E/2010/CRP.3

18 June 2010

English only

Substantive session of 2010
New York, 28 June – 23 July 2010
Item 4 of the provisional agenda*
The role of the United Nations system in implementing the ministerial declaration of the high-level segment of the 2009 substantive session of the Council

Theme of the Coordination Segment: implementing the internationally agreed development goals and commitments in regard to global public health

Conference Room Paper

* E/2010/100

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Background

This conference room paper includes information aimed at supplementing the Report of the Secretary-General on the same topic. As the views of the World Health Organization (WHO) are extensively covered in the latter report, those views are therefore not repeated in this paper, which focuses on the contributions of other UN system entities.

In its resolution 2008/29, the Economic and Social Council decided that its coordination segment should be devoted to the review of the implementation of the Ministerial Declaration adopted at the previous year's Annual Ministerial Review. The coordination segment of the 2010 substantive session will therefore focus on the theme "Implementing the internationally agreed development goals and commitments in regard to global public health" and will review the role of the UN system in this regard.

The Ministerial Declaration adopted by the Council has promoted collaborative actions through policy guidance at various levels, in particular:

- developing a comprehensive and integrated approach to achieving the Millennium Development Goals (MDGs),
- strengthening health systems through primary health care to advance the goal of universal access to health services,
- promoting health as an outcome of all sectoral policies,
- promoting greater policy coherence in international assistance,
- strengthening and building innovative partnerships among relevant actors, and
- sustaining and enhancing financing for health and development, despite the recent economic downturn.

By so doing, the Declaration has promoted consensus on issues ranging from non-communicable diseases, communicable diseases, neglected tropical diseases, health systems, health literacy, e-health, trade related intellectual property rights, climate change and health to financing, partnerships and engagement of all other sectors like education, and infrastructure. Based on the outcome of the Annual Ministerial Review, the main objectives of the 2010 coordination segment are:

- to review on-going work of the UN system to realize global public health objectives and to assess progress made in this field
- to examine existing and new initiatives to align system-wide work with the approach highlighted by the 2009 Ministerial Declaration

- to assess UN system effectiveness in promoting more integrated and comprehensive public health policies in developing countries

The segment and the report submitted to it will provide a useful contribution to the MDG Summit, to be held in September 2010, on the health dimension of the MDG review.

Chapter I Overview of the current work of the UN system in regard to health

- **Trends in global public health, including progress made in relation to health related MDGs**

Economic and Social Commission for Western Asia (ESCWA)

In the Western Asian region, the health-related MDGs (goals 1, 4, 5, 6 and 8) are falling short of the targets set in many countries. This is leading to a gap in attainment of the aspirations, a gap that requires scaling up of programmes, strengthening of health systems across disease groups, and improved action across sectors. Furthermore, these goals were defined at a time when the global recession and global food crises were not anticipated, when climate change was still being doubted, and when the burden and the negative socioeconomic impact of non-communicable conditions was not adequately recognized.

Today's reality is far different and today's goals need to reflect this reality, in particular when looking at the first Millennium Development Goal, the eradication of extreme poverty and hunger. This is particularly poignant when taking into consideration:

- The Non-Communicable Diseases (NCDs) epidemic is growing faster in poor countries with NCDs than in richer ones,

- Studies by the WHO in forty-two countries (including two in the WHO Eastern Mediterranean Region) have shown that 2%–3% of households face catastrophic health care expenditures and that 1%–2% are pushed into poverty when they become sick

- Globally, a pattern emerges, across continents, of poor populations in low income countries, burdened by NCDs, lacking access to public services, paying out of pocket in the private sector, and consequently impoverished by the cost of care.

Furthermore, the NCD epidemic threatens to overwhelm national health systems. In Oman, it is estimated that there will be a 210% increase in the demand for health care by 2025, and treatment of cardiovascular diseases alone will account for 21% of total health care expenditures. At the other extreme, the health system in the Occupied Palestinian Territory is burdened by the cost of treatment abroad. In 2005, more than 31,000 patients were referred for treatment outside the Palestinian Ministry of Health facilities, within the Occupied Palestinian Territory or in neighboring countries at total cost of about US$60 million. In low-income countries,

costs are more likely to be borne by individuals themselves. In Sudan, the cost of caring for a family member with diabetes is 23% of the household income for a child and 9% of household income for an adult.

The NCD epidemic slows economic growth. As a leading cause of premature deaths, NCDs reduce incentives for savings (in the expectation of a shorter life) and they reduce social capital (the death of a teacher or skilled labourer eliminates the investment in the development of their skills and forgoes the benefit of their future work to society). The socio-economic cost of NCDs and injuries is enormous and is rising rapidly. These conditions cause considerable disability and premature death leading to lost productivity. The rapidly increasing health costs are impoverishing, and inaction is a tremendous burden to sustainable development.

Economic Commission for Africa (ECA)

In the last decade, economic performance in Africa improved and annual average growth rates averaged 5 %. However, this was not translated into improvements in the social indicators. Africa remains plagued by poverty, high child and maternal deaths, and preventable infectious diseases exacerbated by malnutrition and poverty.

Available data indicates that HIV prevalence among female adults (aged 15-49) is highest in Southern Africa and lowest in North Africa. All the countries with a female adult prevalence rate of 25 % and above are in Southern Africa. By contrast, several North and West African countries, have all maintained a very low, adult female HIV prevalence rate of about one % or less.

Many African countries acknowledge that Tuberculosis (TB) is a major public health problem, especially among those with high HIV/AIDS prevalence. Most governments have put in place national TB control programmes and strategic plans focused on raising awareness and improving TB case detection and the cure.

Malaria is the number one cause of morbidity and mortality for all ages. Most countries, including Ethiopia, Malawi, Mozambique, Sudan, and Tanzania reported having a Roll Back Malaria (RBM) programme, as well as other strategic programmes aimed at improving malaria management. These programmes are created especially for vulnerable groups such as children and pregnant women, and vector control through the use of Insecticide-Treated Bed Nets (ITBNs).

Other public health issues posing serious challenges to development in Africa are reproductive rights and reproductive health. The main sexual reproductive health issues being addressed by African countries include: maternal, infant and child health; adolescent reproductive health, family planning, prevention and management of reproductive tract infections, especially Sexually Transmitted Infections (STIs, including HIV/AIDS; prevention and management of complications of abortion; and harmful traditional practices including FGM).

Trends in reproductive health indicators show that among major regions of the world, Africa records the highest rate of maternal mortality. Of 529,000 maternal deaths occurring annually, 48 % took place in Africa. For each maternal death, there were 30 to 50 morbidities, including temporary and chronic conditions. More recent estimates of maternal mortality rates indicate that the condition might be deteriorating in a number of African countries several of which have maternal mortality ratios exceeding 1,500 per 100,000 live births (Sierra Leone, Malawi, Angola and Niger). Most of the countries in the lower distribution bracket are

Southern and Northern African countries having maternal mortality ratios under 100 per 100,000 births (Egypt, Libya, Tunisia, Algeria, Morocco, South Africa, Namibia and Botswana).

Of concern is the fluctuating trends in maternal mortality ratios; for instance in Namibia, where the ratio seems to be rising from 227 in 1992 to 271 in 2000 and to 449 in 2006. One of the most dramatic increases ever recorded is that of Southern Sudan – from 509 in 1999 to 1,107 in 2007. Mauritius and Seychelles reported justifiably low levels of maternal mortality given their strong health infrastructure and management capacity. There is no doubt that pregnancy-related deaths can be considerably minimized in Africa. The health risks of mothers are greatly reduced when more babies are delivered under the supervision of health professionals. All African countries recognize that efforts focusing on the provision of antenatal care, ensuring skilled attendance at birth; improving access to Basic and Comprehensive emergency obstetric and newborn care; providing quality family planning services; ensuring basic postnatal and newborn care; and providing post-abortion care are important to improving maternal and newborn health in Africa.

