

Applying best practices to make programmes work

An important part of WHO's work is to implement public health programmes in countries in the most effective way possible. The *Bulletin* interviewed three WHO experts to find out some of the best practices that made their programmes work.

WHO programme on the Evaluation of Diagnostic Tests

Rosanna Peeling, Manager of Diagnostics Research and Development in the Special Programme on Research and Training in Tropical Diseases (TDR) cited the development of a Diagnostics Evaluation Scheme as one of TDR's recent successes. Launched in 1999, the programme facilitates the development, evaluation and implementation of diagnostics for infectious diseases in tropical countries, such as malaria and sleeping sickness as well as tuberculosis and sexually transmitted diseases. The TDR team and its partners in 35 countries are working to ensure that developing countries have access to quality-assured diagnostics at negotiated prices. Their work on rapid syphilis tests led to the initiation of national plans for the elimination of congenital syphilis in several WHO regions.

Q: What practices made your programme work?

A: We focus on technology that is appropriate for primary health-care providers to use in developing countries and we collaborate closely with control programmes in endemic countries in every aspect of our work. These two factors are key to our success. Disease control, especially in resource-constrained settings, is complex. To deliver appropriate diagnostics, we have to be aware of the social, economic and technical context in which they will be used. With a long-term view to the large-scale use of diagnostics in control programmes, we consult our partners to develop, from the outset, a framework for gathering evidence to estimate potential impact and cost-effectiveness. Embedded in the framework are the development and application of international standards for the design and conduct of diagnostic evaluations. The quality of this evidence is vital when advocating for widespread implementation and sustainable adoption of these tests by donors and public health authorities in the countries where they are needed. Although we always think big, our approach is to start small, do it really well, and then gradually expand. We are a small Geneva-based team and most of our work relies on a network of partners, particularly in developing countries. We have been really fortunate because of the dedication, competence and sheer hard

work of our partners, and a measure of our success lies in the way they have made these projects their own.

Q: What were the lessons you learnt for the future when implementing this programme?

A: We start by asking disease control programmes about their diagnostic needs, and use this information to guide our search for appropriate technologies. This user-inspired approach has proven successful and we will continue our research in this way. By maintaining regular contact with the control programmes, we have been able to disseminate the results of our research as

Rosanna Peeling

- Focus on technology that is appropriate for developing countries
- Start small, do it really well, and then scale up
- Partners are engaged and make WHO programmes their own

they become available, and receive feedback. This has added value to our work since the control programmes can see the research cycle as a dynamic process. However, our programme is only one of many that national control programmes have to deal with. Often they face major difficulties handling the conflicting agendas of multiple donors. In countries already suffering from severe constraints, ill-conceived and uncoordinated integration of vertical programmes into a broader health system may end up hampering what little health care is already available. We have learnt how to work more closely with the WHO regional offices and our partners in countries to allow more horizontal integration of control activities. It is an area we need to strengthen if our work is to make a difference. ■

Helping countries make health-care programmes a reality

In the late 1990s, several international agencies and donors became concerned that technical guidelines and programmes in the field of reproductive health were not being implemented in some countries. In 1999, WHO, USAID and other organizations launched what has become known as the Implementing Best Practices (IBP) initiative to help countries translate evidence-based policies, programmes and guidelines into reality. IBP partners work on collaborative assignments and with country teams in Benin, Ethiopia, India, Kenya, Uganda, the United Republic of Tanzania and Zambia to harmonize approaches, reduce duplication of effort and develop strategies. The partnership has also helped to develop an electronic communication system known as the IBP Knowledge Gateway. This web-based system allows communities of practice — groups of people who share what they know — to exchange knowledge and experiences in implementing reproductive health programmes. The system was launched in late 2003 and has over 3800 members from 58 countries and 146 communities of practice. The IBP secretariat is based at WHO, Department of Reproductive Health and Research and is staffed by Suzanne Reier, Technical Officer, and Maggie Usher-Patel, Scientist. By June 2006, 23 international organizations had joined the partnership.

