WHO Executive Board adopts resolution on Pneumonia

The treatment and prevention of pneumonia has been tabled for discussion at the upcoming World Health Assembly in May 2010. This is based on a resolution on "Accelerating progress towards achievement of Millennium Development Goal 4 to reduce child mortality: prevention and treatment of pneumonia" adopted by WHO's Executive Board in January this year.

A report on this issue prepared by WHO and submitted to the Executive Board highlights the fact that MDG 4 -- to reduce child mortality by two-thirds by 2015 from the 1990 rate -- can only be achieved through intensified efforts to address pneumonia -- the number one killer of children under five. Child mortality due to pneumonia is strongly linked to malnutrition, poverty and inadequate access to health care. Consequently, more than 98% of the 1.8 million child deaths due to pneumonia each year occur in developing countries, mostly in marginalized communities.

Three groups of effective interventions to protect, promote and treat pneumonia are highlighted, as outlined in the WHO/UNICEF Global Action Plan for the prevention and control of Pneumonia (GAPP):

- **Protect** children by providing a healthy environment where they are at low risk of pneumonia by recommending exclusive breastfeeding for six months, ensuring adequate nutrition thereafter, preventing low-birth-weight, reducing indoor air pollution and promoting hand washing;
- **Prevent** children becoming ill with pneumonia by vaccinating against its causes: measles, pertussis, pneumococcus, *Haemophilus influenzae* b (Hib), as well as preventing and treating HIV in children; and
- **Treat** children who become ill with pneumonia through effective case management in communities, health centres and hospitals.

Most child deaths due to pneumonia would be avoided if these interventions were implemented on a broad scale and reached the most vulnerable populations. But currently, only half (54%) of the children with pneumonia in developing countries are taken to a qualified health-care provider, and less than one-fifth (19%) receive life-saving antibiotics. To date, few countries have included a pneumococcal conjugate vaccine in their national immunization programmes, and exclusive breastfeeding up to six months is only practised by 22% of mothers.

The investment required between 2010 and 2015 to deliver these interventions to all children in the 68 countries with the highest levels of child mortality is estimated at US$38 billion. WHO and UNICEF also estimate that, if implemented, this would result in a 67% reduction in the number of deaths due to pneumonia by 2015, with a cumulative total of 5.3 million child lives being saved between 2010 and the end of 2015, thereby significantly contributing to achievement of MDG 4.

The resolution calls on WHO and its Member States to take a number of specific actions to more effectively address pneumonia, in line with the recommendations of the GAPP.

To download the report presented to the Executive Board, go to: [http://apps.who.int/gb/ebwha/pdf_files/EB126/B126_40-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/EB126/B126_40-en.pdf)

On 3 March, WHO's Director-General, Dr Margaret Chan, together with the heads of the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF) and the United Nations Development Fund for Women (UNIFEM), adopted a Joint Statement on Accelerating Efforts to Advance the Rights of Adolescent Girls. The statement text is as follows:

"As leaders gather for the fifteen-year review of the Beijing Platform for Action, we, the members of the United Nations Adolescent Girls Task Force, jointly pledge to intensify our efforts to fulfil the human rights of adolescent girls. During the next five years, we will aim to increase our agencies’ support to developing countries to advance key policies and programmes that empower the hardest-to-reach adolescent girls, particularly those aged 10 to 14 years.

Many of the 600 million adolescent girls living in developing countries remain invisible in national policies and programmes. Millions live in poverty, are burdened by gender discrimination and inequality, and are subject to multiple forms of violence, abuse, and exploitation, such as child labour, child marriage and other harmful practices. The full potential of these girls and their contribution to their communities have yet to be realized.

We are convinced that educated, healthy and skilled adolescent girls will help build a better future, advance social justice, support economic development, and combat poverty. They will stay in school, marry later, delay childbearing, have healthier children, and earn better incomes that will benefit themselves, their families, communities and nations. Investing in their rights and empowerment will help accelerate the achievement of internationally-agreed development goals, including the Millennium Development Goals (MDGs).

