

WHO-Facts Sheet

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Kuwait Medical Journal 2007, 39 (4): 391-396

1. NEW GUIDE ON PALLIATIVE CARE SERVICES FOR PEOPLE LIVING WITH ADVANCED CANCER

WHO released its first guide on planning palliative care services for people living with advanced stages of cancer. The guide, which is based on consultations with more than 70 leading cancer experts in the world, has identified highly effective low-cost public health models to care for terminally ill cancer patients, especially in developing countries.

The guide, 'Palliative Care: Cancer Control Knowledge into Action, WHO Guide for Effective Programmes' was launched on the occasion of World Hospice and Palliative Care Day, 6 October, 2007.

Palliative care is an approach that improves the quality of life of patients and their families facing life-threatening illness by providing pain-relief and management of other distressing and debilitating symptoms. Palliative care services are appropriate from the time of diagnosis of a life-threatening illness and throughout the course of the illness. Preliminary estimates show that each year, 4.8 million people who suffer from moderate to severe pain caused by cancer do not receive treatment.

"Everyone has a right to be treated, and die, with dignity. The relief of pain - physical, emotional, spiritual and social - is a human right" said Dr Catherine Le Galès-Camus, WHO Assistant Director-General for Noncommunicable Diseases and Mental Health. "Palliative care is an urgent need worldwide for people living with advanced stages of cancer, particularly in developing countries, where a high proportion of people with cancer are diagnosed when treatment is no longer effective."

The new guide is aimed primarily at public health planners. It provides guidance on how to conduct a national situation analysis and response review, mapping the burden of cancers in advanced stages against palliative care services available, and recommending plans for low-cost public health models to close any gaps.

"Simple and low-cost public health models of palliative care can be implemented to reach the majority of the target population, particularly in developing countries where the majority of cases are diagnosed in late stages", said Dr Benedetto Saraceno, Director a.i. for Chronic Diseases and Health Promotion. "These models consider the integration of palliative care services in the existing health system, with a special emphasis on community- and home-based care."

In 2005, 7.6 million people died of cancer out of 58 million deaths worldwide. More than 70% of all cancer deaths occur in developing countries, where resources available for prevention, diagnosis and treatment of cancer are limited or nonexistent. Based on WHO projections, cancer deaths will continue to rise with an estimated 9 million people dying from cancer in 2015, and 11.4 million dying in 2030.

Yet many of these deaths can be avoided. More than 40% of all cancers can be prevented. Others can be detected early, treated and cured. Even with late stage cancer, the suffering of patients can be relieved with good palliative care.

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2. NEW WHO POCKET-CHARTS WILL SAVE LIVES BY PREDICTING HEART ATTACK AND STROKE

A new book of pocket-charts that will help health workers to identify people at risk of heart attacks and strokes and save lives by prescribing the most appropriate treatment is published by the World Health Organization (WHO). The charts can be adapted for use in any setting, in any country, with any patient.

The "Pocket Guidelines for Assessment and Management of Cardiovascular Risk" can be carried and used by any health care worker and is available in six languages. The guide contains easy-to-use charts that can predict the risk of a heart attack or a stroke and could help health workers to save and improve the lives of people in all countries.

"This is a real breakthrough. Now, health care workers everywhere - whether they are in a high-tech medical center in a big city, or riding a bicycle to visit patients in the countryside - can use a simple assessment and treatment tool to prevent heart attacks and strokes," said the WHO Director-General, Dr Margaret Chan. "Primary health care workers now have a new tool to assess and manage people at risk of heart attacks and strokes. This brings cardiovascular care to the places and people who need it most."

This is the first cardiovascular disease risk-prediction system that can be used worldwide and is also specially designed for use with people everywhere, including in low-resource settings. It is an important innovation that will help health workers to target limited health care resources at people who are at higher risk of developing heart attacks and strokes.

These guidelines will be distributed to health workers in the form of pocket guides that have been produced for each of the WHO regions (risk profiles are different for different parts of the world). The pocket guides are available in hard copy and on the WHO website http://www.who.int/cardiovascular_diseases/resources/publications/en/index.html

"We are never prepared for the sudden death of a family member or a friend from a heart attack or stroke", said Dr Catherine Le Galès-Camus, WHO Assistant Director-General for Noncommunicable Diseases and Mental Health. "Cardiovascular diseases are increasing towards epidemic proportions in developing countries - they already account for one-third of global deaths, and almost 10 percent of the global burden of disease, and are likely to become the developing world's leading cause of death in 2010. There is reason for hope, however, given that huge potential

exists to control this emerging epidemic. These risk charts are a major new tool for providing the best health care to all the world's people".