<http://www.ibpinitiative.org>

Global Polio Eradication Initiative

The Global Polio Eradication Initiative — led by WHO, Rotary International, the US Centers for Disease Control and Prevention (CDC) and UNICEF — was launched in 1988 when the World Health Assembly adopted a resolution to eradicate polio. At the time, more than 350 000 children were paralysed by the disease each year, and polio was endemic in more than 125 countries. Since then, tremendous progress has been made and the disease burden has been reduced by more than 99%. In 2006, four countries remain polio endemic — Afghanistan, India, Nigeria and Pakistan — and fewer than 600 cases were reported worldwide by 21 June 2006.

David Heymann, Representative of the WHO Director-General for Polio Eradication, said he expects that all countries will be able to interrupt polio transmission in 2006, except Nigeria, where at least a further 12 months are needed to finish the job.

Q: Which practices helped to make this programme a success?

A: Polio eradication follows two major strategies: routine immunization with oral polio vaccine and mass vaccination campaigns to top off that routine coverage. These strategies are underpinned by networks of medical personnel and laboratories: field medical officers to identify persons with polio through surveillance of acute flaccid paralysis and to support countries in planning and implementation of immunization activities; and laboratories to confirm and analyse the presence of poliovirus. Practices that have worked are: the integration of micro-planning (including community mapping) with

the planning of vaccination campaigns; monitoring the performance of vaccination campaigns using pre-established performance indicators; and assessing their impact through surveillance. Additional practices that have ensured strong and valid surveillance include weekly assessment of the performance of surveillance using quantitative reporting indicators, and annual certification of laboratory quality through external quality assessment.

Q: What were the lessons you learned when implementing this programme?

A: The first lesson is that scientific evidence must be validated and used as the basis for policies. When difficulty occurred, for example, in interrupting transmission in high population density countries, scientific evidence was used to find the solution — a monovalent oral polio vaccine that is now available to countries in the final stage of eradication. The second and possibly most important lesson is that a well-defined

David Heymann

- Scientific evidence must be validated and used as basis for policies
- Establish strong surveillance mechanisms, performance monitoring and effective planning
- Well-defined partnership capitalizes on complementary strengths

partnership brings complementary strengths to the table. Polio eradication depends on collaboration between four leading partners: WHO, Rotary International, CDC and UNICEF, and on the implementation of programmes by countries with guidance from WHO's regional and country offices. Frequent and regular communication is necessary, whether it be phone conferences to discuss advocacy or fundraising between the four core partners, or within each organization to discuss planning, budgeting and implementation among staff at headquarters and those in regional and country offices. Each partner, with its comparative advantage, has made the polio eradication initiative a success: Rotary — because of its capacity to raise funds and advocate at all levels of government; UNICEF — with its strength in social mobilization and vaccine supply; CDC — with its provision of technical experts, and WHO — by ensuring eradication norms, standards and policies, global monitoring and technical support to governments. ■

WHO's strategy on Integrated Management of Childhood Illness

Elizabeth Mason, Director of WHO's Department of Child and Adolescent Health and Development (CAH), says that since WHO launched the Integrated Management of Childhood Illness (IMCI) strategy in 1995 it has been implemented in more than 100 countries. In some countries it has already led to improvements in child survival and health. The programme started in response to a request from countries to expand the remit of the management of diarrhoeal diseases and acute respiratory infections to cover all the major life-threatening conditions of childhood. It is based on the idea that health workers need to look at the child as a whole.

Q: What are the practices that helped to make IMCI a success?

A: IMCI is a very simple tool based on evidence, and it simplifies the approach to managing the child while at the same time considering the child as a whole. It also includes communications skills between the health worker and the

mother, so that the health worker feels empowered to advise parents better, so that the parents are more likely to understand and adhere to the advice. A lot of the feedback on IMCI has been on health worker skills and confidence: confidence in their decision-making, and skills to make the best decision for

Elizabeth Mason

- Empower health workers (providers) and educate parents (clients)
- All programmatic tools need to be ready before implementation
- Be quick to present positive results for advocacy purposes

that child. Whether the best decision is to give or not give an antibiotic, or to refer or counsel the mother — health workers actually have a systematic review process to follow. They can make a decision based on a clear set of well-defined instructions, and that decision leads them to the correct action. IMCI guidelines and materials are adapted to the epidemiological, political, and social environment of a country. The guidelines thus meet a country's specific

needs in terms of illnesses (e.g. malaria or HIV), drug policy (which drugs are available at which level of health facility) and organizational structure. The fact that it has been essential to build from the beginning and continually nurture partnerships with other principal actors in child health creates a stronger technical and funding base, and helps develop harmonious assistance to countries.