We will work with governments, civil society, communities, adolescent girls and boys on five strategic priorities:

1. **Educate adolescent girls**: Ensure adolescent girls have access to quality education and complete schooling, focusing on their transition from primary to post-primary education and training, including secondary education, and pathways between the formal and non-formal systems.

2. **Improve adolescent girls' health**: Ensure adolescent girls’ access to age-appropriate health and nutrition information and services, including life skills-based sexuality education, HIV prevention, and sexual and reproductive health.

3. **Keep adolescent girls free from violence**: Prevent and protect girls from all forms of gender-based violence, abuse and exploitation, and ensure that girls who experience violence receive prompt protection, services and access to justice.

4. **Promote adolescent girl leaders**: Ensure that adolescent girls gain essential economic and social skills and are supported by mentors and resources to participate in community life.

5. **Count adolescent girls**: Work with partners to collect, analyse, and use data on adolescent girls to advocate for, develop and monitor evidence-based policies and programmes that advance their well-being and realize their human rights.

We will work in a coordinated manner with other relevant global initiatives. We call on Member States to join us in accelerating efforts to protect the rights of adolescent girls. Together, we can build a future of gender equality and social justice."

The Joint Statement was launched at a reception hosted by the United Nations Foundation, on the sidelines of the 54th session of the UN Commission on the Status of Women in New York. WHO's Assistant Director-General for Family and Community Health, Daisy Mafubelu, gave an address at the high-level event.

In addition, WHO hosted a panel on "What would it take to make health systems work better for women?". The discussion centred on evidence in the recent WHO report on "Women and Health", which highlights the need to strengthen health systems so that they are better geared to meet women’s needs across the life-course.

Generating demand and community support for sexual and reproductive health services for young people

To support the health sector in identifying and implementing interventions to create demand for sexual and reproductive health services by adolescents and to stimulate community acceptance and support for their provision, a global review of the evidence was compiled.

Evidence was reviewed from 30 studies on interventions for generating demand through information, education and communication, and assessments were done of the effectiveness of interventions for garnering community acceptance and support.

The available evidence clearly highlights the importance of engaging parents, adolescents and communities as part of a comprehensive strategy for improving health service use by adolescents. Young people are most likely to use youth-friendly services in those communities that demonstrate most awareness and approval. A supportive social environment also results in higher utilization rates.

The review highlights the need for stronger programme design and for the evaluation of projects that work with families and communities on influencing reproductive health behaviour and service use.

To download the document, go to: www.who.int/child_adolescent_health/documents/9789241598484

PMTCT strategic vision 2010–2015

This publication reflects an important part of WHO's health sector response to HIV/AIDS and will contribute directly to the new Outcome Framework of the Joint United Nations Programme on HIV/AIDS (UNAIDS).

The purpose of this document is to define WHO’s commitment to global and country support to scale up access to prevention of mother-to-child transmission (PMTCT) of HIV services and integrate these services with maternal, newborn and child health programmes. The objectives included in PMTCT strategic vision 2010–2015 illustrate WHO’s ongoing commitment to the United Nations General Assembly Special Session (UNGASS) goals on PMTCT and strengthening support for PMTCT within the context of the Millennium Development Goals (MDGs).

To download the document, go to: www.who.int/child_adolescent_health/documents/9789241599030

Joint statement on growth standards and identification of severe acute malnutrition in infants and children

This Joint statement on the WHO child growth standards and the identification of severe acute malnutrition in infants and children presents the recommended weight-for-height cut-offs to identify children with severe acute malnutrition, summarizes the rationale for their adoption, and advocates for their harmonized application.

It aims to improve the identification of infants and children aged six to 60 months in need of treatment for severe acute malnutrition. The statement also reviews the implications of its application on patient load, discharge criteria and programme planning and monitoring.

To download the document, go to: www.who.int/child_adolescent_health/documents/9789241598163
Women Deliver 2010 & Countdown to 2015
Washington D.C., USA
7-9 June 2010

A joint conference of the "Countdown to 2015: tracking progress on maternal, newborn and child survival" and "Women Deliver" will be held in Washington D.C., 7-9 June 2010.