To ensure that the pocket guide gets into the hands of the health care workers who should use it, WHO will be collaborating with national Ministries of Health and health-focused nongovernmental organizations to organize 'training of trainers' workshops and distribution of the pocket guide.

The risk-prediction charts integrate the following risk factors when predicting the risk of a heart attack or stroke in the 10 year period following the patient assessment:

Age, Sex, Tobacco use, Blood pressure, Diabetes status, Blood cholesterol.

The pocket guide also incorporates management recommendations, based on the risk of developing heart attacks and strokes, in the following areas:

Smoking cessation, Dietary changes, Physical activity, Weight control, Alcohol intake, Antihypertensive drugs, Lipid lowering drugs, Hypoglycaemic drugs, Antiplatelet drugs, Anticoagulant treatment, Revascularization surgery, Drugs that are not recommended.

Background: Cardiovascular disease (CVD) is the number one cause of death globally, causing one third of all deaths. In 2005, 11.8 million people died of heart attacks and other heart diseases, and 5.7 million died of stroke. Around 80% of these deaths were in low- and middle-income countries. By 2015, an estimated 20 million people will die from CVD annually, mainly from heart attacks and strokes. Socioeconomic costs of premature deaths and disability, and escalating costs of medical care make it all the more urgent to take measures to prevent and control this burgeoning epidemic in low- and middle-income countries where health care resources are limited.

Urbanization and globalization promote tobacco use, unhealthy diet and physical inactivity. These risk factors result in increased risk of people developing heart attacks and strokes because the result is raised levels of blood pressure, blood glucose, blood cholesterol and body weight. These, in addition to increasing age, are major risk factors that determine an individual's chances of having a heart attack or stroke. This is known as the cardiovascular risk.

Until now, individuals have often been assessed and treated based on a single cardiovascular risk factor such as high blood pressure, high blood lipids or diabetes. This approach can result in committing a patient who has only a small cardiovascular risk to many years of drug therapy or, conversely, neglecting to treat those with an overall higher cardiovascular risk. Most importantly, the single

risk factor approach is not cost effective and is not affordable for many low-income and middle-income countries.

For successful prevention and control of the CVD epidemic, the combination of population-based and individual-based strategies are needed to lower the cardiovascular risk of populations and individuals. Population-wide strategies such as tobacco control and promotion of a healthy diet and physical activity are very cost effective in all countries. Cost effective interventions are also available to treat those who have survived heart attacks and strokes. However, treating risk factors such as high blood pressure and blood lipids is cost effective for low-income and middle-income countries only if interventions are targeted at high risk individuals.

In many low-income and middle-income countries, national and state health care budgets and per capita health expenditures are suboptimal. It is imperative, therefore, to use the limited resources that are available as effectively and efficiently as possible. This requires the prioritization of cost-effective approaches and the targeting of those patients who are most likely to benefit from interventions. In any population, those people who are most likely to benefit from cost-effective CVD interventions are the people with the highest cardiovascular risk.

The World Health Organization, in collaboration with the International Society of Hypertension (ISH), has developed cardiovascular risk prediction charts that enable cardiovascular risk assessment and prediction in non-western populations.

Many health care systems in low-income countries do not have the basic infrastructure facilities to support resource intensive risk prediction tools, particularly in primary health care. The WHO/ISH charts use easily measurable indicators of risk to quantify the 10-year risk of developing heart attacks and strokes. These indicators of risk include gender, age, systolic blood pressure, smoking status, diabetes and total blood cholesterol. For use in low-resource settings, where blood cholesterol measurement is not routinely available, alternative charts have been developed that predict risk without blood cholesterol. Also, in many low-resource settings, urine sugar levels may be used as a surrogate marker for diabetes.

Although the risk-prediction charts and pocket guides are simple to use, short training sessions will be required to introduce the charts into regular health care practice. The charts are ready for use now, and will be updated over time. Like all risk-prediction tools, the accuracy of this tool for specific populations can be improved over the long term by making minor adaptations as data are collated for

individual populations. Technical assistance will be provided, through the WHO-ISH collaboration, to compare this new tool with other risk prediction methods, to further improve accuracy, and to adapt the CVD risk-prediction charts to suit very specific country contexts.

