

## DECISIONS

### **WHA57(1)      Composition of the Committee on Credentials**

The Fifty-seventh World Health Assembly appointed a Committee on Credentials consisting of delegates of the following 12 Member States: Austria, Belize, Canada, Djibouti, Gambia, India, Italy, Kenya, Mali, Myanmar, Papua New Guinea, Uzbekistan.

(First plenary meeting, 17 May 2004)

### **WHA57(2)      Composition of the Committee on Nominations**

The Fifty-seventh World Health Assembly elected a Committee on Nominations consisting of delegates of the following Member States: Bahrain, Brunei Darussalam, Burkina Faso, China (People's Republic of), Democratic Republic of the Congo, Eritrea, Estonia, France, Guyana, Israel, Mexico, Micronesia (Federated States of), Monaco, Mozambique, Nicaragua, Peru, Russian Federation, Sri Lanka, Swaziland, Thailand, Tunisia, Uganda, United Kingdom of Great Britain and Northern Ireland, Uruguay, and Dr Khandaker Mosharraf Hossain, Bangladesh (President, Fifty-sixth World Health Assembly, ex officio).

(First plenary meeting, 17 May 2004)

### **WHA57(3)      Election of officers of the Fifty-seventh World Health Assembly**

The Fifty-seventh World Health Assembly, after considering the recommendations of the Committee on Nominations, elected the following officers:

<b>President:</b>	Mr Muhammad Nasir Khan (Pakistan)
<b>Vice-Presidents:</b>	Dr M.E. Tshabalala-Msimang (South Africa) Mrs A. David-Antoine (Grenada) Mr S. Bogoev (Bulgaria) Dr R. Maria de Araujo (Timor-Leste) Dr Chua Soi Lek (Malaysia)

(First plenary meeting, 17 May 2004)

**WHA57(4) Election of officers of the main committees**

The Fifty-seventh World Health Assembly, after considering the recommendations of the Committee on Nominations, elected the following officers of the main committees:

**Committee A: Chairman** Dr Ponmek Dalaloy (Lao People's Democratic Republic)

**Committee B: Chairman** Dr Jigmi Singay (Bhutan)

(First plenary meeting, 17 May 2004)

The main committees subsequently elected the following officers:

**Committee A: Vice-Chairmen** Dr D. Slater (Saint Vincent and the Grenadines)  
Mrs A. Van Bolhuis (Netherlands)

**Rapporteur** Professor M. Mizanur Rahman (Bangladesh)

**Committee B: Vice-Chairmen** Professor N. M. Nali (Central African Republic)  
Dr S. Al Kharabseh (Jordan)

**Rapporteur** Mrs Z. Jakab (Hungary)

(First meetings of Committees A and B, 18 and 20 May 2004)

**WHA57(5) Establishment of the General Committee**

The Fifty-seventh World Health Assembly, after considering the recommendations of the Committee on Nominations, elected the delegates of the following 17 countries as members of the General Committee: Botswana, Chad, Chile, China (People's Republic of), Cuba, France, Ireland, Kazakhstan, Liberia, Libyan Arab Jamahiriya, Niger, Nigeria, Russian Federation, Trinidad and Tobago, United Kingdom of Great Britain and Northern Ireland, United States of America, and Yemen.

(First plenary meeting, 17 May 2004)

**WHA57(6) Adoption of the agenda**

The Fifty-seventh World Health Assembly adopted the provisional agenda prepared by the Executive Board at its 113th session with the deletion of one item and three subitems, and the addition of a supplementary item.

(Second plenary meeting, 17 May 2004)

**WHA57(7) Verification of credentials**

The Fifty-seventh World Health Assembly recognized the validity of the credentials of the following delegations: Afghanistan; Albania; Algeria; Andorra; Angola; Antigua and Barbuda; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Belgium; Belize; Benin; Bhutan; Bolivia; Bosnia and Herzegovina; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cambodia; Cameroon; Canada; Cape Verde; Central African Republic; Chad; Chile; China; Colombia; Congo; Cook Islands; Costa Rica; Côte d'Ivoire; Croatia; Cuba; Cyprus; Czech Republic; Democratic People's Republic of Korea; Democratic Republic of the Congo; Denmark; Djibouti; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Georgia; Germany; Ghana; Greece; Grenada; Guatemala; Guinea; Guinea-Bissau; Guyana; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Latvia; Lebanon; Lesotho; Liberia;<sup>1</sup> Libyan Arab Jamahiriya; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Marshall Islands; Mauritania; Mauritius; Micronesia (Federated States of); Mexico; Monaco; Mongolia; Morocco; Mozambique; Myanmar; Namibia; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Palau; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Republic of Moldova; Romania; Russian Federation; Rwanda; Saint Kitts and Nevis; Saint Lucia; Saint Vincent and the Grenadines; Samoa; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Serbia and Montenegro; Seychelles; Sierra Leone; Singapore; Slovakia; Slovenia; Solomon Islands; Somalia; South Africa; Spain; Sri Lanka; Sudan; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Thailand; The former Yugoslav Republic of Macedonia; Timor-Leste; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Turkmenistan; Tuvalu; Uganda; Ukraine; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Uzbekistan; Venezuela; Viet Nam; Yemen; Zambia; Zimbabwe.

(Fourth and seventh plenary meetings, 19 and 21 May 2004)

**WHA57(8) Election of Members entitled to designate a person to serve on the Executive Board**

The Fifty-seventh World Health Assembly, after considering the recommendations of the General Committee,<sup>2</sup> elected the following as Members entitled to designate a person to serve on the Executive Board: Australia, Bahrain, Bolivia, Brazil, Jamaica, Kenya, Lesotho, Libyan Arab Jamahiriya, Luxembourg, Romania, Thailand, Tonga.

