世 界 卫 生 组 织

执 行 委 员 会
第一〇九届会议
临时议程项目 7.2

EB109/38
2001年11月16日

执行委员会各委员会的报告

世界卫生组织/联合国儿童基金会/联合国人口基金卫生协调委员会的报告

1. 世界卫生组织/联合国儿童基金会/联合国人口基金卫生协调委员会在联合国总部举行了其第三次会议（2001年4月19 – 20日于纽约），联合国人口基金担任东道组织。Pia Rockhold博士（丹麦）代表联合国人口基金执行局当选为会议主席。总干事、联合国儿童基金会执行主任Carol Bellamy女士和联合国人口基金副执行主任Kunio Waki先生向会议发表讲话。

2. 委员会收到一份实施其在第二次会议（1999年12月2 – 3日于日内瓦）所提建议[1]的进展报告。关于降低孕产妇死亡率和发病率（包括使用微量营养素），委员会强调，必须改进关于孕产妇和围产期健康的数据质量，必须确保在怀孕、分娩和产后期公平获得适当保健，并且需要进一步支持减少怀孕期间贫血的活动。关于青少年卫生与发育，委员会提倡对暴力采取性别措施，并且强调传播与性卫生和计划生育有关的信息和提供这方面服务的重要作用。关于HIV/艾滋病，这三个组织均认可以在潜在的父母中HIV感染的初级预防、在感染HIV的妇女中避免意外怀孕和防止感染HIV的母亲向婴儿传播病毒为基础的联合国从三方面防止母婴传播HIV的战略。关于协调国际人口与发展会议（ICPD+5）的后续行动，有关生殖卫生方面基准指标的工作已就17项指标产生一致意见。关于分性别卫生数据的工作正在继续进行。委员会还表明有必要筹资以继续联合国系统极为有益的免疫规划并敦促这三个机构开展宣传以促进对2001 – 2005年根除脊髓灰质炎倡议全球战略计划的支持。

3. 委员会收到了一份关于联合国系统在卫生发展的全部门方法方面作用的介绍以及

[1] 见文件EB105/15 Add.1。

关于在一个国家在进程初期（柬埔寨）和已参与三年的另一个国家（乌干达）应用这些方法方面经验的报告。在其下一次会议上，委员会将讨论改进联合国对全部门方法的支持的进展报告；将列入议程的还有注重于孕产妇和新生儿健康、暴力 – 尤其是针对妇女和女童的暴力以及HIV/艾滋病与青年的详细介绍和讨论在一个或两个国家的进程。

4. 执委会拟可注意所附的报告[1]。

[1] 只有英文。

WHO/OMS **UNICEF** **UNFPA/FNUAP**

WHO/UNICEF/UNFPA Coordinating Committee on Health **CCH3/01/6**
Third session 16 May 2001
New York, 19-20 April 2001

Report of WHO/UNICEF/UNFPA Coordinating Committee on Health (CCH)

United Nations Headquarters, New York
19-20 April 2001

CONTENTS

OPENING OF THE SESSION (Agenda items 1-4) (Document CCH3/01/1)

1. In the absence of the outgoing Chair, Dr Attiyat Mustapha (Sudan), UNICEF Executive Board, who was unable to attend, Mr Kunio Waki, Deputy Executive Director of UNFPA, opened the meeting and welcomed the participants (see List of Participants in Annex 1).

2. Dr Pia Rockhold (Denmark), UNFPA Executive Board, was elected Chair and Professor João Yunes (Brazil), WHO Executive Board, Mr Walid Abdulwahed M. Al-Ethary (Yemen), UNICEF Executive Board, and Dr Girma Azene (Ethiopia), UNFPA Executive Board, were elected Rapporteurs.

3. Referring to the provisional agenda (document CCH3/01/1), the Chair proposed that the Committee might wish, under item 10, Other business, to reflect on its terms of reference and to define more clearly its role and functions, in order to ensure that its meetings achieved better continuity and a greater sense of purpose. The agenda, as amended, was adopted (Annex 2).

4. Dr Brundtland, Director-General of WHO, reiterated the purpose of the Committee as being to deal with coordination and collaboration in the service of health development. This was more than being helpful – it was an essential new way of working within the United Nations, and one which had been emphasized in the ground-breaking series of conferences in the 1990s. These had resulted in an international consensus around strategies, goals and targets, epitomized in the Millennium Summit Declaration which set the framework for future collaboration within the United Nations system and placed health issues among the key objectives for priority attention.

5. She described WHO's planned scaling-up of responses to health problems like malaria, tuberculosis and diseases associated with tobacco use, those which contribute to deepening the problems of the world's poorest people, in cooperation with national governments, other United Nations-system organizations, and a broad range of development partners. Such actions would necessitate the development of reliable monitoring and evaluation systems, and effective government stewardship, perhaps accompanied by an increase in external support through poverty reduction strategies, sector-wide approaches, bilateral projects or emergency assistance, with development of human capacity at local and national levels. WHO was committed to working with several intergovernmental bodies such as the European Commission and the Heads of State of the Organization of African Unity to encourage the provision of extra resources for action at country level in the next 10 years, and to support their long-term commitment to achieving better health outcomes for the poor. New mechanisms for ensuring that global initiatives benefited the poorest countries were being developed.

