995 also enabled the Division to enter the new 1996-1997 biennium with a satisfactory carryover.

5.6 Revised programme budget for 1996-1997

The newly-developed budget for 1996-1997 reflects a reassessment of anticipated Regular Budget and extrabudgetary support. It also takes into consideration the reorganization of the Division's Research and Development structure, and the reduction of staff in headquarters and regional offices. Overall, the proposed budget is US\$ 5.7 million, or 18.6%, less than the actual obligations in 1994-1995. Nearly all of this reduction is in technical support to countries, and a significant part of this involves the abolition of regional posts. This is in response to the recommendations of the 1995 TAG meeting, which urged that other agencies be called upon to support implementation, and suggested that the Division's greatest strengths lay in its ability to carry out priority research and to develop guidelines for country use. Nonetheless, regional and country support still represents 42% of the 1996-1997 budget, compared with 48% in 1994-1995.

The proposed budget totals US\$ 25.1 million. Of this, US\$ 5.3 million is expected from the Regular Budget, which leaves US\$ 19.8 million to be financed from extrabudgetary sources.

The Division currently has a shortfall of US\$ 7.7 million. Estimates of probable contributions from current donors suggest that this shortfall will be made up and that there will be an appropriate carryover into the next biennium of US\$ 3.8 million.

The Division plans to try to raise additional resources, and has developed what may be called a "positive contingency" budget, listing the activities that could be added should these efforts be successful. One important item, the addition of staff to the Division, stems from the belief that recent budget cuts have left too few staff to carry out the already extensive list of planned activities.

6. ADOLESCENT HEALTH AND DEVELOPMENT PROGRAMME

In her introductory remarks Dr Türmen stated that WHO's Adolescent Health Programme (now renamed Adolescent Health and Development), despite its small size, has led the field in adolescent health. It has collaborated closely with other agencies and NGOs and its key contribution has been in the development of special methods for adolescent health appropriate for use in all cultures. Dr Türmen acknowledged the importance of UNFPA support to WHO's work in adolescent health, without which little could have been achieved. Scientific evidence, public health needs and the moral imperative to promote human development have all come together in ADH and its importance is reflected by the increasing demands from Member States for assistance in this area.

The meeting considered:

- (a) an overview of the objectives of ADH and what it has accomplished;
- (b) the proposed future activities of ADH;
- (c) the proposed programme budget for 1996-1997.

6.1 Introduction, objectives and accomplishments

Dr Herbert Friedman, Chief ADH, began by saying that this is an exciting and challenging time for adolescent health. Commitment to meet the health needs of young people is gaining momentum as countries recognize that it is in adolescence that key behaviours and relationships are initiated which have profound consequences, not only for young people, but for their future families and for the health of their societies for many years to come. The rapidly increasing number of governments, intergovernmental agencies and NGOs which are committed to policy and programming for adolescent health, attests to the progress made. It is a challenging time, because this increased commitment requires the highest quality technical support and the greatest degree of cooperation among all interested parties, if resources are to be used wisely, optimal impact achieved, and damage avoided.

Action for adolescent health in WHO began 20 years ago in the area of adolescent reproductive health. This was made possible by the sustained support and cooperation of UNFPA. The main thrust of ADH activities will continue to meet this need. The sexual maturation and reproductive health needs of adolescents is universal and one of the main changes which come with puberty. But adolescence, above all, is a period in which development is more rapid than at any other time apart from the neonatal period. Over the years we have learned that the best way to promote adolescent reproductive health is to promote adolescent health as a whole. WHO reflected this in the establishment of the Adolescent Health Programme in 1990. What we are learning now is that the best way to promote adolescent health will be to promote the physical, psychological and social development of adolescents of both sexes which underlies health behaviours and relationships.

i) Programme objectives

The overall objective of ADH is to promote the health and development of young people between the ages of 10 and 24¹ through support for the formulation and implementation of effective policies and programmes in Member States. This support has specific objectives:

- to expand the knowledge base for adolescent health and development. This includes an understanding of the meaning, parameters and status of adolescent physical, psychological and social health and development, and an understanding of specific action which will promote the health and development of adolescents in all societies;
- to advocate for policy and programming for adolescent health and development based on the most up-to-date knowledge, building on what exists to achieve effective and sustainable programming;
- to develop and adapt methods which will facilitate action in countries to better understand and meet the needs for adolescent health and development;
- to help expand human, institutional and material resources available in countries to promote the health and development of adolescents;
- to provide technical cooperation to countries and partners to ensure that knowledge, methods and resources for adolescent health and development are made available systematically and efficiently.

ii) Programme accomplishments

Creating consensus. Through close partnerships with other programmes in WHO, partners in the United Nations system - especially UNFPA and UNICEF - and NGOs, ADH has markedly influenced the content and structure of programming for adolescent health throughout the world.

Learning what works. ADH has identified, from research and programme experience, those practices which underly successful programming. These include:

- putting young people at the centre through their meaningful involvement throughout programming;
- addressing multiple health problems which have common antecedents and which benefit from similar interventions;
- combining interventions which create a safe and supportive environment for healthy development with those that prevent health problems; providing adolescents with information and building their skills; and providing adolescents with counselling and health services when needed;
- extending and linking interventions in various settings to meet the needs of young people in differing circumstances.

WHO defines "adolescence" as the second decade of life, from 10 through 19 years; "youth" from 15 through 24 years; and uses the phrase "young people" to describe those between 10 and 24 years of age.

Providing special methodologies. ADH has developed and adapted special methodologies for use in any culture to help create interest, assist understanding, and stimulate action in adolescent health. Among the methods used widely are those designed for planning multisectoral action, behavioural research, and training in counselling skills with special reference to adolescent sexuality and reproductive health.

Informing the field. ADH has produced more than 200 publications and documents in a variety of languages. Two of the most important recent publications are: "The Health of Young People: a challenge and a promise" and the joint WHO/UNICEF: "A Picture of Health? A review and annotated bibliography of the health of young people in developing countries".

Increasing human resources. Professionals from almost every country have participated in the many planning, research and training workshops and meetings held, or facilitated, by ADH. These have resulted in, among others, the first guides to the teaching of counselling skills; direct technical cooperation with, for example, the UNFPA Country Support Teams; the development of a regional course; and a joint WHO/UNFPA/UNICEF roster of health specialists in adolescents.

Technical input for country programming. Much of ADH's direct collaboration in country level activities has been through the development and application of research and programming tools. Now, as an increasing number of countries are ready to formulate adolescent health policy and/or are developing programming at the national level, there is a clear need for high quality technical support and cooperation among all agencies interested in facilitating programmes.

6.2 Future directions

Ms Jane Ferguson, Technical Officer ADH, began her presentation by noting that one of the hallmarks of ADH has been its broad approach to thinking about adolescent health. This has enabled the contributions of diverse professionals and organizations in defining the field and has yielded many possibilities for action. Now that there are other organizations supporting adolescent health, the need for ADH is to focus on a few areas rather than broadening into new ones.

New proposals for activities are being prepared, often with other organizations in order to make best use of the limited financial and human resources. Proposals vary in duration and resource requirements, but each contributes to country programming for adolescent health through concentration on one of three objectives:

- Extend the knowledge needed in areas of importance for country programming including greater elaboration of interventions, especially in the health sector and sectors related to the promotion of adolescent development.
- Increase the numbers of people with requisite knowledge and skills for planning, delivering and evaluating adolescent health programmes by enhancing the content, methodologies and mechanisms of training.
- Provide technical information and tools necessary to support country programming to scale, including the tools needed for assessment, target-setting, monitoring and evaluation.

6.3 Proposed programme budget 1996-1997

The confirmed funding for 1996-1997 stands at US\$ 908,000. An additional proposal under consideration by several donors, if approved, would bring the total to US\$ 2,366,700 for the biennium. Of this, 62% would be for current staff costs, the rest for activities. Some 90% of ADH funding has come from extrabudgetary sources. Activities are divided broadly into research and development, information and advocacy, and transfer of technology. All of these feed into the technical cooperation with countries and partners. Further proposals have been developed of which one, from the WHO/UNFPA/UNICEF Study Group of Programming for Adolescent Health, to be jointly executed by UNICEF and ADH, was distributed to some participants. ADH will continue to use the support it receives to underwrite activities of importance to several parties.

A single consolidated proposal for future activities was not presented, in part because of the several new proposals under active consideration by various donors. These proposals were available for review by MIP participants.