(Seventh plenary meeting, 21 May 2004)

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<sup>1</sup> Credentials provisionally accepted.

<sup>2</sup> Document A57/38.

**WHA57(9) Intellectual property rights, innovation and public health**

The Fifty-seventh World Health Assembly decided to request the Director-General to delay submission of the final report on the outcome of the work of the Commission on Intellectual Property Rights, Innovation and Public Health, established pursuant to resolution WHA56.27, until the 117th session of the Executive Board (January 2006) since additional time was necessary for the Commission to complete its work.

(Seventh plenary meeting, 21 May 2004)

**WHA57(10) Budget allocations to regions**

The Fifty-seventh World Health Assembly, after considering the report on regular budget allocations to regions,<sup>1</sup> noting the recommendations contained in paragraph 21, decided to request the Director-General to draw up, in consultation with Member States and regions, guiding principles, based on objective criteria, to be applied in the allocation of funds from all sources, taking into account equity, efficiency and performance, and support to countries in greatest need, in particular least developed countries, which would be considered by the Executive Board at its 115th session.

(Eighth plenary meeting, 22 May 2004)

**WHA57(11) United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee**

The Fifty-seventh World Health Assembly nominated Dr J. Larivière, delegate of Canada, as member of the WHO Staff Pension Committee, and Dr A.A. Yoosuf, delegate of Maldives, as alternate member, each for a three-year period, namely until May 2007.

The Fifty-seventh World Health Assembly also nominated Dr L. Waqatakirewa, delegate of Fiji, as member of the Committee for the remainder of the term of office of Mr L. Rokovada, namely, until May 2005.

(Eighth plenary meeting, 22 May 2004)

**WHA57(12) Policy for relations with nongovernmental organizations**

The Fifty-seventh World Health Assembly decided to postpone consideration of the new policy on nongovernmental organizations<sup>2</sup> in order to provide the Director-General time to consult all interested parties with a view to reaching consensus on the terms of the relevant resolution to be submitted to a subsequent Health Assembly through the Executive Board.

(Eighth plenary meeting, 22 May 2004)

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<sup>1</sup> Document A57/24.

<sup>2</sup> See document A57/32.

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**WHA57(13)      Selection of the country in which the Fifty-eighth World Health Assembly would be held**

The Fifty-seventh World Health Assembly, in accordance with Article 14 of the Constitution, decided that the Fifty-eighth World Health Assembly would be held in Switzerland.

(Eighth plenary meeting, 22 May 2004)

**WHA57(14)      Reports of the Executive Board on its 112th and 113th sessions**

The Fifty-seventh World Health Assembly, after reviewing the Executive Board's reports on its 112th<sup>1</sup> and 113th<sup>2</sup> sessions, took note of the reports, commended the work the Board had performed, and expressed its appreciation of the dedication with which the Board had carried out the tasks entrusted to it.

(Ninth plenary meeting, 22 May 2004)

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<sup>1</sup> Document EB112/2003/REC/1.

<sup>2</sup> Documents EB113/2004/REC/1 and EB113/2004/REC/2.



## **ANNEXES**





## **ANNEX 1**

### **Agreement between the Office International des Epizooties (OIE) and the World Health Organization (WHO)<sup>1</sup>**

[A57/28, Annex – 8 April 2004]

The World Health Organization (hereinafter referred to as WHO) and the Office International des Epizooties (hereinafter referred to as the OIE) wishing to co-ordinate their efforts for the promotion and improvement of veterinary public health (VPH) and food security and safety, and to collaborate closely for this purpose

Have agreed to the following:

#### ***Article 1***

- 1.1 WHO and the OIE agree to cooperate closely in matters of common interest pertaining to their respective fields of competence as defined by their respective constitutional instruments and by the decisions of their Governing Bodies.

#### ***Article 2***

- 2.1 WHO shall transmit relevant resolutions of the World Health Assembly and the recommendations of relevant WHO consultations, workshops and other official WHO meetings to OIE for the purpose of circulating them to OIE Members.
- 2.2 The OIE shall transmit the recommendations and resolutions of its International Committee as well as the recommendations of relevant OIE consultations, workshops and other official OIE meetings to WHO for the purpose of circulating them to WHO Member States.
- 2.3 These resolutions and recommendations sent for the consideration of the respective bodies of the two Organizations (hereinafter referred to as the Parties) shall form the basis for coordinated international action between the two Parties.

#### ***Article 3***

- 3.1 Representatives of WHO shall be invited to attend the meetings of the International Committee and Regional Conferences of OIE and to participate without vote in the deliberations of these bodies with respect to items on their agenda in which WHO has an interest.
- 3.2 Representatives of OIE shall be invited to attend the meetings of the Executive Board and of the World Health Assembly and Regional Committees of WHO and to participate without vote in the deliberations of these bodies with respect to items on their agenda in which OIE has an interest.

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<sup>1</sup> See resolution WHA57.7.

- 3.3 Appropriate arrangements shall be made by agreement between the Director-General of WHO and the Director-General of OIE for participation of WHO and OIE in other meetings of a non-private character convened under their respective auspices which consider matters in which the other party has an interest; this especially involves those meetings leading to the definition of norms and standards.
- 3.4 The two Parties agree to avoid holding meetings and conferences dealing with matters of mutual interest without prior consultation with the other party.