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3. NEW STANDARD FOR DOCUMENTING THE HEALTH OF CHILDREN AND YOUTH

WHO published the first internationally agreed upon classification code for assessing the health of children and youth in the context of their stages of development and the environments in which they live.

The International Classification of Functioning, Disability and Health for Children and Youth (ICF-CY) confirms the importance of precise descriptions of children's health status through a methodology that has long been standard for adults. Viewing children and youth within the context of their environment and development continuum, the ICF-CY applies classification codes to hundreds of bodily functions and structures, activities and participation, and various environmental factors that restrict or allow young people to function in an array of every day activities.

The rapid growth and changes that occur in first two decades of life were not sufficiently captured in the International Classification of Functioning, Disability and Health (ICF), the precursor to the ICF-CY. The launch of the ICF-CY addresses this important developmental period with greater detail. Its new standardized coding system will assist clinicians, educators, researchers, administrators, policy makers and parents to document and measure the important growth, health and development characteristics of children and youth.

Children who are chronically hungry, thirsty or insecure, for example, are often not healthy and have trouble learning and developing normally. This classification provides a way to capture the impacts of the physical and social environment so that these can be addressed through social policy, health care and education systems to improve children's well-being.

"The ICF-CY will help us get past simple diagnostic labels. It will ground the picture of children and youth functioning and disability on a continuum within the context of their everyday life and activities. In this way it enables the accurate and constructive description of children's health

and identifies the areas where care, assistance and policy change are most needed," said Ros Madden, Australian Commission on Safety and Quality in Health Care, and, Chair of the Functioning and Disability Reference Group of the WHO Family of International Classifications (WHO-FIC) Network.

The ICF-CY has important implications globally for research, standard setting and mobilizing resources. "For the first time, we now have a tool that enables us to track and compare the health of children and youth between countries and over time," said Nenad Kostanjsek of WHO's Measurement and Health Information team. "The ICF-CY will allow countries and the international community to take informed action to improve children's health, education and rights, by treating their health as a function of the environment that adults provide."

The classification also covers developmental delay. Children who achieve certain milestones later than their peers may be at increased risk of disability. Using this classification, health practitioners, parents and teachers can describe these delays precisely in order to plan for health and educational needs and frame policy debates.

The children and youth version of the International Classification of Functioning, Disability and Health (ICF-CY) is launched today in Venice, with international praise:

- "The publication of the ICF-CY by the WHO provides, for the first time, a standard language to unify health, education and social services for children," said Dr. Margaret Giannini, Director of the Office of Disability, U.S. Department of Health and Human Services.

- "This approach offers a scientific basis for describing each child's functional abilities using a shared language. Further, the ICF-CY has important implications for educational policy, research, and service designs for children and youth with disabilities," said Mary Ruth Coleman Ph.D., President Council for Exceptional Children (2007).

- "The ICF-CY is a tool that can be shared by clinical services as well as by schools, community agencies and government entities. Further, with the visibility of an international WHO standard, the ICF-CY can serve to affirm the universal needs and rights of children," said Rune J. Simeonsson, Chair, WHO Work group on ICF-CY Children and Youth; University of North Carolina.

- "The approach of focusing on how children and youth function physically, socially and mentally within the context of their development and environment has important implications for special education," said Yutaka Oda, President,

National Institute of Special Education, Japan.

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4. BASIC SURGERY SKILLS TO SAVE LIVES AND PREVENT DISABILITY

The World Health Organization (WHO) is expanding its programme to train health care staff in low- and middle-income countries in essential emergency, basic surgery and anaesthesia skills. The programme, which already exists in 22 countries, will boost the capacity of first-level health facilities (rural or district hospitals and health centres) to deal with simple but essential surgery in a growing number of developing regions.

In many cases, death and permanent disability can be avoided through simple surgical interventions following road traffic injuries, interpersonal violence or war, abdominal emergencies, pregnancy complications, congenital abnormalities, fractures, burns, or the consequences of acute infections.

Together, these conditions cause the loss of approximately 11% of total lost years of healthy life (according to the World Health Report 2002). Injuries alone kill more than 5 million people every year, accounting for nearly one in every 10 deaths worldwide.