6.4 Discussion

ADH was commended on its catalytic role in the field of adolescent health and was urged to maintain its technical strengths. Participants acknowledged ADH's role in

- providing a conceptual framework for adolescent health
- advocating for the participation of young people
- building and disseminating the knowledge base
- providing tools for programming
- putting adolescent health on the international and country health agendas
- achieving technical consensus among agencies
- providing technical support to WHO's Regional Offices, to other UN agencies and NGOs.

There was agreement on the importance of adolescent health for public health and the need for greater resources. Attention should be given to the economic arguments for adolescent health. ADH was encouraged to continue its comprehensive approach while providing a clear focus for its activities. Questions were posed about which adolescent health issues were seen as crucial and therefore which interventions should have priority. A number of participants raised the need for better indicators of adolescent health, and for attention to the measurement of outcomes and outputs in order to assess and shape ADH's strategy and activities.

ADH was advised to maintain its strategy of maximum collaboration. It was noted that the new partnership of programmes in FRH provided expanded opportunities, especially in continuing the ADH focus on sexual and reproductive health and in relation to interventions for promoting equitable gender relations. School health approaches were also encouraged. Participants felt it important to preserve the key role of ADH in synthesizing experience, defining the evolving situation and providing normative guidance. Nonetheless, concentrating effort to support programmes in countries as a means to answer the outstanding technical questions was highlighted as critical in the years ahead.

Dr Friedman responded to specific issues as follows:

Priority health problems. While it is true that there are major differences from country to country, and among different groups within countries, some major issues emerge which are almost always of importance. These include adolescent reproductive health problems associated with pregnancy, childbirth, abortion, STD, HIV and AIDS resulting from too early, or unprotected, sexual relations; misuse of substances including tobacco, alcohol and other drugs; unintentional and intentional injury, including suicide; malnutrition - both under and over nutrition; and endemic diseases such as schistosomiasis, malaria and tuberculosis.

Priority action to address these problems. ADH has adopted and encouraged an holistic approach to adolescent health; adolescent health problem behaviours have common roots and are interrelated, as are the means of resolving them. An holistic approach does not mean that each programme does everything, but that, regardless of the entry point, the adolescent is treated as an individual, rather than there being a focus exclusively on a specific illness or injury. While an adolescent might seek health care because of a problem of substance abuse, this is likely to be associated with risky sexual behaviour. Both will have common roots in problematic social relationships and the adolescent's lack of skill and knowledge for dealing with such problems. The key to effectiveness is in linking related services and sectors, providing a true safety net at community level, so that the adolescent can be helped to understand and overcome these problems. Sound information, skills training, access to health services, and a safe and supportive environment, will serve to reduce the major adolescent health problems simultaneously. Training of staff is crucial for this purpose and facilitating the development of human resources is another key objective of ADH.

Impact and outcome measures and priority setting. There is a recognized need for better adolescent health and development indicators which will help establish useful baselines, inform programming and help in measuring programming effectiveness. There is also a need for greater specificity of interventions in programming. There are some inherent problems in the measurement of impact that are unlikely to be solved quickly. Environmental factors which influence adolescent health and development are considerable and make it more difficult to trace the impact of specific interventions. Measurement is difficult: adolescent pregnancy may be hidden or lost; young people who have been helped by a service may not come back; sensitive subjects such as sexuality or suicidal behaviours are notoriously difficult to assess. ADH is addressing this challenge. It is developing a guide for situation analyses and, as part of the proposed Common Agenda, hopes to accelerate adolescent health programming in a number of countries, utilising the Framework for Country Programming developed by the WHO/UNFPA/UNICEF Study Group. This should help address the current priority need for better indicators. This initiative will also help to meet the problem of limited resources since the country framework, with its multiple entry points for programming, provides considerable potential for extending the reach of interventions. At the same time, it will strengthen the complementarity of UN agency work within countries and reduce redundancy. These are the priority areas for ADH. The 16 outputs described in the background document for this meeting identify examples of some specific products.

Programme milestones. It is difficult to link a particular sum spent on a particular activity to its impact on helping countries develop programming and policies at national level. The rapidly increasing number of countries committed to adolescent health is the best milestone, and one which was aimed for quite some time ago. As better health indicators in countries are developed, ADH should be in a stronger position to help countries assess their programming effectiveness and at the

same time evaluate the degree to which WHO's normative inputs and technical cooperation are working.

7. WOMEN'S HEALTH AND DEVELOPMENT PROGRAMME

In introducing the new Women's Health and Development programme, Dr Türmen stated that women's health is necessary everywhere, especially in all WHO's programmes. WHO would like to see its women's health programme become stronger, to be in the forefront of the health agenda and a natural ingredient for all health programmes throughout the world.

The meeting considered:

- (a) a report on progress of work with WHO Regional Offices and WHO programmes and divisions since December 1995;
- (b) WHD's vision, aim and objectives and the proposed activities in three priority areas, namely:
 - the application of a gender perspective to health research, policies and programmes
 - violence against women
 - female genital mutilation.
- (c) staffing and budget.

Dr Claudia García-Moreno, Chief WHD, reviewed these topics except for female genital mutilation which was presented by Ms Efua Dorkenoo, Consultant WHD.

7.1 Report on progress since December 1995

- A meeting with WHD Regional Focal Points identified areas of common concern in which joint work is planned. These areas are the improvement of collection of data on women's health at country level, violence against women, and gender and health training. Regular annual meetings are proposed to discuss specific strategies for actions in countries, to share information and to assess progress.
- An FRH Gender Working Group has met regularly to develop joint activities mostly on reproductive health.
- WHD has identified priority areas for its own focus, based on most likely impact. WHD also plays a catalytic and complementary role in regard to other programmes. Its clear programmatic identity allows WHD to access information and participate visibly in programme-wide and WHO-wide discussions and decisions. WHD works closely with other programmes in FRH, particularly the Reproductive Health programme (for example, in working groups on indicators, abortion and methodologies for needs identification). WHD is on the Steering Committee for the Renewal of the Health for All Strategy and has contributed to WHO documents introducing gender and women's health issues, for example in the Guidelines for the United Nations Resident Coordinator system on Primary Health Care.

- WHD has nurtured and expanded collaboration with women's NGOs, in keeping with its objective to strengthen and support their participation in the design, implementation and monitoring of WHO and government health policies and programmes. A database of NGOs is being prepared with HRP. A joint meeting is being discussed with the International Women's Health Coalition to review experiences of involvement of women in the planning and implementation of health policies.

7.2 WHD's vision, aim and objectives and proposed activities

WHD believes that:

- women's health and development can only be addressed adequately through a participatory approach across all ages that enables women to take control over their lives and health;
- a gender approach can improve the effectiveness and quality of health services and interventions for women and men;
- it is essential to focus on the most disadvantaged and to work in partnership with other programmes within WHO, other agencies and with NGOs.

The overall aim of WHD is to contribute to the promotion and improvement of women's health and rights, and to the development of health programmes and policies that promote gender equity in health.

The objectives of WHD are to:

- develop sound technical bases for policies and actions on gender and women's health issues;
- foster the integration of a gender perspective into health research, policies and programmes in WHO and in countries;
- generate knowledge and test interventions to address specific, neglected or emerging women's health issues ;
- ensure the participation and strengthening of women and women's organizations in the design, implementation and evaluation of health research, policies and programmes;
- advocate for and disseminate information on the health situation of women nationally and internationally as well as within WHO.

WHD has two thematic dimensions, an over-arching one - to bring a gender perspective to bear on health research, policies and programmes - and a specific one - to increase knowledge and develop technical bases for policy and action on emerging and neglected women's health issues. These aims will be achieved by serving as a catalyst for action by all parts of WHO, by generating specific tools and materials, and by providing technical support to other programmes and to countries, in close interaction with women's health and rights organizations.

i) Integrating a gender perspective into health research, policies and programmes.

A gender perspective sheds light on the ways in which the social construction of women and men's roles interact with their biological differences to shape their health status and their access to health care and other resources to protect their health. Dr García-Moreno provided two examples to demonstrate how a gender approach to research, policies and programmes provides significant insights for practical prevention and control interventions.

The first example, on leishmaniasis in Colombia, showed how assumptions regarding transmission and sex-specific prevalence rates were biased. A study with a gender perspective identified that women had less access to treatment (even when locally available) and that transmission affected all household members, without preference for sex. The second example looked at how the discourse and action on women and HIV has developed over the last decade and identified gaps due to a lack of a gender perspective. Dr García-Moreno ended with a series of questions on gender issues that need to be addressed in HIV/AIDS policies and programmes. The challenge remains that of translating an understanding of the impact of gender inequalities on women's and men's health into interventions for change. More systematic research and practical tools are needed for this.