#### *Article 4*

WHO and OIE shall collaborate in areas of common interest particularly by the following means:

- 4.1 Reciprocal exchange of reports, publications and other information, particularly the timely exchange of information on zoonotic and foodborne disease outbreaks. Special arrangements will be concluded between the two Parties to coordinate the response to outbreaks of zoonotic or/and foodborne diseases of recognized or potential international public health importance.
- 4.2 Organizing on both a regional and a world-wide basis meetings and conferences on zoonoses, foodborne diseases and related issues such as animal feeding practices and anti-microbial resistance related to the prudent use of anti-microbials in animal husbandry and their containment/control policies and programmes.
- 4.3 Joint elaboration, advocacy and technical support to national, regional or global programmes for the control or elimination of major zoonotic and foodborne diseases or emerging/re-emerging issues of common interest.
- 4.4 Promoting and strengthening, especially in developing countries, VPH education, operationalization of VPH and effective co-operation between the public health and animal health/veterinary sectors.
- 4.5 International promotion and coordination of research activities on zoonoses, VPH and food safety.
- 4.6 Promoting and strengthening collaboration between the network of OIE Reference Centres and Laboratories and that of WHO Collaborating Centres and Reference Laboratories to consolidate their support to WHO Member States and OIE Members on issues of common interest.

#### *Article 5*

- 5.1 WHO and OIE will, in the course of the preparation of their respective programmes of work, exchange their draft programmes for comment.
- 5.2 Each party will take into account the recommendations of the other in preparing its final programme for submission to its governing body.
- 5.3 WHO and OIE will conduct one annual coordinating meeting of high level officials from headquarters and/or regional representation.
- 5.4 The two Parties should devise administrative arrangements necessary to implement these policies, such as the sharing of experts, common organization of joint scientific and technical meetings, joint training of health and veterinary personnel.

*Article 6*

- 6.1 The present Agreement shall enter into force on the date on which it is signed by the Director-General of WHO and the Director-General of the OIE, subject to the approval of the International Committee of the OIE and the World Health Assembly.
- 6.2 This Agreement may be modified by mutual consent expressed in writing. It may also be terminated by either party by giving 6 months' notice in writing to the other party.

*Article 7*

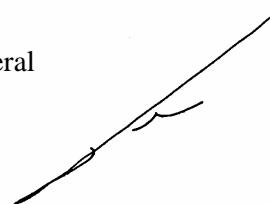
- 7.1 This Agreement supersedes the Agreement between the WHO and OIE adopted by WHO on 4 August 1960 and by the OIE on 8 August 1960.

Adopted by WHO on 18 December 2002 and the OIE on 26 May 2003

Dr D.L. Heymann,  
Executive Director  
Communicable Diseases



Dr B. Vallat  
Director-General



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## ANNEX 2

# **Strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health<sup>1</sup>**

[A57/13, Annex – 15 April 2004]

### INTRODUCTION

1. Reproductive and sexual health<sup>2</sup> is fundamental to individuals, couples and families, and the social and economic development of communities and nations. Concerned about the slow progress made in improving reproductive and sexual health over the past decade, and knowing that the international development goals would not be achieved without renewed commitment by the international community, the Fifty-fifth World Health Assembly adopted resolution WHA55.19 requesting WHO to develop a strategy for accelerating progress towards attainment of international development goals and targets related to reproductive health. The resolution recalled and recognized the programmes and plans of action agreed by governments at the International Conference on Population and Development (Cairo, 1994) and the United Nations Fourth World Conference on Women (Beijing, 1995), and at their respective five-year follow-up review conferences.<sup>3</sup>

2. In response to resolution WHA55.19, and following consultations with Member States and partners, WHO has designed a strategy that builds on actions taken by Member States pursuant to resolution WHA48.10 on Reproductive health: WHO's role in the global strategy, which urged Member States to further develop and strengthen their reproductive health programmes.

3. The strategy presented in this document is intended for a broad audience of policy-makers within governments, international agencies, professional associations, nongovernmental organizations and other institutions. Part I sets out the major discrepancies between global goals and global realities, and describes the principal barriers to progress, noting in particular the inequities related to gender and poverty and the exposure to risk of adolescents. Part II lays out the strategy, which is guided by principles based on international human rights. It highlights the core aspects of reproductive and sexual health services and proposes ways for countries and WHO to take innovative approaches. It concludes by reaffirming WHO's corporate commitment to collaboration with its partners in order to encourage and support Member States in their efforts to attain the United Nations Millennium Development Goals and other internationally agreed goals and targets relating to reproductive and sexual health.

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<sup>1</sup> See resolution WHA57.12.

<sup>2</sup> The definition of reproductive health proposed by WHO and agreed to at the International Conference on Population and Development (Cairo, 1994) includes sexual health (see box).

<sup>3</sup> Twenty-first special session of the United Nations General Assembly for an overall review and appraisal of the implementation of the Programme of Action of the International Conference on Population and Development (New York, 1999) and twenty-third special session of the United Nations General Assembly on Women 2000: gender equality, development and peace for the 21st century (New York, 2000).

## I. GLOBAL GOALS, GLOBAL REALITIES

4. The Millennium Development Goals, which grew out of the United Nations Millennium Declaration adopted by 189 Member States in 2000, provide the new international framework for measuring progress towards sustaining development and eliminating poverty. Of the eight Goals, three – improve maternal health, reduce child mortality and combat HIV/AIDS, malaria and other diseases – are directly related to reproductive and sexual health, while four others – eradicate extreme poverty and hunger, achieve universal primary education, promote gender equality and empower women, and ensure environmental sustainability – have a close relationship with health, including reproductive health. Among the specific targets are:

- to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio;
- to reduce by two thirds, between 1990 and 2015, the under-five mortality rate;
- to have halted by 2015, and begun to reverse, the spread of HIV/AIDS.