6. The present growth in sector-wide approaches (SWAps) to development cooperation in health arose from the economic constraints of the 1980s which stifled the momentum of the primary health care movement and led to project-oriented support that lacked sustainability. SWAps changed the role of the donor, as they started from nationally developed policies, strategies and budgets, and were jointly financed by government and development partners. They provided an opportunity to obtain the optimum synergy and effectiveness in work with governments and people in the poorest countries.

7. A central concern was addressing the challenge of strengthening the health system's response to HIV/AIDS. Resources must be substantially increased and management capacity enhanced.

8. The Global Health Sector Strategy currently being developed by WHO would identify key priorities for health sector action in HIV/AIDS and focus attention on the delivery of complementary prevention and care interventions, working through public and private sectors.

9. Of the key issues facing WHO, three required urgent attention: the health of the newborn; HIV and young people; and violence, especially against women and girls. Health care for pregnant women and newborns should be seen as part of the same continuum. This was particularly important as the proportion of infant deaths occurring within the first few days of life was increasing. Targeted, selective interventions such as immunization and oral rehydration therapy had resulted in substantial reductions in post-neonatal mortality but early neonatal mortality remained an issue due to the poor health and nutritional status of the mother, coupled with inadequate care. The health of young people, a significant sector of the population, was of concern, particularly as globally over half of all new HIV infections occurred in this group. Young people needed information, skills and services to help them to protect themselves. Dr Brundtland also reported increased efforts in the areas most likely to threaten healthy adolescent development: sexual and reproductive health, including HIV; substance use, especially tobacco and alcohol; and mental health. Violence, especially against girls and women, was also of great concern. A multicountry study was being conducted by WHO to assess the extent of the problem. There was also a need for enquiry into how to address other forms of violence such as sexual abuse. In collaborating with countries to address these issues, it would be crucial to avoid overloading health systems with demands for data and ensure consistency in definitions, approaches and methodologies used to generate indicators, with the ultimate goal of improving programme performance and delivering better health to those in need.

10. Ms Bellamy, Executive Director of UNICEF, noted the need for and presence of, increased collaboration and complementarity between the three agencies, especially at country level. The Committee session was a useful forum for assessing progress and opportunities within the context of continually greater expectations. She highlighted two particular areas of important joint activity: health-sector SWAps and the collaborative drive to improve the coverage and quality of immunization services.

11. UNICEF was actively engaged in collaborative SWAps activities in 23 countries; the approach was fully embraced although effectiveness could be further enhanced. SWAps strengthened coordinated policy for high priority sectors, reduced aid fragmentation, promoted national ownership and promised generally enhanced impact and sustainability of development cooperation. UNICEF's involvement brought in the child rights perspective, the incorporation of development goals and objectives that reflected the priority needs of children and women, included cross-sectoral concerns, promoted broad participation in the SWAps and advocated effective linkages between those approaches and the wide range of other current programming frameworks.

12. Immunization was one of the top five organizational priorities for UNICEF. Long-term disease control needed a strong system for delivery of routine immunization, complemented by targeted activities, and a wider package of health services. In many poorer or developing nations important future considerations included the need for financial support, and the shortcomings of the health systems, such as the possibly unsafe administration of injectable vaccines. The Global Alliance for Vaccines and Immunization (GAVI) provided one of the best illustrations of effective partnerships to improve health.

13. Mr Waki, Deputy Executive Director of UNFPA, welcomed all the participants on behalf of Ms Thoraya Obaid, Executive Director of UNFPA, who was unable to join the meeting until the second day. He drew attention to the importance of the Committee in adding value to the strengths of the three organizations involved. It also provided the opportunity for open interaction between Board Members and the Secretariat, to revisit key issues and to build further upon existing collaboration. One of the immediate and long-term challenges was to improve understanding of the complex environment in which health policy was implemented and of the links between population and development and between reproductive health and poverty. It was essential to continue to examine those issues within various economic, social and cultural contexts, and to find practical approaches for achieving the social and behavioural changes needed to ensure real progress in improving health.

14. Many of the goals set out by the World Summit for Children, the follow-up to the International Conference on Population and Development (ICPD+5) and the Millennium Summit were particularly relevant to WHO, UNICEF and UNFPA, goals that dealt with the well-being of the most vulnerable, namely women and children. The five-year review and appraisal of the ICPD Programme of Action in 1999 had identified key areas that required further intensified action: maternal mortality; HIV/AIDS; adolescent reproductive health; gender equality and women's empowerment; the security of reproductive health commodities, especially in low-income countries; and questions of population, environment and sustainable development. UNFPA was committed to working with governments to strengthen their national capacity to meet those challenges.

15. UNFPA was highly committed to SWAps particularly in the health and education sectors and hoped to participate at all stages of the policy dialogue in the areas of reproductive health and gender. SWAps represented an opportunity to ensure policy coherence, donor coordination, equitable use of resources, and effective management for results. However, they also constituted a challenge, for example, in monitoring the use of limited resources. He looked forward to the discussions on that topic which he hoped would lead to the development of a common policy as well as operational and programme management guidance for the field offices of the three agencies. UNFPA programmes emphasized reproductive health information and services for all, including safe motherhood, family planning, and prevention and treatment of sexually transmitted infections, with a special focus on HIV/AIDS. He highlighted the work of UNFPA in the areas of prevention of HIV; collaboration on improvements in the coverage and quality of health services in order to prevent maternal deaths; collaboration to strengthen partnerships between providers and consumers; coordination of efforts towards the fulfilment of the rights of adolescents to information and participation, with special emphasis on the involvement of adults (e.g. parents and teachers); and on the development of indicators that better reflected the situation of girls and women. Adolescent health and development should be emphasized in the forthcoming United Nations General Assembly Special Session on Children (September 2001) and in the preparatory documents for that event.