WHD will develop practical tools to help the health sector apply a gender perspective to the collection and analysis of epidemiological data, to health policies and programmes. These will include:

- a review paper and annotated bibliography on gender analysis in health;
- guidelines on gender and health for service-providers;
- a gender and reproductive health training course (jointly with the Women's Health Project in South Africa and the Harvard School of Public Health). This will identify practical and accessible examples of how a gender perspective can be applied to health planning and priority setting. The overall initiative aims to seed such courses in interested institutions over a four-year period.

ii) Violence against women

The WHD initiative is focused on the role of the health sector in the prevention and management of violence against women, including how health care providers can identify and respond appropriately to victims of violence, especially in resource-poor settings. WHD is an active member of the WHO Task Force on Violence and Health.

Since the December 1995 MIP, WHD has held a consultation on violence against women, with a focus on violence by partners/ex-partners. The meeting reviewed existing information, identified knowledge gaps and made recommendations. The activities proposed include:

- A multicountry study on the dimensions, health consequences and risk factors for violence against women in families, including particular attention on measurement of psychological and emotional trauma.

- Collaboration with the Health Policy and Development Project in Washington on the development and field-testing of a Manual on Research Methodologies for the Study of Violence against Women.
- Establishment of a global database.
- A review of existing interventions for prevention and management of the consequences of violence against women, with particular attention to their appropriateness and sustainability in resource-poor settings. WHD will convene a small meeting to review experiences with interventions against violence in health care settings by both governments and NGOs from Brazil, Ireland, Malaysia, the Philippines, South Africa and Zimbabwe.
- Preparation of advocacy materials including an information kit (to be completed towards the end of 1996) and collaboration with the joint WHO/FIGO Task Force to prepare a workshop on violence against women in August 1997.

iii) Female genital mutilation

Ms Dorkenoo presented a summary of the problem, including data from recent DHS surveys in Côte d'Ivoire and the Central African Republic which show a total prevalence rate of 43% of female genital mutilation in women in both countries. The planned activities, to be undertaken jointly with AFRO and EMRO, are as follows:

- A review of programmatic interventions for reducing the incidence of FGM. This will involve a broad review of known projects through questionnaires and country case studies of projects that have been well monitored.
- Basic epidemiological and social research, in collaboration with HRP, to improve and augment interventions. A protocol development workshop of potential investigators is planned. Existing data are being collected to assess their utility for more accurate estimates.
- Development of guidelines for the prevention and management of health consequences of FGM, with particular attention to aspects of psychosexual counselling and support for women and girls who have experienced FGM.
- Advocacy: A joint WHO/UNFPA/UNICEF statement is ready for publication and the FGM Information Kit is being updated to include new data.
- Continued provision of technical support to countries, NGOs and other agencies.

7.3 Staffing and budget

WHD currently has one full-time professional staff and three consultants. Another professional is assigned to a project in collaboration with Division of Emergency and Humanitarian Action on violence against women in conflict situations. In spite of limited resources, a substantial amount has been achieved. But WHD has been forced to be reactive rather than proactive and to operate on a project-by-project basis. In order to make a sustained impact and achieve long-term commitments additional professional staff and increased multi-year programme funds are required.

Dr García-Moreno presented the minimum budget needed by WHD for the activities proposed for the biennium. This was compared with the funds available to WHD for the present biennium. In summary, funds for the catalytic role of integrating gender issues into WHO activities are very few. The need to increase the understanding and appreciation of the process required to develop gender perspectives throughout WHO was highlighted. Funds are available for FGM and to a much lesser extent for violence, but are not sufficient for WHO to make a critical difference. Dr García Moreno highlighted the unique role of WHO among all actors to legitimize action on these highly taboo areas and to work on them with health professionals.

The choice presented to donors reflected the opportunity to build on the existing momentum to engage people within WHO and other organizations to take action on gender and women's health issues. A quantum leap could be made with modest resources. Finally, the meeting was reminded that donors, governments and WHO have agreed in recent international conferences that women's health and the promotion of gender equality require urgent action and that this will require financial commitment as well.

7.4 Discussion

A number of meeting participants complimented WHD on having successfully identified all the needs involved in addressing a very important issue and on having developed a coherent, targeted plan. It was considered important that WHO take on these very difficult issues and it was appropriate, given limited resources, to focus on the three priority areas of the integration of gender perspectives, violence against women and female genital mutilation. The fact that women comprise 50% of the world's population should be underlined and equality could only be achieved by paying more attention to this 50%. There was strong support for the emphasis on the integration of a gender perspective in WHO's work and the meeting highlighted the need for guidelines to combat a general gender bias in the health sector, not only to influence policies of WHO programmes, but also those of other agencies and of countries.

Given the considerable challenges and ground to be covered, some participants expressed the hope that WHO would be able to strengthen both the staffing and funds available to WHD for carrying out its work. Moreover, the limited resources lend importance to the need to avoid duplication of effort. In this regard participants welcomed the many indications of collaboration and complementarity of activities detailed by Dr García-Moreno.

The meeting noted that the World Health Assembly, at its meeting in May 1996, had adopted a Resolution that called upon the Director-General to report on the impact of violence on public health. The MIP felt that such a report should include the health implications of violence against women, including, possibly, the importance of the adolescent years.

Violence against women was seen as a social problem that can only be contained through intersectoral action beginning with an appropriate national legislative structure. Perhaps WHO could play a greater advocacy role for action by policy-makers in reducing violence against women and FGM in particular. Advocacy for the improved status of women would be a very positive contribution to those and other aspects of women's health. Activities in these areas presented clear opportunities for collaboration with others and Dr García-Moreno provided additional information on this. The work of WHD, for example, is complementary to activities of the Global Commission on Women's Health which is exploring work on legal aspects of violence against women, as well as

taking on advocacy for the promotion of the non-acceptance of such violence. One possible contribution by WHO, in collaboration with others, would be to collect data on the health consequences of violence against women. Collaboration is also under discussion with the UN Centre on Human Rights, while WHD is discussing violence against women in refugee and conflict situations with the newly-appointed staff member responsible for women's health and development in the UN High Commission for Refugees. Managerial guidelines for reproductive health care for displaced people are being developed in discussion with the United Nations High Commission for Refugees (UNHCR) and UNFPA under a grant from the Mellon Foundation. A project on care for victims of violence against women post-conflict is being initiated in Rwanda with Italian funding. Within WHO there is a natural linkage with ADH to identify feasible interventions for promoting equitable gender relationships.

MIP participants were particularly supportive of efforts to develop and test interventions to improve the capacity and ability of health care workers to deal with victims of violence against women and of FGM. In explaining the role of WHD in addressing preventive and curative dimensions of cervical cancer, Dr García-Moreno said that these matters were mostly under the responsibility of RHT, with which WHD was having discussions on developing simple factsheets on cervical cancer for women's NGOs.

Dr García-Moreno, responding to a call from several participants for an improved database which includes sex-disaggregated data, stressed that this was a major concern for WHD which was collaborating with WHO's Regional Offices on this issue. The aim was to collect and analyse sex-disaggregated data and use such data as a basis for the development of indicators for women's health.

8. REPRODUCTIVE HEALTH PROGRAMME

In her opening address to the MIP, Dr Türmen had stated that a Reproductive Health programme had been established in FRH which brings together research and technical support in reproductive health. The research arm of WHO's Reproductive Health programme is the cosponsored UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction. The Division of Reproductive Health (Technical Support) - RHT - complements the work of HRP in offering countries and other partners the guidance and tools they need to develop and implement equitable and cost-effective programmes that address priority reproductive health concerns. HRP, as a cosponsored programme, has its own governing body, the Policy and Coordination Committee (PCC) which would be meeting from 19-21 June. Since HRP's work and future plans were to be discussed at PCC, the MIP would focus on the overall plans for the Reproductive Health programme and the specific activities to be implemented by RHT.

The meeting considered:

- (a) an overview of WHO's Reproductive Health programme describing WHO's role in improving reproductive health, its aims, goals and priorities;
- (b) the proposed programme of work of the Reproductive Health programme for 1996-1997;
- (c) the proposed programme budget for the Division of Reproductive Health (Technical Support) for 1996-1997.