Economic Commission for Asia and the Pacific (ESCAP)

In the Asia and the Pacific region, progress has been slow against maternal mortality, and many regions are still a long way from achieving the target of reducing the maternal mortality ratio by three quarters between 1990 and 2015. Globally, the number of maternal deaths exceeds half a million, with South Asia accounting for 187,000 deaths. Maternal mortality is impacted by deficiencies within health systems, such as those related to infrastructure and human resources, as well as a number of determinants outside the purview of health systems, such as gender equality and socio-cultural factors.

Economic Commission for Europe (ECE)

The health status of the population in the ECE region has improved in the past decades, as indicated by longer life expectancy at birth. However, important inequality in health outcomes associated with social and economic factors is growing in the region. Sub-regions and groups within countries still have dramatic differences in health closely linked to demographic or economic transition or degrees of social disadvantage. For example, the average life expectancy for the Eastern Europe, Caucasus and Central Asia (EECCA) countries deteriorated sharply during the transition crisis - between 1991 and 1994 - and then recovered only partly. In many of these countries changes in lifestyles and behaviour – like excessive alcohol intake have led to changes in the patterns of mortality and the burden of disease, with chronic non-communicable conditions, injuries and violence affecting health more strongly.

While the region seems to be on good track in achieving the health related MDGs, large inequalities both across and within countries persist: for example, child mortality (MDG 4) is declining more slowly in the EECCA countries, and five of them are unlikely to reach the target. Three more may reach it only with additional effort. The situation of maternal mortality and MDG 5 is more variable. Similar to child mortality, four EECCA countries have higher rates and are not on track to reach the target, and four more may be able to attain it if they increase their efforts.

Another example of widening gaps is the alarming spread of multi drug-resistant tuberculosis and environmental health problems due to air pollution in urban industrial centers and the combustion of solid fuel

in homes. Tuberculosis accounts for nearly 50% of the mortality from infectious and parasitic diseases among people aged 25–64 years in the European Region. It is a main reason for increasing mortality from infectious diseases in the Region since 1990, especially in the EECCA countries, where the rate has more than doubled. The mortality rate from tuberculosis increases with age in most country groups, except the EECCA, where younger people have higher mortality. This suggests the effects of such factors as poor diet and alcohol intake, which are aggravated by poor socioeconomic conditions and coinfection with sexually transmitted infections, especially HIV.

The inequality is also related to HIV: according to UNAIDS estimates, Eastern Europe and the EECCA remains one of the few regions where HIV prevalence continues to rise; from an estimated 630,000 in 2001 to 1.5 million in 2008. Nearly 90% of newly reported cases in the region were from the Russian Federation and Ukraine. In Central Asia and the Caucasus, the number of newly reported HIV diagnoses is also rising, with Uzbekistan having the largest incidence rate in Central Asia. The worrying developments of tuberculosis and HIV pandemic in the region clearly pose a threat to the achievement of MDG 6

International Labour Organization (ILO)

Key measures observed during the current financial and economic crisis include cuts in budgets available for social health protection coverage. These cuts are part of general cuts in public spending, resulting in constrained access to necessary health services for workers and their families. These trends are aggravated by increased unemployment and reduced possibilities for workers to generate income. While since 2008 employment in health services has registered an overall increase of 2.3% in the countries surveyed, in some countries and regions, health services have terminated the contracts of temporary or non-union health workers and frozen current staffing levels, leaving vacancies unfilled.

Protecting maternity at work has been a core issue for the ILO. Particular concerns include ensuring that women's work does not threaten the health of the woman or child during or after pregnancy, and that women's reproductive roles do not compromise their economic and employment security. These concerns are reflected in the adoption of three Conventions on maternity protection (the Maternity Protection Convention, 1919 (No. 3); the Maternity Protection Convention (Revised), 1952 (No. 103); and the Maternity Protection Convention, 2000 (No. 183)), which have progressively expanded the scope and entitlements of maternity protection at work. In this context the ILO also collects information on the maternity protection legislation of its Member States. The 2010 report shows that, globally, 30% of ILO Member States fully meet the requirements of Convention No. 183 on the duration and financing of maternity leave. There has been a gradual improvement in maternity protection worldwide, with more countries providing at least 14 weeks of maternity leave and shifting away from employer liability systems of financing toward more equitable financing systems. However, greater commitment and action are needed to accelerate this trend.

Against this background, the Social Protection Floor Initiative of the UN System Chief Executives Board, led by ILO and WHO, has proved to be of key importance to cushion the impact of the crisis. At its core is the building of a coalition of international agencies and donors, supporting countries in their efforts to plan and implement sustainable social transfer schemes and essential social services on the basis of the concept of a Social Protection Floor. Efforts of the Social Protection Floor also include reducing vulnerability to HIV and AIDS and mitigating its impact among persons affected by the pandemic.

As a co-sponsor of UNAIDS, ILO collaborates with all its members to promote universal access to HIV prevention and AIDS treatment and support, to ensure continued reduction of the HIV pandemic. Global health initiatives aiming at coordinating both international agencies and donors, such as the Providing for Health Initiative (P4H) which comprises ILO, WHO, the World Bank, bilateral partners and others, have proved an efficient and effective way to address such issues.

These approaches are an integral part of the Global Jobs Pact – endorsed by the UN General Assembly and ECOSOC, the G20 Leaders, and the International Business Council of the World Economic Forum. It addresses the social dimension of globalization through decent work, social protection and training support for the unemployed and those most at risk of unemployment. It encourages better global public health by improving access for those seeking health services and improving the quality of health services provided through better working conditions for those who deliver those services.

International Maritime Organization (IMO)

Through the IMO regional presence office in Nairobi, IMO and the Port Management Association of Eastern and Southern Africa (PMAESA) have embarked on a series of studies to assess the impact of HIV/AIDS on ports which form a vital part of the transport infrastructure necessary for the sustainable development of the region. The first study was carried out in the port of Mombasa, Kenya, from 18 August to 9 September 2008; the second study was carried out in the port of Dar es Salaam, United Republic of Tanzania, from 5 to 20 February 2009; and the third study was undertaken in the port of Durban, South Africa, from 15 August to 15 September 2009. The studies adopted a participatory approach in developing action plans that would provide port workers with knowledge, skills, programmes and activities to prevent the spread of HIV/AIDS. A common finding of the studies was that there was evidence of HIV/AIDS-related stigma and discrimination in the workplace and that this could be eradicated through more effective awareness-raising and workplace education programmes.

International Organization for Migration (IOM)

Migration itself is not a risk to health, but conditions surrounding the migration process can increase vulnerability to ill health, including marginalization, stigma, violence and exploitation. This is particularly true for those who are forced to migrate, fleeing natural or man made disasters or human rights violations, or for migrants who find themselves in an irregular situation, such as those who migrate through clandestine means or fall in the hands of traffickers or end up in exploitative situations.

At risk are also the many migrant workers, many of whom are involved in degrading, dirty and dangerous jobs (3Ds), and who despite their contribution to national economies, have the least access to health and social services. That these vulnerable groups in society which are at high risk for abuse, exploitation and discrimination - particularly at times of crises- find the least access to health and social services goes against both social justice principles and good public health practice. We believe that there is an urgent need for advocacy, awareness raising, and dialogue on this theme, amongst both sending and receiving countries. Furthermore, reduction in wages, poorer working conditions, discrimination and stigma of migrants mistakenly perceived as taking the jobs of local workers, will impact on the quality of life and health of migrants and families left behind.

Migration is increasingly circular and multi-directional, therefore vulnerability of migrants, threats posed by cross-border spread of communicable diseases, marginalization and stigma, are challenges to social and economical stability and to our international relation systems. Responses need to be found in global and regional cooperation amongst countries that aim at guaranteeing a continuum of health prevention and care for mobile populations across borders.