PROGRESS IN IMPLEMENTING RECOMMENDATIONS MADE BY THE COORDINATING COMMITTEE ON HEALTH AT ITS SECOND SESSION (Agenda item 5) (DOCUMENT CCH3/01/2)

16. The technical officers concerned from WHO, UNICEF and UNFPA introduced the five sections of the report contained in document CCH3/01/2, outlining progress and drawing attention to the recommendations and action points that had been implemented, areas where implementation was ongoing, and areas of future action and concern. A list of the action points is given in Annex 3. The Committee noted that significant progress had been achieved in the general area of advocacy and that work was continuing in the areas of programme development, implementation, monitoring and evaluation. It recommended that future reports should show more clearly the extent to which the Committee's recommendations had been fulfilled, and should demonstrate the links between the various actions taken by the three agencies. With regard to follow-up on the Committee's recommendations, it was noted that each agency had different priorities and that there was a general problem of allocation of specific follow-up responsibilities.

Reduction of maternal mortality and morbidity (including use of micronutrients)

17. The Committee was informed that action point 16A (concerning advocacy efforts) had been implemented. It had not proved feasible to proceed with the establishment of Maternal Health Theme Groups at country level as suggested in action point 16B as it was felt that the issue was generally covered by broader health theme groups or other country coordination mechanisms. Work in the areas covered by action points 16C-16I (dissemination of a joint planning guide; dissemination of policy

documents and technical guidelines; collaboration on the finalization of the IMPAC approach; collaboration on criteria and standards for improving the quality of women-friendly reproductive health services; improvement of the nutritional status of girls and women; collaboration with ILO regarding the implications of the revised ILO Maternity Protection Convention; and operationalization of the terms of paragraph 66 of document A/S-21/5/Add.1 concerning gender-sensitive standards for the care and treatment of women and girls) was under way with a view to strengthening policy guidance and implementation.

18. Attention was drawn to the recent progress in safe motherhood programmes (including efforts to ensure Skilled Attendance at Birth, and the new WHO initiative Making Pregnancy Safer), noting the need to maintain the conceptual and practical links between maternal and neonatal health. The three agencies were also collaborating on activities to achieve increased support and funding for reproductive health services and on programmes to create economic and educational opportunities for girls and women. Significant progress had been made in reducing iodine and vitamin A deficiencies, further details of which would be reported at the forthcoming United Nations General Assembly Special Session on Children. Maternal and newborn health programmes should continue to be integrated with overall efforts to support health systems, where appropriate through SWAps.

19. The Committee emphasized the need to improve the quality of data on maternal and perinatal health which were primary indicators for assessing health and development. It was also vital to ensure equitable access to appropriate care during pregnancy, delivery and in the postpartum period, and to improve support for activities to reduce anaemia in pregnancy. WHO, UNICEF and UNFPA, together with nongovernmental organizations, should encourage governments to ratify the ILO Maternity Protection Convention and to ensure implementation of standards relating to maternity leave and breastfeeding at work.

Adolescent health and development

20. The Committee heard that action points 19A , 19C , 19D and 19G (on advocacy, operationalizing the country programming framework, development of a summary progress report, and specification of certain indicators) would be further advanced during the upcoming United Nations General Assembly Special Session on Children. Whilst recognizing that adolescent health and development was an issue that necessitated interagency collaboration, recommendation 19B (on the establishment of Adolescent Health Theme Groups) had been considered not feasible, as the level of current involvement already at country level meant that additional formation of theme groups would be inappropriate. Action point 19E (on developing a plan of action for expanding capacity at regional and country levels) had not yet been achieved, although progress was being made with expansion of activities at the regional level, collaborative work on technical and normative issues, and on identification of protective factors for young people. Regarding action point 19F (on the review and definition of research priorities) it was noted that work was under way in WHO to define a research agenda in collaboration with the other agencies. The importance of working together on definition of information and services needed was noted.

21. The Committee commented on the importance of a gender approach to violence. Male violence outside the home was frequently perpetrated against other males, while that perpetrated in the home was mostly against women and children. In many countries a high proportion of deaths among male adolescents was due to homicide related to drugs, alcohol, and firearms, and issues such as lack of education and employment opportunities. Adolescents were the targets of advertising by the tobacco and alcohol industries and exposed to pornographic and violent media including interactive games. It was noted that adult health behaviours and development were strongly influenced by health behaviours during adolescence.

22. The problem of how to communicate with adolescents so as best to equip them to protect themselves and make the most suitable lifestyle choices was debated, with strong support for peer education and involvement of nongovernmental organizations in sensitive areas. The importance of involving young people in policy-making was stressed. It would be helpful to look at the success stories in countries to ascertain where work by nongovernmental organizations and peer counselling had had good effects, so as to repeat those successes elsewhere.

23. The Committee drew attention to the importance of sexual health, and the related area of information and access to family planning services for young people. Teenage pregnancies, including wanted pregnancies for married teenage women, were a particular concern. Delaying first pregnancy should be encouraged to enhance life opportunities for girls and reduce complications associated with early pregnancies. The Committee agreed that knowledge had expanded fast but more information was still needed on health services and behavioural issues. New approaches should be developed using peer participation. There was also a need to improve the quality of data and monitoring.

