United Nations E/CN.9/1998/3

Economic and Social Council

Distr.: General
19 December 1997

Original: English

Commission on Population and Development
Thirty-first session
23-27 February 1998
Item 4 of the provisional agenda*
Follow-up actions to the recommendations of the International Conference on Population and Development: health and mortality, with special emphasis on the linkages between health and development and on gender and age

Monitoring of population programmes: programme experience in implementing health and mortality activities

Report of the Secretary-General

Summary

The present report has been prepared by UNFPA in accordance with the topic-oriented and prioritized multi-year work programme of the Commission on Population and Development, which was endorsed by the Economic and Social Council in its resolution 1995/55. The topic for 1998 is health and mortality, with special emphasis on the linkages between health and development, and on gender and age.

This report is intended to provide a broad overview of the range of activities in the above-mentioned areas which have arisen in response to the pressing need to improve the quality of life and health in developing countries. That need has received clear expression at international conferences, most particularly at the International Conference on Population and Development, and in national policies and programmes. The report reflects responses to a questionnaire sent to developing countries through UNFPA representatives. Questionnaires were sent to 130 countries, and responses were received from 80; 11 non-governmental, multilateral and intergovernmental organizations also responded.

* E/CN.9/1998/1.

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I. Introduction

1. This report is intended to provide a broad overview of the range of activities in the areas of health and mortality, with special emphasis on the linkages between health and development, and on gender and age, which have been implemented in programme countries of the United Nations Population Fund (UNFPA) since the International Conference on Population and Development (ICPD), which was held in Cairo, Egypt, in September 1994.[1] The report reflects responses received from countries through UNFPA representatives. It assesses the policies and programme activities that countries have implemented in order to improve health and reduce mortality. In accordance with the substantive topics identified in chapter VIII of the ICPD Programme of Action,[1] special emphasis is directed to action taken to strengthen primary health care and the health-care sector; to promote child survival and health and women's health and safe motherhood; and to slow the spread of HIV/AIDS infection.[2]

2. In order to obtain the information necessary for the preparation of this report, a questionnaire was sent to 130 developing countries through UNFPA representatives. Responses were received from 80 countries and 11 non-governmental, intergovernmental and multilateral organizations with the following breakdown: 29 from sub-Saharan Africa, 18 from Asia and the Pacific,[3] six from Arab States, four from Europe and economies in transition, 23 from Latin America and the Caribbean, seven from international non-governmental organizations, one from intergovernmental organizations, and three from United Nations agencies.

3. The response rate to the request for information from country offices was 57 per cent. For Africa (63 per cent), Asia and the Pacific (64 per cent) and Latin America and the Caribbean (70 per cent), the rate of response was satisfactory but not optimum. Most programme countries in Central Asia and those countries undergoing emergencies were understandably unable to complete the questionnaire. The low level of response (23 per cent) from the Arab States and Europe is due primarily to the non-completion of the questionnaire by the Gulf States, Eastern European countries and the successor states of the former Soviet Union. The response rate was 23 per cent from international non-governmental organizations but only 2 per cent from intergovernmental organizations. These response levels were obtained after an initial request and two reminders for assistance were sent to all potential respondents. The response rate was 74 per cent for those countries with resident UNFPA representatives.

II. Health and development

A. Health reform and financing

4. Two types of reform in the health-care sector are reportedly under way. The first involves systematic revision of the training of staff and of the delivery and monitoring of services and other features of the system in response to the Programme of Action. This includes, most notably, an emphasis on counselling, intensification of a reproductive health perspective and an emphasis on adolescent health. The revised approaches are being incorporated into existing activities — for example, through in-service training — and adapted to curricula and plans for new services and providers. A good example is Nepal, where a long-term health plan has been adopted which emphasizes child survival and reproductive health.

5. The second type of reform is more fundamental and may involve the transformation of the health-care sector. Twelve African countries report having undertaken steps to start such a reform. In Madagascar, decentralization with community participation and integration of activities at the local level is in place and this is being accompanied by the strengthening of the district-level health sector.

6. Nearly all of the responding Asian countries (17 out of 19) report actions to revise and reform the health sector. In Bangladesh, efforts are under way by the Government, assisted by the World Bank, to examine the reforms needed for the integration and delivery of primary health care services. A similar effort, also assisted by the World Bank, is under way in Egypt. In Cambodia and Azerbaijan, health reforms are linked with changes in the modes of health financing. In several countries, such as Thailand, policies on health are being linked closely with overall policies designed to improve the quality of life. In some countries, these efforts have just begun. The Government in Yemen has established a health reform committee, chaired by a Minister, with the goal of developing guidelines and a new policy for reform.