5. Additional benchmarks were agreed in 1999 at the twenty-first special session of the United Nations General Assembly for an overall review and appraisal of the implementation of the Programme of Action of the International Conference on Population and Development. For example, by 2015, the proportion of all births assisted by skilled attendants should reach 90% globally and at least 60% in countries with high rates of maternal death.<sup>1</sup>

**Reproductive and sexual health and rights as defined in the Programme of Action of the International Conference on Population and Development<sup>1</sup>**

“Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.” (Paragraph 7.2)

“Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. ...” (Paragraph 7.3)

<sup>1</sup> United Nations document A/CONF.171/13: Report of the ICPD.

<sup>1</sup> United Nations document A/S-21/5/Add.1, paragraph 64.

6. The definition of reproductive health adopted at the International Conference on Population and Development in 1994 (see box) captures the essential characteristics that make reproductive and sexual health unique compared to other fields of health. Reproductive health extends before and beyond the years of reproduction, and is closely associated with sociocultural factors, gender roles and the respect and protection of human rights, especially – but not only – in regard to sexuality and personal relationships.

7. The adoption of these comprehensive definitions at the International Conference on Population and Development marked the beginning of a new era, and the achievements of the past decade are many and profound. For example, the concept of reproductive and sexual health and rights has, with few exceptions, been widely accepted and has begun to be used by international health and development bodies, national governments, nongovernmental organizations and other parties. New reproductive health policies and programmes have been defined in almost all countries. Their adoption has produced significant changes in some countries in the conventional modes of delivering maternal and child health or family planning services.

8. Following this conceptualization of, and commitment to, reproductive and sexual health, new partnerships have been forged at national, regional and global levels. New evidence has also been collected in previously neglected areas such as the burden of disease due to reproductive and sexual ill-health and its relation to poverty, and gender-based violence. The number of evidence-based best practices in reproductive and sexual health care has grown substantially, and the scope of clinical and behavioural research and of internationally recognized standards, norms and guidelines has broadened.

9. Experience has shown that, even in low-income settings, innovative country-specific approaches can considerably reduce maternal mortality and morbidity, for example. The challenge now is to formulate innovative national strategies for making health services accessible to the people in greatest need, such as adolescents and the poor, in order to attain international goals. At present, many countries suffer from persistently high rates of maternal mortality and morbidity, perinatal mortality, reproductive tract infections and sexually transmitted infections including HIV, unwanted pregnancies, unsafe abortion, and risky sexual behaviour, as the data below show.

## **Global situation**

### **Pregnancy, childbirth and health of newborns**

10. Each year, some eight million of the estimated 210 million women who become pregnant, suffer life-threatening complications related to pregnancy, many experiencing long-term morbidities and disabilities. In 2000, an estimated 529 000 women died during pregnancy and childbirth from largely preventable causes. Globally, the maternal mortality ratio has not changed substantially over the past decade.

11. Regional inequities are extreme, with 99% of these maternal deaths occurring in developing countries. The lifetime risk of death from maternal causes in sub-Saharan Africa is 1 in 16 and in South-East Asia 1 in 58, compared with 1 in 4000 in industrialized countries.

12. Most maternal deaths arise from complications during childbirth (e.g. severely obstructed labour, especially in early first pregnancies; haemorrhage and hypertensive complications), in the immediate postpartum period (sepsis and haemorrhage), or after unsafe abortion. Factors commonly

associated with these deaths are the absence of skilled health personnel<sup>1</sup> during childbirth, lack of services able to provide emergency obstetric care and deal with the complications of unsafe abortion, and ineffective referral systems.

13. More than 50% of women living in the world's poorest regions – the percentage is higher than 80% in some countries – deliver their babies without the help of a skilled birth attendant. In sub-Saharan Africa these proportions have not changed over the past decade. Antenatal care is available and widely used in industrialized countries; by contrast, in the late 1990s, almost half of pregnant women in southern Asia and one third in western Asia and sub-Saharan Africa received no antenatal care at all, compared with less than one fifth in eastern Asia and in Latin America and the Caribbean.

14. Of the 10.8 million deaths worldwide of children under five, 3.0 million occur during the first seven days of the neonatal period. Additionally, an estimated 2.7 million infants are stillborn. Many of these deaths are related to the poor health of the woman and inadequate care during pregnancy, childbirth and the postpartum period. The neonatal mortality rate (death in the first 28 days) in developing countries has remained unchanged since the early 1980s at about 30 deaths per 1000 live births. Furthermore, a mother's death can seriously compromise the survival of her children.

### **Family planning**

15. Contraceptive use has substantially increased in many developing countries and in some is approaching that practised in developed countries. Yet surveys indicate that, in developing countries and countries in transition, more than 120 million couples have an unmet need for safe and effective contraception despite their expressed desire to avoid or to space future pregnancies.

16. Between 9% and 39% of married women (including women in union) have this unmet need for family planning. Data suggest that unmarried sexually active adolescents and adults also face this unmet need. About 80 million women every year have unintended or unwanted pregnancies, some of which occur through contraceptive failure, as no contraceptive method is 100% effective.

### **Unsafe abortion**

17. Some 45 million unintended pregnancies are terminated each year, an estimated 19 million of which abortions are unsafe;<sup>2</sup> 40% of all unsafe abortions are performed on young women aged 15 to 24. Unsafe abortions kill an estimated 68 000 women every year, representing 13% of all pregnancy-related deaths. In addition, they are associated with considerable morbidity; for instance, studies indicate that of every five women who have an unsafe abortion, at least one suffers a reproductive tract infection as a result; some of these infections are serious, leading to infertility.