HIV/AIDS (with a focus on mother-to-child transmission)

24. Significant progress had been achieved in implementing action point 22A relating to the global interagency initiative for the reduction of mother-to-child transmission of HIV (MTCT).[1]

25. The three-pronged strategy recommended by the United Nations agencies to prevent MTCT comprised primary prevention of HIV among parents-to-be; prevention of unwanted pregnancies in HIV-positive women; and prevention of HIV transmission from HIV-infected women to their infants (through the provision of a short-course antiretroviral drug regimen to the pregnant woman and newborn, safe delivery practices and support for safer infant feeding practices). Initial modelling indicated that it was important to give due emphasis to all three components and not to focus solely on the prophylactic use of antiretrovirals. Improved care and support for HIV-infected individuals and their families was also needed. The three agencies, with the support of the UNAIDS Secretariat, were continuing to coordinate their efforts successfully through the Inter-Agency Task Team for the Reduction of MTCT. At a technical consultation on interventions to prevent MTCT and their policy implications held in October 2000 it had been agreed that a number of antiretroviral regimens were suitable for general implementation. It had also been concluded that the 1998 guidelines on infant feeding practices in HIV-infected mothers remained valid. Attention was also drawn to the need to include nutrition in consideration of HIV/AIDS in future work and to emphasize that breastfeeding remained the best means of feeding most babies.

26. The technical consultation in March 2000 had provided a useful opportunity to share experiences on MTCT prevention pilot projects in 14 countries. The major challenge was to scale up such activities within existing health services and to link them to reproductive health, maternal and child health care and HIV/AIDS care and support services. Political support and additional resources were required to sustain the momentum generated following the XIII International AIDS Conference held in Durban, South Africa, in July 2000.

27. It was agreed that discussion on this section of the report should be taken together with the discussion on follow-up to ICPD+5.

[1] It has recently been proposed that the term “prevention of mother-to-child transmission (PMTCT)” should be replaced by the term “prevention in mothers and transmission to children (PMTC)”.

Coordination of follow-up to the International Conference on Population and Development (ICPD+5)

Benchmark indicators

28. The specific action point (24A) to convene a technical consultation on benchmark indicators on reproductive health had been achieved, and work was ongoing to strengthen national capacity and monitor progress. With regard to action point 24C (making support for the prevention of HIV transmission among adolescents a priority), that support would continue, and be followed up. The technical aspects of HIV/AIDS activities listed in 24D were suggested as areas for future work.

29. The Committee heard that an interagency working group had been convened to reach consensus on a limited number of feasible, understandable and useful indicators for global monitoring. A total of 17 indicators had been agreed upon, which were to be used by each of the three agencies in their global monitoring of reproductive health.

30. Increasing attention was being paid to using process indicators, such as the percentage of deliveries assisted by a skilled health care worker, for monitoring maternal mortality and to the development of capacity to generate and use indicators.

Gender

31. The work proposed in action point 24B on sex-related data; development of gender equity and equality; and the development of a common set of gender and health indicators and of specific policy and programme initiatives to accelerate progress was continuing.

32. The Committee heard that sex-disaggregated health indicators are the first step in gender analysis, as called for in the Common Country Assessment Indicators Framework. On other gender issues, harmful practices related to women's health, including female genital mutilation, had been under surveillance to estimate the extent and nature of the problem and its evolution over time; work was also under way to monitor and measure other practices harmful to the health of women and girls such as trafficking and domestic violence. The results of a WHO multicountry study on the incidence and impact of violence against women would be disseminated widely and used as a basis for action to improve the health and lives of women.

HIV/AIDS

33. Action points 24C and 24D on HIV/AIDS in adolescents were being followed up as indicated in the report. The three agencies had strengthened their collaboration in these areas, in particular through the Inter-Agency Working Group on Young People and HIV, and were working in a synergistic manner, taking into account institutional comparative advantages. It was important to sustain the progress made so far and to move the work forward. The forthcoming United Nations General Assembly Special Session on HIV/AIDS was providing a further opportunity for interagency collaboration.

34. HIV prevention measures were feasible and cost-effective in all countries and should be introduced in all relevant programmes. However, it was important to pay due attention to the balance between prevention and care. An integrated approach was required, regardless of the prevalence or status of the epidemic in any given country or community or the planning timeframe for any advocacy, legislative or intervention effort.

35. The Committee drew attention to the rapid growth in HIV infection rates in women in many countries and to the difficulties in reaching young people and other vulnerable groups with appropriate information and education messages. While giving due attention to the HIV/AIDS crisis in Africa, it was also important to focus on other areas of the world, such as the Caribbean and Russia, where the HIV/AIDS epidemic was growing. Although there were differences in the development of transmission patterns, the global nature of the epidemic made it imperative to open up the debate in every country and to counteract stigma and discrimination against all those affected by the disease.

Immunization

36. Remarkable progress had been made in advancing several aspects of immunization coverage and quality (action points 29A-29H). These areas should continue to receive attention, building capacity and maintaining commitment.

37. The Committee urged the three agencies to foster support for the Polio Eradication Strategic Plan 2001-2005 and to address three challenges:

- to work with the United Nations Secretary-General's Office, the United Nations Security Council and all other possible mechanisms to ensure safe access to unreached communities;
- to support the elimination of maternal and neonatal tetanus and fill the funding gap; and
- to understand that the GAVI/Global Fund was not designed as the sole funding source for immunization and to continue adequately to fund and strengthen further immunization services.