7. In line with the goal articulated in the Programme of Action which urges Governments to "seek to make basic health-care services more sustainable financially ... by making appropriate use of community-based services, social marketing and cost-recovery schemes, with a view to increasing the range and quality of services available",[4] many countries are moving away from a tradition of complete financing of basic health care from governmental revenues in favour of alternative arrangements. Twelve African countries report use of fee-for-service or cost-recovery activities, and other countries have initiated financing

programmes. These include drug revolving funds, laboratory fees, partial or full payment for services, and other arrangements. Senegal has adopted a strategy based on the Bamako Initiative[5] and applied it in 45 health districts where patients are required to pay fees for preventive or curative consultations to cover recurrent costs. Financing for the health posts is dependent on those fees. Patients also pay for essential drugs. In each of the reforms just described, greater emphasis is given to the provision of primary health care and improving access to services. In at least 15 countries in Africa, private-sector health insurance is either being tested as a pilot project, is legally permissible or is available.

8. Hospital fees and user fees are also reported as policies in Asia, where Malaysia, Cambodia and Bangladesh are using partial- or full-cost recovery for services. In many of these same countries the way has been cleared for the introduction of health insurance. A number of countries in Asia already have health insurance programmes in operation. These include coverage of governmental workers and some private-sector employees in 10 countries — including Indonesia, Thailand, the Islamic Republic of Iran and the Philippines. Yemen has adopted a policy where cost-sharing is encouraged, and the community is asked to be responsible for managing health services and to participate in the cost-recovery system.

9. At the same time, and also in accordance with the Programme of Action, programmes to improve access, acceptability and affordability of services are intended to reduce the differentials that restrict the availability of health services to the poor. At the country level, the reproductive health programme in Bhutan aims to increase the proportion of pregnant women attending antenatal services by targeting those who cannot pay for private services. Information, education and communication (IEC) efforts aimed at the poor in the Islamic Republic of Iran have promoted increased use of the primary health care network and have attempted to reduce the difference in health status between women living in cities and those in the most remote areas of the country. Reduction or elimination of charges and fees for health services to the poor in the Republic of Korea and other countries has a similar goal. Increasing the number of service delivery points in Nepal and the Philippines will benefit disadvantaged groups. Several countries are responding to the needs of indigenous peoples by extending the number of facilities and by training service providers in the relevant languages and in the cultural and social practices that will enable them to better meet the needs of those groups.

B. Improving the quality of life

10. The Programme of Action says that "all countries should give priority to measures that improve the quality of life and health by ensuring a safe and sanitary living environment for all population groups".[6] Provision of clean water and sanitary services are frequently featured in programmes and policies focused on quality of life and the environment. Country-level programmes in nations such as Comoros and Eritrea include a national priority directed to provision of safe water and sanitary facilities, and in Senegal the adoption of a code of hygiene has been put in place, down to the community level. Other countries in Asia, the Middle East and Latin America are responding by putting in place policies and programmes to raise awareness and taking action to prevent an increase in pollution and degradation of the environment. In the South Pacific, countries have adopted policies and programmes advocating the concept of "healthy islands."

11. The Philippines provides a notable example of a "healthy places" strategy which is being implemented through advocacy of basic sanitation and the removal of threats to the environment. It emphasizes promoting healthy habits in schools; rekindling the commitment of local governmental units, non-governmental organizations, and the private and public sectors to make lodging facilities, food establishments and marketplaces more sanitary and healthful; and promoting healthy workplaces, non-polluting vehicles and clean and sanitary streets. Increasing the level of awareness of the public is designed to stimulate action to ensure a safe and healthy environment. Policies and programmes in several other countries in Asia, including Nepal and the Republic of Korea, share this emphasis on providing a safe, healthy and sanitary living environment.

C. Meeting the needs of special groups

12. Work-related health policies and programmes are emerging as important elements in development plans in several countries. The provision of health services at the workplace is sometimes open to family members, as in Namibia and Uganda. These services may be provided or financed by the private sector, an non-governmental organization or the Government. In other countries, policy reforms have been initiated to promote and protect the health of workers by means of an occupational health act or similar structure. Policies adopted in various countries in Asia have also emphasized the need for protection of the health and safety of workers. In Fiji, new requirements call for a medical

examination for employment, and a health compensation act has been passed to assist those who have suffered harm in the workplace as the result of unsanitary conditions. India has adopted a policy to protect domestic servants, and the Philippines has put forward an occupational health and safety code to protect many classes of workers.

