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**CAH** CHILD AND ADOLESCENT HEALTH AND DEVELOPMENT

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# **REPORT OF THE SECOND MEETING OF THE CAH TECHNICAL STEERING COMMITTEE**

29 May–2 June 2000



DEPARTMENT OF CHILD  
AND ADOLESCENT HEALTH  
AND DEVELOPMENT  
**WORLD HEALTH ORGANIZATION**

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## 1. Introduction

The second meeting of the Technical Steering Committee (TSC) of the WHO Department of Child and Adolescent Health and Development (CAH) was held in Geneva from 29 May to 2 June 2000. The Department was created in 1998, with the arrival of Director-General Dr Gro Harlem Brundtland, to promote the health and well being of children from birth up to 19 years of age. It was formed through a merger of two previously existing groups:

- The Division of Child Health and Development (CHD) and
- The Adolescent Health and Development (ADH) Programme.

In 1999 the staff of CAH developed a plan of work for the age range of birth up to 19 years and produced a combined budget for the 2000-2001 biennium.

The CAH Department is located within the Cluster on Family and Community Health (FCH). Dr Olive Shisana, Executive Director of FCH, opened the meeting. She welcomed meeting participants and presented an overview of the new corporate strategy for the WHO Secretariat.

She explained that the following four strategic directions will provide a broad framework for focusing the technical work of WHO:

- Reducing excess mortality, morbidity and disability.
- Reducing risk factors and promoting healthy lifestyles.
- Developing health systems that equitably improve health outcomes, respond to peoples' legitimate demands and are financially fair.
- Developing an enabling policy and institutional environment in the health sector and promoting an effective health dimension to social, economic, environmental and development policy.

Dr Shisana listed the priority areas where WHO will strengthen its focus, increase its efforts and provide additional resources. The priorities are malaria, HIV/AIDS, tuberculosis, maternal health (Making Pregnancy Safer), mental health, tobacco, cancer, cardiovascular disease, diabetes, chronic respiratory disease, food safety, blood safety, health systems and investing in change in WHO. She noted that work on two of the WHO priorities (i.e. HIV/AIDS/STIs and Making Pregnancy Safer) fall within the responsibility of the FCH cluster.

Dr Shisana then briefed the meeting participants about the personnel changes at WHO since the last TSC meeting. In her remarks, she announced that the Director of CAH, Dr Jim Tulloch, left WHO in February 2000 to head a United Nations team addressing health issues in East Timor. She explained that the Department was actively recruiting a new director, and complemented the Department's team coordinators for their fine work during rotations as acting director. At cluster level, Dr Shisana informed the committee that she planned to leave WHO in July 2000 to take a position in South Africa as a professor at the National School of Public Health.

Dr Shisana commended the CAH staff for defining a clear workplan for the biennium (2000 - 2001). She closed her remarks by expressing her confidence that the TSC would conduct a sound review of the workplan and offer constructive advice to the Department about how the plan could be strengthened.

Dr Shisana then introduced a new TSC member, Dr Julieta Rodrigues Rojas, and presented Professor Knut-Inge Klepp, who was unable to attend the 1999 TSC meeting. She concluded by requesting Dr Linda Richter, the previous vice-chair of the TSC, to serve as chairperson for the meeting.

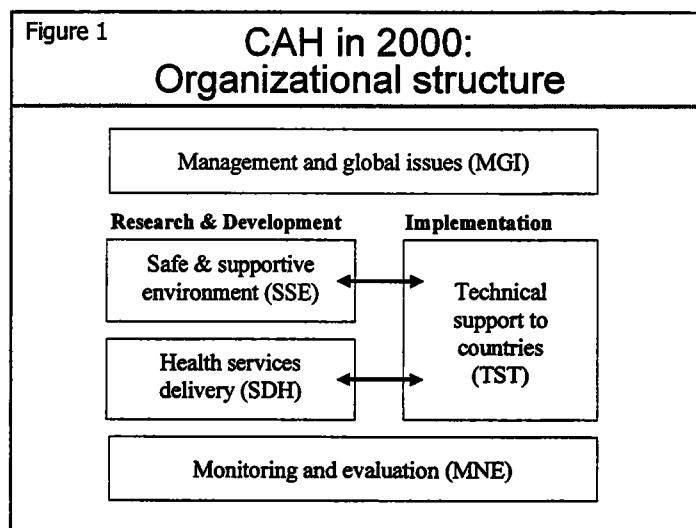
## 2. Overview of CAH

Dr Jennifer Bryce, acting director of CAH, presented the goals, themes and structure of the Department and provided an overview of the major work areas. She reported that the process of developing a comprehensive global strategy on child and adolescent health and development for WHO had been suspended after the departure of the CAH Director, but had recently been restarted.

Dr Bryce summarized the following major themes of the Department:

- Working toward a life-cycle approach.
- Improving equity and ensuring rights.
- Linking research, development and support for implementation.
- Applying a systematic framework for public health programme development.

The Department is organized into five teams, reflecting the major areas of work (Figure 1). The work of the various teams is interconnected and reflects the CAH theme of linking research, development and support for implementation. Furthermore, in order to ensure continuity across teams, most professional staff members contribute to the work of two different teams.



The TSC members raised three overarching issues that remained important throughout the meeting. First, they recognized a need to maintain and increase support for child and adolescent health on the public health agenda at all levels: globally, within WHO, and at regional and country levels. Second, they suggested that the themes and work of CAH might need to be redefined in ways that would increase its visibility and importance on these agendas. It was felt that this reconceptualization would be an

important part of the process of developing a global WHO strategy on child and adolescent health and development. Third, the TSC noted the significant expansion of the mandate of the two merged units (i.e. CHD and ADH) to cover the entire age group from birth up to 19 years, and expressed concern about whether there had been a concomitant increase in the Department's human and financial resources.

### **3. Report on activities carried out in 1999**

The CAH team coordinators and selected staff members then provided an overview of the work of the Department during 1999.

#### **3.1 Working to reduce childhood deaths and improve child health and development**

##### *3.1.1 Technical support to regions and countries*

Dr Gottfried Hirschall presented a brief summary of the Department's work to provide technical support to countries in collaboration with the WHO regional offices. The primary objective of the work in this area is to build capacity for sustainable implementation of child and adolescent health and development activities at regional and country levels. The Department's technical support team fulfils the following primary functions:

- Facilitating strategy development and planning in regions;
- Catalysing and supporting partners in their implementation efforts; and
- Assisting with the introduction of new tools at country level.