38. The Committee commented that immunization had been one of the most beneficial programmes undertaken in the United Nations system. It was acknowledged that the funding gap needed to be closed and continued finance ensured for vaccine activities.

39. The role of GAVI was discussed, with the observation that the Initiative was a facilitating mechanism. It added to public awareness of the need for immunization and represented a good example of effective coordination among partners. The difficulties of reaching the unreached were discussed. National "Days of Tranquillity" were allowing poliomyelitis vaccination activities to go on even in situations of conflict.

SECTOR-WIDE APPROACHES (SWAps) FOR HEALTH DEVELOPMENT (Agenda item 6) (Document CCH3/01/3)

40. Dr Hatib N'Jie, WHO Project on Strategies for Cooperation and Partnership, introduced the discussion on sector-wide approaches (SWAps) for health and development, outlining the context for the development of such approaches and the basic principles underlying them. Dr Sok Touch, Director of the Department of Communicable Disease Control of the Ministry of Health of the Kingdom of Cambodia, and Professor Francis Omaswa, Director-General of Health at the Ministry of Health of Uganda, analysed their country experiences of SWAps.

41. Core principles of the approaches were: national ownership and leadership of the process and product; improved management of development assistance (which was not synonymous with basket funding); and cooperation based on the agreed national health agenda. SWAps also provided opportunities for capacity-building. There was a need to develop relationships of flexibility and trust, and to foster a peer relationship with all participants in the process. A major challenge was to take the country point of view, not a global one. United Nations agencies had to respond to that in both their

country and global planning. Global health partnerships and initiatives should ensure a more flexible approach to fit the local context of each country. That focus would improve the performance of health systems in countries. It was particularly important that SWAps were a management tool that should support the development of existing health systems, so that what was built would last. Duplication of mechanisms was counterproductive. Coordination with other agencies was important to avoid this. Experience in Cambodia showed that being flexible and calling the SWAp "sector-wide management" provided a way for previously undecided parties to be included in the partnership process. The spectrum of possibilities for SWAps ranged widely, depending on need, from "soft" (allowing for varying levels of partner support within the national agenda) to "rigid" (where all resources went towards the agreed national agenda and budget through a common financing arrangement).

42. In Cambodia, UNFPA, UNICEF and WHO had achieved a close working relationship and were fully involved in the Ministry of Health mechanisms to coordinate partner inputs and establish partnerships for health development. The development of the SWAp was one of the specific outputs of a joint United Kingdom Department for International Development, Norwegian Agency for Development Cooperation, UNDP and WHO Health Sector Reform project, which was also supported by UNICEF and UNFPA. All were involved in the joint sector review and UNFPA and WHO were providing technical assistance for the ongoing sector-wide management process. The United Nations Development Assistance Framework (UNDAF) process clearly defined the contribution made by the United Nations country team members to the achievement of national development goals and emphasized capacity-building and national ownership, both of which were key features of the sector-wide management process. The Framework also represented a shift from project to programme support, which facilitated that approach.

43. The enabling environment of the SWAp in Uganda stemmed from the commitment of the Government, the people and development partners to implementing reforms in governance. The SWAp had evolved over a period of three years through a wide consultative process involving civil society and development partners and clearly led by government. The implementation of the Health Sector Strategic Plan using agreed mechanisms, structures and instruments had resulted in improved coordination, trust and performance within the sector. The remaining challenge was to build the capacity to implement the SWAp among all concerned, including government and development partners. United Nations agencies in Uganda were supportive of the SWAp process with for example WHO acting as effective broker and coordinator of the donor group, UNICEF on capacity-building at the interface between the community and the formal health system, while UNFPA provided support in the fields of population, reproductive health and gender-related issues.

44. While recognizing the critical role of SWAps in strengthening national stewardship and ownership of health development and in building national, district and local capacity, three areas of concern were identified in the approaches. There was a need to achieve a balance between process and health outcomes and to reach the poor and unreached. Focus on one sector should not preclude attention to cross-sectoral issues such as nutrition, education, water, sanitation, etc.

45. The Committee stressed the need for stronger involvement by the United Nations agencies; they had a significant responsibility to become actively involved from as early a stage as possible in the development of country policies, strategies and work plans. It was essential to support the process, including cross-cutting issues, and look at issues "from the bottom up". It was likewise important to strengthen the capacity of government and United Nations agencies at country level to enhance the quality and continuity of the support provided and thereby stabilize the development process. There was also a need for United Nations agencies to continue to strengthen their participation and to adjust and position themselves by synchronizing and coordinating that participation at headquarters and country level through the Common Country Assessment and UNDAF.

46. Concern was expressed at the possibility of agency mandates becoming marginalized and in this context the recommendations made in paragraphs 26 and 27 of document CCH3/01/3 were endorsed, with particular emphasis on enhancement of United Nations capacities and complementarities. The need for accountability in the way the agencies worked was explored, referring to paragraph 18 of the document, and the wish expressed for an agreed way of monitoring.

47. The United Nations Development Assistance Framework was discussed as a possible mechanism and entry point for the United Nations contribution to SWAps. The possibility of improving the process was discussed in the light of enhanced coordination and collaboration among agencies. The UNDAF process was described as providing opportunities for strengthening capacities in planning, analysis, and service delivery, given review of what had been successful in pilot projects. SWAps were one part of the mechanisms to improve health action at country level.