The 61st (2008) World Health Assembly has passed Resolution WHA 61.17 *Health of Migrants* that includes - art.1 (8), which calls on Member States "to *promote bilateral and multilateral cooperation on migrants' health among countries involved in the whole migratory process"*. We believe this provision particularly relevant in the context of the *Foreign Policy and Global Health* agenda, and vital to achieve the necessary inter-country consensus, shared values, harmonized health protocols and multi-sectoral dialogue without which this resolution cannot be fully implemented. In a globalized world, better and global health is the outcome of processes across borders and societies, and not the outcome of single country health system. Migration, in fact, bridges economical, political and health systems and cuts across related policies. For this reason, multi disciplinary and sector stakeholders should work in partnership to address inequalities within countries and regions and ensure through policy coherence "health in all policies" and "health for all" as pillars towards the realization of the MDGs.

Joint United Nations Programme on HIV/AIDS (UNAIDS)

Significant progress has been made by countries in the efforts to achieve universal access to HIV prevention, treatment, care and support by 2010. However, the epidemic continues to outpace the response, whereby five new infections occur for every two individuals starting on antiretroviral therapy. Unless progress is dramatically accelerated – especially with regard to HIV prevention, the world will not meet the MDG 6 target - to halt and begin to reverse the HIV epidemic by 2015.

As of December 2008, an estimated 33.4 million people were living with HIV worldwide. Four million people were receiving Anti-Retroviral Therapy (ART) in low- and middle-income countries – a 10-fold increase in five years (2003-2008). However, despite this scale-up, ART was available only to 42% of those in need. Furthermore, under the new WHO treatment guidelines (Dec 2009) recommending earlier initiation of therapy, millions more HIV-positive people will become eligible for treatment, significantly lowering the current ART coverage.

The number of HIV-positive women receiving treatment for prevention of mother-to-child transmission of HIV has tripled, from 15% in 2005 to 45% in 2008. However, only 21% of pregnant women received HIV testing and counseling, while only one third of those who tested HIV-positive were subsequently assessed for their own ART needs.

Globally, the rate of annual new HIV infections has slowed, with a 17% reduction since 2001. Nonetheless, 2.7 million new HIV infections occurred in 2008 alone, 40% of which – among young people (15-24 years old). Against this background, it is particularly alarming that less than 40% of young men and women have accurate knowledge about HIV transmission.

In 2008, half a million people living with HIV died of tuberculosis (one in four AIDS deaths). Yet, only 22% of TB patients knew their HIV status, and only 1.4 million people living with HIV were screened for TB.

In 2008, an estimated US$ 15.6 billion from all sources was invested in the HIV response in low- and middle-income countries. This falls short of the estimated US$ 25.1 billion necessary to achieve universal access.

The financial and economic crisis has both increased the vulnerability of households affected by HIV and strongly reduced the capacity of low- and middle-income countries to sustain their component of the HIV response. UNAIDS studies show that the impact of the economic crisis on HIV is more likely to increase in the medium term. Low-income countries with generalised epidemic are exposed to the risk of flat-lining or reduced HIV financing from key donors for HIV. Countries like Malawi, Tanzania and Uganda are already experiencing such funding declines. In addition, most high-prevalence middle-income countries like Botswana, South Africa and Swaziland are facing growing difficulty to finance their HIV response due to the impact of the crisis.

Continued HIV spending is a critical prerequisite for the health, development and stability of future generations. HIV interventions are cost-effective and help avert the massive hidden economic and development costs associated with the epidemic. HIV programmes are also generating broad-based benefits for national health systems: attracting new financial resources for health, promoting strong community participation and increased demand for health information, building systemic capacity (i.e. strengthened procurement and supply management systems), and introducing chronic-disease management approaches for the first time in many resource-limited settings.

Office of the United Nations High Commissioner for Human Rights (OHCHR)

Human rights must be at the core of the discussion on the UN system work on global public health, including progress made in relation to health-related MDGs and the impact of the multiple crises on health. All agencies and organizations under the UN system, each with their unique mandate and focus, are governed by the UN Charter and thus share a commitment to the promotion and protection of all human rights as enshrined in the Universal Declaration on Human Rights and the nine core international human rights treaties[1] as well as other international instruments. Furthermore, the 2000 Millennium Declaration, from which the Millennium Development Goals emanated, and the 2005 World Summit Outcome recognized human rights, development and peace and security as three core pillars of the UN, and contained clear and unprecedented commitments from member States to mainstream human rights in their national policies as well as within UN-supported development programming.

United Nations Development Fund for Women (UNIFEM)

Health is a fundamental human right. Reducing gender inequalities and supporting the empowerment of women are critical aspects of ensuring this right is upheld. Poverty, poor living and working conditions and gender discrimination are powerful determinants of maternal mortality, morbidity, maternal health and increased vulnerability to HIV and AIDS for women and girls around the world. The intersections between

[1] http://www2.ohchr.org/english/bodies/treaty/index.htm.

empowerment of women, violence against women, sexual and reproductive health and HIV/AIDS are indisputable. In response to the HIV epidemic, home-based care and care provisioning in households has emerged as a key response in many countries, due to shortages of health care workers, and adequate facilities for providing care. Deeply rooted poverty and ever-growing gaps in services and safety nets associated with health sector reforms, decentralization, privatization and cuts to social spending have fueled gaps in care. Care giving in the context of AIDS falls primarily on women and girls in households and communities. Recognizing the State's obligations to provide these services are critical, as are supporting households facing this disproportionate share of HIV/AIDS care.

While in some countries we are starting to see a decline in the numbers of new HIV infections in women and girls[2] , the reality is that in many parts of the world, stark gaps remain. Globally, of the 31.3 million adults (15 years +) living with HIV/AIDS in 2008, 15.7 million were women (50.1%)[3]. In Sub-Saharan Africa, in 2008, about 60 % of adults living with HIV were women, resulting both from their greater physiological susceptibility to heterosexual transmission of HIV, and from the social, legal and economic disadvantages they often confront. In the Caribbean, where women account for about half of all infections, infection rates for adolescent and young women are significantly higher than for males their own age. Globally, the proportion of women receiving services for prevention of mother-to-child transmission of HIV quadrupled from 10 % (2004) to 45 % (2008)[4]; however only 21% of pregnant women received HIV testing and counseling, and only one third of those identified as HIV-positive during antenatal care were subsequently assessed for their eligibility to receive antiretroviral therapy for their own health[5]. Studies show increasing links between violence against women and HIV – for example, a survey among 1,366 South African women showed that women who were beaten by their partners were 48% more likely to be infected with HIV than those who were not[6]. More specifically, at the country level, much more needs to be done to: improve access to quality HIV treatment, prevention, care and support and to effectively link HIV prevention and support services to existing health care service provisioning and to address structural drivers of vulnerability.

Gender inequality and violations of women's rights make women and girls particularly susceptible, leaving them with less control than men over their bodies and their lives. In particular, women and girls often have less information about HIV and fewer resources to take preventive measures. Economic dependency and unequal power relations make it difficult for women to negotiate safer sex, and widespread sexual violence exacerbates the risk of HIV transmission. Responses to the gender dimensions of the epidemic, such as linkages between violence against women and HIV and AIDS; or the huge number of women providing unpaid care in families and communities struck by HIV and AIDS remain absent in too many national AIDS strategies. In addition, women's organizations, in particular networks and organizations of women living with HIV, are absent from key decision-making processes in the national AIDS response. In fewer than 10 % of the 79 countries surveyed by UNAIDS in 2006 did women participate fully in developing national AIDS plans.

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[2] UNAIDS 2008.
[3] All statistics from 2009 AIDS Epidemic Update:
http://data.unaids.org/pub/Report/2009/2009_epidemic_update_en.pdf.
[4] UNAIDS and World Health Organization, 2009 AIDS Epidemic Update, UNAIDS, Geneva, 2009.
[5] World Health Organization, *Women and Health: Today's Evidence Tomorrow's Agenda*, WHO, Geneva, 2009.
[6] Dunkle, Kristin L. et al. 2004. "Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa" The Lancet. 363(9419): 1415.