Implementation of the Integrated Management of Childhood Illness (IMCI) strategy, which is the Department's main strategy for the young child, expanded at an impressive rate in 1999. At the time of the TSC meeting, at least 70 countries had introduced the strategy, and 16 were progressing towards achieving national coverage. All WHO regions, together with partner agencies, had developed an IMCI implementation plan and accelerated activities to increase national capacity in various technical areas (e.g. planning, adaptation, training). In addition, the regional offices began to take a more active role in building a pool of competent consultants to support IMCI implementation.

Important achievements were reported in all three components of the IMCI strategy. In the component of improving the skills of health staff, more than 15,000 health professionals from approximately 70 countries had been trained in IMCI. Training was initiated for community health workers in the American Region, and for basic health workers in the South-East Asian Region. In addition, 20 countries introduced the IMCI concept into undergraduate training institutions for different categories of health professionals. In 39 countries, where IMCI has been introduced, breastfeeding counselling training courses have been conducted. These courses are increasingly linked and coordinated with IMCI activities.

In collaboration with UNICEF, progress was also made to further define the third component of IMCI, which aims to improve family and community practices. The Department produced draft instruments to support the planning process, and assisted several regions and countries in planning and implementing this component.

Dr Hirschall reported that WHO partners have increasingly adopted IMCI as a main strategy to improve child health. In particular, the IMCI strategy has been included in 32 World Bank supported projects, encouraged in the context of the Roll Back Malaria Initiative and recognized in the American Region's launch of the Healthy Children Goals 2002.

The future challenges identified by the team are to achieve satisfactory IMCI coverage while maintaining high standards and quality activities. Dr Hirschall suggested that more human and financial resources would be required at global, regional and national levels to meet growing demands from the large number of countries entering the expansion phase of IMCI implementation.

In the discussion that followed, the TSC urged CAH to further define the implementation steps for the third component of IMCI, including a process for involving communities in both planning and implementing interventions to improve family and community practices.

Overall, the TSC members acknowledged the progress made in expanding the implementation of the IMCI strategy, both by adding new activity areas (e.g., pre-service training, training of community health workers) and by providing technical support to an increasing number of countries. The TSC appreciated the systematic process used for joint planning between headquarters staff and the respective teams in the regional offices, and complimented CAH for its rigorous efforts to build capacity for IMCI implementation at regional and country level.

### *3.1.2 Research and development to improve health worker performance and health systems*

Dr Hans Troedsson presented the objectives of the Department's research and development activities to improve health worker performance and health systems. He summarized the progress of work in setting standards for care, improving health worker skills, improving health system support for IMCI and answering questions through clinical research.

In 1999, the Department's work included the following activities related to setting standards for care:

- Development of options for treatment when referral is difficult or impossible, which will lead to the development of simple guidelines.
- Revision of the textbook titled *Primary Child Care*. The new edition will incorporate IMCI as a central component of child health care.

- Updating of the IMCI Adaptation Guide. The revised guide provides the latest technical information and recommendations for preparing national clinical guidelines on IMCI.
- Preparation of technical updates on wheeze, dengue haemorrhagic fever, and sore throat.
- Development of guidelines for the management of sick young infants in collaboration with the Department of Reproductive Health and Research (RHR).
- Completion of a manual on the *Management of the child with a serious infection or severe malnutrition: Guidelines for care at the first referral level in developing countries* and of guidelines for *Emergency Triage Assessment and Treatment (ETAT)* to be used for small hospitals without specialized staff.

In addition, Dr Troedsson reported on the following development activities in the area of improving health worker skills:

- Strengthening the pre-service training of health workers. This project has three interrelated components: a survey of ongoing efforts to include the IMCI clinical guidelines into academic programmes for doctors, nurses and other health professionals; collaboration with a limited number of medical schools to facilitate, monitor and document the process of introducing IMCI teaching; and identification of major paediatric textbooks and collaboration with their editors to incorporate IMCI into the texts. A model handbook for use in IMCI pre-service training was completed.
- Exploring alternative approaches to training. Approaches under investigation for IMCI include distance learning, computer-based learning and on-the-job coaching.

Several guidelines and tools for improving health system support for IMCI are now available or in the final stages of development. These materials include the IMCI Planning Guidelines, the IMCI Costing Model, the Drug Supply Management (DSM) training materials and the Drug Management for Childhood Illness (DMCI) tool. Dr Troedsson then provided an update on the collaboration between CAH and the Essential Drugs and other Medicines Policy Department (EDM).

In the area of clinical research, the following studies and results were presented:

- Causes of death in the neonatal period. Results of a recently-published multi-centre study of the causes of death occurring in the neonatal period showed that simple clinical signs can effectively identify seriously-ill children in the first 3 months of life. Work has therefore begun to include the first week of life in the IMCI guidelines.
- Management of pneumonia. Multi-centre studies are investigating the efficacy of new antimicrobial treatment of pneumonia.
- Management of children with wheeze. Studies are investigating how to improve the recognition of wheeze and the prevalence of wheeze and non-severe pneumonia.
- Management of sore throat, severe pneumonia and bacterial meningitis. Studies are investigating resistance to antimicrobial drugs used in the treatment of sore throat, severe pneumonia and bacterial meningitis.

- Case management of diarrhoea. The efficacy of a modified ORS solution for use in the management of dehydration in severely malnourished children was evaluated.
- Management of dysentery. A multi-centre clinical trial is evaluating the efficacy of a short-course treatment of dysentery.

The TSC appreciated the work carried out by the Department in these areas. They emphasized the importance of maintaining close links between research, development and implementation, including the need to update references and information on research findings and evidence-based interventions regularly and to make this information easily available to countries, institutions and interested partners.

The TSC encouraged CAH to support and conduct further operations research on the effectiveness of interventions delivered through IMCI, particularly those interventions for which conclusive evidence is not yet available.

The TSC was pleased to learn that CAH had taken the initiative to identify how to strengthen the links between different levels of health care services and the community.