REVIEW OF THE RESOLUTIONS AND DECISIONS OF THE GOVERNING BODIES OF WHO, UNICEF AND UNFPA (Agenda item 7) (DOCUMENT CCH3/01/4)

48. The Chair drew the Committee's attention to document CCH3/01/4 which contained resolutions of the World Health Assembly and decisions of the Executive Boards of UNDP/UNFPA and UNICEF adopted since the last session that were relevant to the work of the Committee. The Committee took note of World Health Assembly resolutions WHA53.12 (Global Alliance for Vaccines and Immunization) and WHA53.14 (HIV/AIDS: confronting the epidemic); UNDP/UNFPA Executive Board decisions 2000/8 (UNFPA and sector-wide approaches), 2000/11 (Future programme directions of UNFPA in the light of the outcome of ICPD+5) and 2000/13 (Ensuring reproductive health in emergency situations); and UNICEF Executive Board decision 2000/9 (Follow-up to the World Summit for Children).

DATE AND PLACE OF THE NEXT MEETING (Agenda item 9)

49. The Committee noted that, in accordance with its terms of reference and the practice of rotation, its next session would be chaired by a member of the Executive Board of WHO.

50. The Committee agreed that the next session would be held at WHO headquarters, Geneva, within the timeframe stipulated by the Committee's terms of reference. The precise dates would be notified in due course.

OTHER BUSINESS (Agenda item 10)

Agenda of the fourth session of the Coordinating Committee on Health

51. It was agreed that the agenda should include a progress report on improving United Nations support to sector-wide approaches through staff orientation to SWAps and other new and evolving approaches to development assistance.

52. It was also agreed that the agenda should include an in-depth presentation and discussion on the SWAps process in one or two countries. The presentation should assess the effectiveness of collaboration between the United Nations agencies and with other partners within the process. The presentation should, to the extent possible, focus on the progress made within the three technical areas of: maternal and newborn health; violence, especially against women and girls; and HIV/AIDS and

young people. To take advantage of the rich scope for discussion that the topic would provide, it was agreed that the session should extend for a full two days.

53. The Committee discussed its current terms of reference, roles, functions and methods of work. Among the concerns raised were the added value of the Committee given the remarkable strides made in recent years in interagency collaboration at both the managerial and technical levels; the costs in financial resources and staff time of CCH sessions, with the participation of 16 members from three Executive Boards; and problems of continuity given the rotating nature of the membership of the Executive Boards of the three agencies. It was agreed that the secretariat of the Committee should develop terms of reference and conduct a joint review of this matter, to be presented and discussed at the agenda of the fourth session.

CLOSURE OF THE SESSION (Agenda item 11)

54. After the customary exchange of courtesies, the session was closed.

ANNEX 1

LIST OF PARTICIPANTS

I. MEMBERS OF THE EXECUTIVE BOARD OF WHO[1]

Professor Syed Modasser Ali
Director
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Dhaka, Bangladesh

Mr Johan Debar
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Monsieur le Professeur R. Abouo N'Dori
Ministre de la Santé
Ministère de la Santé publique
Abidjan, Côte d'Ivoire

Dr Karam Karam
Minister of Tourism
Ministry of Tourism
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II. MEMBERS OF THE EXECUTIVE BOARD OF UNICEF

Dr Alieu Gaye
Head of Medicine
Royal Victoria Hospital
Banjul, Gambia

Ms Sonia Felicity Elliot
Permanent Mission of Guyana to the United Nations
New York, NY, United States of America

Ms Jose Van Hussen

[1] The member from Vanuatu was unable to attend.

Head, Social Policy Department
Ministry of Foreign Affairs
The Hague, Netherlands

Professor Alexander Viktorovitch Karaulov
Chairman, Health Commission
Russian United Nations Association
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Mr Walid Abdulwahed M. Al-Ethary
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III. MEMBERS OF THE EXECUTIVE BOARD OF UNFPA

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Deputy Director
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IV. COUNTRY TEAMS

Cambodia

Dr Sok Touch

Director, Department of Communicable Disease Control
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Dr Bill Pigott
WHO Representative in Cambodia
Phnom Penh, Cambodia

Uganda

Professor Francis Omaswa
Director-General of Health Services
Ministry of Health
Entebbe, Uganda

Mr Michel Sidibe
UNICEF Representative in Uganda
Kampala, Uganda

Mr James Kuriah
UNFPA Representative in Uganda
Kampala, Uganda

V. SECRETARIAT

UNICEF

Ms Carol Bellamy, Executive Director
Dr Yves Bergevin, Chief, Health Section
Mr Denis Caillaux, Secretary, UNICEF Executive Board

UNFPA

Mrs Thoraya Ahmed Obaid, Executive Director
Mr Kunio Waki, Deputy Executive Director
Ms Mari Simonen, Director, Technical Support Division
Dr France Donnay, Chief, Reproductive Health Branch

WHO

Dr Gro Harlem Brundtland, Director-General
Dr Tomris Türmen, Executive Director, Family and Community Health
Dr Bill Kean, Director, External Cooperation and Partnerships
Dr Paul Van Look, Director, Reproductive Health and Research

VI. OBSERVER[1]

UNAIDS

Mr David Lawson, Liaison Officer, UNAIDS Office in New York

[1] The World Bank was unable to be represented in the capacity of Observer.