8.1 Overview of WHO's Reproductive Health programme

Dr Susan Holck, Director RHT, speaking on behalf of RHT and HRP, recalled that the December 1995 MIP had been presented with an overview of WHO's Reproductive Health programme which focused on a history of HRP and the then Division of Family Health, emphasizing that there were plans for the two programmes to work much more closely together. A brief sketch of the future programme of work had been presented. The MIP had requested more information to be made available to the present meeting including a programme of work which was outcome-oriented, an indication of the resources that would be needed to implement the proposed programme and a clear indication of complementarity with other partners in reproductive health.

During the past six months, in addition to continuing the ongoing work, the two divisions had worked together to produce such a programme of work which was outlined in the principal background document for the MIP. Dr Holck reiterated that the Reproductive Health programme comprised HRP, RHT and relevant activities of ADH and WHD, all of which had been active in reproductive health for many years. What was new in the document was that it presented a single common programme of work for WHO's Reproductive Health programme for 1996-1997, and complemented rather than replaced HRP's approved Programme Budget for the same period. Its aim was to provide a common framework for the work of WHO's Reproductive Health programme. Each division had explicit roles facilitating complementarity and streamlining working relationships. The method of work was evidence-based, making clear the steps that are involved in both the normative/technical support and research activities. In the document, MIP participants would be able to see indications of many ongoing and proposed joint activities.

In reviewing what people need to achieve reproductive health, Dr Holck referred to the importance of knowledge and the personal skills required to make best use of that knowledge. There was a need for an enabling environment that would permit people to act on their decisions and achieve their fullest reproductive health potential. Finally, access to quality health services in reproductive health is essential, with regard both to prevention and to care and rehabilitation. In responding to these needs, WHO's Reproductive Health programme would aim to improve people's access to the information and services they need, to widen the choices available to people, particularly to women, enabling informed choices and greater control over their reproductive health and lives, and to enable people to be active participants in the development and implementation of reproductive health strategies and programmes. WHO would encourage sound public health policies in reproductive health and promote national and international action for sustainable and effective reproductive health strategies.

The challenges in reproductive health are many and WHO would need to set priorities in deciding how best it can contribute. Among criteria to be used in this process would be the public health importance of the issue concerned which would clearly influence the anticipated impact, the availability of known cost-effective interventions or the likelihood that they can be developed, the potential impact of these interventions and WHO's core competencies. While applying these criteria, it would be important to acknowledge that, at the global level, the central elements of any reproductive health strategy must include meeting the needs of individuals and couples for fertility regulating methods of their choice, the reduction of maternal and newborn morbidity and mortality, and the prevention and management of RTIs, including those which are sexually-transmitted.

The Reproductive Health programme would work through an iterative process linking technical and normative work with research (represented in diagrammatic form in the reference document). Briefly described, the underlying principle upon which the work will be based is that research, norms and standard setting, and technical cooperation must derive from a rigorous and systematic scientific review and analysis of all available evidence. This systematic review, which involves both HRP and RHT, results in recommendations on international best practice for the issue in question and the development, introduction and evaluation at country level of the relevant norms, standards and guidelines. At the same time, the systematic review identifies the knowledge gaps and permits decisions on WHO's priority research agenda and support to research itself at the global and country levels. Experience gained through the technical support to countries and the information gathered through research feed into the pool of available information and the iterative, evidence-based, process continues.

Initial experience from applying the model to current and proposed activities showed that more emphasis should be placed on the central column where the majority of interactions between the two divisions would take place. This would likely strengthen both divisions, increasing their effectiveness.

The overall aim of the Reproductive Health programme would be to promote and support an expanded global effort to enable people to protect their own health as it relates to sexuality and reproduction and have access to, and receive, reproductive health services when needed. Four over-arching goals had been articulated with regard to healthy sexual development, maturation and relationships, the achieving of reproductive health intentions, and the avoidance of illness, disease, injury and disability relating to sexuality and reproduction.

8.2 Reproductive Health programme: proposed programme of work 1996-1997

In presenting the proposed programme of work for the Reproductive Health programme for 1996-1997, Dr Holck focused on the priority areas and those activities that were new, indicating goals and sub-goals, objectives and examples of outcomes. The proposed programme of work would address each of the four over-arching goals that had been presented to the MIP in December 1995, namely to ensure that people benefit from the necessary knowledge and skills, enabling environment, and quality health care services so that they can:

- Goal 1: have the capacity for healthy, equitable and responsible relationships and sexual fulfilment, and experience healthy sexual development and maturation;
- Goal 2: achieve their reproductive intentions - the desired number and timing of children - safely and healthfully;
- Goal 3: avoid illness, disease and disability related to sexuality and reproduction and receive appropriate counselling, care and rehabilitation when needed;
- Goal 4: avoid injury related to sexuality and reproduction, and receive appropriate counselling, care and rehabilitation when needed.

The background document prepared for the MIP gave details of the goals, the objectives for each goal and the planned outputs for each objective. Participants were asked to note that much of the work to be carried out under Goals 1 and 4 had been presented by ADH and WHD, respectively.

Given the time constraints Dr Holck, in her presentation, would refer mostly to work to be undertaken in addressing Goals 2 and 3 focusing on priority areas and those activities that are new.

Goal 2 includes five sub-goals. Sub-goal 2.1 is to enable people to decide if, when and how often to have children using family planning methods of their choice that are as safe and effective as possible. This is an area where HRP and RHT would work most closely together focusing on increasing choice, generating quality information and reducing unnecessary medical and other barriers. Outcomes would include new improved methods of contraception, more options for both women and men in choosing contraceptive methods, and up-to-date information especially on new methods and those for which new issues are emerging.

Sub-goal 2.2 relates to unsafe abortion, a major cause of mortality and morbidity among women in developing countries. All components of the Reproductive Health programme would need to collaborate in this work and the main focus would be on improving access to care for abortion-related complications and on reducing recourse to unsafe abortion. Examples of outcomes would include guidelines on ways to reduce barriers to care and more data on non-surgical abortion. A variety of countries and agencies will come together in a meeting to be organised by WHO in early 1997 to share experiences in this important area.

Sub-goal 2.3 concerns the promotion of the health of women in relation to pregnancy and childbearing, while sub-goal 2.4 addresses the need to reduce maternal mortality and morbidity. Efforts in this area will be considerable as WHO views it as the most neglected area of reproductive health. Almost 600,000 women die each year of pregnancy-related complications and maternal mortality indicators show the widest discrepancy of all health indicators between developed and developing nations. Little was known or done about this problem until the launching of the Safe Motherhood Initiative ten years ago. Experience since then in trying a number of approaches suggested that something different was needed from either the risk approach or a focus only on emergency care for complications. Strategies will include systematic reviews providing a basis for evidence-based action focusing on what works. The Reproductive Health programme will work closely with programmes in WHO responsible for strengthening health systems and for promoting health care reform. The strengthening of partnerships with other agencies, in particular UNICEF and the World Bank, will be required. The promotion of an expanded effort to reduce death and disability related to pregnancy and childbirth will be modelled on the approaches of CHD so that guidelines and other materials can eventually be used together.

The reduction of newborn mortality and morbidity was the topic of sub-goal 2.5 which will focus on better care for mothers and basic newborn care. This area closely relates to the work of CHD. Research on cost-effective interventions is an example of the likely outcomes of work in this area.

Goal 3 concerns the prevention and care for illness related to reproduction and sexuality. This is a new area of work for the Reproductive Health programme which will build on HRP's research on RTIs as they relate to infertility. The role STDs play in HIV transmission is well established and work on STDs will clearly call for close collaboration with UNAIDS and with other programmes in WHO, such as the Office of HIV/AIDS and Sexually Transmitted Diseases (ASD). Work will address the prevention of transmission and acquisition of RTIs including the iatrogenic infections caused by invasive procedures (especially unsafe abortion) and the provision of care for complications. The main aim will be to incorporate STD prevention and care into other reproductive

health services. Outcomes will include workshops for policy-makers and planners and guidelines on how to include STD prevention and care in family planning and maternal and newborn health services.

Cervical cancer is the most common cancer and a major cause of mortality among developing country women. Since cervical cancer is both preventable and curable if detected early, the focus will be on the development of simple and affordable technologies for diagnosis and treatment in resource-limited settings and the monitoring of the development (by others) of a vaccine against the human papilloma virus (HPV). Research by HRP in this area is addressing the relationship between oncogenic strains of HPV and hormonal contraception. Outcomes will include systematic review of technologies for diagnosis and treatment, and monitoring of the vaccine development.