### 3.1.3 *Research and development to improve family and community practices*

Dr Jose Martines presented the research and development activities of the former CAH working group on improving family and community practices. He explained that the objectives of the working group were the development and testing of tools to improve the quality of interactions at the health facility between health workers and the community, and to strengthen community actions to promote health, prevent disease and support families in initiating and sustaining key practices for the health, nutrition and development of their children.

Dr Martines reported on the progress made during 1999 on the following activities to improve interactions at the health facility between health workers and the community:

- Research on the impact of IMCI nutrition counselling training, and on family responses to recommendations for follow-up consultations and referral to hospital.
- Development of various guidelines and training materials to promote breastfeeding to improve infant feeding in emergencies, and to train health workers to counsel mothers on complementary feeding and on infant feeding counselling of HIV positive mothers.
- Development of a manual for health workers on how to identify appropriate complementary foods and infant feeding practices.
- Development of a module on *Care for development* for use in IMCI training and of a plan for the field test of this module.
- Publication of reviews on the role of relactation and on the management of mastitis and breast abscess.
- Publication of the results of a meta-analysis of the effects of breastfeeding on mortality.

Dr Martines also reported on the following activities to strengthen community actions to promote health, prevent disease and support families to initiate or sustain key behaviours for child health and development:

- Research to design and evaluate large-scale, community-based interventions to improve child nutrition.
- Research and development of guidelines for the assessment of careseeking problems and the identification of possible interventions.
- Development of tools to assist the planning for IMCI implementation in the community.
- Development of IMCI training courses for community health workers.
- Preparation of an inventory of training materials and other tools used by national programmes to promote community interventions for child development.

In addition, Dr Martines reported on research carried out to build the evidence base for interventions to prevent child mortality and morbidity through improved zinc intake and reduced indoor air pollution.

The TSC appreciated the progress achieved on a large number of priority research and development projects. It noted with satisfaction the advances made with regard to the promotion of early child development, and encouraged the Department to continue its efforts in this area.

### 3.2 Working to meet the health and development needs of adolescents

Dr Peju Olukoya presented an overview of the Department's work to meet the health and development needs of adolescents. She began her presentation by summarizing the consensus of previous TSCs on the year 2010 goals for adolescents. This consensus recognised that adolescents need:

- Opportunities;
- Access to information and services; and
- Safety and support.

Dr Olukoya then presented a summary of the Department's function and focus for adolescent health and development, major areas of progress, and suggestions and questions for future work. She reported that the CAH objectives for adolescent health and development are to build the evidence base for adolescent needs and services, to develop standards and tools and to provide technical support to member states and partners, including United Nations partners and WHO colleagues.

During 1999, the Department undertook work to improve the response of the health sector to the needs of adolescents, to define what to measure and how in relation to adolescent health and development and to mobilize interagency support. Dr Olukoya reported on progress made in the following areas:

- Defining standards of health care for adolescents. This included, for example, assistance to the WHO Department of Reproductive Health and Research (RHR) for the development of guidelines on the integrated management of pregnancy and childbirth (IMPAC), and completion of expert review papers on selected adolescent health issues that will contribute to the development of tools for health care providers.
- Developing an orientation programme on adolescent health and development for health care providers.
- Moving forward with the joint UNICEF and WHO project on the measurement of adolescent health and development.
- Expanding inter-agency support as well as support to the WHO regions.

Dr Olukoya then presented a draft of the adolescent component of the UN global agenda for children. The draft statement stressed the need for adolescent participation in activities and decisions that affect their lives, for building adolescent capacities and values, for providing them with basic services and opportunities and for ensuring safety and support in their environments.

Dr Olukoya concluded by asking the TSC how CAH should organize and position itself in relation to the UN global agenda for children in order to more efficiently and effectively contribute to meeting the health and development needs of adolescents.

The TSC recognized the complexities and broad scope of the issues to be addressed in the area of adolescent health and development, and acknowledged the importance of adolescent participation in activities and decisions.

The TSC members suggested that more clarity is needed from WHO on the use and importance of life skills, and on the meaning of community in relation to adolescents. They indicated that greater efforts are needed to reach out-of-school adolescents and to update policies and legislation related to adolescent health and development.

### 3.3 Monitoring and evaluating interventions to improve child and adolescent health and development

Until mid-1999, the monitoring and evaluation activities of CAH were based in three working groups: Health Systems and Management (HSM), Technical Support to Countries (TSC) and Adolescent Health and Development (ADH). In 1999 the Department consolidated most of these activities into one team.

Dr Thierry Lambrechts presented activities planned and undertaken in 1999 in the following areas of monitoring and evaluation:

- World-wide monitoring of IMCI implementation;
- Indicators, measurement methods, consensus building and health information systems;
- Multi-country evaluation of IMCI impact and cost-effectiveness; and
- Measurement of adolescent health and development.

CAH continued to use a limited set of milestones to track country progress in IMCI implementation. At the same time, the Department initiated a process for revising and extending the milestones to reflect new IMCI interventions and to better monitor the expansion of the strategy. Dr Lambrechts reported that, when appropriate, additional milestones will be identified to monitor interventions for older children and adolescents.

The Department also identified priority indicators and supplemental measures for IMCI implementation at health facility and household levels. Work in this area was carried out in collaboration with partners, through an interagency working group on IMCI monitoring and evaluation. Many CAH partners are now using these indicators. To assist in measurement at the facility level, CAH developed, field-tested and is working to finalize survey instruments and methods. For child health indicators at the household level, the Department reviewed existing population-based surveys and offered guidance to countries in selecting the tool most appropriate to their needs and survey objectives. The Department also published a paper that summarizes issues and possible solutions for addressing the incompatibilities between IMCI and health information system (HIS) classifications.

Dr Lambrechts noted that the Interagency Working on IMCI Monitoring and Evaluation, created in 1997, had successfully completed its mandate. He reported that a new interagency structure would be formed to coordinate all monitoring and evaluation activities related to IMCI, including impact studies, and to promote consistency among approaches.

Dr Lambrechts then summarized the activities of the multi-country evaluation of IMCI impact and cost-effectiveness. The primary objectives of the evaluation are to document the effect of IMCI interventions on health worker performance, health systems and family behaviours, and to measure the impact of the IMCI strategy as a whole on health outcomes. By the end of 1999, the multi-country evaluation consisted of a set of studies using complementary designs in four countries where IMCI is being implemented. More countries are expected to join the evaluation effort in the future.