A multi-partner initiative, the "Countdown to 2015" produces and analyzes the most recent data available to report on the achievement of MDGs 4 & 5 in 68 priority countries that account for 97% of maternal and child deaths.

The "Countdown" partners include more than 20 UN agencies -- including WHO, UNICEF, UNFPA, the World Bank, and the Partnership for Maternal, Newborn and Child Health (PMNCH) -- as well as a number of NGOs, institutes, and donor agencies. The 2010 edition of the Countdown report will be presented at the conference.

The theme of the "Women Deliver" conference is "Delivering solutions for girls and women," with a focus on political, economic, social/cultural, and technological solutions.

The joint conference will bring together experts and creative thinkers in maternal and child health, human rights, gender, sexual and reproductive health, HIV/AIDS, and other sectors to highlight the importance of investing in women and children to achieve the MDGs.

For more information on the Countdown to 2015, go to: www.countdown2015mnch.org/media-centre/2010-latest-news

For more information on Women Deliver, go to: www.womendeliver.org/conferences

International Year of Youth
12 Aug 2010 - 11 August 2011

On 18 December 2009, the United Nations General Assembly adopted a resolution proclaiming the year commencing on 12 August 2010 as the International Year of Youth, with the theme "Dialogue and Mutual Understanding". The Year will coincide with the 25th anniversary of the first International Youth Year in 1985 on the theme "Participation, Development and Peace".

The Year is intended to generate attention for youth participation and youth development and provide an impetus to partnerships among youth organizations around the world.

Developments related to the United Nations International Year of Youth can be followed on social marketing sites FaceBook and Twitter.

For more information on the International Year of Youth, go to: http://social.un.org/youthyear/

To download the resolution (available in all official UN languages), go to: www.un.org/Docs/journal/asp/ws.asp?m=A/RES/64/134
Q&A with Professor Savitri Goonesekere

Professor Savitri Goonesekere is an international expert on the rights of women and children. She was the first woman Vice-Chancellor at the University of Colombo, Sri Lanka, where she is currently Emeritus Professor of Law. From 1999 until 2002 she was a member of the United Nations Committee on the Elimination of Discrimination against Women. Goonesekere has contributed to advocacy and law reform initiatives in Sri Lanka and has published widely on family law, human rights, law and development issues.

Prof Goonesekere recently worked with CAH on a human-rights-based assessment of Sri Lanka’s laws, regulations and policies on adolescents’ access to reproductive and sexual health information and services. She spoke to Sarah Cumberland with the WHO Bulletin about the importance of taking a human rights approach to health.

Q: On 20 November 2009, it was the 20th anniversary of the United Nations Convention on the Rights of the Child (CRC). Sri Lanka is often cited as a model for its work in reducing child and maternal mortality and in improving literacy. How has the CRC contributed to this?

A: Sri Lanka has a good record of achievement with regard to children. In my country, we have had visionary policies on health and education, meaning that every child has had the right to go to school and the right to basic health and that has been reflected in very good social indicators for children even before the CRC. In a sense, politicians had put rights in place through these policies but they weren’t written into the 1978 Constitution’s Bill of Rights.

Q: What changes followed the CRC in Sri Lanka?

A: Before the convention, we did not consider “rights” were necessary for all children, and child abuse was addressed only from the point of view that they are “children in difficult situations”. The convention linked the concept of good governance and state accountability. Giving access to health and education for all children, recognizing gaps in coverage and the need to prevent disparities in health delivery are now state obligations. Protecting children from abuse and exploitation must also receive high priority. The CRC is a powerful accountability measure for ensuring an effective public health system.

Q: Is the CRC really necessary for a country with sound laws and policies?

A: Implementing all the standards on child rights in the CRC is not an easy task. An ideal situation does not prevail in any country, not even developed countries. Some argue that if “the health policies are in place, why do we need to put them in the constitution and other laws?” The reason is clear. Political systems are very fragile. All it takes is a change in a health minister. If someone comes in with a different attitude, everything can change. If a right is not in place in a law or constitution, it’s very easy to pull it back.

Q: Is there cynicism about what human rights can achieve?