Dr Holck referred to cross-cutting issues relating to all four over-arching goals. She stressed the broad advantages of the reproductive health approach which provides opportunities for the setting of priorities across components, making sure that the balance of services is appropriate. It also provides opportunities to link components when appropriate, for example STD prevention and care with family planning services. Member States were raising challenging questions in seeking advice in moving from the current provision of "vertical programmes" to a more integrated reproductive health care package. Examples were given of this. In addressing these issues, the Reproductive Health programme will focus attention on defining the minimal package of interventions and quality services and the associated costs, will attempt better to define the magnitude and costs of reproductive ill-health, and will encourage the integration of interventions and services where this is likely to be cost-effective and have clear advantages.

There were references to a variety of activities undertaken jointly between HRP and RHT and to those being undertaken in a collaboration between the Reproductive Health programme and UNAIDS.

8.3 Division of Reproductive Health (Technical Support): proposed programme budget 1996-1997

Participants were reminded that the Programme of Work, which had just been described, represents the combined effort of RHT and HRP with significant contributions from ADH and WHD. HRP's detailed programme budget had been approved in June 1995 by PCC and progress would be reviewed later in the week. The MIP would now be presented with the proposed programme budget (PPB) for 1996-1997 of the Division of Reproductive Health (Technical Support).

In preparing the 1996-1997 PPB, RHT had focused on the priority areas of work. RHT believes that the work outlined, though ambitious, could be done with existing staff provided that additional funds are made available for activities to the level indicated in the budget document. Much of the work is already under way, but progresses slower than it would if additional resources were made available. For example, RHT developed midwifery training modules but was unable to print and distribute them until recently when additional support was made available through specified funds from a bilateral donor. The STD work has not begun owing to a lack of resources.

The budget had been built by aggregating the costs involved in RHT's contribution to the achievement of each of the outputs described in the proposed Programme of Work. The first graph summarized the budget by programme goal and sub-goal. RHT would give highest priority to work on maternal mortality and morbidity (42%) since this is a relatively neglected area of work in

reproductive health and WHO has an important role to play. The second priority would be the cross-cutting issues (19%) where WHO has a comparative advantage in bringing together various components to answer general questions about reproductive health that had been referred to earlier. Family planning (12%) would involve work to complement HRP's research programme. Relatively less resources will be allotted to maternal health promotion (9%), neonatal mortality and morbidity (8%), reproductive tract infections (7%), unsafe abortion (4%) and infertility (less than 1%).

The second graph showed the budget breakdown by programme function. The emphasis was on the setting of norms and standards (36%) and technical cooperation with countries (24%). Policy-setting and management required in running the Division would take 19%, while advocacy and information would take 14% and research 7%. The third graph showed that WHO's Regular Budget would contribute some 14% of the \$9.5 million needed to implement the work proposed, while 86% would have to come from extrabudgetary funding.

8.4 Special Programme of Research, Development and Research Training in Human Reproduction

The Director of HRP, Dr Giuseppe Benagiano, emphasized HRP's commitment to a successful partnership with other programmes in FRH in improving family and reproductive health. He also stressed that fruitful collaboration with the other programmes had long preceded the establishment of this new programme area.

HRP had played a significant role prior to the ICPD meeting in establishing and defining the concept of reproductive health and its component parts. In recent months HRP had been an enthusiastic partner with others in FRH in further defining WHO's role in meeting reproductive health challenges. There would be an equal partnership with RHT in implementing the activities that had been described by Dr Holck to address the four over-arching goals of the Reproductive Health programme. HRP's own conceptual framework, in which its four main goals are interlinked with five strategic Programme components, has an inherent adaptability which allows easy expansion in response to changing research challenges.

The full programme of work pursued by HRP was to be reviewed at the PCC meeting of 19-21 June. In summary, work had continued in eight major areas:

- surveying reproductive health;
- assessing and improving reproductive health services;
- responding to gender considerations and people's needs;
- expanding family planning options;
- evaluating the long-term safety and efficacy of family planning methods;
- increasing male responsibility in reproductive health;
- developing new methods of fertility regulation for women;
- helping countries to address and resolve regional and national research priorities in reproductive health.

The partnership with RHT, ADH and WHD was fundamental to the continuation of this work.

Dr Benagiano then highlighted five important areas in which HRP works together with its partners in FRH. These are:

- the development of reproductive health indicators;
- research on maternal mortality and morbidity;
- the identification of new medical eligibility criteria for contraceptive use;
- introduction and transfer of new, or under-utilized, reproductive health technologies;
- research on adolescent reproductive health.

He reviewed in more detail two of these joint activities, namely the development of indicators and research on maternal mortality and morbidity.

Dr Benagiano ended by reiterating HRP's commitment to its role in the Reproductive Health programme, while maintaining and strengthening its links with the other cosponsors, namely the United Nations Development Programme (UNDP), UNFPA and the World Bank.

8.5 Discussion

The presentations on the Reproductive Health programme, on RHT and on HRP, were received very warmly by MIP participants who felt that WHO had made a major step forward in clearly defining a comprehensive WHO agenda in reproductive health that encompasses the different elements of reproductive health defined at the ICPD in Cairo in 1994. Several long-term providers of extrabudgetary funding to WHO's reproductive health programmes felt that concerns and questions about the reorganization of reproductive health activities in WHO had been addressed adequately and the complementarity of the activities in reproductive health to be undertaken by the component programmes of FRH had become clear. The emphasis on certain aspects of reproductive health, especially the much neglected issues of maternal morbidity and mortality and the efforts to reduce unsafe abortion, was welcomed by several participants.

The constructive collaboration and cooperation between HRP and RHT, as expressed in the diagram illustrating process and products, was to be welcomed, although the division of responsibility for some research activities was still not entirely clear. Since HRP's activities are focused on fertility regulation and only 7% of the budget for RHT is allocated to research, there may be significant areas of reproductive health not being addressed through research. For Goals 1 and 4, no specific funds were allocated under the Reproductive Health programme on the understanding that the work will be covered in the ADH and WHD programmes. These two programmes, however, had already indicated that they were able to provide only seed funds. In this circumstance, it was important to identify where responsibility would lie in addressing the important issues included in Goals 1 and 4 and there was a danger that many would not be addressed at all if there were not adequate funds.

Dr Türmen, in responding to a specific question, felt that consultation with HRP's PCC would be required before attempting a redefinition of priorities for research activities and the division of responsibilities between RHT and HRP.

The agenda for research and technical support activities in reproductive health was ambitious and would most likely require clear priority setting, with difficult decisions both within and between programmes, if funding fell short of what was needed. Such an agenda will need collaboration with others in important areas, such as the establishment of reproductive health indicators. Collaboration is also needed in the development of methodologies and tools for the assessment of reproductive health needs and the identification of resources and for facilitating the incorporation of such activities in national processes of reproductive health programme planning. Other agencies and programmes

were active in these areas and it would be important for these groups to consult with each other frequently in the coming months to plan on future collaboration and cooperation.

The recently published document setting out medical eligibility criteria for prescribing contraceptive use was cited as an excellent example of a valuable product of collaboration involving different WHO programmes, other international and governmental agencies and NGOs. This was the kind of work that could well lead to additional funding for activities in the interface between the programmes which together carry out reproductive health activities within FRH.

While the drawing together of all components of reproductive health in a single comprehensive Reproductive Health programme is to be commended, it will nevertheless be important not to reduce the focus of attention on specific components. In this regard, it may be important to look closely at some of the details of the programme budget.

The encouragement of sound public health policies in reproductive health is a laudable goal. Thought could be given to encouraging ministries in other sectors like agriculture, housing, the environment and education, all of which have an impact on reproductive health, to work together with the health ministry in providing an effective response to reproductive health needs.

Data on reproductive health indicators are generally presented by country. However, disaggregation of country data according to religion, minority groups, etc. could be useful in identifying people in special need or who are especially disadvantaged.

Dr Holck provided the following clarifications and responses to specific comments and questions from participants.

- The special needs of people, especially women, subject to war, displacement and other difficult circumstances, were readily acknowledged and it would be important for WHO actively to address the needs of such groups of people, even when the environment is far from supportive. Work is already ongoing with UNHCR in this area and there will be opportunities to work with others. There is a need to reduce threats to reproductive health, such as rape, as well as to improve services to people in difficult circumstances.
- There is no simple solution to the challenge of ensuring safe motherhood. It is clear, however, that we cannot rely only on predicting which women will develop complications and providing care for them. Nor is it feasible to arrange institutional deliveries for all pregnant women. An innovative approach is needed and the key appears to be that of promoting skilled birth attendants and access to care for complications.
- Lack of time had prevented Dr Holck from providing details of what WHO would do to address Goals 1 and 4 of WHO's Reproductive Health programme, those of enabling healthy sexual development and reducing the risk of injury associated with sexuality and reproduction. Much of the work in these two areas will fall under the ADH and WHD programmes, respectively, and their budgets are to a large extent those for Goals 1 and 4 of the Reproductive Health programme.