The WHO Emergency and Essential Surgical Care Project trains health staff in simple surgical procedures, anaesthesia and emergency care. After training and with the help of basic equipment, health care staff are able to perform surgical procedures that save lives and prevent disability.

"The initiative signifies a shift in the way we think about surgery," explains Dr Luc Noel, in charge of clinical procedures at WHO. "Until recently, surgery was a neglected health issue in developing countries because it was assumed to be too expensive and sophisticated."

Surgical intervention has become a common component in the management of patients with HIV/AIDS. Some complications associated with HIV infection (such as abscesses, anorectal disorders, lymphadenopathies, lipotrophy or mild forms of Kaposi's sarcoma) are also diagnosed and treated with simple surgical interventions. Current evidence shows that basic surgical and anaesthetic services should be integrated into primary health-care packages.

"Why should a child die from appendicitis, or a mother and child succumb to obstructed labour, when simple surgical procedures can save their lives?" said Dr Meena Cherian, who heads the surgery programme at WHO.

The quality of emergency and essential surgical care is often constrained by inadequate basic equipment for interventions that are simple but vital, such as resuscitation, giving oxygen, assessing anaemia and inserting a chest drain.

Other barriers to the timely and appropriate delivery of basic surgical services in low and middle income countries include poor infrastructure and insufficient numbers (and training) of health-care professionals.

In most developing countries, adequate surgical services are found only in tertiary centres in urban areas. Furthermore, the migration of health professionals leaves a shortage at primary-health facilities, where services are provided by non-specialist or even non-medical personnel, many of whom are inadequately trained.

However, a number of isolated, local initiatives have shown that even with only basic training and technologies, many lives can be saved or improved.

For instance, clubfoot (a congenital deformity of the foot, marked by a twisted position of the ankle, heel and toes) can greatly impede mobility in children; if untreated, clubfoot can lead to severe disability and loss of productive life. Clubfoot is estimated to occur in 1-2 per 1000 live births, which translates into well over one hundred thousand cases worldwide per year. Clubfoot diagnosed at birth or soon after can often be treated using a minimally invasive technique called the Ponseti method.

The Ponseti method involves multiple manipulations and plaster castings early in a child's life. Proper implementation of the Ponseti method results in a dramatic decrease in the number of clubfoot cases that require surgery. These techniques have been quite effective in the industrialized world; they require minimal resources and can be implemented by health personnel in primary health care facilities. Recent programmes in Africa, India and South America are training local health care professionals in the Ponseti technique. In Uganda, over one hundred professionals have been trained, resulting in effective treatment of 95% of new cases of clubfoot.

WHO will present future actions of the Emergency and Essential Surgical Care Project to stakeholders and partners at a meeting of the Global Initiative for Emergency and Essential Surgical Care in Dar-es-Salaam, Tanzania, on 24-25 September. At the meeting, WHO will also seek support from multi-lateral donors to expand the initiative.

WHO established the Global Initiative for Emergency and Essential Surgical Care in 2005 to improve access to and quality of surgical care in the developing world. A broad partnership

of internationally recognized organizations and individuals, the GIEESC counts 22 countries representing all WHO regions among its members.

Stakeholders include doctors (surgeons, anaesthetists, paediatricians, obstetricians, nurses), economists, donors, non-governmental organizations, professional societies. A meeting co-hosted by WHO, the World Bank, Global Health Sciences, the Rockefeller Foundation and the Karolinska Institute (Sweden) was held in June 2007 to promote access to surgical services in resource-constrained countries in sub-Saharan Africa.

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5. NEW GUIDANCE ON INSECTICIDE-TREATED MOSQUITO NETS

The World Health Organization (WHO) issued new global guidance for the use of insecticide-treated mosquito nets to protect people from malaria. For the first time, WHO recommends that insecticidal nets be long-lasting, and distributed either free or highly subsidized and used by all community members.

Impressive results in Kenya, achieved by means of the new WHO-recommended strategy, show that free mass distribution of long-lasting insecticidal nets is a powerful way to quickly and dramatically increase coverage, particularly among the poorest people.

Previously, WHO's guidelines focused primarily on providing insecticide-treated mosquito nets for use by children under five years old and pregnant women. However, recent studies have shown that by expanding the use of these nets to all people in targeted areas, increased coverage and enhanced protection of vulnerable groups can be achieved, while protecting all community members. In areas of high transmission of malaria, where young children and pregnant women are the most vulnerable, WHO now recommends making their protection the immediate priority while progressively achieving full coverage.