Q: What lessons did you learn for the future, when implementing this programme?

A: One key lesson was that you need to have the programmatic tools at the

same time as the training tools. One of the initial criticisms was that IMCI was just a training programme, since the other programmatic areas were not developed well enough initially. Another key lesson was in our presentation of IMCI to countries. For example, the training of health workers is done in a fairly intensive 11-day course. For the health worker, it is a short time to learn a great deal of material. For the decision-makers, it is a long time to take health workers from their posts. For the funders, it is expensive. Overall, you have a mixture of interests. In the packaging, we were focused more on the

content than on an explanation of why that length of time is necessary. Having all programmatic tools ready may have been a more successful way of ensuring agreement among the decision-makers and the funders. In addition, we need to be quicker to present positive results. Although we embarked on a very comprehensive multi-country evaluation of IMCI, we didn't pay sufficient attention to more punctual evaluation and feedback that would give results we could communicate to the ministries of health and to partners. I would do that differently in future. ■

Recent news from WHO

- WHO welcomed the **focus on infectious diseases** and **detailed health commitments made by the G8** countries in a final statement at 15–17 July summit in St. Petersburg, Russia. "The G8 spoke together on the essential need to tackle infectious diseases, because of their health, social, security and economic impacts," said WHO Acting Director-General Anders Nordström. "The commitments are detailed and specific, and represent another step forward in G8 leadership on public health." The G8 pledged to improve the ways in which the world cooperates on surveillance for infectious diseases, including improving transparency by all countries in sharing information. The G8 also committed to continued support to fight HIV/AIDS, tuberculosis, malaria, and to eradication of polio. Nordström led a senior WHO team at the summit to contribute to discussions on infectious disease, and he addressed G8 leaders, in the presence of heads of state or government officials from Brazil, China, the Congo, Finland, India, Kazakhstan, Mexico and South Africa, as well as UN officials who had been invited.
- The Codex Alimentarius Commission has adopted new standards on the maximum allowable levels of a number of key contaminants and food additives in order to protect the health of consumers. At its latest session, which ended on 7 July, the Commission set standards for the maximum allowable amounts of contaminants such as lead and cadmium in certain foods. Additionally, newly adopted codes of practice will give guidance to governments on how to prevent and reduce dioxins and aflatoxins in food.
- WHO issued updated guidelines on 28 June for the airline industry to reduce the risk of tuberculosis (TB) and other infectious diseases being passed from passenger to passenger on board aircraft. The **Tuberculosis and Air Travel guidelines** stipulate that people with infectious TB must postpone long-distance travel, while those with multidrug-resistant tuberculosis (MDR-TB) must postpone any air travel.
- WHO launched the world's first-ever international guidelines on **safe places to swim and bathe** on 27 June. The guidelines aim to protect people from the health risks associated with swimming pools, spas and other recreational bathing areas.
- Indonesia hosted an international expert consultation on **avian influenza** from 20 to 22 June. During the meeting, experts reviewed the status of the H5N1 virus in humans and animals. The group made recommendations on improving control of the virus in animals and humans, and it reviewed the lessons learned for rapid response and containment.
- WHO and the United Nations Population Fund pledged to step up efforts to address the increasing levels of **sexual and reproductive ill-health** after a 16 June meeting on the issue. The move follows two World Health Assembly resolutions on the issue in 2005 and 2006. Inadequate sexual and reproductive health services have resulted in maternal deaths and rising numbers of sexually transmitted infections, particularly in developing countries. WHO estimates that 340 million new cases of sexually transmitted bacterial infections, such as syphilis and gonorrhoea, occur annually in people aged 15–49 years. Many are untreated because of lack of access to services.

For more about these and other WHO news items please see: <http://www.who.int/mediacentre/events/2006/en/index.html>