- Cervical cancer is an enormous problem in developing countries, but there would be little point in spending time and effort on establishing and implementing screening programmes if there were no capacity for the treatment of the cancers thus detected. The two activities must be linked, which is more feasible for precancerous conditions.
- Priority setting had been arrived at through a combination of intensive discussion among staff of all the programmes involved and specific advice had been sought from HRP's Scientific and Technical Advisory Group, its Gender Advisory Panel and its Steering Committee for Research on Technology Introduction and Transfer. A meeting to review developing country needs had also provided very valuable input.
- This was the first time that specific plans and a detailed budget for reproductive health activities, other than those in HRP, had been prepared. While the RHT budget presented in the background document gave details at the goal and sub-goal level, similar information did exist for activities proposed at the level of objectives and outputs. This information would contribute to discussion on priorities in the coming months, especially if there is a budgetary shortfall. Staff were already planning the process of setting priorities to ensure that the programme of work is focused and feasible given the resources available. Broadly speaking, it was clear that in the event of a shortfall some new activities would not start and some ongoing activities would slow down. At the next MIP it would be possible to report on what funds had been received and how any shortfall was managed.
- Designated funding would, in principle, be possible at the level of goals, sub-goals or objectives. The more specified the funds, the more difficult it would be, however, to guarantee a comprehensive, balanced programme of work. This would be especially true were funds to be designated at the specific project level which would also add substantially to the administrative burden.
- RHT will certainly follow the common format for financial reports and budgeting that is now being developed for all WHO programmes.
- It is true that funds available to WHO to carry out work in reproductive health are quite small in comparison to those expended by some large bilateral funding agencies. The diagram demonstrating process and products in the Reproductive Health programme illustrated best the kinds of activities that WHO can do well. For example, the Organization is well placed to bring together representatives of the various organizations working in a particular area. Such a group would undertake systematic review and analysis of all available evidence, perhaps with further contributions from consultants. What would come out of the process would be conclusions and a consensus that helps guide all groups and institutions, especially those with more funds than WHO. In this way, WHO, with its authoritative standing, can play a valuable catalytic role.
- At the next MIP the Reproductive Health programme would be pleased to report more fully on how work is actually carried out in collaboration with countries, other international and bilateral programmes and with NGOs.
- The restructuring of reproductive health activities and the interactions between RHT and HRP, as illustrated in the model of process and products, most certainly has implications for the

structure and work of the technical and advisory bodies. There has already been much discussion and agreement of the value of a common Scientific and Technical Advisory Group for the two divisions. In general, staff have become more conscious of the need to involve both researchers and people who understand programme needs to ensure that the systematic analysis of available evidence produces complementary agendas for research and technical support activities.

9. DISCUSSION OF THE FORM, NATURE AND RESPONSIBILITIES OF THE MIP

The Chairman reminded participants that this was the second Meeting of Interested Parties to review activities and plans under the new programme area of Family and Reproductive Health. The MIP of December 1995 had scheduled the present meeting for just six months later, thereby to precede the meeting of HRP's own governing body, while at the same time being able to take account of the outcome of the World Health Assembly's discussions of reproductive health. It was now appropriate for the MIP to consider its own function in reviewing or advising FRH.

There was considerable discussion of this issue with several participants contributing thoughts about the timing, frequency, format and function of the MIP. The suggestion was made, and adopted, that it would be best were the various issues to be identified at the present meeting and for participants to reflect on them and write their comments and suggestions direct to Dr Türmen in the coming weeks. The issues proposed by the Chairman, by various participants and by Dr Türmen are presented below, together with some of the thoughts expressed at the meeting.

- (a) What is the purpose of the MIP? To some extent the MIP replaces similar meetings held previously by individual programmes. Is this appropriate? Dr Türmen noted that the MIP brings together representatives of countries, of the donor community, of NGOs, of women's health advocacy groups, of professional societies and of different WHO programmes and its Regional Offices. There is an open forum for discussion and everyone has an opportunity to contribute. This is a valuable process for FRH and it should continue.
- (b) What is the role of the MIP in relation to the two governing bodies, WHA/EB and the PCC, with which it intersects? The official setting of priorities for the WHO programmes within FRH is certainly the WHA/EB and for HRP it is the PCC. The MIP itself does not have a policy-setting role but this is a valuable opportunity for a group of related programmes to present their work for discussion by a single body with the same individuals representing each government or institution.
- (c) How important is the information sharing as an objective of the MIP? Most felt that the opportunity to exchange information and see the linkages between different programme areas was a valuable component of the meeting.
- (d) How should the MIP be structured, how long should it be and should each programme present every time? Participants felt that more time was needed for adequate discussion since it is the discussion that provides the most valuable output of the meeting. In this regard it may be important to make sure that what is presented to the meeting is not material that could just as easily have been read. Certainly, participants should come to the meeting having read the documents thoroughly in order to maximize the discussion time and the value of the outputs. Discussions of substance had suffered from a shortage of time and it may be necessary to plan

opportunities for more substantial interaction with the individual programmes either in meetings held every other year, or in simultaneous discussions immediately prior to a larger MIP that looks at all of FRH and which receives reports from the discussions of individual programmes. Costs are a consideration and must be taken into account when deciding whether to extend the period of the MIP (and on its size - this was a much larger meeting than are the MIPs of other WHO programmes). Consideration could be given to reducing the time available for coffee and lunch, although this may also be seen as a valuable time for informal consultations among participants.

- (e) How often should the MIP take place? An interval of 12 months would seem an appropriate time between meetings, since less than this does not allow sufficient time for progress. The MIP would need to precede HRP's PCC in order to be able to feed into PCC deliberations.

10. CONCLUDING SESSION

10.1 Concluding remarks

Dr Türmen thanked all participants, and the Chairman, for the valuable contributions made during the meeting to the further development of the FRH programme area. This was the first opportunity for these related technical public health programmes to present - together and in a common forum comprising countries, NGOs, agencies and donors - their mission, guiding principles, objectives, strategies and anticipated outputs. This was also the first time these programmes had been reviewed sequentially, by the same body and by the same individuals from each government.

FRH is a heterogeneous mix, bringing large, long-established and successful programmes together with smaller and newer programmes. WHO's objective is to build upon the successes, strengthen the activities further, and, at the same time, enlarge the range of activities to address a continually evolving agenda.

The Secretariat had listened with interest to participants' comments, suggestions and concerns. In particular, a number of specific issues raised, that were common to all programmes, were noted:

- the need to focus activities and priorities on the basis of explicit criteria, including the public health importance of the issue, the feasibility of interventions, cost-effectiveness and impact;
- the continuing need for information and data to inform priority-setting and underpin monitoring. Such information and data must be sex-disaggregated and age-disaggregated;
- the importance of an impact-oriented approach to programme development and implementation;
- the need to establish effective monitoring and evaluation mechanisms in all programmes. This will involve developing indicators - of input, process, outcome, impact - and producing guidelines for countries for collecting and analysing the necessary data in order to ensure regular assessment of progress in relation to objectives;
- the need for clear plans of work, time frames and intermediate milestones;

- the need to avoid duplication and make most effective use of limited resources. The programme areas within FRH need to be complementary and mutually supportive;
- the need for collaborative activities among programme areas, so that all can benefit from the richness and diversity of perspectives. FRH will strengthen the linkages, within and outside FRH, including with partner agencies and NGOs.

10.2 Closure

In closing the meeting, the Chairman stated that the MIP had had two days of intensive discussion on four major public health programmes that address:

- Child survival and health
- Adolescent health and development
- Women's health and gender issues
- Reproductive health and newborn health.

These programmes address critical stages of life. They address closely related issues and dealing with them will have cumulative effects across the life span of the individual and, for communities, influence the next generation.

The FRH reorganization will facilitate closer collaboration among these programmes. However, they also need to maintain their technical specificity, to build on their achievements and to respond to continually evolving needs of individuals and countries. To do so they need assured and stable financial support. All the programmes are trying to do more and staff are working at full capacity. Donors need to provide the dedicated staff with the necessary funding for activities. FRH itself would also need funding to respond to emerging and innovative approaches, support common initiatives and provide an enabling environment.

The Chairman declared the meeting closed.