In the context of the economic and financial crisis, it is clear that as government budgets are squeezed, financing for HIV prevention and treatment programmes will be imperiled. Yet it is precisely at times of economic hardship that socio-cultural determinants of increased HIV infection, such as poverty and gender inequality, are intensified. It is clear that much more needs to be done to make the money work more effectively and efficiently for women, girls and promote gender equality at the country level.

United Nations Education, Scientific and Cultural Organization (UNESCO)

UNESCO supported the development of comprehensive approaches in education which include synergies with school health, feeding and nutrition activities to contribute to achieving improved health outcomes and health equity in countries. The Education for All (EFA) Working Group (December 2009) and the EFA High Level Group (February 2010) stressed that inclusive, holistic education strategies, policies and provision must be integrated into broader multi-sectoral frameworks and policies for addressing social inclusion. Stronger synergies are needed between education, health, nutrition, peace, employment, the environment, sustainable development, economic growth and conflict prevention and mitigation. The involvement of key partners in managing such policies and programmes is a determinant of success, which would consequently allow greater sustainability and could leverage greater resources. Funding should be secured for global social protection initiatives such as the "Rapid Social Response Programme" as well as for targeted, multi-sectoral social investments, including cash transfer and school feeding programmes. The EFA Working Group and High Level Group also called upon EFA partners to remove household cost-barriers through provision of school health, meals and nutrition interventions.

HIV and AIDS continue to be major global health priorities. Although important progress has been achieved in preventing new HIV infections and in lowering the annual number of AIDS- related deaths, the number of people living with HIV continues to increase. AIDS-related illnesses remain one of the leading causes of death globally and are projected to continue as a significant global cause of premature mortality in the coming decades (WHO, 2008).

UNESCO has continued to support the global response to HIV and AIDS through optimizing its coordination and partnerships with the other UNAIDS Cosponsors, by acting as the lead agency in the UNAIDS technical support division of labour for HIV prevention with young people in educational institutions, and as a main partner in eight other technical support areas (including human rights, governance and mainstreaming; strategic information; workplace policies and programmes; prevention for out-of-school young people; dietary/nutrition support; and displaced populations).

UN Relief and Works Agency for Palestine Refugees in the Near East (UNRWA)

The United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) has been the main comprehensive primary health care provider for Palestine Refugees for the past 60 years and represents the most accurate source of information on their health status. It works in five areas of operation, the West Bank, Gaza, Lebanon, Jordan and Syria.

The focus of the Agency has shifted over the years from emergency aid delivery to human development. The curative and preventive health services provided include preconception, ante-natal, postnatal care of pregnant

women, family planning, comprehensive medical examination and follow-up of infants (growth curve monitoring, medical check ups and vaccinations), school health services, outpatient consultations, oral health, management of diabetes and hypertension and secondary prevention of cardiovascular diseases in refugees over 40 years of age.

Control of communicable diseases is achieved in part by high vaccination coverage and in part by the early detection and management of outbreaks through a health centre-based epidemiological surveillance system. The environmental health programme controls the quality of drinking water, provides sanitation and carries out vector and rodent control in refugee camps thus reducing the risk of outbreaks. Today, the Agency manages a network of 138 clinics, located both inside and outside the refugee camps, serviced by 4,644 health care workers, including 449 doctors. In 2007 alone, UNRWA's primary health system provided 10.3 million medical consultations.

Although the Agency started operating in a classic post-conflict situation, since then the socioeconomic conditions of its beneficiaries have diversified according to the political and economic situation of their host countries, including the recognition of refugee status and the level of access they are granted to government services. To describe the health status of Palestine refugees, their socio-economic peculiarities and the general health status of the host countries where they reside should be taken into consideration. UNRWA's goals with regard to health, including MDGs, coincide with the targets of the countries in which it operates.

More than four and a half (4.76) million[7] Palestine refugees are assisted by UNRWA, a rapidly growing, young population with high fertility rates and increasing life expectancies. Across UNRWA's area of operation 37.1% of refugees are children below 18 years of age. The demographic profile of the registered Palestine refugees in Lebanon, Jordan and Syria is comparable to that of other countries of the Near East; conversely in the occupied Palestinian territory (oPt), particularly in the Gaza Strip, there is a higher proportion of children under 15 and the fertility rate is higher both considering UNRWA and national estimates. The UNRWA calculated 2007 dependency ratio, measured as the proportion of the population below 15 and above 65 years of age, was almost 85.3% in the Gaza Strip. This implies that the economic burden on family units is particularly high, even not taking into account the contextually high unemployment rates and worsening poverty levels.

MDG targets for infant mortality have been reached by UNRWA in Jordan, Lebanon and the West Bank. Rates are in line with host countries except in Syria that consistently reports lower mortality figures. This could be related to the different sampling of the surveys as Palestine refugees in Syria are only 2.3 % of the population whereas they constitute between 11.4 and 71.5 % of the population in other areas of operation, making an overlapping of survey results more likely. There are signs of a stabilization of infant mortality trends especially observing the preliminary results of the UNRWA 2008 survey for Jordan, West Bank and Syria. This was expected as post delivery and neonatal assistance is mainly provided by public health care services and, therefore infant mortality rates cannot be expected to decrease significantly below national levels until health infrastructure and human resource development allows secondary and tertiary facilities to reduce prematurely, low birth weight and malformation related deaths, that are the leading causes of infant mortality today.

[7] UNRWA Registration Statistical Bulletin fourth quarter 2008.

Other MDG indicators for Palestine Refugees residing outside the oPt are overall comparable to those of their host countries. In the oPt however, the Gaza Strip compares overall unfavorably with the West Bank although they share the same healthcare providers and have comparable populations. This finding is consistent whether considering data for the whole Gazan population (Palestine National Authority/WHO) or refugees (UNRWA). The Gaza Strip has consistently higher infant and maternal mortality rates, a lower life expectancy, and reports higher levels of under-nutrition and micro-nutrient deficiency. Vaccine-preventable diseases are well under control in all UNRWA's areas of operation and MDG monitored measles immunization coverage is consistently above 95 % and in line with national rates. The decline in infectious disease incidence is a generalized trend in the region and leading causes of death of Palestine refugees have shifted from communicable to non communicable diseases such as cardiovascular diseases and cancer. However diseases associated with poor environmental health, such as viral hepatitis and enteric fevers, are still a public health threat reflecting local endemic patterns.

High coverage of UNRWA Primary Health Care services has a different meaning than the same finding in a country. It is an expression of an increasing economic vulnerability and/or limitation to health access that are making Palestine refugees more and more dependant on the Agency as their sole health care provider. There has been a dramatic increase in the coverage of UNRWA mother and child health services since 1990 that tends to exceed coverage rates reported by host countries, in particular in the Gaza Strip and Lebanon where the socio-economic conditions of Palestine Refugees are the harshest. Conversely within the oPt, coverage is lower in the West Bank, again underlining the difference between these refugee groups even though they both have full access to Palestinian National Authority health services

United Nations University-International Institute for Global Health (UNU-IIGH)

Social health insurance is a health financing mechanism which has been implemented in many developing countries. However, health financing schemes are known to suffer from a number of problems which will invariably affect its sustainability. Use of fee-for-service, as provider payment mechanism in social health insurance has been shown to affect efficiency. Increase in health care cost funded under social insurance schemes has been attributed to supplier induced demand linked to fee-for-service provider payment mechanisms. Case-mix system has been used since 1985 in many developed countries to enhance efficiency and quality of care under the social insurance scheme. However, implementation of case-mix system in developing countries is still very limited, mainly because of the lack of technical capacity to plan and implement the system.