Dr Lambrechts reported that the measurement project for adolescent health and development had successfully built a network of programme managers and researchers. The first phase of the project, which involved seven countries, focused on measuring protective factors, defining a programming and measurement framework, adapting and developing measurement tools and strengthening the evidence base for the association between protective factors and major health outcomes related to adolescents. Implementation of selected activities will begin in the second phase of the project.

The TSC complimented the Department for its commitment to monitoring and evaluation, welcomed the creation of a monitoring and evaluation team and encouraged the initiative to create a new interagency mechanism to oversee the Department's activities in IMCI monitoring and evaluation.

TSC members stressed the importance of supervision for sustained quality of care, and identified a need for priority indicators to measure the health and development of

children older than five years. They also noted that the five to nine year old age group is often referred to as school-age children. As school age is not limited to this age range and many children in this age range are not in school, they suggested consistent use of the terminology "five to nine year age-group".

### 3.4 Working to promote the rights of children and adolescents to health and health care

Ms Margaret Reeves presented an overview of the activities undertaken by the Department to promote the rights of children and adolescents to health and health care. In 1997 it was recognized that the UN Convention on the Rights of the Child (CRC), through its legally binding status, its almost universal ratification by states and its monitoring and reporting mechanisms, provides a practical tool for strengthening work in the area of child and adolescent health and development. The framework of the CRC provides standards for planning as well as for working with and for children and adolescents. The former Division of Child Health and Development (CHD) initiated activities in early 1998 to establish WHO as an actor in the area of child rights, and to help place health on the child rights agenda.

Progress made by CAH during 1999 within the following areas:

- Building the capacity of WHO staff and partners to interpret and use the CRC in their daily work. The Department developed an orientation workshop on child rights and prepared resources and documents for use by WHO staff and partners.
- Providing technical support on the topics of health and health care to the UN Committee on the Rights of the Child. CAH, in collaboration with other WHO departments, prepared situation analyses on child and adolescent health for 30 countries under review by the CRC Committee. The Department also prepared a document on child health indicators to assist the monitoring of child rights, which will be revised in collaboration with UNICEF.
- Strengthening collaboration with partners within the UN system and with Non-Governmental Organizations (NGOs).

In the discussion that followed, the TSC members expressed appreciation for the Department's commitment to child rights and welcomed the progress made in this area. They acknowledged that the CRC and its reporting cycle provide important opportunities to promote, monitor and evaluate responses to the health and development needs of children and adolescents. The TSC also recognized a need for health professionals to be more aware of, and involved in, child rights activities.

## 4. Updates on selected topics

### 4.1 HIV and infant feeding

Dr Felicity Savage-King presented an overview of the following activities related to HIV and infant feeding, and their implications for practice and policy:

- Technical consultation on infant and young child feeding held in collaboration with UNICEF in Geneva (March 2000).
- Research on the factors affecting HIV transmission through breastfeeding.
- Meeting on the prevention of mother-to-child transmission of HIV in Gaborone, Botswana (March 2000).
- First regional training course on HIV and infant feeding counselling and policy development for Anglophone countries in Harare, Zimbabwe (April 2000).

Following the technical consultation on infant and young child feeding, CAH began working with other departments in WHO, and with UNICEF, to finalise a comprehensive strategy for infant and young child feeding. The strategy will include a focus on the feeding of infants in exceptionally difficult circumstances, including those infants born to mothers with HIV.

Recent research suggests that the quality of breastfeeding may affect the risk of HIV transmission. Results indicate that the risk of HIV transmission increases with mixed feeding (i.e. a mixture of breastfeeding and replacement feeding) and with mastitis, including sub-clinical mastitis. There is an urgent need for WHO to support further research in order to confirm these findings.

During the meeting on the prevention of mother-to-child transmission of HIV, held in Botswana, it was reported that activities to promote breastfeeding in sub-Saharan Africa have slowed with the realisation that HIV is transmitted through breastfeeding. Participants of the meeting concluded that there is an urgent need to strengthen and accelerate infant feeding counselling for both HIV positive and HIV negative mothers in order to ensure the best feeding method in all situations.

To this end, a regional training course on HIV and infant feeding counselling and policy development was conducted in Harare, Zimbabwe. The results of the course showed that a policy on HIV and infant feeding needs to be included as part of an overall infant feeding policy, and not in isolation, if breastfeeding and infant health are to be protected.

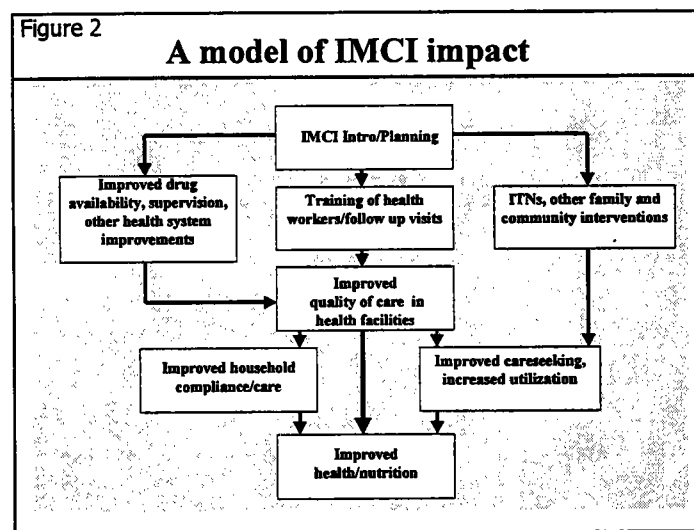
Dr Savage-King also reported that HIV and infant feeding training courses need to be conducted in conjunction with training in breastfeeding counselling, so that all mothers may have the support necessary to feed their infants optimally. To support this concept, CAH is working to promote the wider introduction of coordinated training using *Breastfeeding Counselling: A Training Course*, and *HIV and Infant Feeding: A Training Course*.

The TSC recognized breastfeeding support as a critical intervention to improve the health of young children and their mothers, and commended the Department for actions taken to clarify the relationship between breastfeeding and the vertical transmission of HIV.