### **Sexually transmitted infections, including HIV, and reproductive tract infections**

18. An estimated 340 million new cases of sexually transmitted bacterial infections, most of which are treatable, occur annually. Many are untreated because they are difficult to diagnose and because

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<sup>1</sup> "Skilled birth attendant" or "skilled health personnel" refers to a health professional such as a midwife, doctor or nurse, who is trained and competent in the skills needed to manage normal childbirth and the immediate postnatal period, and who can identify complications and, as necessary, provide emergency management and/or refer the case to a higher level of health care.

<sup>2</sup> An unsafe abortion is defined as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both (see The prevention and management of unsafe abortion, Report of a technical working group, document WHO/MSM/92.5, 1992).

competent, affordable services are lacking. In addition, millions of cases of mostly-incurable viral infections occur annually, including five million new HIV infections, 600 000 of which are in infants owing to mother-to-child transmission.

19. Sexually transmitted human papillomavirus infection is closely associated with cervical cancer, which is diagnosed in more than 490 000 women and causes 240 000 deaths every year. Three quarters of all cervical cancer cases occur in developing countries where programmes for screening and treatment are seriously deficient or lacking.

20. More than 100 million mostly-curable sexually transmitted infections occur each year in young people aged 15 to 24. These infections facilitate the acquisition and spread of HIV. Almost half all new HIV infections occur in young people. Despite recent positive trends among young people (especially females) in some African countries, overall about twice as many young women as men are infected with HIV in sub-Saharan Africa. In 2001, an estimated 6% to 11% of young women in sub-Saharan Africa were living with HIV/AIDS, compared with 3% to 6% of young men. In other developing regions, the proportion of women with HIV/AIDS is also higher than for men. Additionally, reproductive tract infections, such as bacterial vaginosis and genital candidiasis, which are not sexually transmitted, are known to be widespread, although the prevalence and consequences of these infections are not well documented.

21. Sexually transmitted infections are also a leading cause of infertility: some 60 to 80 million couples worldwide suffer from infertility and consequent involuntary childlessness, often as a result of tubal blockage caused by an untreated or inadequately treated sexually transmitted infection.

22. Together, these aspects of reproductive and sexual ill-health (maternal and perinatal mortality and morbidity, cancers, sexually transmitted infections and HIV/AIDS) account for nearly 20% of the global burden of ill-health for women and some 14% for men. These statistics do not capture the full burden of ill-health, however. Gender-based violence, and gynaecological conditions such as severe menstrual problems, urinary and faecal incontinence due to obstetric fistulae, uterine prolapse, pregnancy loss, and sexual dysfunction – all of which have major social, emotional and physical consequences – are currently severely underestimated in present global burden of disease estimates. WHO estimates unsafe sex to be the second most important global risk factor to health.

## **Barriers to progress**

### **Inequities related to gender**

23. Gender disparities in health are often striking. Families may invest less in nutrition, health care, schooling and vocational training for girls than for boys. Sex discrimination and low social status of girls and women frequently result in poor physical and mental health, physical or emotional abuse, and low levels of control over their own lives, particularly their sexual and reproductive lives.

24. Violence against women in its many forms has an impact on their reproductive and sexual health. In particular, violence from an intimate partner, which occurs throughout the world, includes physical, sexual and emotional abuse. Studies show that between 4% and 20% of women experience violence during pregnancy, with consequences both for them and their babies, such as miscarriage, premature labour and low birth weight. Available data suggest that in some countries nearly one woman in four experiences sexual violence from an intimate partner. Rape and sexual assault by acquaintances and strangers is also common. Trafficking of women and children and forced prostitution are also serious problems, particularly in some regions. The consequences for reproductive and sexual health are extensive and include unwanted pregnancy, unsafe abortion, chronic pain syndromes, sexually transmitted infections including HIV, and gynaecological disorders.



### **Adolescents' exposure to risk**

25. In most countries, taboos and norms about sexuality (including practices such as child marriage, female genital mutilation and early sexual initiation) pose strong barriers to providing the information, reproductive health services and other forms of support that young people need to be healthy. Yet, sexual and reproductive behaviours during adolescence (between the ages of 10 and 19) have immediate and long-term consequences. In some parts of the world, sexual activity begins during adolescence, and is often risky, whether within or outside marriage. Adolescents rarely have the ability or support to resist pressure to have sexual relations, negotiate safer sex, or protect themselves against unintended pregnancy and sexually transmitted infections. For very young girls, pregnancy carries a high risk of maternal mortality and morbidity. Meeting the needs and protecting the rights of the 1200 million adolescents worldwide are essential to safeguard the health of this and future generations.

### **Inequities related to poverty and access to health services**

26. Poverty is almost universally associated with inequitable access to health services, particularly maternal health services. The burden of reproductive and sexual ill-health is greatest in the poorest countries where health services tend to be scattered or physically inaccessible, poorly staffed, resourced and equipped, and beyond the reach of many poor people. Too often, improvements in public health services disproportionately benefit the better-off, and it is theoretically possible to achieve some of the international health goals without including the lowest income quintile and vulnerable population groups.

27. Since the 1980s, various health-sector reforms have been introduced in many countries, affecting availability of, and access to, health services, including those for reproductive and sexual health. Financing projects, such as prepaid insurance schemes and means-tested subsidies, have frequently failed to result in the desired equitable access for poor people. Thus, special attention is needed to ensure that disadvantaged groups can access prevention, treatment and life-saving services such as emergency obstetric care.