WORLD HEALTH ORGANIZATION

FAMILY AND REPRODUCTIVE HEALTH

Second Meeting of Interested Parties

Geneva, 17-18 June 1996

Executive Board Room

LIST OF PARTICIPANTS

COUNTRIES

ALBANIA

Mme Nedime CEKA, Coordinator, Mother and Child Programme, Reproductive Health Section, Ministry of Health, Tirana

ARMENIA

Dr Simon ALEXANIANTS, Deputy Director, WHO Collaborating Centre on Reproductive Health, Senior Scientist, Armenian Research Centre on Maternal and Child Health Protection, Yerevan

AUSTRALIA

Mr Angus MACDONALD, Representative, Australian Agency for International Development (AusAID), Counsellor (Development), Permanent Mission of Australia to the United Nations Office at Geneva

Mrs Ann KERN, Consultant to AusAID, Permanent Mission of Australia to the United Nations Office at Geneva

BANGLADESH

Dr Jahir Uddin AHMED, Director, Maternal and Child Health Services, Directorate of Family Planning, Ministry of Health and Family Welfare, Dhaka

BELGIUM

- * Dr Jacques LARUELLE, Administration Générale de la Coopération au Développement, G61/13 Bureau Organismes spécialisés, Bruxelles (unable to attend)

CANADA

Dr J. LARIVIERE, Senior Medical Adviser, International Affairs Directorate, Intergovernmental and International Affairs Branch, Department of National Health and Welfare, Ottawa

Ms Danielle TESTELIN, Senior Programme Manager, United Nations Programmes, Multilateral Technical Cooperation Division, Multilateral Programmes Branch, Canadian International Development Agency, Hull

Ms Alex VOLKOFF, Director, United Nations Programmes, Multilateral Technical Cooperation Division, Canadian International Development Agency, Hull

COLOMBIA

Dr Constanza GIRALDO, Sub-direction of Health Promotion, Ministry of Health, Santafé of Bogota

EGYPT

Dr Mohamed SHAABAN, Head, Department of Mother and Child Health, Ministry of Health, Egypt Child Survival Project (MCH Department), Cairo

FINLAND

Miss Eeva-Lusa VAKKILAINEN, Senior Adviser, Finland, Ministry of Social Affairs and Health, Department of Social and Health Services

Dr Matti RIMPELÄ, Senior Medical Officer, Stakes, National Research and Development, Centre for Welfare and Health, Helsinki

FRANCE

Madame le Docteur Simone DORMONT, Chargée de la Coopération avec l'OMS, Département des Relations internationales, INSERM, Paris

GERMANY

Dr Rolf KORTE, Head, Health, Population and Nutrition Division, Deutsche Gesellschaft für technische Zusammenarbeit (GTZ), Eschborn

Dr Herbert KRUMBEIN, Head, Federal Ministry for Economic Cooperation and Development Division, Friedrich-Ebert-Allee 40, 53113 Bonn

Mr Uwe-Eitel FRIESE, Second Secretary, Federal Ministry for Economic Cooperation and Development Division 221, Friedrich-Ebert-Allee 40, 53113 Bonn

Dr Sebastian PAUST, Permanent Representative of Germany to the United Nations Office and other International Organizations at Geneva

GHANA

Dr Fred SAI, President, International Planned Parenthood Federation, Accra
(Chairman)

Dr George K. AMOFAH, Regional Director of Health Services, Ashanti Region, Ghana

IRAN

Dr Fatemeh RAMEZANZADEH, Senior Expert, Ministry of Health and Medical Education,
Tehran

Dr Zahra ALLAMEH, Deputy of Family Health Department, Ministry of Health and Medical
Education, Tehran

ITALY

Dr Eduardo MISSONI, Health Expert, Directorate-General for Development Cooperation,
Ministry of Foreign Affairs, Rome

JAMAICA

Dr Beryl IRONS, Senior Medical Officer - Maternal and Child Health, Ministry of Health,
Kingston - (Rapporteur)

JAPAN

Mr Toshiyasu IKENAGA, First Secretary, Permanent Mission of Japan to the United Nations
Office and other International Organizations at Geneva

LUXEMBOURG

Madame le Docteur Danielle HANSEN-KOENIG, Directeur de la Santé, Ministère de la Santé,
Luxembourg

MALAYSIA

Dr Abdul Aziz bin MAHMOOD, Director, Division of Family Health, Ministry of Health, Kuala
Lumpur

NETHERLANDS

Mrs Renilde Steeghs, DESU Officer, UN AID Section, Ministry of Foreign Affairs, The Hague

Ms Aagje Papineau Salm, Health and Population Adviser, Ministry of Foreign Affairs,
The Hague - (Vice-Chairman)

Mr W. van Reenen, First Secretary, Permanent Mission of the Kingdom of the Netherlands,
Geneva

NORWAY

Ms Marit BERGGRAV, Senior Health Advisor, NORAD, Oslo

Ms Johanne SUNDBY, Advisor, National Board of Health, Researcher, University Medical Anthropology, Norway

SPAIN

Mrs Lucia MAZARRASA, Head, Section of Professional Training, Escuela Nacional de Sanidad, Instituto de Salud Carlos III, Ministerio de Sanidad y Consumo, Madrid

SWEDEN

Dr Lennart FREIJ, Senior Research Adviser, Department for Research Cooperation, SAREC, Swedish International Development Cooperation Agency (Sida), Stockholm

Dr Jerker LILJESTRAND, Consultant Adviser - Reproductive Health to Sida/SAREC, Baltic International School of Public Health, Karlskrona

Dr Hellen OHLIN, Senior Research Officer, Department for Research Cooperation, SAREC, Swedish International Development Cooperation Agency, Stockholm

SWITZERLAND

Dr Matthias KERKER, Collaborateur au Service des Ressources humaines, Secteur Santé, Direction de la Coopération au Développement et de l'Aide humanitaire, Département fédéral des Affaires étrangères, Bern

Dr Peter SCHUBART, Chef de Clinique, Hôpital régional, Delémont

Professor Niklaus GYR, Department of Internal Medicine, University Hospital, Basel

THAILAND

Dr Suwanna WARAKAMIN, Chief, Family Planning Technical Development Section, Family Health Division, Department of Health, Ministry of Public Health, Nonthaburi

TURKEY

Professor Dr Ayse AKIN, General Director, Ministry of Health, MCH/FP Department and Professor at the Hacettepe University, Public Health Department, Ankara

UNITED KINGDOM

Dr David BELLAMY, Principal Medical Officer, Department of Health, London

Mr Philip MASON, Head, Reproductive Health, Overseas Development Administration, London

Dr David NABARRO, Chief, Health and Population Division, Overseas Development Administration, London

Mr J. WORLEY, Population and Reproductive Health Specialist, Overseas Development Administration, London

Mr Timothy SIMMONS, First Secretary, Permanent Mission of the United Kingdom of Great Britain and Northern Ireland to the United Nations Office and other International Organizations at Geneva

Ms Helen FRARY, Third Secretary, Permanent Mission of the United Kingdom of Great Britain and Northern Ireland to the United Nations Office and other International Organizations at Geneva

UNITED STATES OF AMERICA

Mr Jeff SPIELER, Chief, Research Division, Office of Population, Center for Population, Health and Nutrition, United States Agency for International Development, Washington, D.C.

Dr Caryn MILLER, Child Health Research, Office of Health and Nutrition, United States Agency for International Development, Washington, D.C.

Dr Felicia Stewart, Deputy Assistant Secretary for Population Affairs, Department of Health and Human Services, Washington, D.C.