## 4.2 IMCI: An evaluation framework

Dr Jennifer Bryce presented an overview of an evaluation framework and of selected evidence for IMCI. She reported that WHO is working with partners to strengthen the evidence base for IMCI as a basis for improved IMCI development and implementation efforts, as well as for advocacy. In 1999, CAH developed an evaluation framework to guide this effort.

The presentation was organized around an impact model that describes the process through which the introduction of IMCI is expected to lead to improvements in children's health and nutritional status (Figure 2). Each arrow in the model represents an assumption, and therefore a question, about how the IMCI strategy will lead to improvements in child health and nutrition.



Dr Bryce explained that the types of evidence that can be used to evaluate IMCI are varied. They include the results of operations research, which can range from rigorous randomized trials, through simulations and modelling, to small-scale research to investigate specific implementation questions. An important additional type of evidence is the documentation of experience by districts and countries implementing IMCI. The type and quality of evidence must be carefully considered when drawing conclusions.

The application of the evaluation framework suggests the following:

- The efficacy of interventions included in the IMCI strategy is proven. The challenge, therefore, is to assess the effectiveness of IMCI as a service delivery mechanism.
- Available evidence points to the cost-effectiveness of IMCI, but more data, and data of better quality, are needed.
- A formal multi-country evaluation of IMCI will provide further evidence on outcomes, impact and cost-effectiveness. Support is needed to ensure that the evaluation is done fully and well.

- Partners and WHO regional offices play a critical role in developing and evaluating IMCI – both because of the technical inputs they can provide, and because they can support the adequate implementation of IMCI so that the most important questions related to effectiveness can be addressed. These questions include whether IMCI can be implemented and sustained on a large scale, and whether it will lead to significant improvements in child health and nutrition.

The TSC found the work on strengthening the evidence base to be particularly timely. They suggested a possible need for qualitative research to complement the more quantitative studies already included in the evaluation, and for more in-depth research to evaluate satisfaction among patients and health workers.

### 4.3 The health and development of adolescent boys

Mr Paul Bloem summarized the reasons for addressing the health and development needs of adolescent boys, and presented an overview of the activities undertaken by the Department on this topic.

In most of the world, adolescent boys have a higher risk of dying than their female counterparts. In addition, the specific health needs and health-related behaviours of boys have direct consequences on their future health as adults, on the health of adolescent girls and on the economic development of their countries. Optimizing the health and well being of boys is also a matter of human rights.

Mr Bloem reported on the following CAH activities aimed at describing the main issues and interventions related to the health and development of boys:

- Literature review;
- Consolidated report of a regional survey of programmes; and
- Consultation and report on working with boys.

Mr Bloem explained that specific health topics, such as mental health, sexual and reproductive health, and violence and substance abuse, require special attention when working with boys. The important effect that socialization has on the health seeking behaviours of boys, and on their access to health care, has been a central finding of the work in this area. Mr Bloem pointed out that the work of CAH does not stand alone. A survey of programme activities in the European Region and research in the American Region has provided important guidance for future work in this area.

The TSC members commended the work being done in this area. They suggested that future research and development work might consider how masculinity is formed, the socialization process of boys, trends over time and geographical areas, and the situation of both boys and girls.

#### 4.4 Youth friendly health services

Dr Venkatraman Chandra-Mouli began his presentation by describing the importance of health services for adolescent health and development, in line with the Common Agenda for Action in Adolescent Health endorsed by UNFPA, UNICEF and WHO.

Adolescents are a very diverse population segment, and have different needs depending on their stage of development and circumstances. Even more importantly, these needs are likely to change rapidly. Health services have an important role to play in helping 'well' adolescents stay healthy, and in restoring 'ill' adolescents to good health. Health services activities related to adolescents can be categorised as follows:

- Providing information & advice on 'demand'.
- Screening for health problems (including problem behaviours).
- Detection/diagnosis & management of problems.
- Referral to other health/social service providers when necessary.

When health information and services are of good quality, but not made available and accessible to adolescents, the result is *missed opportunities* for the prevention of health problems and for their early detection and effective treatment. Actions are required in three inter-related areas: expanding the range of available health services, enhancing their quality and improving their friendliness.

Dr Chandra-Mouli then went on to describe the ways in which health services are being provided to adolescents; to present an analysis of the commonly occurring barriers to the provision and utilisation of health services to/by them; and to identify the characteristics of adolescent friendly health services based on experiences in both developed and developing countries.

The action-research projects supported by CAH during the 1996-97 and 1998-99 biennia were designed to make it easier for different groups of adolescents to get the health services they need: those in school, those 'on the street' and those who have been displaced - internally or externally. Many lessons that have been learned from these projects and from the initiatives of other organisations.

In the discussion that followed, TSC members recognised the need not only to improve the knowledge and skills of health care providers, but also to foster positive attitudes towards adolescents. They suggested that while adolescents in many places identify health workers as highly credible sources of information, they are less likely to seek or obtain information and advice from health workers than they are from other, often less credible, sources.

TSC members cautioned against the inadvertent promotion of adolescent medicine as a speciality. Instead they endorsed the Department's approach of working to strengthen the capacity of health care providers to meet the needs of all age groups, including the special needs of adolescents. In addition, they suggested that the ability of teachers to work and communicate with adolescents needs to be strengthened.

#### 4.5 Focusing resources on effective school health (FRESH)

Dr Venkatraman Chandra-Mouli began by spelling out the rationale for investing in the health of children and adolescents in the 'school-age' group (5 to 18 year olds), and of using the opportunities provided by schools as a setting to promote health and development. He then outlined the rationale for the FRESH start initiative, a collaborative initiative of UNICEF, UNESCO, WHO and the World Bank.

The following extract from the concept paper for the FRESH start initiative highlights the rationale for this initiative: "Positive experiences by WHO, UNICEF, UNESCO and the World Bank suggest that there is a core group of cost-effective activities which could form the basis for intensified and joint action to make schools healthy for children, and so contribute to the development of child-friendly schools."