ANNEX 2

AGENDA

1. Opening of the session

2. Election of Chair and Rapporteurs

3. Adoption of agenda and timetable

4. Statements by the Executive Heads of WHO, UNICEF and UNFPA

5. Progress in implementing the recommendations made by CCH at its second session

   (a) Reduction of maternal mortality and morbidity (including use of micronutrients)

   (b) Adolescent health and development

   (c) HIV/AIDS (with a focus on mother-to-child transmission)

   (d) Coordination of the follow-up to ICPD+5

      (i) Benchmark indicators
      (ii) Gender
      (iii) HIV/AIDS

   (e) Immunization

6. Sector-wide approaches (SWAps) for health development

   (a) The role of organizations of the United Nations system

   (b) Country experiences

7. Review of the resolutions and decisions of the governing bodies of WHO, UNICEF and UNFPA

8. Approval of the draft report

9. Date and place of the next meeting

10. Other business

11. Closure of the session

ANNEX 3

REPORT ON PROGRESS IN IMPLEMENTING THE RECOMMENDATIONS MADE BY CCH AT ITS SECOND SESSION: ACTION POINTS[1]

REDUCTION OF MATERNAL MORTALITY AND MORBIDITY (INCLUDING USE OF MICRONUTRIENTS)

16A. Advocacy efforts should continue at interregional and regional levels, in order to mobilize more resources for the implementation of national programmes, especially in countries with high maternal mortality.

16B. The secretariats of WHO, UNFPA and UNICEF should explore the feasibility of establishing Maternal Health Theme Groups at country level, as subgroups of the Health Theme Groups mentioned in the 1998 report of CCH.[2] This would include a review of the experience (e.g. the membership, objectives, activities, cost and results achieved) of existing Theme Groups. This review should be accomplished within one year, and specific recommendations should be made and acted upon where feasible before the next meeting of CCH. The Theme Groups would (i) share information; (ii) develop a coordinated action plan to support national programmes and select a few focused country-specific priority interventions, for which adequate technical support was ensured; and (iii) assist governments in their efforts to raise funds within the action plan. Following the pattern of the United Nations Theme Groups on HIV/AIDS, the groups would act as the backbone of larger coalitions involving stakeholders in different sectors and a cross-section of partners.

16C. A joint planning guide, as a companion document to the Joint Statement on *Reduction of Maternal Mortality*, should be rapidly finalized and disseminated to support the work of country theme groups in building national capacity.

16D. Policy documents and technical guidelines should be widely disseminated and their use evaluated.

16E. UNFPA, UNICEF and the World Bank should collaborate closely with WHO in the finalization of the Integrated Management of Pregnancy and Childbirth (IMPAC) approach through external review and participation in the development of tools to supplement this strategy, in order to make IMPAC a common framework for improving maternal and newborn health care at country level. Issues to be addressed through this collaboration include monitoring, family and community practices, costing and financing, regulation of providers' practices, transportation/communication, and staff development.

16F. The interagency collaboration on criteria and standards for improving the quality of women-friendly reproductive health services should continue under the leadership of WHO.

[1] Reproduced from documents CCH2/99/9/Report and CCH3/01/2.

[2] *Report of the WHO/UNICEF/UNFPA Coordinating Committee on Health* (1998), CCH(98)/Report, paragraph 52.

16G. All organizations should promote actions to improve the nutritional status of girls and women including those recommended in the Consensus Document[1] to reduce anaemia in pregnancy.

16H. The Director-General of WHO and the Executive Directors of UNICEF and UNFPA are urged to work with the Director-General of ILO to ensure that he is aware of the health implications of the draft revised ILO Maternity Protection Convention, the negative impact it will have on children's and women's rights and the fact that removal of nursing breaks from the Convention will deny women rights that have been theirs since 1919.

16I. WHO, UNICEF and UNFPA should operationalize the terms of paragraph 66 of document A/S-21/5/Add.1.

ADOLESCENT HEALTH AND DEVELOPMENT

19A. WHO, UNICEF and UNFPA should continue efforts to act as advocates for adolescent health and development, and to use opportunities related to the ongoing follow-up to the ICPD Programme of Action and the development of the Future Global Agenda for Children.

19B. The secretariats of WHO, UNFPA and UNICEF should explore the feasibility of establishing Adolescent Health Theme Groups at country level, as subgroups of the Health Theme Groups mentioned in the 1998 report of CCH.[2] This would include a review of the experience (e.g. the membership, objectives, activities, cost and results achieved) of existing Theme Groups. This review should be accomplished within one year, and specific recommendations should be made and acted upon where feasible before the next meeting of CCH. The Theme Groups would (i) share information; (ii) develop a coordinated action plan to support national programmes and select a few focused country-specific priority interventions, for which adequate technical support was ensured; and (iii) assist governments in their efforts to raise funds within the action plan. Following the pattern of the United Nations Theme Groups on HIV/AIDS, the groups would act as the backbone of larger coalitions involving stakeholders in different sectors and a cross-section of partners.

19C. WHO, UNICEF and UNFPA should develop a practical tool to operationalize the WHO/UNFPA/UNICEF country programming framework on adolescent health and development, to assist countries with implementation.

19D. The three organizations should develop an outline to summarize the implementation and impact of collaborative and individual efforts to promote adolescent health and development in countries, taking due account of the relevant goals in plans of action already internationally agreed upon.