- **The impact of the multiple crises (food, climate, economic and financial, H1N1 flu) on health efforts and how the UN system has jointly adapted its health response**

Economic Commission for Africa (ECA)

To address the multiple crises, lessons learned can be shared from the past experience of UN system-wide initiative such as the Commission on HIV/AIDS and Governance in Africa project, launched in 2003 by the former UN Secretary General Kofi Annan. It was a complement to the vital work of prevention being done by the UN and other agencies, with a rigorous agenda that charted the way forward on HIV/AIDS and governance in Africa in the three crucial areas of: a) the implications of sustained human capacity losses for the

maintenance of state structures and economic development; b) the viability (technical, fiscal and structural) of utilizing anti-retroviral (ARV) medication as an instrument of mitigation; and c) synthesizing best practices in HIV/AIDS and governance in key development areas with a view to formulate policy recommendations.

Economic Commission for Europe (ECE)

Pandemic (H1N1) 2009 influenza, the severe economic downturn, acute effects of climate change and the 2008–2009 food crisis have strongly highlighted the need to address socially determined inequity in health. In fact, social-environmental determinants of health are more and more important in shaping individuals' health, risk of disease exposure, vulnerability and outcomes. Socially disadvantaged people are at higher risk for pandemic illnesses, premature mortality, and hazardous living conditions. Social-environmental factors may include employment and working conditions, living environments, the availability of and access to health and social protection services, education and social cohesion or connectedness.

According to the WHO, more than 1.7 million annual deaths (18% of all deaths) are attributable to environmental factors in the European Region (excluding North America). The environment accounts for an estimated one third of the total burden of disease for children and adolescents aged 0–19. Well-designed environmental health interventions could reduce total mortality in the Region by almost 20%. The burden of disease due to known environmental factors is unevenly distributed between countries, varying up to fourfold across the Region. This is due to multiple factors, including differences in exposure to a combination of risk factors such as unsafe drinking water, poor sanitation and hygiene and air pollution.

Lack of access to safe drinking water is still a leading cause of death among children aged 0–14 years in the ECE Region. About 13,000 annual deaths (5.3% of the total mortality among children: ranging from 0.2% in EU 15 and Scandinavian countries to 7.5% in NMS and Central Asian countries) are attributable to diarrhoeal diseases related to exposure to unsafe drinking-water. About 21 million people in Central Europe and EECCA countries do not have access to improved sources of water and 50 million lack access to improved sanitation. Rural populations tend to have poorer access to safe drinking-water supply. The slow progress in achieving universal access to safe drinking-water and improved sanitation, especially in rural areas in the eastern part of the Region, jeopardizes the achievement in the Region of MDG 7 (ensuring environmental sustainability) and the fulfillment of a basic human right.

Unsafe environmental conditions play a major role in determining injuries. For example, an estimated 25% of road traffic injuries in Western Europe are attributable to environmental conditions, such as road infrastructure and the availability of pavements and facilities for cyclists and pedestrians. Injuries represent the third leading cause of death in the Region, with almost 800,000 lives lost annually; 66% of these deaths are preventable, and the costs are an estimated 2% of GDP. The political and economic transition in the Region has resulted in increased inequality in injuries. Differentials between countries are high and increasing.

Outdoor and indoor air pollution is an important determinant of health, increasing mortality from cardiovascular and respiratory diseases and reducing life expectancy by about 8.6 months in EU countries. It reduces life expectancy by more than 13 months in the most polluted countries. In the past two decades, significant progress has been achieved in reducing the emissions of some air pollutants, such as sulfur, nitrogen oxides and lead. This is mostly due to improvements to industrial and energy production processes

and increased energy efficiency and fuel quality. The average exposure by country varies by a factor of three in the Region.

Food and Agriculture Organization (FAO)

With its UN mandate for improving nutrition and food security, agriculture and rural development, FAO plays a unique role in contributing to the prevention and mitigation of the impacts of diseases on rural societies. The overall objective of FAO's work on diseases is to enhance food security, improve nutritional well-being and support rural development by mitigating the impact of health threats through food and agriculture interventions.

Since 1988, FAO has been responding to the impact of HIV and AIDS on food security, farming systems and rural livelihoods. The Organization has developed a variety of policy and programme guidelines and advocacy tools, and is at the forefront of analytical and policy-support work to address the interactions between agriculture and the AIDS epidemic.

Recent research by FAO has focused on the long-term implications of AIDS for agriculture-dependent populations in light of the evolving context of the epidemic (i.e. changing epidemiology, increasing availability of ART). FAO's analyses highlight the need to view the epidemic as a changing phenomenon and address it within a broader social, economic and ecological context.

Recognizing that agriculture-based livelihoods entail the interdependence between crops, livestock and humans, FAO has recently conducted research to assess the interactions and co-occurrence of animal, human and crop diseases on the food security and livelihoods of smallholder farmers. Findings reveal the need for a paradigm shift in order to effectively and adequately address the magnitude of disease burdens and their implications, as well as to intensify collaboration between disciplines.

In support of awareness raising efforts and to disseminate research findings, FAO has developed an Agriculture and Health wiki site as a knowledge platform to share information and materials on the linkages between agriculture and health. The wiki houses presentations, articles, publications, working papers, tools and relevant links on various themes related to the interconnections between health, agriculture and food security.

FAO has been developing a resource guide on AIDS and agriculture, as a tool to enhance the analytical and operational capacity of agricultural policy-makers and practitioners to respond to the impacts of AIDS on rural livelihoods and food security. The guide is designed to enhance capacity-building at the country level to respond to the challenges of AIDS in farming, fisheries, livestock production, forestry, and the other sub-sectors critical for rural livelihoods.

In response to the increased number of orphans as a result of AIDS, FAO has partnered with WFP and others to develop an initiative for building knowledge and self-esteem of orphans and other vulnerable children whose parents could not pass on the necessary life skills before dying of AIDS. Since 2004, more than 600 JFFLS have been set up and over 18,000 children have been trained.

<u>Proposed input from the One Health Agenda</u>

The current dynamics in the world food and agriculture are at the heart of the evolving animal and pandemic influenza health risks. A set of global factors increasingly drive disease emergence at the animal-human-environment interface. These broader dynamics require a shift in veterinary-public health approaches with more emphasis going to the cross-sectoral and multi-disciplinary nature of disease emergence.

Veterinary and public health systems in poorer countries are in need of urgent technical and financial support so that they function to the novel global standards for animal and human disease prevention, surveillance and response in line with the International Health Regulations, the OIE's World Animal Health Information System and the joint FAO/OIE/WHO Global Early Warning System.

Under the umbrella of the UN System Influenza Coordination (UNSIC), a seminal document entitled "Contributing to One World, One Health: A strategic framework for reducing risks at the Animal-Human-Ecosystems Interface" (2008) was prepared by FAO, OIE, WHO, UNICEF and the World Bank. This is an important reference document providing the basis for using the One Health approach to addressing generically emerging and re-emerging infectious animal and zoonotic diseases at the animal-human-environment interface impacting negatively on people's well-being, safety and livelihoods.

The above strategy document identified important drivers of emergence, spread and persistence of infectious diseases and provided a broad framework for minimizing the impact of these diseases by enhancing disease intelligence, surveillance and emergency response systems at national, regional and international levels, and supporting them with strong and stable public and animal health delivery services. The guiding principles proposed in this Strategy promote a long term holistic vision and support for the resource poor, most vulnerable population of our global communities.

The livestock sub sector continues to expand (SOFA 2009). Rapid growth and technological innovation already led to profound structural changes in the livestock sector, including: a progressive move from smallholder mixed farms towards large-scale specialized industrial production systems; a shift in the geographic focus of demand and supply in the developing world; and an increasing emphasis on global sourcing and marketing. These changes have implications for the ability of the livestock sub sector to expand production in sustainable ways that promote food security, poverty reduction and public health.

The agro-ecological drivers of disease emergence have to be identified and confronted. The risks posed by the mix of traditional and industrial production systems coinciding in the same farming landscape and sharing the same distribution and marketing channels have to be addressed with some urgency. The same applies to conflicts that arise at the meeting points of rural economies and natural ecologies and the encroachment of the latter.