A: There is a cynicism about rights and what they can do, especially in developing countries. This just encourages states not to implement the treaties they have signed. Human rights laws create a culture of support for implementing health policies by helping the community to monitor the state’s actions and programmes. They can’t get away with saying “we can’t help this situation”. Even in a country such as ours, which has some fairly sound laws and policies on health systems and a fairly good administrative system for health delivery, there are gaps and weaknesses. Examples are the regional variations in health and education services and child abuse.

Q: You have completed an assessment of adolescents’ rights of access to reproductive and sexual health information and services in Sri Lanka. What did you find?

A: We found that Sri Lanka’s focus on child protection has benefited children in the younger age group, but has largely neglected young people. The problem is that we group adolescents as either children or young people but their needs are quite specific. Adolescents’ health problems are becoming more complex. Health providers need to acknowledge adolescents have a right to basic health services in some neglected areas such as reproductive health based on access to information and the right of choice. Over the years, problems have emerged including exploitation of children, particularly young girls who work in domestic service when they should be in school, sexual abuse of adolescents within the family and in the community. Teenage pregnancy is an emerging problem.

Q: Sri Lanka has an exceptionally good record in the region for its attempts to eliminate child marriages. Why do they still occur?
A: Our laws and policies on access to education helped in the implementation of minimum age laws. Although the legal age of marriage is now 18 years, educational opportunities for girls have been disrupted in areas affected by years of armed conflict. There is recent evidence of corruption in registration of under-age marriages. Girls under 18 are being married and sometimes sent to work in foreign employment by illegal agencies.

Q: Are older adolescents in Sri Lanka likely to get the right to make their own health decisions?
A: I am currently on a committee working on family law reform. I hope that we will be able to recommend a law that will specifically guarantee an adolescent “age of discretion” above 16 years of age so that this group has the choice to make decisions on their health. Our research found that, though some court cases and criminal laws have recognized that an adolescent over 16 has decision-making rights, schools and hospitals are not aware that adolescents have this right as there is no specific legislation.

Q: If abortion is legal in Sri Lanka, why is there such a high incidence of “backstreet” abortions?
A: Abortion is legal in an extremely limited situation (only to save the life of the mother) so there is a high incidence of illegal abortion in Sri Lanka. This is an area in which the laws are actually contributing to ill health and even death. The very limited access to legal abortion means that many young women and adolescents turn to backstreet abortionists.

Q: How can viewing this issue from a human rights perspective assist?
A: We need to look at abortion in terms of the public health implications of unsafe abortions on the mother, not in terms of pro-life issues. Women should have the right to health, and viewing this issue from a human rights perspective can help. Some doctors and health professionals are now planning to use the human rights framework in terms of women’s health to create support for law reform.

Q: Do adolescents have access to contraception?
A: Family planning has had success in giving adolescents access to contraception. It is now available in hospitals and they can also buy condoms over the counter. But, in cases of sexual violence such as rape, where young women or adolescents may need emergency contraception, they do not always obtain services. Teen pregnancy is also partly due to a lack of focus on sex education.

Q: What is being done to improve sex education in schools?
A: There is a tremendous reluctance to take on sexual health because it is considered by some policy-makers to be too culturally sensitive. At the same time, adolescents and young people are flooded with potentially harmful messages from the Internet and other sources which do not give proper information or encourage responsible sexual behaviour. Our research recommended that sex education must be integrated in schools with sensitivity. The problem is that education authorities can produce teaching modules but teachers do not want to teach them. A nongovernmental organization with which I work is planning a project to train a group of teachers who understand adolescent problems and have the sensitivity and capacity to develop an effective school programme. One principal of a boys school asked us not to come to his school because his personal perspective was that sex education would give the boys the wrong ideas. Can you imagine how they would teach this subject with these attitudes?

Q: Now that the assessment has been done, what is the next step?
A: We hope that the Ministry of Health will take our report and the recommendations into account as they plan their responses. We also hope that this study will motivate other developing countries to integrate a human-rights based approach into health policy formulation and service delivery.

To download the WHO Bulletin interview with Prof Goonesekere, go to: www.who.int/bulletin/volumes/88/2/10-030210

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