13. National policies for assistance to the disadvantaged are found in a number of countries. These provide for care and treatment of the blind and others with disabilities. Increasingly, Governments are recognizing the growing prevalence of disablement and the need to prevent and treat it. Active programmes of physical rehabilitation and training to strengthen financial self-sufficiency are under way in, for example, Cape Verde, Ethiopia and Senegal. In several countries, non-governmental organizations make a major contribution to programmes for disabled and handicapped persons. In the Central African Republic, national and international non-governmental organizations are working closely with the Government in programmes for handicapped persons. The Republic of Korea has passed legislation to protect the disabled and provide access to information and facilities. Financial assistance is provided for the diagnosis of health problems, and medical rehabilitation services have been expanded to increase the number of facilities and reduce medical charges to low-income disabled persons. Similar efforts are supported in the Philippines, with emphasis on helping families to cope with disabled members and on providing support for capability-building programmes to develop self-reliance and independence. Policies and programmes for the disabled are reported in 11 countries in Asia. They typically include assistance from non-governmental organizations and Governments in providing training and support for those who can work and in conducting research and evaluation of causes and treatment of disability.

14. Programmes and policies supporting the needs of older persons are most frequently seen in Asian countries. Policies and programmes in the Republic of Korea help older persons to live independent lives at home. In Fiji, Malaysia, Pakistan and the Philippines, non-governmental organizations have played a major role with Governments in establishing residential accommodations, providing training and addressing health needs. In Bangladesh, programmes for older persons and institutional responses to their needs are seen in the establishment of the Institute of Geriatric Medicine and the formation of the National Committee on Ageing at the ministerial level. Non-governmental organizations are active in creating awareness among people of the needs of older persons. Important innovations are also taking place in Africa where programmes to address the health needs of older persons are reported in countries such as Malawi, Mozambique, Senegal and the United Republic of Tanzania. Programmes to provide social and housing support are reported in several countries; they often feature cooperation between non-governmental organizations and the Government in meeting the needs of this rapidly growing population.

15. In every geographical region and in all countries, there is growing awareness of the importance of policies and programmes that address the health needs of adolescents, including their reproductive health needs, which have often been neglected. In many countries, such as Bangladesh, Eritrea, India and the United Republic of Tanzania, early marriage and subsequent early childbearing not only are health risks to young women but also prevent their full social development and reduce the contribution that each individual can make to social development and community life. Recognizing this, policies and programmes in Burkina Faso, the Central African Republic, Uganda and Zambia, for example, have been developed to improve adolescent reproductive health through youth-to-youth services and the provision of youth-friendly service facilities. Non-governmental organizations have played a major role in providing assistance to adolescents in those African countries.

III. Primary health care and the health-care sector

16. The Programme of Action says that “all countries should make access to basic health care and health promotion the central strategies for reducing mortality and morbidity”.[7] Accessibility to basic health services appears to be improving in most of the countries that responded to the UNFPA survey. The number of service providers is increasing through recruitment and training. Existing staff are undergoing retraining to increase technical skills and improve the quality of care. In most countries, new facilities and equipment have been provided and established facilities are being refurbished. In a few instances — in Zambia, for example — countries report that staff are being redeployed to underserved areas. More outreach facilities are being supported, and community-based distribution of health care is increasing. Some efforts have been made — for example, in South Africa — to reallocate resources from provision of tertiary care to basic-care settings. This, however, is a difficult process, often encountering resistance. The overall goal is to reduce the average distance for users to service delivery points to 5 kilometres, thereby increasing the proportion of persons who have access to services. To date, there is no agreement across

countries as to the standard to be adopted for measuring access.

17. Acceptability of basic health care services has been addressed in country programmes by improving technical and normative standards, training service providers in new skills, including client counselling techniques, and strengthening the emphasis on culturally appropriate approaches to service delivery. On the client side, some countries, such as Eritrea, are emphasizing the use of IEC programmes to educate people on health care, health promotion and the importance of developing an active interest in individual and family health.

18. Community distribution of family planning and basic health care services is a well established mode of programme activity in all regions. Reliance on this delivery system is reinforced by decisions to decentralize the management of health systems to the most basic effective level. In Bangladesh, Bhutan, Botswana and Viet Nam, community organizations and residents have a direct role in implementing delivery of services. In Nepal, for example, the National Health Policy includes provision of primary health care and family planning at grass-roots levels through community participation in the management and delivery of services by outreach clinics. The clinics are managed by user groups through the formation of a management committee at the local level. Community participation in the formulation of health policy and local involvement by community leaders in selecting services to be provided is reported in Yemen. In Nigeria, the community is involved in programme planning in the Women's Health Organization Project; in programme monitoring and management, by encouraging the formation and activities of village and district health development committees; and in resource mobilization and renovation of health facilities.