The components of the initiative are:

- Health-related policies
- Safe water & sanitation facilities
- Skills-based health education
- School-based health & nutrition services

These four components are to be implemented in the context of:

- Effective partnerships between health workers & teachers
- Effective community partnerships
- Pupil awareness & participation

School-based and school-linked health services can make an important contribution in preventing health problems, and in responding to them if and when they arise, among school going children and adolescents. Work is under way to clarify both the 'operational' and the 'technical' issues related to the FRESH initiative, especially the 'package' of health interventions to be delivered and the ways and means by which this package could be delivered. Development activities are being carried out by CAH in conjunction with the Department of Communicable Disease Control, Prevention and Eradication. Dr Antonio Montessoro of that department then described the work that was under way in this area.

The TSC commented on the need to clarify the Department's technical support role with respect to the five to nine year age group. It was suggested that efforts be made to define the role of CAH vis-à-vis other departments within WHO in promoting and supporting the FRESH initiative. The TSC also suggested that it would be important to define the place of the FRESH initiative in relation to other existing initiatives such as Child Friendly Schools (UNICEF) and Health Promoting Schools (WHO).

TSC members noted that there are several mental health related issues which need to be addressed in the five to nine age group, as well as for those aged ten to 19. Although there are positive experiences in many countries in involving teachers in the provision of a limited range of health interventions, they suggested that it would be important to be aware of the danger of overwhelming them with this task.

## 5. Financial matters

A presentation on financial matters, by Ms Cathy Wolfheim, covered the following items: the financial report for the biennium 1998-1999, the financial status of CAH at the end of that period, and the revised budget for the Department for 2000-2001.

### 5.1 Financial report for 1998-1999

Obligations incurred up to 31 December 1999 for Child and Adolescent Health and Development totalled US\$ 30.5 million. This represents an increase of US\$ 2.1 million, or 7%, compared with obligations for 1996-1997, but a decrease of US\$ 5.9 million, or 16%, compared with the revised budget for 1998-1999.

The general decrease in expenditures compared to budgeted amounts reflects a combination of lower programme support costs than anticipated, and the deferral or delay of certain research and development projects. During the second half of the biennium, a significant amount of time was spent re-forming the new Department, leading to the deferral of certain projects and the re-examination of priorities. In addition, a number of staff who left the Department for retirement or other reasons were not replaced during the biennium.

For purposes of clarity and comparability, the financial report and the financial status were presented in two distinct budget segments, one for each of the former programmes that merged to become the Department: Child Health and Development (CHD), and Adolescent Health and Development (ADH).

Obligations incurred up to 31 December 1999 for CHD totalled US\$ 27.8 million. This represents an increase of US\$ 1.3 million, or 0.5%, compared with obligations for 1996-1997, but a decrease of US\$ 4.3 million, or 13.4%, compared with the revised budget. Obligations for Research and Development represented 24.2% of the total; this is 6.7% less than planned, and 10% less than in 1996-1997. The proportion of the budget spent on Technical Support to Countries increased from 61% in 1996-1997 to 62.7% in 1998-1999; this is 7.8% more than had been planned. Obligations for Programme Management and Support remained approximately as planned, but decreased by 3.3% from the previous financial period.

Obligations incurred up to 31 December 1999 for ADH totalled US\$ 2.8 million. This is US\$ 1.42 million, or 34%, less than the revised budget. Obligations for Research and Development were US\$ 0.9 million, or 40% less than the budgeted amount; for Technical Support to countries they were US\$ 0.2 million, or 18% less than planned, and for Programme Management and Support, obligations were US\$ 0.1 million, or 25% less than budgeted.

## 5.2 Financial status of the Department at 31 December 1999

The financial position at the end of 1999 shows an essential carryover from 1998-99 to the current biennium, and a balance. This balance is due in part to the lower obligations than planned, as described above. It is also due to several significant contributions being received at the end of the biennium, including specified contributions for research on antimicrobial resistance. Expenditures against these funds will be charged during the biennium 2000-2001.

For CHD, extrabudgetary contributions remained relatively stable since the last financial period, while there was an overall increase in regular budget. Total ADH income more than doubled compared with the previous biennium.

## 5.3 Revised budget for 2000-2001

The biennium 2000-2001 is the first full financial period for CAH. Following an internal reorganization of the Department, the revised budget was reorganized according to the five Departmental teams: Safe and Supportive Environment (SSE), Health Services Delivery (SDH), Technical Support to Regions and Countries (TST), Monitoring and Evaluation (MNE) and Management and Global Issues (MGI).

Overall, the proposed budget for CAH for 2000-2001 totals US\$ 54.4 million. This is US\$ 23.8 million greater than the total of obligations for the two programmes in 1998-1999, and US\$ 18.1 million greater than the proposed budget. This increase in predicted expenditures reflects the increase in the scope and breadth of the Department's work. The revised budget provides for 31 professional and 12.5 general services staff at Headquarters, and one intercountry position seconded to the World Bank.

Of the total budget, approximately US\$ 6.9 million is expected from the regular budget, leaving a balance of US\$ 47.5 million to be financed by extrabudgetary sources.

The TSC discussed the size and scope of the Departmental budget, and several issues were raised. These included: the proportion of increase over the obligations from last biennium; the justification to donors of the large balance from 1998-1999; the distribution of budgeted funds between work on child and adolescent issues; and the need for a contingency plan in case sufficient funds are not forthcoming. It was agreed that the significant increase in budget was justified by the expanded mandate of the Department, and that the balance was also justified, given the necessary re-organization during the last biennium. The TSC suggested that the level of expenditures be reviewed periodically.