In Kenya, from 2004 to 2006, a near ten-fold increase in the number of young children sleeping under insecticide-treated mosquito nets was observed in targeted districts, resulting in 44% fewer deaths than among children not protected by nets, according to preliminary data from the Government of Kenya. This is the first demonstration of the impact of large-scale distribution of insecticide treated mosquito nets under programme conditions, rather than in research settings, where, in different parts of Africa, reduction observed in overall mortality

has ranged from 14 % up to 60 %.

These achievements can be attributed to three principal ingredients which all need to be present for malaria control efforts to succeed: high political commitment from the government, strong technical assistance from WHO, and adequate funding from bilateral and multilateral donors.

"WHO's new evidence-based guidance provides a road map for ensuring that life-saving long-lasting insecticidal nets are more widely available and used by communities, and are more effective in protecting poor women and children," said Dr Margaret Chan, the Director-General of the World Health Organization. "The collaboration between the Government of Kenya, WHO, and donors serves as a model that should be replicated throughout malarious countries in Africa."

In 2001, the Ministry of Health of Kenya developed the new national strategy for malaria control targeting increased coverage of insecticide treated mosquito nets. In 2006, President Mwai Kibaki launched an effort funded by a US\$ 17 million grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria, to distribute 3.4 million long-lasting insecticidal nets free of charge to children in 45 of Kenya's 70 districts through two campaigns. The Division of Malaria Control of Kenya, working with an international research team, has been monitoring the coverage and impact of this intervention.

Between 2002 and 2006, with a GBP 6 million grant from the United Kingdom Department for International Development, WHO has advocated for and supported the Kenyan Government to undertake free mass distribution, provided technical support for the preparation of two Global Fund proposals, and provided a full-time logistician to support planning and implementation of free net distribution. WHO's contribution also included helping to outline delivery mechanisms and pricing strategies to reach coverage targets, sharing knowledge and lessons learnt related to net distribution, and strengthening partnerships. Two WHO staff work full-time on supporting the Kenyan Government's malaria control programme.

"The Government of Kenya is strongly committed to achieving improved and equitable health outcomes for all Kenyans, particularly women and children. The incredible gains in Kenya have been made possible with donor funds, which enabled us to buy these nets, and WHO's technical

support, which helped ensure that they reached those who most need them," said Charity Ngilu, Minister of Health of Kenya.

Insecticide-treated nets are mosquito nets treated with insecticides which repel, disable or kill the vector mosquitoes which transmit malaria. Conventional insecticide treated mosquito nets need to be re-treated regularly, while long-lasting insecticidal nets (LLINs) are designed to be effective without re-treatment for the life of the net.

The new WHO guidance on nets recommends that campaign-like mass distribution strategies be complemented by delivery through routine health services to achieve and maintain high levels of coverage.

At around US\$ 5 per net, LLINs are a simple and cost-effective intervention against malaria. Until recently, progress in scaling up insecticide treated mosquito nets has been slow in many countries, due in part to the inability of the international community to reach a consensus on how to deliver them to achieve and sustain high coverage. Approaches have included commercial channels, social marketing, and free or subsidized distribution through routine public health services or campaigns.

In some cases, a small co-payment may motivate health workers to distribute long-lasting insecticidal nets, thus boosting coverage, but the new WHO guidance stresses that cost should not be a barrier to access. Thus far, only free distribution has enabled rapid achievement of high population coverage and elimination of inequities in net use, as has been demonstrated in Kenya.

"This data from Kenya ends the debate about how to deliver long-lasting insecticidal nets," said Dr Arata Kochi, head of the WHO's Global Malaria Programme. "No longer should the safety and well-being of your family be based upon whether you are rich or poor. When these nets are easily available for every person, young or old, malaria is reduced."

Malaria, which is preventable and treatable, still kills more than one million people each year, mainly African children under five years of age.

For more information contact: Valerie Crowell, HIV/AIDS, Tuberculosis and Malaria, Technical Officer, WHO, Geneva, tel: +41 22 791 1204, email: crowello@who.int The new WHO guidance can be found here: <http://www.who.int/malaria/itnguidelines.html>