19. Changes and revisions in health curricula in response to new emphases raised by the ICPD have been widespread. Nearly all developing countries have expanded the curricula for physicians, community health workers and other health providers to include reproductive health, including family planning, in basic health curricula. In Malaysia, additional materials have been added on the health needs of youth, on women's health and on the health of older persons. A special emphasis on counselling skills is noted in Botswana, Mozambique, Nigeria and a number of other countries.

IV. Child survival and development

20. When child survival and development programmes were launched in the 1980s, they concentrated on growth monitoring, breastfeeding, immunization and the use of oral rehydration salts to combat the dehydration caused by diarrhoea. These four methods of saving children's lives address major causes of morbidity and mortality during the first year of life and through age five. Child survival policies have now evolved beyond the four programmes introduced in the 1980s. In the present inquiry, a majority of countries in each region report that various new policies directed to child survival and development have been put in place. These have included targeting specific causes of death, strategic choices of comprehensive case management (an initiative supported by UNICEF and others) and of integrating child health into reproductive health services for parents. These efforts are not being made in isolation from other development programmes. In Indonesia, for example, child survival policies are linked to efforts at poverty alleviation. Botswana, Malawi, Thailand and some South Pacific countries address the problem through school health programmes that include provision of nutrition and health services at schools.

21. Nearly all countries have established child health nutrition programmes, which usually include surveillance of malnutrition levels, growth monitoring, information materials directed to mothers, and interventions directed to specific problems. UNICEF reports that policies supporting vitamin A supplementation have been adopted in 61 countries and that 28 countries provide vitamin-A supplements to children. In the present inquiry, provision of vitamin-A supplements was frequently reported as a specific programme component, as is the provision of iodized salt for the prevention of goiter and mental retardation. Country responses indicate that there is little reported need for special programmes focused on the nutritional status of girls. However, while protein-energy malnutrition is declining overall, in some countries improvements are greater for boys at specified ages than for girls.

22. In some countries, nutrition policies are integrated into development programmes. In Namibia a food and nutrition policy, established in 1995, states that the Government will give priority to empowering the population to become self-reliant in meeting their food and nutrition needs at the household level by promoting good food, health and nutrition practices. Households and individuals must therefore have access to adequate resources to produce the necessary food commodities, knowledge and understanding of how to use those resources to their best advantage, and access to safe water supply, health clinics and reliable market structures to enable full exploitation of the resources.

23. Advocacy and IEC support for breastfeeding are in place in all geographical regions. Seventy per cent of the countries responding report that such programmes are well

established and that they have increased exclusive breastfeeding or stopped a decline in the practice that had begun in the previous decade. Where noted, the advocated duration of breastfeeding is from four to six months. At the same time, there was frequent mention in the survey of adoption of a code against the use of milk substitutes. These efforts are nearly always cited as elements of the "baby-friendly" hospital initiative. UNICEF estimates that over 12,000 hospitals have been designated "baby-friendly" as a result of hospitals' efforts to promote and protect breastfeeding. Support for breastfeeding is provided by a variety of organizations, including Governments, through ministries of health and non-governmental organizations, such as national breastfeeding committees. For example, in the Islamic Republic of Iran, a national breastfeeding committee, headed by the Minister of Health, has encouraged hospitals and medical universities to promote the practice. A national centre for the promotion of breastfeeding was established, with four additional provincial centres to implement training programmes. A study in 1995 showed that 59 per cent of rural and 46 per cent of urban infants are exclusively breastfed for the first four months of life. In Honduras, breastfeeding is promoted as an infant survival strategy through national and intra-hospital committees on breastfeeding and regulation of the commercialization of milk substitutes.

24. There is nearly universal adoption of immunization programmes across the regions. The Expanded Programme of Immunization (EPI) and other mass programmes are the norm to prevent the major childhood diseases. Less commonly reported were efforts to control other infections and parasites. Perhaps only one third of countries report implementation of programmes to control acute respiratory infection. Only a few countries in Africa, where 90 per cent of all clinical cases of malaria are seen, highlighted programmes to reduce malaria in children, even though the World Health Organization (WHO) has reported that those at greatest risk from the disease are children under age 5 in malaria-endemic areas.