## 6. Conclusions and recommendations

### 6.1 General

- 6.1.1 **As in 1999, the TSC urges WHO to increase its organizational, policy and financial support for the enlarged mandate of CAH. The TSC also urges the Director-General to advocate forcefully for the needs of children and adolescents across the Organization and with partners, stressing the significance of interventions in this age range as a prerequisite for building healthy adults and communities.**
- 6.1.2 The TSC recognizes that the reorganization of WHO has led to an expanded public health mandate for CAH, and that priority projects have had to be deferred or delayed due to staff shortages. **The TSC recommends that the vacant professional posts within CAH be filled as quickly as possible, including the Director's post.**
- 6.1.3 The TSC commends CAH for their accomplishments over the last year, as evidenced in the programme report and the presentations made during the meeting. The TSC approves the workplans as presented, and particularly appreciates the detailed summary made available for their review. The high quality of the work is particularly noteworthy given the context of organizational change and staff shortages.
- 6.1.4 The TSC notes with satisfaction that CAH invests considerable effort in fostering partnerships at global, regional and country levels, and emphasizes the importance of this for concerted country action. **The TSC requests CAH to make sufficient staff resources available to intensify this coordination, in particular with the United Nations partners.**
- 6.1.5 The TSC recognizes that the challenges of reorganization have demanded considerable staff time during the past year. In looking to the future, therefore, **the TSC recommends that the approved programme of work be maintained and supported by the new Director and Executive Director.**
- 6.1.6 The TSC endorses the major themes of the Department: taking a life-cycle approach; improving equity and ensuring rights; linking research, development and implementation; and applying a systematic framework for programme development. **The TSC strongly urges CAH to move ahead with the development of a strategy to guide their work, and that of WHO and partners, in the area of child and adolescent health and development. This strategy should include an overarching conceptual framework that portrays the major factors that affect health, growth and development in the years from birth to 19. This framework should:**
- present the rationale and evidence for placing child and adolescent health and development high on the international development agenda;

- highlight the special needs of subgroups (e.g., specific age groups, orphans due to HIV);
- demonstrate how interventions in one age group positively affect health and development in later life and in the next generation;
- highlight how linkages across intervention areas benefit the entire age range;
- take into account the Convention on the Rights of the Child; and
- define clear links between CAH and other WHO units, with a recognition that in some areas CAH should have primary responsibility while in others it will play a supporting role.

This strategy can be used both to guide the Department and as an advocacy tool.

- 6.1.7 The TSC commends the Department on the development of a sound and detailed work plan. The TSC notes, however, that the work plan includes many discrete products, some of which are closely related to one another. **The TSC encourages CAH to streamline and consolidate the work plan as opportunities present themselves.** Recommendations 6.1.8 – 6.1.10 offer specific examples of ways in which this might be done.
- 6.1.8 The TSC finds that some of the activities of CAH can contribute in important ways, as well as benefit from, the current WHO priority areas including malaria, making pregnancy safer, tobacco and HIV. **In those areas where it is appropriate, the TSC recommends that CAH work closely with these priority initiatives.**
- 6.1.9 The TSC recognizes and appreciates efforts by CAH to integrate work areas and priorities of the former Division of Child Health and Development (CHD) and the Adolescent Health and Development Programme (ADH), and recognizes that this merger has created significant opportunities, as well as challenges. The TSC appreciates that the Department has made a sincere effort to build on the strengths brought to the merger by both units. The TSC recognizes that the merger of activities might have more benefits in some areas than in others. **The TSC recommends that the Department continue to work toward establishing appropriate levels of integration for its activities and explores mechanisms to facilitate and improve the cohesion among groups of products within and across teams.**
- 6.1.10 Specifically, **the TSC recommends that CAH define opportunities to extend work that currently focuses on one age group to address the needs of other age groups in the range 0-19.** Promising areas for extension include clinical issues, health services delivery and safe and supportive environments.
- 6.1.11 The TSC congratulates CAH on the significant progress made in the area of child and adolescent rights. **The TSC encourages CAH to fully integrate a rights approach in its work, and to play a leadership role in developing a rights perspective within the work of WHO.**
- 6.1.12 The TSC recognizes the opportunities that health sector reforms provide for putting child and adolescent health and development high on the political agenda, and commends the Department for the substantial progress made in

providing technical expertise to the World Bank and countries in planning health sector reforms. The TSC nevertheless remains concerned about missed opportunities and urges the Department to find innovative ways to intensify support to governments and partners during health sector reform planning and implementation. In particular, **the TSC requests CAH to consider how support for adolescent health activities can be facilitated in planning of health sector reforms and World Bank supported projects.**

- 6.1.13 The TSC welcomes WHO's initiative to participate in the global debate on poverty reduction, and the development of a Poverty Reduction strategy, recognizing that children and adolescents are especially affected by poverty both in terms of prevalence and consequences for their future health and development. **The TSC recommends that CAH continue to participate in the WHO Working Group on Cost-Effective and Feasible Interventions.** The TSC looks forward to a report of progress in this area during its next meeting.
- 6.1.14 Given the enlarged mandate of the Department, a broad range of expertise is needed to carry out the Terms of Reference of the TSC. Therefore, **the TSC recommends that CAH review and if necessary revise the composition of the TSC to ensure appropriate coverage of the technical areas addressed by the Department.**
- 6.1.15 Given the detail and the large number of products that need to be reviewed, **the TSC recommends that in planning the next meeting, a mechanism be developed to focus discussions on selected pertinent issues.** These issues may be defined either by the TSC or by the Secretariat.
- 6.2 Recommendations on technical support and monitoring and evaluation
- 6.2.1 The TSC endorses the Technical Support Team's workplan for 2000-2001, and appreciates its integrated format. The new emphasis on documentation of experiences is particularly welcome. **The TSC stresses the importance of information exchange and urges CAH to increase investment in this area.**
- 6.2.2 The TSC considers the Department's approach for technical support to regions and countries exemplary, with due emphasis on strategy development and capacity building. The TSC welcomes regional initiatives to generate resources and commends the regional teams for being increasingly successful in this regard.
- 6.2.3 **The TSC recommends that CAH give increased attention to the development of approaches for improving family and community practices as an essential component of any strategy to improve child and adolescent health and development.** The TSC notes that this component is particularly appropriate for integration of interventions addressing a wider age range.