19E. WHO, UNICEF and UNFPA should develop a plan of action for expanding capacity at regional and country levels to further programme implementation and should specify responsibilities and timelines.

19F. The three organizations should review and define research priorities.

[1] UNU/UNICEF/WHO/MI, *Preventing iron deficiency in women and children: Background and consensus on key technical issues and resources for advocacy, planning and implementing national programs.* Micronutrient Initiative, Ottawa, in press.

[2] *Report of the WHO/UNICEF/UNFPA Coordinating Committee on Health* (1998), CCH(98)/Report, paragraph 52.

19G. WHO, UNICEF and UNFPA should consider the specification of interventions which address parenting, the role of society and the community *vis-à-vis* adolescent health and development.

HIV/AIDS (with a focus on mother-to-child transmission)

22A. WHO, UNICEF and UNFPA should accelerate implementation of activities related to the global interagency initiative for the reduction of mother-to-child transmission of HIV. It should be impressed on policy-makers that access to information and to testing and counselling constitutes a fundamental human right.

COORDINATION OF THE FOLLOW-UP

24A. **Benchmark indicators.** WHO should convene a technical consultation on benchmark indicators on reproductive health, cosponsored by UNFPA and UNICEF, involving all other appropriate partners particularly representatives from developing countries. The objectives of the meeting would be to: (i) agree on a common set of not more than 15 indicators for reproductive health; (ii) develop a plan of work to provide guidance and technical assistance to countries in order to strengthen their capacity to collect and report on these indicators; and (iii) agree on how jointly to implement such a plan.

24B. **Gender.** UNICEF, UNFPA and WHO should:

- promote the disaggregation and analysis of all health-related data by sex;
- develop common approaches and messages in regard to gender equity and equality and ensure that these are disseminated throughout the organizations;
- develop a common set of gender and health indicators to be used by countries both to monitor their progress toward gender equity and equality and to develop specific policy and programme initiatives to accelerate such progress.

24C. **HIV/AIDS.** WHO, UNFPA and UNICEF, within the framework of UNAIDS, should increase their focus on and support to the prevention of HIV transmission among adolescents, in particular in countries where HIV levels among adolescents are high, making this a priority issue within the overall follow-up action proposed on adolescent health and development.

24D. **HIV/AIDS.** Programmes should focus on: sexuality education for both young women and young men, jointly where feasible; advocacy and awareness creation on the issues of sexual violence and exploitation; and an examination of whether existing laws and policies help adolescents protect themselves from HIV infection.

IMMUNIZATION

29A. WHO and UNICEF should continue to collaborate closely at global, regional and country levels to improve the coverage, scope and quality of immunization services. The two organizations should seek to agree on and coordinate objectives, strategies, timeliness, resource allocation and technical support at all levels through joint assessment and planning exercises. The two

organizations have a critical role to play at country level. They should collaborate to ensure that GAVI milestones are met and that good plans are developed for use of the Global Fund for Children's Vaccines and other resources. The two organizations should devote sufficient administrative and technical capacity to supporting these activities.

29B. WHO and UNICEF should continue jointly to call, at the highest political level, for commitment by poliomyelitis-endemic countries and donor countries to the target date for poliomyelitis eradication of the end of the year 2000. The two organizations should urge the poliomyelitis-endemic countries to translate this commitment into acceleration, with additional immunization activities and strengthening of poliomyelitis surveillance, and should urge donor countries to ensure that the funds and support they have committed themselves to provide will be made available in a timely manner. Deployment of funds in full and in a timely manner is especially important given the increasing need to order oral poliomyelitis vaccine (OPV) far in advance to ensure an adequate supply of vaccine. The two organizations should ensure the provision of sufficient administrative and technical capacity to support poliomyelitis eradication activities.

29C. WHO and UNICEF should take full advantage at the highest political level of the capacity of the United Nations and other organizations with expertise or influence in conflict-affected areas to negotiate a safe working environment and access to unreached communities for poliomyelitis National Immunization Days as well as other essential health services, especially in Afghanistan, Angola, Democratic Republic of the Congo, Somalia and southern Sudan.

29D. WHO, UNICEF and UNFPA should jointly call for commitment by countries where maternal and neonatal tetanus remains a public health problem to reach and sustain the elimination of this disease. The three organizations should call for donor country governments to support these efforts. The three organizations should ensure that sufficient administrative and technical capacity is committed to supporting countries in reaching and sustaining the goal.

29E. Recognizing that poliomyelitis eradication and MNT elimination activities reach the hardest-to-reach populations, WHO, UNICEF and UNFPA should use these two disease control initiatives to learn and establish new ways to continue to reach these populations in a sustained manner with immunization and other essential services, such as vitamin A supplementation and deworming, through capacity-building in immunization service management and strengthening of immunization infrastructure in hard-to-reach areas.

29F. WHO, UNICEF and UNFPA should urge all developing countries to commit resources to increasing the coverage, scope and quality of immunization services, and donor country governments to provide adequate financial and technical assistance, especially to the poorest countries.

29G. WHO, UNICEF and UNFPA should urge all countries including donor countries and agencies to adopt the WHO-UNICEF joint policy on safety of injections in immunization services. WHO, UNICEF and UNFPA should urge all countries to use Auto-Disable syringes for all services where technically feasible.

29H. WHO and UNICEF should advocate and assist in the capacity-building needed to improve the quality of data to enable immunization coverage and disease outcome measures to be better indicators of the success of the poverty reduction process.

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