V. Women's health

25. The Programme of Action calls on all countries to seek to effect significant reductions in maternal mortality by the year 2015. Central to these concerns is an understanding that the quality of women's health, and in particular reproductive health, is lagging behind advances seen in other health indicators. As noted by WHO, UNFPA and UNICEF, maternal mortality is a particularly sensitive indicator of inequity and women's health, and available information amply documents that there has not been any real improvement in maternal mortality rates in recent years. After the ICPD, UNFPA and WHO recognized that improving reproductive health was an essential component of development. The strategy to achieve it is based on four principles — namely, to build on what already exists; to promote linkage and functional integration of reproductive health information and services into primary health care; to meet the needs for core components of fertility regulation, reducing maternal and newborn morbidity and mortality and preventing and managing sexually transmitted diseases (STDs); and to involve both men and women in achieving reproductive health.

26. At the country level, policies and programmes have been initiated to reduce the risks faced by women during the reproductive years. Closely spaced births, births to very young women and the strain on a woman's health that follows having to return to work immediately after delivery are recognized as increasing the risk to health. One response to the latter problem is the institutionalization policies and regulations on maternity leave. The provision of maternity leave is cited as a practice in Mauritius and has been submitted for inclusion in the civil reform act in Ethiopia, which would provide up to three months leave. All eligible mothers are entitled to 60 days leave in Kenya; in Rwanda, employees in the formal sector have three months of maternity leave; Botswana has three months of leave with full pay; Namibian women have one month of leave after delivery; and 45 days of leave is the norm in Uganda.

27. Countries in Asia have similar policies and programmes. In the 14 Asian countries providing such information, the period of maternity leave varies from 45 to 133 days, with most countries providing for three months of leave. In a few countries — e.g., India and the Philippines — 15 days of paternity leave is also allowed. The practice of maternity leave is most fully established with government and large private-sector organizations. It is a much less common provision for the vast majority of women who work in rural settings or in small industries. Non-governmental organizations have actively supported adoption of policies for maternity leave and have been successful in countries such as Bangladesh in gaining governmental support.

28. The situations of women in many countries pose risks to their health. This has been recognized in some settings through policies adopted to protect women's rights in the family and social settings, in both domestic and community environments. These efforts are quite varied and reflect what are seen as local needs. Malawi, Niger, the Philippines and the Syrian Arab Republic report policies and revisions of laws to protect the health of women at their places of work. Certain domestic work environments pose special risks to the health

of women; they are recognized in Ethiopia, the Islamic Republic of Iran and Nepal. In the Comoros, the family code has been strengthened, and a Minister is assigned the task of promoting women's rights and health. Cambodia was one of the few countries reporting adoption of a governmental policy to reduce domestic violence as part of an approach to protecting women's health. The Philippines has adopted a policy to prevent violence against women from rape, assault and incest.

29. Strengthening women's role in decision-making in areas of sexual and reproductive health is seen as part of a larger policy to protect women's health. Policies and programmes to achieve that end at several levels of society are found in several countries such as Cambodia. Efforts to create opportunities for women to play a stronger role are also reported in Bhutan, Ethiopia and the Islamic Republic of Iran. In the Philippines, it is a basic governmental principle that family planning and reproductive choice should be exercised by individuals and couples. Moreover, gender-training activities run by women's health organizations and other non-governmental organizations include a women's health orientation module on reproductive health and rights, sexuality and sexual rights. The programme in the Islamic Republic of Iran also includes IEC efforts directed at educating men on women's rights and decision-making roles. The United Nations organizations in the Islamic Republic of Iran have supported those efforts. The UNFPA country programme emphasizes women's development and empowerment components in each core area of assistance.

30. In 15 African countries, activities are being undertaken to eliminate the practice of female genital mutilation (FGM), which can have devastating effects on the health of women. Such activities include advocacy; awareness creation; creation of national committees or task forces against such harmful practices; media and sensitization campaigns; socio-cultural research; development and dissemination of information materials; and training of health care providers. Local and national non-governmental organizations and other national institutions have organized several workshops and seminars on this topic in the concerned African countries, and their work is being supported by bilateral and multilateral organizations, including, in many cases, UNFPA.

Safe motherhood

31. UNFPA has been active in advancing the Safe Motherhood Initiative, which is based on data that show that pregnancy-related mortality and morbidity are major contributors to the overall burden of disease among women of reproductive age in developing countries. The present inquiry shows that this approach has received wide support: safe maternal care programmes are common to all countries in each geographical region. Facilities are being established or renovated; training is provided and curricula revised; and referral systems are being developed and made more effective in all reporting countries.