- 6.2.4 The TSC agrees that school health is an appropriate entry point for addressing the health of the 5-9 year age group. The TSC requests CAH to prepare a summary of activities under way to address the needs of the 5-9 age group across WHO for review at the next meeting.
- 6.2.5 Recognizing what has been learned through youth participation, **the TSC urges the Department to apply the principles of participation across the life span and across WHO initiatives.**
- 6.2.6 The TSC recognizes that progress in development of new technologies for prevention and management of HIV/AIDS (e.g. MTCT reduction, rapid testing) is likely to create special demands for technical support from countries who will want to introduce these. **The TSC urges CAH to continue to anticipate and prepare for the introduction of such new technologies, in order to be able to provide technical guidance in coordination with other WHO departments and partners.**
- 6.2.7 The TSC appreciates the importance of breastfeeding support as a critical intervention to improve the health of young children and their mothers. **The TSC recommends that breastfeeding counselling training should continue to be promoted, linked with IMCI training and other initiatives aimed at improving infant feeding practices.**
- 6.2.8 The TSC commends the Department for the development of the HIV and Infant Feeding Counselling Course (HIVC). **It recommends that training be offered to countries that have 'Prevention of Mother to Child Transmission of HIV' programmes. The TSC also recommends that WHO encourage the inclusion of HIVC in the overall infant feeding policy, and encourage that the national body responsible for promotion of infant feeding take responsibility for its dissemination, in close collaboration with the national HIV/AIDS prevention team.** HIVC training should be linked with breastfeeding counselling training, and where possible integrated into one course.
- 6.2.8 The TSC appreciates the Department's commitment to monitoring and evaluation, and welcomes the creation of a Monitoring and Evaluation Team (MNE). The selection of areas of work is appropriate. The area of strengthening the evidence base for strategies and interventions is particularly timely. **The TSC recommends that particular emphasis be given to studies of the cost and cost-effectiveness of interventions.**
- 6.2.9 **The TSC notes with regret that second priority has been given to projects related to the 5-9 age group within the MNE team, and recommends that this be redressed.**
- 6.2.10 The TSC recognizes the important progress made in the development of survey tools and methods and in the identification of options to reconcile health information systems (HIS) and IMCI classifications. **The TSC recommends that where functioning HIS exist, CAH should put more emphasis on strengthening them.**

- 6.2.11 Monitoring, evaluation, and supervision are critical elements for sustained quality of care. **The TSC recommends that the Department should give due attention to the development of approaches to strengthen supervision, as a collaborative effort across teams and with other departments.**
- 6.2.12 The TSC notes that there are no priority indicators to measure health and development of children beyond 5 years of age. **The TSC recommends that CAH play a leadership role in building consensus around a limited number of priority indicators for older children and adolescents.** These indicators will be critical to the process of placing the 5-19 year age group high on the public health agenda. CAH should encourage countries to collect and report epidemiological data on the 5-19 age group in 5 year age intervals and by sex.
- 6.2.13 The TSC welcomes CAH's initiative to create a new interagency mechanism to oversee the Department's monitoring and evaluation activities related to child and adolescent health. **The TSC urges the Department to operationalise the new mechanism and to sustain its effort in promoting consistency of indicators and evaluation approaches across organizations and partners.**
- 6.3 Recommendations on research and development
- 6.3.1 The TSC commends the Department on the development of strong and coherent plans for research and development in the areas of safe and supportive environment and health services delivery.
- 6.3.2 Recognizing that adolescent pregnancy impacts on the health and development of the mother and infant, **the TSC recommends continued interdepartmental activities to discourage pregnancy among adolescents and to promote safe pregnancy when it occurs.** The supportive role of the father during pregnancy, birth and infancy should also be recognized.
- 6.3.3 The TSC, recognizing the magnitude of neonatal mortality, is pleased to see CAH's commitment to address this area in collaboration with other WHO units and partners. The TSC notes with pleasure progress in the development of guidelines. **The TSC urges the Department to increase its level of involvement in work to improve neonatal care.** In this work, adequate recognition should be given to the fact that individuals other than formal birth attendants may have an important role to play in reducing mortality in the neonatal period. Both health facility and community-based approaches should be used to improve neonatal care.
- 6.3.4 The TSC appreciates the attention the Department has given to anaemia throughout the 0-19 age range. **The TSC requests that the Department define the extent of the problem of anaemia and its potential effects on health, development, and school performance.**

- 6.3.5 The TSC recognizes that conceptual work on new projects such as adolescent development and help-seeking should concentrate on laying out the broad picture. **The TSC recommends, however, that when developing and testing interventions, the Department focus on selected content, such as tobacco use or sexually transmitted infections.**
- 6.3.6 The TSC notes with pleasure the strong evidence that country activities designed to prevent dehydration in children have been effective in reducing mortality. **The TSC recommends that although needed research on diarrhoeal diseases and dysentery should continue, CAH should also put additional effort into interventions to prevent diarrhoea.**
- 6.3.7 The TSC appreciates the actions taken by the Department to clarify the relationship between breastfeeding and the vertical transmission of HIV. **The TSC urges the Department to move swiftly to clarify these issues further within the broader context of HIV and infant feeding.**
- 6.3.8 The TSC believes that any changes in the recommendations made by WHO in relation to the type of antibiotic or duration of treatment to be used in the management of pneumonia and meningitis are likely to have major repercussions at country level. **The TSC recommends that CAH continue to ensure that research in this area is designed, conducted, documented and interpreted with utmost care. The TSC also recommends that the important issues of cost and cost-effectiveness be carefully considered when evaluating antibiotic regimens.**
- 6.3.9 The TSC is pleased to learn of the initiative to revitalise the WHO Inter-departmental Working Group on Availability and Rational Use of Drugs Needed for IMCI. **The TSC recommends that CAH defines its role relative to the other current and potential members of the Working Group in the areas of access and rational use of drugs, including drug supply management and financing for drugs.**
- 6.3.10 The TSC recognises and is encouraged by the Department's work to improve the accessibility of health services to adolescents and provision of safe and supportive environments. **The TSC recommends that CAH draw on this in developing an overall framework for addressing user-friendliness of health services for the 0 to 19 age group.**

#### 6.4 Financial matters

- 6.4.1 The TSC congratulates the Department for the clarity of the budget presentation. The TSC believes that the preparation of such financial documentation at the Departmental level is an important part of management, and is needed to support the review of the work plan.
- 6.4.2 The TSC recognizes that there was a balance carried over from the previous biennium, and finds that this is justified given staff shortages and unavoidable delays in some projects.

- 6.4.3 The TSC is pleased to see the shift from separate budgets for child- and adolescent-related activities in 1998-1999 to an integrated budget for 2000-2001.
- 6.4.4 The TSC endorses the significant increase in the revised budget for 2000-2001. The TSC believes that this budget is appropriate given the work plan, and encourages CAH to seek the necessary additional financial support both within and outside WHO.