Dr Yvonne Maddox, Deputy Director, National Institute of Child Health and Human Development, NIH, Bethesda

VIET NAM

Dr Do Trong HIEU, Director, Maternal Child Health and Family Planning Department, Ministry of Health of the Socialist Republic of Viet Nam, Hanoi

UNITED NATIONS AGENCIES

UNAIDS

Dr Jinichi SUZUKI, External Relations Officer, UNAIDS, Geneva

UNITED NATIONS CENTRE FOR HUMAN RIGHTS

Ms Maarit KOHONEN, Human Rights Officer, Legislation and Prevention of Discrimination Branch, United Nations Centre for Human Rights, Palais des Nations, Geneva

UNITED NATIONS CHILDREN'S FUND (UNICEF)

Dr France DONNAY, Senior Advisor on Women's Health, UNICEF, New York

Mr Bruce DICK, Senior Youth Advisor, HPU, UNICEF, New York

UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP)

Mr Frank HARTVELT, Deputy Director, Science, Technology and Private Sector Division, UNDP, New York

UNITED NATIONS EDUCATIONAL, SCIENTIFIC AND CULTURAL ORGANIZATION (UNESCO)

Dr Sabiha H. SYED, Senior Programme Specialist, Interdisciplinary Agency Cooperation Project, Environment and Population Education and Information for Development, UNESCO, Paris

Mr R.C. Sharma, Senior Programme Specialist, Environment, Population Education for Development (EPD), UNESCO, Paris

UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES (UNHCR)

- Dr Serge MALE, Senior Epidemiologist, UNHCR, Geneva (unable to attend)
- Mrs Kate BURNS, Senior Reproductive Health Officer, Programme and Technical Support Section, UNHCR, Geneva

UNITED NATIONS POPULATION FUND (UNFPA)

Dr Nicholas DODD, Chief, Reproductive Health Branch, Technical and Evaluation Division, UNFPA, New York

WORLD BANK

Dr Thomas MERRICK, Senior Population Adviser, Population, Health and Nutrition Department, The World Bank, Washington, D.C.

Ms Anne TINKER, Senior Health Specialist, Population and Human Resources Department, The World Bank, Washington, D.C.

FOUNDATIONS*FORD FOUNDATION*

Dr José BARZELATTO, Director, Reproductive Health and Population, The Ford Foundation, New York

FUNDACIÓN PARA ESTUDIO E INVESTIGACIÓN DE LA MUJER/FOUNDATION FOR STUDIES AND RESEARCH ON WOMEN

Dr Mabel BIANCO, President, Fundación para Estudio e Investigación de la Mujer, Buenos Aires

OTHER AGENCIES, NGOs, etc.*ASSOCIATION FOR VOLUNTARY AND SAFE CONTRACEPTION*

Dr Amy POLLACK, President, AVSC International, New York

CENTRE INTERNATIONAL DE L'ENFANCE (CIE)

Dr Michel PÉCHEVIS, Maternal and Child Health, CIE, Paris

CENTRE FOR PARTNERSHIP IN DEVELOPMENT

Dr Sigrun MØGEDAL, Director, DIS, Centre for Partnership in Development, Oslo

CONTRACEPTIVE RESEARCH AND DEVELOPMENT PROGRAM (CONRAD)

Dr Henry L. GABELNICK, Director, CONRAD Program, Arlington, Virginia

COUNCIL ON HEALTH RESEARCH FOR DEVELOPMENT (COHRED)

Dr Yvo NUYENS, Coordinator, Council on Health Research for Development, Geneva

FAMILY HEALTH INTERNATIONAL

Dr Judith FORTNEY, Director of Scientific Affairs, FHI, Research Triangle Park, NC

INTERNATIONAL ASSOCIATION FOR ADOLESCENT HEALTH (IAAH)

Dr A. MONROY, Vice-President (IAAH), Focus on Young Adults, Washington, D.C.

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH (ICDDR,B)

Dr John Patrick VAUGHAN, Director, Community Health Division, ICDDR,B, Dhaka

INTERNATIONAL CONFEDERATION OF MIDWIVES (ICM)

Miss Joan WALKER, Secretary-General, ICM, London

Ms Jule FRIEDRICH, ICM, London

INTERNATIONAL COUNCIL OF NURSES (ICN)

Ms Magali BERTHOLET, Nurse Consultant, ICN, Genève

INTERNATIONAL DEVELOPMENT RESEARCH CENTRE (IDRC)

Dr Anwar Islam, Medical Sociologist, Senior Program Officer, Programs Branch, IDRC, Ottawa

INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS (FIGO)

Professor Aldo CAMPANA, Faculty of Medicine, Hôpital Cantonal Universitaire de Genève, Department of Obstetrics and Gynecology, Geneva

INTERNATIONAL FEDERATION OF PHARMACEUTICAL MANUFACTURERS ASSOCIATIONS (IFPMA)

Dr Odette MORIN CARPENTIER, Scientific Executive, IFPMA, Geneva

Dr E.W. BERGINK, Programme Manager Reproductive Medicine, N.V. Organon, The Netherlands

INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES (IFRC)

Dr Hakan SANDBLADH, Head of Relief Health Services, IFRC, Geneva

INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF)

Dr Pramilla SENANAYAKE, Assistant Secretary-General, Technical Services, IPPF, London

INTERNATIONAL UNION AGAINST TUBERCULOSIS AND LUNG DISEASE

Ms Penny ENARSON, Coordinator, ARI Programme, IUATLD, Paris

INTERNATIONAL WOMEN'S HEALTH COALITION

Dr Adrienne GERMAIN, Vice-President, International Women's Health Coalition, New York

PROGRAM FOR APPROPRIATE TECHNOLOGY IN HEALTH (PATH)

Dr Gordon PERKIN, President, PATH, Seattle, Washington

POPULATION COUNCIL

Dr George BROWN, Vice President, Programs Division, Population Council, New York

WOMEN'S HEALTH ORGANIZATION OF NIGERIA

Professor Adepeju A. OLUKOYA, Coordinator, Women's Health Organization of Nigeria,
Lagos

WOMEN'S HEALTH PROJECT

Dr Barbara Jane KLUGMAN, Coordinator, Women's Health Project, Centre for Health Policy,
Department of Community Health, University of the Witwatersrand, Johannesburg

WORLD ORGANIZATION OF SCOUT MOVEMENT

Mr Abdoulaye SAR, Director, Community Development, WOSM, Geneva

WORLD HEALTH ORGANIZATION

Chairperson of the Technical Advisory Group of the Division of Child Health and Development

Professor Alexander Samuel MULLER, Emeritus Professor of Tropical Health, University of
Amsterdam, Academic Medical Centre, Department of Social Medicine, Amsterdam

HEADQUARTERS - FAMILY AND REPRODUCTIVE HEALTH

Dr Tomris TÜRMEN, Executive Director, Family and Reproductive Health

CHD (Division of Child Health and Development)

Dr Jim TULLOCH, Director
Mr R.C. HOGAN, Programme Management Officer

**HRP (Special Programme of Research, Development and Research Training in Human
Reproduction)**

Dr Giuseppe BENAGIANO, Director
Dr Paul VAN LOOK, Associate Director
Dr Francis WEBB, Office of the Director

RHT (Division of Reproductive Health Technical Support)

Dr Susan HOLCK, Director
Ms Carla ABOUZAHAR, Maternal Health and Safe Motherhood

ADH (Adolescent Health and Development)

Dr Herbert FRIEDMAN, Chief
Ms B.J. Ferguson

WHD (Women's Health and Development)

Dr Claudia GARCIA-MORENO, Chief

HEADQUARTERS - OTHER

Dr Hu Ching-Li, DDG, a.i.

Dr A. ISSAKOV, ARA

Dr Antonio GERBASE, ASD

Mr George MICOD, BFI

Dr Sam Muziki, DAP

Ms Rosemary VILLARS, DGO
Dr Graeme CLUGSTON, FNU
Dr M. de ONIS, FNU
Ms Randa SAADEH, FNU
Mr James CHEYNE, GPV
Mr H. BENAZIZA, HPR
Dr Ilona KICKBUSH, HPR
Mr Tom TOPPING, Legal Counsel
Dr John ORLEY, MSA/MNH
Dr Michel JANCLOES, SSC
Dr Carol VLASSOF, TDR

REGIONAL OFFICES

REGIONAL OFFICE FOR AFRICA (AFRO)

Mrs Zeline PRITCHARD, Regional Adviser, Women, Health and Development and Adolescent Health, AFRO, Brazzaville

REGIONAL OFFICE FOR THE AMERICAS (AMRO)

Dr José SOLIS, Acting Coordinator of the Program on Family Health and Population Program, PAHO/AMRO, Washington, D.C.

REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN (EMRO)

Dr Ghada HAFEZ-SHISHAKLI, Director, Health Protection and Promotion, EMRO, Alexandria

Dr Ramez MAHAINI, Short-term Professional, Family Planning for Health, EMRO, Alexandria

REGIONAL OFFICE FOR EUROPE (EURO)

Dr Gajane DOLIAN, Acting Regional Adviser for Sexuality and Family Planning, EURO, Copenhagen

REGIONAL OFFICE FOR SOUTH-EAST ASIA (SEARO)

Dr Suniti ACHARYA, Regional Adviser, MCH, SEARO, New Delhi

REGIONAL OFFICE FOR THE WESTERN PACIFIC (WPRO)

Dr J. ANNUS, MCH, WPRO, Manila

mip2.list (2.9.96)