32. It is now recognized that maternal morbidity and mortality cannot be significantly reduced without providing ready access to essential obstetrical services that are safe and effective to all women who need them. In the Arab States region, the Syrian Arab Republic, Sudan and Yemen are all undertaking training activities in safe delivery and emergency obstetrical care. The same is true for sub-Saharan Africa, Latin America and Asia. In the Islamic Republic of Iran, a committee for the reduction of maternal mortality has been established under the direct supervision of the Minister of Health and Medical Education. The committee has counterparts at the provincial level. Every maternal death has to be reported to a committee for a review of underlying causes and methods of future prevention. The committees design educational modules and organize refresher courses on complications of pregnancy and childbirth for physicians and university-educated midwives. Since the ICPD, with UNFPA support, renovations, equipment, supplies and specialized training for essential obstetrical care have been put in place in numerous countries as part of new programmes of assistance.

33. Like nutrition programmes for child survival, programmes for maternal nutrition typically include treatment of anaemia through iron supplementation and of iodine deficiency through the use of iodized salt, and programmes to improve levels of intake of vitamin A. In a few instances, more intensive actions are taken, such as support for comprehensive nutrition centres, reported in Sudan, to diagnose and treat women's health needs. Creating awareness of the nutritional requirements of pregnant and nursing women and the promotion of good eating habits through IEC and advocacy is being undertaken in Yemen, which also provides essential food to the poor through the World Food Programme and other agencies.

34. Reproductive health implies that individuals and couples have the ability to reproduce, that women can go through pregnancy and child-birth safely, and that infants survive and grow to a healthy maturity. This also implies that people are able to have the number and spacing of children they desire and that they are safe in having sex. Family planning is central to all aspects of reproductive health and has a bearing on prevention of STDs, the consequences of unwanted fertility, infertility and maternal and child survival.

Programmes and policies for family planning are in place in over 145 countries. To reduce unwanted pregnancies, country-level programmes, supported by UNFPA and other international organizations, have promoted improved access to quality care in family planning, revised technical materials for clinic and community-based family planning service providers to reflect the latest recommendations for medical eligibility criteria for contraceptive use, and strengthened IEC and counselling materials.

35. Country-level initiatives have also been undertaken to clarify the approaches to such emerging needs as emergency contraception and the special family planning needs of selected populations, such as adolescents, refugees and displaced persons. The joint programme of the Office of the United Nations High Commissioner for Refugees (UNHCR)/UNFPA of assistance in emergency situations has established procedures through which essential reproductive health supplies are made available to refugees and internally displaced persons.

36. Abortion prevention and the treatment of complications resulting from abortion is a sensitive issue in most countries. Access to effective family planning services is supported in country-level programmes as the most useful means of prevention of the unwanted pregnancy that leads to abortion. When unsafe abortion occurs, many countries, including Malawi, Mozambique and Nepal, report that the resulting complications are treated by trained staff with suitable clinical care. Women who have terminated a pregnancy through abortion are in critical need of family planning services. WHO advocates that policy makers should modify those policies that are obstacles to the delivery of post-abortion family planning services, commit human and financial resources to programmes, and elicit political and managerial support for post-abortion family planning. A workshop on post-abortion family planning for central and district-level programme managers, held in 1997 in Turkmenistan and supported by WHO, was part of a larger programme of assistance to country-level programmes.

VI. HIV/AIDS

37. In all regions, policies and legal frameworks have been strengthened in response to the threat of further increases in the incidence of the AIDS pandemic. In countries in sub-Saharan Africa where HIV prevalence may be among the highest in the world, strategic five-year plans have been developed, and in several instances a second set of five-year plans is now in operation. Even in those countries that report relatively low levels of HIV/AIDS infection, actions have been taken to establish structures to prevent the growth of the pandemic. Nearly all countries, in all regions, have created national AIDS prevention and control organizations, either in the form of an AIDS committee, council, programme, commission, or have created a special unit within an existing structure such as the Ministry of Health. In Indonesia, for example, a Presidential Decree was issued in May 1994 creating a multisectoral AIDS prevention control commission, with ministerial representation from several sectors. The commission has sponsored a comprehensive AIDS strategy to promote healthy behaviour among members of the general public, protect people from infection, reduce vertical transmission and provide support for those who are infected.