### **Other challenges**

28. Recent years have witnessed a decline in overall development aid, while new mechanisms of external financing for health have come into play, such as poverty reduction strategy papers, sector-wide approaches and direct budget support. Also, major new sources of health-sector funding, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, concentrate resources on specific diseases and interventions. It is important to ensure that these new developments contribute to the building of sustainable health-system capacity, including that for reproductive and sexual health services.

29. In many countries, inadequate human resources are a major barrier to the expansion of comprehensive reproductive and sexual health services, and to better quality of care. Weaknesses include the severe shortage of personnel, inadequate skills of available personnel, rapid turnover and loss of skilled workers, and the inefficient use and distribution of those who are already in the system. Low or unpaid salaries and poor training, supervision and working conditions are root causes of poor performance and high turnover of health-care professionals. Strategic planning for building and retaining an appropriately skilled health workforce, including for instance skilled birth attendants, is crucial to progress in reproductive and sexual health care.

30. In addition to the barriers that poor and other disadvantaged people face in accessing health services generally, such as distance from services, lack of transport, cost of services and

discriminatory treatment of users, reproductive health presents special difficulties. These derive from social and cultural factors such as taboos surrounding reproduction and sexuality, women's lack of decision-making power related to sex and reproduction, low values placed on women's health, and negative or judgmental attitudes of family members and health-care providers. A holistic examination by communities and local health-care providers of beliefs, attitudes and values offers an important start to overcoming these fundamental obstacles.

31. Over the past two decades, advances have been made in life-saving technologies in reproductive health and effective clinical and programmatic practices. Even with electronic databases and interactive tools, however, many health systems and service providers have little or no access to this new information. Effective demonstration projects in many countries, including introduction of technology and best practices, often fail to be implemented on a larger scale. Failure to use appropriate strategic planning based on adequate qualitative and quantitative data has limited the understanding of reasons for poor quality of services and people's lack of access to, and use of, services.

32. In some countries, laws, policies and regulations may hinder access to services (e.g. excluding unmarried people from contraceptive services), unnecessarily limit the roles of health personnel (e.g. preventing midwives from performing life-saving procedures such as removal of the placenta), bar the provision of some services (e.g. over-the-counter provision of emergency contraception), or restrict the importation of some essential drugs and technologies. Removal of such restrictions is likely to contribute significantly to improving people's access to services.

## **II. THE STRATEGY TO ACCELERATE PROGRESS**

33. The overarching objective of the strategy is to accelerate progress towards meeting internationally agreed reproductive health targets and, ultimately, to attain the highest achievable standard of reproductive and sexual health for all.

### **Guiding principle: human rights**

34. WHO's strategy for accelerating progress rests on internationally agreed instruments and global consensus declarations on human rights, including the right of all persons to the highest attainable standard of health; the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so; the right of women to have control over, and decide freely and responsibly on, matters related to their sexuality, including sexual and reproductive health – free of coercion, discrimination and violence; the right of men and women to choose a spouse and to enter into marriage only with their free and full consent; the right of access to relevant health information; and the right of everyone to enjoy the benefits of scientific progress and its applications. In order to ensure that these rights are respected, policies, programmes and interventions must promote gender equality, give priority to poor and underserved populations and population groups, especially adolescents, and provide special support to those countries that bear the largest burden of reproductive and sexual ill-health.

### **Core aspects of reproductive and sexual health services**

35. The five core aspects of reproductive and sexual health are: improving antenatal, perinatal, postpartum and newborn care; providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating sexually transmitted infections including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and promoting sexual health. Because of the close links between the different aspects of reproductive and sexual health, interventions in one area are likely to have a positive impact on the others. It is critical for

countries to strengthen existing services and use them as entry points for new interventions, looking for maximum synergy.

36. In most countries, the major entry point will be antenatal, childbirth and postpartum services, which form the backbone of primary health care. Central to reducing maternal morbidity and mortality, and perinatal mortality, are the attendance at every birth of skilled health personnel and comprehensive emergency obstetric care to deal with complications. Provision of these services requires effective referral systems for communication and transport between service points. Maternal health services offer a key opportunity to reach women with family planning. They are also an excellent means through which to offer women prevention, counselling, testing and treatment for HIV infection and for preventing HIV transmission during pregnancy and birth and through breastfeeding. Indeed, it is only through these services that these interventions can be adequately provided. These points are further elaborated in the WHO strategy for making pregnancy safer.

37. As a preventable cause of maternal mortality and morbidity, unsafe abortion must be dealt with as part of the Millennium Development Goal on improving maternal health and other international development goals and targets. Several urgent actions are needed, including strengthening family planning services to prevent unintended pregnancies, and, to the extent allowed by law, ensuring that services are available and accessible. Also to the extent allowed by law, provision of safe abortion services requires training health-service providers in modern techniques and equipping them with appropriate drugs and supplies, all of which should be available for gynaecological and obstetric care; providing social and other support to women with unintended pregnancies; and, to the extent allowed by law, providing abortion services at primary health care level. For those women who suffer complications of unsafe abortion, prompt and humane treatment through post-abortion care must be available.

38. The success of family planning services in most countries of the world is evidenced by the great increase in contraceptive use in developing countries over the past two to three decades. These programmes are an essential part of services to reduce maternal and perinatal morbidity and mortality because they enable women to postpone, space and limit pregnancies. As these services are directly concerned with the outcomes of sexual relationships, they also have great potential for leading the way in promoting sexual health and efforts to prevent sexually transmitted infections and HIV transmission.