It is estimated that on average one new animal disease emerges every year and over 70% of these diseases are also infective to humans. Several interrelated factors and global trends contribute to this phenomenon. Perhaps the most fundamental factor is the trend in human population growth, projected to rise to eight billion by 2025, mostly in Asia, Africa and Latin America, where also most of the poor current live.

Almost concurrently to this trend, there are a large number of Asian countries that are experiencing strong economic growth. The relatively wealthy and growing numbers of the middle class population in Asia are generating a greater demand for high quality animal source protein. The significant demand for animal food will necessitate production of a huge number of live animals. In 2008, over twenty-one billion food animals were produced to feed over six billion people. By 2020, this demand will increase by 50% requiring a raise of an additional ten billion food animals.

It is anticipated that the sheer absolute numbers of people and animals will have wide-ranging and serious implications on the availability, use and management of land and water, forests and wildlife resources. The change in climate, in ecosystems, and the greater contacts with wild animals will result in increased exposure to new disease carrying vectors and pathogens. The higher density of domestic animals and humans likely present conducive environments for existing and emerging pathogens, and the projected increase in movement of people and animals will increase opportunities for the exchanges of pathogens worldwide.

International Organization for Migration (IOM)

Multiple crises such as food, climate, economic and financial, and H1N1 flu, have impacted both human and financial resources for the delivery of primary health care and the MDGs. The UN System and partners including IOM contribute towards the consolidated action plan for animal and human influenza to address seven strategic objectives, through identified specific outputs and activities.

In July 2009, IOM has had the honour to address migrant health at the High Level Segment of the ECOSOC, and to co-host with WHO and OSAGI a breakfast event on the theme '*promoting migrant women health needs to achieve MDGs'*. The breakfast saw the participation amongst others of the Honorable President of the ECOSOC, and of the distinguished representative from Indonesia, one of the seven co-signatories of the *Oslo Declaration*. Some of the recommendations here presented were formulated by the participants to this event.

Unfortunately the ECOSOC *Ministerial Declaration* failed to make reference to the increasing vulnerability of migrants to diseases, the difficulties they often encounter in accessing health service in an equitable way, and the burden on human suffering and lost opportunities that this represents for the migrants themselves and their families; not to mention the public health costs that this causes to their community of origin when they come back sick, and of course for the countries that host them while abroad.

United Nations Population Fund (UNFPA)

Slowing economic growth can complicate programme implementation in health and rights, and gender equality due to the potential weakening of domestic investment, national-social protection systems, decreased development spending and possibly increased social and political instability. All of which impacts the availability, quantity and quality of health services, with the prospect of limited access to services, increased out-of-pocket payments and catastrophic health expenditures that impacts severely on young, poor and vulnerable populations. In response, UNFPA has started collaborating with other UN agencies on the design and launch of the Global Impact and Vulnerability Alert System (GIVAS). Under the umbrella of the Social Protection Floor Initiative, UNFPA has become part of a formal working group which supports and promotes country driven strategies that protect a minimum level of access to essential services and income security for

all. In addition, the UN-Secretariat provides extra funding to specific countries and UN-agencies on the basis of need through the Central Emergency Response Fund (CERF) and the Rapid Impact & Vulnerability Analysis Fund (RIVAF). At the country level, the UN-country teams (incl. UNFPA) work with development partners to support governments in their efforts to mitigate the impact of the crisis.

Each year, half a million women die from pregnancy-related causes (85% of maternal deaths are concentrated in sub-Saharan Africa and Southern Asia[8]). Maternal under-nutrition, including anemia contributes to increased maternal morbidity and mortality. Currently some 50 million or 40% of pregnant women in developing countries are anemic and closely spaced births contribute to anemia in the reproductive years[9]. While access to skilled birth attendants has improved[10], emergency obstetric care for delivery complications remains too limited[11]. An estimated 215 million women who want to avoid a pregnancy are not using an effective method of contraception with a disproportionately high number in low-income countries (54%)[12].

Unsafe abortion continues to account for a significant (an estimated 13%) proportion of maternal deaths. Unplanned pregnancies can be addressed by increasing access to family planning services[13]. Adolescent birth rates have declined most in countries with initial relatively low levels while high adolescent fertility has persisted in many countries[14]. HIV/AIDS and malaria are major contributors to maternal mortality in many parts of sub-Saharan Africa[15]; Disparities in the ability to realize family formation preferences in the spacing and number of births between wealth groups, by age and by rural-urban residence are large, and growing, in settings with high maternal and child mortality.

UN Relief and Works Agency for Palestine Refugees in the Near East (UNRWA)

As an Agency working in a chronically unstable environment, UNRWA is continuously challenged to face crisis. Conflicts in Lebanon and more recently in the Gaza Strip have forced the health programme to react rapidly in order to ensure continuity of comprehensive primary health care delivery and to respond to new needs of refugees. It has led to the establishment of new services such as mental health to deal with the consequences of protracted violence and insecurity, and physiotherapy and rehabilitation to assist those affected by permanent disability. It has also made the Health Programme strongly decentralized and able to adapt rapidly to limits imposed by logistic impediments and security concerns. This has limited the disruption

[8] United Nations Children's Fund, *Progress for Children: A Report Card on Maternal Mortality*, No. 7, Unicef, New York, 2008.
[9] Haider BA, Bhutta ZA.Multiple-micronutrient supplementation for women during pregnancy. *Cochrane Database of Systematic Reviews* 2006, Issue 4. Art. No.: CD004905. DOI: 10.1002/14651858.CD004905.pub2. (http://apps.who.int/rhl/reviews/CD004905.pdf).
[10] Gill K. et al., Women Deliver. The Lancet, Volume 370, Issue 9595, Pages 1347 – 1357 (http://www.icrw.org/docs/women-deliver-lancet-published.pdf).
[11] United Nations Population Fund and Guttmacher Institute*, Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health*, New York, 2009.
[12] United Nations Population Fund and Guttmacher Institute*, Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health*, New York, 2009.
[13] United Nations Population Fund and Guttmacher Institute*, Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health*, New York, 2009.
[14] UNDG, DRAFT Summary of Progress and Lessons Learnt – MDGs 4, 5, and 6 (www.undg.org/docs/10822/MDGs-4,-5-and-6.doc).
[15] Kasiira Z., et al Maternal mortality in the informal settlements of Nairobi city: what do we know? Reproductive health 2009;6.

of services like epidemiological surveillance and treatment of chronic diseases that suffer the most in times of conflict.

The result of these management choices has been a limitation of the consequences of socio-economic hardship and conflict on the health of Palestine refugees. Although UNRWA beneficiaries remain an extremely vulnerable population, MDG, demographic indicators and epidemiological trends are still in line with those observed in the region. Exception to this are the worrisome signs arising from the Gaza Strip, mirroring worsening humanitarian conditions there as the result of the blockade and suggesting the need specifically to empower UNRWA's financial and logistic capacity in delivering health in this location.

There is no human development without good health. It affects the way people live, their productivity, income, life standards and risk of premature death. It influences the socio-economic levels of households, has an effect on education and ultimately on social mobility. Palestine refugees are a socially disadvantaged population and are victims of health inequalities. Their lives have been conditioned for generations by social, political and economic forces that go beyond their control. UNRWA's effort of providing the best possible comprehensive primary health care services to Palestine refugees is part of a greater mission of the UN and Governments globally to address the social determinants of health and achieve health equity. UNRWA's efforts to enable refugees to live healthy, full and productive lives, is an example of how the international community is striving to promote social justice and protect its most vulnerable communities.

The living conditions of Palestine refugees in the host countries are diverse, with varying levels of inequity and access to health and heath services. Lebanon hosts 425,640 Palestine refugees, of whom about 53.2 % live in refugee camps. Palestine refugees in Lebanon cannot benefit from the State's social service and UNRWA is their main health care provider. Their generally illegal resident status, the employment restrictions they face combined with the high cost of work permits, account for their protracted financial dependence[16].