38. At the international level, the United Nations system has focused its efforts, through UNAIDS, on strengthening and supporting country capabilities to coordinate, plan, fund, implement, monitor and evaluate an expanded response to HIV/AIDS. As of September 1997, 132 United Nations theme groups on HIV/AIDS had been established in 155 countries to support work in national capacity-building. In Botswana, the common framework in support of the eighth national development plan includes six projects. In Pakistan, joint planning between the United Nations theme group and the Government has increased national and international commitment to the programme. UNAIDS also gives a high priority to efforts to develop, advocate and implement best practices in combating the epidemic; 19 such best practices have now been issued by UNAIDS, which has brought together scientists at regional workshops to improve surveillance. UNFPA has supported these and other efforts. In 1996, UNFPA provided over $20 million for HIV/AIDS, including prevention activities in 124 countries, and also collaborated with more than 115 non-governmental organizations in those activities.

39. Country-level programmes to prevent or reduce the spread of HIV/AIDS vary greatly in response to local needs. Most often, the programmes include several elements: awareness creation and IEC on the practice of safe sex, correcting misinformation about the disease and increasing knowledge among service providers; testing and distribution of safe blood supplies; training of health workers in methods of diagnosis and management, including counselling skills; activities to address the needs of high-risk groups such as commercial sex workers and the military; and increasing the availability and use of condoms. Sentinel surveillance systems to monitor the growth of the epidemic have been established in several African countries. In the Africa region, special efforts have been made through awareness creation and legal action to prevent discrimination against persons with HIV/AIDS and to ensure access to health care at the local level. In the Comoros an inquiry reported widespread

discrimination against those infected with HIV; IEC programmes were rapidly put into place by the Government and non-governmental organizations to address the problem.

40. The long period between first symptoms and the death of persons suffering from AIDS places great strain on already hard pressed families. To ease the strain, programmes have been developed in the United Republic of Tanzania to provide counselling to families. Especially noteworthy in sub-Saharan Africa is the emphasis on community-level involvement through home-based care of AIDS patients in a number of countries, including Botswana, Ghana, Kenya, Malawi, Namibia and Zambia.

41. The prevention and management of sexually transmitted diseases (STDs) and HIV/AIDS are usually integrated with the delivery of basic health-care services. In most country programmes, efforts to prevent STDs, including HIV/AIDS, are integrated with reproductive health-care services. This has been done through the introduction of special training for existing health-care providers on counselling, awareness creation, best practices and case management. Several countries, including Botswana, Honduras, Namibia, Turkey, Uganda and Viet Nam, report that HIV/AIDS prevention programmes are being jointly undertaken at the interministerial or interdepartmental levels to bring the greatest effort to bear on the problem.

42. Countries with a significant level of HIV/AIDS have adopted measures to meet the challenge of massive changes in demand for services and the reduced ability to provide care because of illness among health personnel. Measures have also been taken to make adjustments in health systems that are faced with a need to integrate HIV-related services into the existing system, as in the case of STDs and blood safety. In Thailand, AIDS patients receive financial assistance from the Government. The 1996 budget allocation for the national AIDS programme included support for the prevention of behavioural and social risk factors, health promotion and medical services, including universal precautions and blood safety, provision for counselling, assistance for those living with AIDS, research on and evaluation of programmes, and administrative and management support. Support to families affected by AIDS is reported by Bangladesh, Bhutan, Fiji and Indonesia. Much of the assistance comes from non-governmental organizations such as the International Committee of the Red Cross and Red Crescent and national AIDS committees.

VII. International non-governmental support

43. The strong contributions of national non-governmental organizations to health programmes have been mentioned throughout this report. International non-governmental organizations have also made major contributions; since the ICPD they have advanced numerous policies and programmes on health and mortality in developing countries. UNFPA supports and works with a number of international non-governmental organizations in promoting women's health and reproductive health. They include Access to Voluntary and Safe Contraception (AVSC), the Center for Development and Population Activities (CEDPA), the Commonwealth Medical Association (CMA), the International Council on the Management of Population Programs (ICOMP), the International Planned Parenthood Federation (IPPF), the International Women's Health Coalition (IWHC), the Japanese Organization for International Cooperation in Family Planning (JOICFP), Marie Stopes International, the Population Council, the Population Institute, the Program for Appropriate Technology in Health (PATH), and the Women's Environment and Development Organization (WEDO).