39. Sexually transmitted infections are being diagnosed and treated by pharmacists, drug sellers and traditional healers, often ineffectively. Various attempts have been made to reach women by integrating sexually transmitted infections management into existing maternal and child health and/or family planning services, but with limited success. Nonetheless, experience shows that integration of sexually transmitted infection prevention into family planning services, especially through counselling and discussion of sexuality and partner relationships, has increased the use of services and improved quality of care. These approaches can be built on and improved in order to expand coverage and outreach to men, youth and other groups not previously the focus of family planning. In addition, presumptive treatment in groups at high risk and comprehensive, community-based programmes to control sexually transmitted infections could greatly contribute to the reduction of HIV transmission rates.

40. Additional gains from strengthening reproductive health services are numerous. They include attention to violence against women, which is now being tackled in various country settings with, for instance, provision of emergency contraception, abortion (to the extent allowed by law) if requested, treatment of sexually transmitted infections and post-exposure prophylaxis for HIV infection after rape, screening and treatment of cervical cancer, prevention of primary and secondary infertility, and treatment of gynaecological conditions. Well-designed and effectively delivered reproductive and sexual health services, especially those involving community participation, can also contribute to

improved user-provider relations, men's participation, and women's empowerment to make reproductive choices.

41. All reproductive and sexual health services have a key role to play in providing information and counselling in promoting sexual health. Appropriate information can also contribute to better communication between partners and healthier sexual decision-making, including abstinence and condom use.

## **Actions**

42. WHO proposes the following key action areas for countries, and is committed to supporting Member States in building and strengthening their capacity to improve reproductive and sexual health. Each country needs to identify problems, set priorities and formulate strategies for accelerated action through consultative processes involving all stakeholders. Five overarching activities are: strengthening health systems capacity, improving information for priority setting, mobilizing political will, creating supportive legislative and regulatory frameworks, and strengthening monitoring, evaluation and accountability.

### **Strengthening health systems capacity**

43. A prerequisite for attaining the Millennium Development Goals relating to maternal and infant survival and HIV/AIDS, as well as the broader reproductive and sexual health goals, is the existence of a functioning system of essential health care at the primary, secondary and tertiary levels. In some countries, basic health service capacity will have to be strengthened substantially in order to enable provision of a comprehensive range of essential reproductive and sexual health services. Planning at national level for reproductive and sexual health will have to cover sustainable financing mechanisms, human resources, quality in service provision and use of services.

44. **Sustainable financing mechanisms.** The central importance of reproductive and sexual health needs to be reflected in national health-sector planning and strategic development. Health-sector reforms and related initiatives such as sector-wide approaches to donor funding have been promoted as a means of strengthening health systems. The challenge is to ensure that these initiatives and other financing mechanisms foster good quality, comprehensive reproductive and sexual health services, and progress towards universal access.

45. Necessary **actions** in this area are:

- (1) to make reproductive and sexual health central to national planning and strategy development processes, including poverty reduction strategy papers and WHO country cooperation strategies;
- (2) to ensure that reproductive and sexual health is appropriately reflected in national health-sector plans, including those covering the "3 by 5" initiative, proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria, and other relevant initiatives;
- (3) to prioritize reproductive and sexual health in essential service packages under health-sector reforms and sector-wide approaches; and
- (4) where new financing mechanisms such as cost sharing are being introduced, to design ways to facilitate access to services by adolescents, poor people and other disadvantaged groups, to monitor the effects of such policies and to adapt them to local conditions.

46. **Human resources.** Training, recruiting, deploying and retaining skilled health personnel are central elements in improving health and health care generally. Many core reproductive and sexual health interventions can be made by mid-level professionals and paramedical workers. The challenge is to determine the cadres of health workers, skills and forms of training that are most necessary to provide the prioritized reproductive and sexual health services. Enabling conditions will have to be created for health workers to realize their full potential and to motivate them to work with all population groups, including the poorest.

47. Necessary **actions** in this area are:

- (1) to determine the essential requirements at all levels for numbers and distribution of health workers with the skills needed to perform prioritized reproductive and sexual health interventions;
- (2) to assess and improve work environments, conditions of employment and supervision;
- (3) to formulate a strategy to motivate and retain skilled personnel; and
- (4) to promote policies that enable health-care workers to use their skills to the full.

48. **Quality in service provision.** Up-to-date practices implemented in teaching hospitals and special projects are frequently not adopted throughout the system, with the result that overall performance remains poor and inequalities in both quality and access persist. Decentralized planning and responsibility associated with health-sector reforms need to give special attention to facilitating system-wide adoption of good practices. Logistical systems for sustained provision of essential commodities must be established.

49. Necessary **actions** in this area are:

- (1) to conduct strategic planning, involving health professionals and managers, to assess current quality of care and to determine the best way to improve quality within existing resource constraints;
- (2) to design and test strategies to expand interventions of proven effectiveness;
- (3) to formulate, adopt and monitor standards for clinical practice in private and public sectors;
- (4) to recruit partners among nongovernmental organizations and within the private and commercial sectors to maximize availability and use of reproductive health services; and
- (5) to promote the sharing of lessons learnt within and between countries.

50. **Use of services.** Where health services exist, there are many reasons – social, economic and cultural – why people nevertheless do not use them, particularly in relation to reproductive and sexual health. Identifying and overcoming obstacles requires working with women, young people, and other community groups to understand better their needs, analyse problems and find acceptable solutions.

51. Necessary **actions** in this area are:

- (1) to carry out social and operations research to identify barriers to use of services and devise and test measures to overcome them; and
- (2) to use participatory approaches to work with communities, public and private sector institutions, and nongovernmental organizations to overcome such barriers and promote appropriate use of available services.