Syria and Jordan host 472,109 and 2 million refugees respectively[17]. Palestine refugees in these countries enjoy full social rights. In Syria they are given the rights of citizens. In Jordan, Palestine refugees are granted citizenship based on criteria such as place of origin (i.e. the West Bank) and year of arrival. The Gazans living in Jordan face restrictions on access to higher education and jobs[18] and are therefore the most vulnerable group[19]. Palestine refugees, whilst remaining a potentially fragile population overall, have in these countries been allowed to enter the labour market and have social mobility.

The occupied Palestinian territory is suffering the long-term effects of socio-economic hardship with a progressive isolation of Gaza and a growing lack of geographic contiguity in the West Bank. Restrictions on the movement of Palestinian people and goods in and out of Gaza and within the West Bank are affecting not

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[16] ICRC: *Access to health care services for Palestinian refugees in Lebanon*, ICRC Delegation, Beirut 2007.
[17] UNRWA Registration Statistical Bulletin fourth quarter 2008.
[18] IRIN Middle East: "Plight of Palestinian refugees worsening in most parts of Middle East" in Humanitarian *news and analysis, United Nations Office for the Coordination of Humanitarian Affairs,* 2007 resource available on the web http://www.irinnews.org/Report.aspx?ReportID=72841.
[19] Refugee Study Center and Norwegian Refugee Council. *Forced Migration review* Refugee Study Centre Department of International Development, Oxford 2006.

only access to basic services such as health, but also limiting commercial activities[20] and contributing to worsening socio-economic conditions.

The lack of energy continuity and the difficulty for needful patients to access tertiary care outside the Gaza Strip were issues raised, among others, by UNRWA and the WHO repeatedly during 2008. Although the factors contributing to the observed differences in the health status of Palestine refugees in the Gaza Strip and the West Bank are probably diverse, it is relevant to note that West Bank residents have some level of access to Israeli high quality health services that is only exceptionally available to Gazans. Moreover shortage of medical supplies and of other essential goods such as fuel and electricity are much more frequent in the Gaza Strip and have led to dysfunctions in the provision of healthcare[21]. The last conflict has only worsened the chronic difficulty of assisting people in the Gaza Strip starting from the limitations in the movement of people and goods in and out of the area that jeopardize the supply of essential drugs and medical equipment. In addition to this the damage to health structures, roads and UN facilities during hostilities in January 2009 has further impaired humanitarian action in the Strip.

With its cross-cutting approach to comprehensive primary health care, UNRWA is in a unique position to implement targeted preventive and curative services and to access vulnerable communities. The Health programme addresses the issue of the refugees' health from birth to old age, implementing health prevention and promotion activities at various levels. Moreover, coordination among the Health, Education and Relief components of UNRWA are an added value. Health education from exclusively medical environments reaches schools and other community aggregation centers allowing the development of community based initiatives, the direct supervision on the impact of infrastructure on health, freely available essential drugs, and the monitoring of their management to comply with WHO standards. Although the four sets of reforms identified by WHO do not apply directly to UNRWA, as it is not a government, the holistic access to communities, its recognized mandate and consolidated experience in health delivery has made UNRWA a stakeholder in promoting the Primary Health Care focus on equity, solidarity and gender and in improving global health.

Although not a state, UNRWA is holistically assisting a particularly vulnerable population providing not only health care but also a social safety net that encompasses education, food assistance, job creation programmes and micro credit schemes. However, the Agency is facing serious challenges. A combination of rapid population growth, change of epidemiological pattern to non-communicable diseases which are costly to prevent and manage, increased demand for services, integration of new activities within primary health care and growing financial constraints, is overstretching UNRWA's Health Programme and undermining its capacity to buffer the negative effects of poverty, food insecurity, unemployment, violence and social and institutional isolation on the health of its beneficiaries.

Conflict with its long-term effects in terms of health needs and service delivery requirements is not the main challenge UNRWA faces; it only increases the difficulty of assisting Palestine refugees in the Near East. Given the outmost importance of health as a fundamental human right indispensable for the exercise of other human rights, it is critically important for all stakeholders and governments concerned to exert every effort to ensure

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[20] UNRWA: "Emergency Appeal 2008" resource available on web http://www.un.org/unrwa/publications/pubs07.html.

[21] Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine refugees. UNRWA Health Director's report to the World Health Assembly in May 2008.

sustainable access to health care for Palestine refugees in the Near East and in particular for those residing in the West Bank and Gaza. Due to the specificity of the UNRWA mandate, the scope of its activities and the unstable security environments in which it operates, the humanitarian action carried out by UNRWA must be acknowledged as independent, allowing full and secure access of diplomatic and humanitarian personnel, as required under international humanitarian law.

It is imperative that the Governments of UNRWA's hosting countries continue to invest in health, extending the coverage of crucial health services to the Palestine refugee population in order to reduce poverty, spur economic development and promote a network of social security. Lastly, it is crucial to keep in mind the increase of served population and demand for health services due to economic hardship hitting the refugees. With the financial constraints affecting the program, the achievements, in terms of scoring commendable indicators comparable to host countries, could be reversed if adequate resources are not availed to the Program.

World Food Programme (WFP)

WFP focuses strongly on achieving the MDG goals, especially MDG 1 on reducing hunger and poverty. Consequently nutrition plays a key role in WFP's Strategic Plan 2008-2013, which not only aims to save more lives but also to improve the quality of these lives. Better growth and development of young children and improved health, well-being, and productive capacity of WFP's beneficiaries in general are the expected outcomes.

The focus on improved nutrition is reflected in most of WFP's programs ranging from emergency operations to protracted relief and recovery as well as development operations. Changes are being made to the food basket in order to better meet the nutritional needs of different target groups. By Dec 2008, the use of new or improved food commodities and/or delivery modalities focusing on preventive rather than recuperative approaches formed part of ongoing or planned activities in at least 20 countries. In this context building local capacity related to the production of specific nutritious commodities using locally available ingredients and processing facilities forms another key element of WFP's strategic objectives. Better meeting nutritional needs of vulnerable groups also supports achievement of other MDGs, notably those aimed at reducing child and maternal mortality.

HIV and TB seriously undermine nutritional status of the people infected with either or both diseases. In chronically food-insecure settings, these nutritional issues often compound pre-existing under-nutrition. WFP's new HIV and AIDS policy which will likely be approved by its Board in 2010, therefore, stipulates that WFP should work with governments and other partners to ensure adequate nutrition interventions are provided for People Living with HIV (PLHIV) and people infected with active TB. The nutrition intervention is designed to ensure uptake and initial adherence to treatment, nutritional recovery and, therefore, is critical to achieve treatment success. The products used should be highly specialized, nutritious foods products. Entry and exit to the programme is defined by bio-medical criteria.

WFP food assistance in health sector programmes is already adjusting operational modalities to improve integration of nutrition services within comprehensive care and treatment programmes in many countries throughout East and Southern Africa. While continuing to acknowledge the comprehensive food needs at the

household level, food assistance programmes in support of ART are focusing on the nutritional vulnerability of the patient, using individual nutrition screening tools (e.g. Body Mass Index) as entry points for initiation and termination of food assistance.

HIV and TB are also a shock to any household affected. To prevent households from engaging in negative coping strategies, WFP also provides to food insecure households a food ration to go along with the specialized food for the patient. For WFP, cash or voucher transfer schemes for the poorest families have strong potential. Evidence is emerging that in high HIV prevalence countries even untargeted schemes can reach approximately 80% of HIV affected households. In Malawi, cash transfer schemes contributed towards an increase in school enrolment, attendance and completion rates of children from beneficiary households, alongside better health and nutrition. (MDG 2)

Chapter II Assessment of UN system efforts to implement the 2009 Ministerial Declaration in a coordinated manner

- **Initiatives of the UN system organizations to align their policies, programmes and activities across the relevant sectors identified by the Ministerial Declaration (communicable diseases, including HIV/AIDS, non communicable diseases, neglected tropical diseases, maternal health, health systems, health workforce, access to health services, health literacy, e-health, etc.)**

Economic Commission for Asia and the Pacific (ESCAP)

ESCAP is undertaking a review of the financial and social barriers to accessing maternal health services in the region and studying the efficacy of various interventions implemented in the region to tackle such barriers. The review builds upon the experiences within and outside the region, and incorporates a strong component of South-South cooperation. The review will be used as the common basis by UN organizations and affiliated agencies for supporting countries in the region in their efforts to reduce maternal mortality.