44. Reports received in response to the UNFPA questionnaire document the support of international non-governmental organizations for such activities as breastfeeding in Niger and certain Caribbean island States and for children's and women's health in Nepal and Nigeria. International non-governmental organizations have supported HIV information and service delivery programmes in each of the four geographical regions. Advocacy for Women's Health has, with European and United Nations institutions, underscored the importance of continued emphasis on improving health and reducing mortality as part of development programmes. Marie Stopes International has played a strong supportive role in national efforts to improve health status and health management. Training in clinical care and counselling is supported by AVSC in several countries and by CEDPA in Nepal, Nigeria and elsewhere. JHPIEGO's programme of international education and training in reproductive health is currently strengthening training capacity in Indonesia, Morocco and Uganda through the development of reference manuals and the training of trainers to provide higher quality services and reduce both morbidity and mortality.

45. IWHC supports non-governmental organizations that provide and advocate national health services in Bangladesh, Brazil, Cameroon, Chile, Indonesia, Nigeria and the Philippines and undertakes global programmes to promote women's reproductive and sexual rights and health. WEDO works primarily in advocacy to promote and monitor issues of women's reproductive and sexual rights and health within

the larger framework of gender, environment and development. WEDO is a global organization that connects over 20,000 activists and organizations worldwide.

46. JOICFP, in partnership with the Planned Parenthood Association of Ghana, supports the training of traditional birth attendants in order to improve the quality of delivery care. In India and Bangladesh, international non-governmental organizations deliver a substantial portion of reproductive health services. Their efforts in service delivery include innovative components; for example, JOICFP fosters self-sufficient services in Nepal through cooperation between the central government and community organizations. Health research has also been supported by non-governmental organizations in clinical settings — for example, AVSC assistance for comparisons of cancer-screening techniques and JHPIEGO support for assessments of training needs in Indonesia and Uganda. A lead role is played by the Population Council in support of health and family planning programmes in each region. Especially important has been the assistance provided to operational research and for strengthening quality-of-care elements in national programmes.

VIII. Health research

47. Nearly all countries responding to the survey support some programmes of health research. The only exceptions are those with resource constraints. Demographic and health surveys were most frequently mentioned in the questionnaire as sources of information. Some countries are undertaking special surveys on nutrition and male reproductive health, and specific mention was made by five countries of research programmes on adolescent health.

48. Several country programmes have developed extensive research agendas. Among the most completely documented are those in Nicaragua, the Philippines, Senegal, Sudan, Viet Nam and Zimbabwe. In Viet Nam research is planned or in progress on the prevalence of reproductive tract infections; the prevalence of abortion and complications resulting from it; youth, premarital sexuality and abortion; and the causes of maternal mortality.

49. Reproductive health, including safe motherhood; male knowledge, attitudes and practice (KAP) studies; and STD studies (including the syndromic approach to the diagnosis of STDs) are included in a number of national research agendas. Abortion research was reported by 12 out of the 74 responding countries; the objectives are usually to estimate prevalence of the problem and identify its causes so that effective preventive actions can be implemented.

IX. Conclusions

50. This review of policy and programme activities in 74 countries, across four geographical regions, reveals a significant level of activity in efforts to improve health and reduce mortality. Among the principal findings are the following:

(a) Fundamental changes are occurring in the structure, financing and types of services provided by the health sector;

(b) Improving access to basic health care is a core element of country policies, and major improvements are already being seen in efforts to reach the least advantaged populations;

(c) Community participation in the delivery of health services is growing;

(d) Child survival programmes have improved infant and child health, and the current emphasis on micro-nutrients promises to bring about further improvements;

(e) The benefits of breastfeeding for child survival have been universally accepted;

(f) Maternity leave policies are becoming the norm among workers in the formal sector in many developing countries;

(g) The special health risks faced by women are being acknowledged and acted upon at the highest governmental levels;

(h) Family planning is seen in all countries as essential in order to reduce unplanned pregnancies and improve reproductive health;

(i) Country-level responses to the HIV/AIDS pandemic have mobilized resources to reduce the rate of growth of HIV infection;

(j) Except in the relatively advanced countries, resources for health research are too limited to support the collection of information needed for decision-making;

(k) Non-governmental organizations have an increasingly recognized role in providing health care, advocacy and awareness creation.

Notes

[1] *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994* (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex.

[2] A principal limitation of the report is the fact that the country-level replies do not provide data on the depth of implementation of programmes and policies or their impact on health and mortality levels.

[3] Combined information on 13 countries in the South Pacific region is counted as a single report.

[4] *Report of the International Conference on Population and Development* ..., annex, chap. VIII, para. 8.8.

[5] The Bamako Initiative was announced in September 1987, at a meeting sponsored by the World Health Organization and UNICEF, of health ministers of the African region.

[6] *Report of the International Conference on Population and Development* ..., annex, chap. VIII, para. 8.10.

[7] Ibid., para. 8.4.