### **Improving information for priority setting**

52. Analysis of epidemiological and social science data is needed to understand the type, severity and distribution of reproductive and sexual risk exposure and ill-health in the population, to interpret the dynamics that drive poor reproductive and sexual health, and to illuminate the links between such ill-health and poverty, gender and social vulnerability. Improved data collection and analysis, including information about costs and cost-effectiveness, are essential bases for selecting among competing priorities for action and for aiming health-system interventions at targets that are most likely to make a difference within the limits of available resources.

53. The process of setting priorities on the basis of good data, however, must involve multiple stakeholders from government, bilateral and multilateral agencies, professional associations, women's groups and other sectors of civil society. Bringing together these different stakeholders with their varied perspectives will help to build a broad consensus, foster collaboration and increase the likelihood that interventions will be successful. Stakeholders must carefully balance cost-effectiveness with equity and consider the need to invest more in order to reach the poor and other underserved groups.

54. Necessary **actions** in this area are:

- (1) to strengthen the capabilities for collecting and analysing data about health status, its underlying determinants and the functioning of health services at local, district and national levels; and
- (2) to set priorities based on data, using a multiple stakeholder consultative process, with attention being paid to equitable access especially for poor and other underserved groups.

### **Mobilizing political will**

55. Creating a dynamic environment of strong international, national and local support for rights-based reproductive and sexual health initiatives will help to overcome inertia, galvanize investment and establish high standards and mechanisms for performance accountability. This requires the involvement of not only ministries of health, but also ministries of finance, education and possibly other sectors, and their counterparts at district and local levels. Political commitment and advocacy must be sufficiently strong to sustain good policies and programmes, particularly for underserved groups.

56. Necessary **actions** in this area are:

- (1) to build strong support for investment in reproductive and sexual health using evidence of benefits to public health and human rights;

(2) to mobilize crucial constituencies (e.g. health professionals, legal experts, human rights groups, women's associations, governmental ministries, political leaders and parties, religious and community leaders) to support a national reproductive and sexual health agenda and make concerted use of the mass media; and

(3) to build a strong, evidence-based case for strategic investment in adolescent sexual and reproductive health and rights, and place them high on the national agenda; to disseminate information on the nature, causes and consequences of adolescents' reproductive health needs and problems, such as their vulnerability to sexually transmitted infections including HIV, unwanted pregnancies, unsafe abortion, early marriage or childbearing, and sexual coercion and violence, both within and outside marriage.

### **Creating supportive legislative and regulatory frameworks**

57. Removal of unnecessary restrictions from policies and regulations, in order to create a supportive framework for reproductive and sexual health, is likely to contribute significantly to improved access to services.

58. Regulations are needed to ensure that commodities (medicines, equipment and supplies) are made available on a consistent and equitable basis and that they meet international quality standards. In addition, an effective regulatory environment is needed to ensure public and private sector accountability for providing high-quality care for all the population.

59. Necessary **actions** in this area are:

(1) to review, and if necessary modify, laws and policies in order to ensure that they facilitate universal and equitable access to reproductive and sexual health education, information and services;

(2) to ensure that regulations and standards are in place so that necessary commodities, which meet international quality standards, are available on a consistent and equitable basis; and

(3) to set performance standards and devise monitoring and accountability mechanisms for the provision of services and for collaboration and complementary action among the private, nongovernmental and public sectors.

### **Strengthening monitoring, evaluation and accountability**

60. Monitoring and evaluation are essential for learning what does and does not work, and why. They may also reveal changing needs and unexpected impacts, both positive and negative.

61. Necessary **actions** in this area are:

(1) to establish and strengthen monitoring and evaluation mechanisms based on a clear plan of what is to be achieved, how and by when, with a clear set of indicators and strong baseline data;

(2) to monitor health-sector reforms, sector-wide approaches, and the implementation of other financing mechanisms such as poverty reduction strategy papers, cost-sharing and direct budget support in order to ensure that they benefit the poor and other socially or economically marginalized groups, and contribute to strengthening reproductive and sexual health services at all levels; and

- (3) to develop mechanisms (such as local committees or community meetings) to increase accountability at facility and district levels.

### **WHO's commitment to attaining global reproductive health goals**

62. In all the action areas outlined above, WHO will continue and intensify its technical assistance to countries by:

- supporting action-oriented research and research-capacity strengthening
- streamlining and carefully focusing evidence-based norms and standards
- advocating globally for reproductive and sexual health.

63. All these activities will systematically pay attention to and promote equity, including gender equity, and the human rights dimensions of reproductive and sexual health.

64. At the global level, WHO will:

- (1) redouble its efforts to implement the Making Pregnancy Safer initiative, as a priority component of the reproductive and sexual health strategy, particularly for countries where maternal mortality is highest;
  - (2) continue to strengthen its partnerships with other organizations in the United Nations system (in particular UNICEF, UNFPA and UNAIDS), the World Bank, associations of health professionals, nongovernmental organizations and other partners in order to ensure collaboration and coordinated actions by a broad range of partners. The new partnership for safe motherhood and newborn health, to be hosted by WHO, will play a critical role in this;
  - (3) promote and strengthen reproductive and sexual health services as the basis of the prevention and treatment of HIV/AIDS, particularly through family planning; antenatal, childbirth and postpartum care; control of sexually transmitted infections; the promotion of safer sex; and the prevention of mother-to-child transmission of HIV. WHO will also ensure attention to reproductive and sexual health by strengthening collaboration with other key public health programmes including immunization, nutrition and prevention and treatment of malaria and tuberculosis, especially in pregnant women; and
  - (4) ensure accountability through reporting on progress towards reproductive and sexual health as part of achieving the Millennium Development Goals.
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