International Telecommunications Union (ITU)

Based on the methodology suggested in the ITU 2008 report "Implementing e-Health in Developing Countries", ITU is working with WHO and other key players on a series of tools underscoring principles, strategies and resources that Member Countries can use when developing their e-Health national master plans.

WHO and ITU are collaborating on the second "Global Observatory for e-Health" report. The report will provide updated information on e-Health projects and strategies being implemented worldwide.

ITU, together with the WHO, the Health Metrics Network, USAID and the World Bank, hosted a Leadership Forum for the Eastern Africa region on "Country Ownership Strategies: Leadership Forum on Health Information Systems (HIS)" (Addis Ababa, Ethiopia, 10-12 August 2009). The Forum aimed to facilitate the implementation of HIS in the region by improving the collaboration between the ministries of health, telecommunication and finance in each country and across the region.

ITU also contributed to the High Level Panel on ICT Applications for a Better Life at the World Summit on the Information Society (WSIS) Forum 2009. (Annual event as part of the WSIS implementation and follow-up process).

ITU and WHO worked together on the organization of the e-Health Pavilion at ITU TELECOM World 2009 (Geneva, Switzerland, 5-9 October 2009). The Pavilion provided a dynamic environment to showcase e-Health applications from around the world.

To ease access to ICT applications resources in the e-Health area, ITU has updated the format of the ITU web site dedicated to e-services and e-Health applications.

Office of the United Nations High Commissioner for Human Rights (OHCHR)

Through numerous joint activities OHCHR and UNAIDS have systematically worked together to promote the achievement of universal access to HIV prevention, treatment, care and support by 2010, in follow up to the 2006 Political Declaration of Member States. Likewise at the 2000 Millennium Summit, Member States made a commitment to halt and begin to reverse the spread of HIV/AIDS by 2015.

Although significant gains have been made in national responses to HIV, including access to treatment, there has been a continual rise in the global population of people living with HIV and a number of barriers continue to impede effective responses to the epidemic. Such barriers include the lack of respect for human rights and overcoming stigma and discrimination. Although a clear commitment to human rights and gender equality was made in the 2001 Declaration of Commitment and the 2006 Political Declaration, programmatic responses which promote human rights are still not prioritized. The Secretary-General's progress report on the implementation of these commitments (A/63/812) highlights the need to tackle HIV-related discrimination, lifting HIV-related restrictions on the entry, stay and residence, and the criminalization of HIV transmission as some of the many human rights challenges that must be overcome in order to achieve the goal of universal access. Evidence suggests that the goal of universal access is not being met because HIV thrives where there is a lack of respect and insufficient human rights protection. National responses to HIV must therefore, better respond to the human rights needs of vulnerable populations in order to see real gains in the goals and targets that Member States set themselves.

The Inter-Agency Standing Committee Task Force on HIV brings together a wide range of UN and non-UN partners to formulate humanitarian policy and ensure effective humanitarian response in relation to HIV in complex emergencies and in natural disasters. This group recently finalized the IASC Guidelines on HIV in Humanitarian Situations which will be piloted during the course of 2010.

Various high level meetings have taken place during 2009 between WHO and OHCHR in line with OHCHR principal objectives of reinforcing bilateral cooperation with UN system partners in view of promoting a human rights-based approach in all health policies. Over the years WHO and OHCHR have worked together on various activities and projects at Headquarters and at country level. Officials in both organizations acknowledge the mutually beneficial outcomes of our cooperation over the years and the importance of building bridges in various thematic areas in the future. Our joint activities in 2009 have helped to shape and

strengthen common views, have provided much needed interaction at the highest levels and a better understanding of each other's organizations.

On 5 March 2009, a first meeting was organized with a specific focus on treaty body monitoring mechanisms at the request of the WHO Health and Human Rights Team. Participants included all Secretaries of treaty body monitoring mechanisms and coordinators of key departments in the WHO with specific interest or experience in treaty body reporting. OHCHR colleagues from the Universal Periodic Review (UPR) process also joined the meeting. Participants discussed previous achievements, lessons learned and challenges faced relating to the WHO cooperation with and contributions to, treaty monitoring bodies, including those that have not been previously engaged.

In April 2009, senior management in both entities shared the view that there is a need to distil good practices, improve information sharing and the joint development of constructive responses to common challenges related to health and the specific areas of each other's work. As way forward two lunchtime dialogues for invited senior WHO and OHCHR officials were organized. The objective of these substantive dialogues was to enhance institutional cooperation between WHO and OHCHR and develop a shared conceptual and operational understanding of the right to the enjoyment of the highest attainable standard of health, the linkages between health and human rights and, more broadly, human rights based approach to health.

The first lunch-time dialogue took place, on 7 September 2009 at WHO-Headquarters, Geneva with the participation of 37 officials from both organizations. The dialogue focused largely on the meaning and understanding of health as a human right, the value added of a human rights based-approach and the importance of human rights language to empower individuals and communities and advocate for policy changes with authorities.

The second lunch-time dialogue took place on 26 November at Palais Wilson, Geneva, with the participation of 35 high level officials and technical level staff. This dialogue was facilitated by the OHCHR Deputy High Commissioner for Human Rights and the Director of the Research and Right to Development Division. Moving from a conceptual discussion into more concrete dimensions of the work, this session explored examples of cooperation and why specific situations require concerted efforts of public health and human rights professionals, and an inter-disciplinary approach to critical issues. Participants raised specific areas where both organizations could play a joint role in supporting national authorities more systematically to incorporate the right to health standards.

OHCHR and WHO produced a publication entitled 'Human Rights and Gender Equality in National Health Strategies: an Analytical tool' which aims to enhance coherence between international commitments on human rights and gender equality, the national legal, policy and institutional frameworks, and their application in health sector strategies. The target-audience of the tool comprises the various national actors involved in health planning and policy-making, implementation or monitoring of health sector strategies. This includes health policy makers and planners, development partners and civil society organizations. By framing public health as a right to health issue the tool emphasizes the importance of dealing with the underlying determinants of health, thereby calling for enhanced advocacy skills of heath sector leaders in influencing more integral and multi-sectoral responses to the public health.

One approach taken by the OHCHR in relation to implementing the internationally agreed goals and commitments in regard to global public health has been through the perspective of the right to development. OHCHR provides support to the Intergovernmental Working Group on the Right to Development and its high-level task force on the implementation of the right to development. This task force has engaged with WHO in relation to global partnerships for development - as identified in Millennium Development Goal 8-target E, on access to essential medicines. Technical discussions and studies have included collaboration with WHO Intergovernmental Working Group on Public Health, Innovation and Intellectual Property (IGWG), the WHO Special Programme for Research and Training in Tropical Diseases (TDR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (TGF).

The dialogue with the IGWG Secretariat addressed inter alia, the IGWG's Global Strategy and Plan of Action (GSPA), which seeks to facilitate access to essential medicines and promote innovation in health products and medical devices. Discussions also focused on the potential for integration of right to development principles in the implementation and interpretation of the GSPA; the need to stimulate more innovation and, research; transfer of technology and capacity-building in developing countries; and accessibility, affordability and quality of medicines in developing countries, corresponding to the normative content of the right to health.

Issues discussed in the course of the dialogue with TDR included the importance of innovation and research to produce essential drugs, under agreements that facilitate availability and preferential pricing in developing countries; challenges of delivery of essential drugs to those in need, the role of local communities in collecting and distributing a drug (community directed interventions) to ensure better distribution, financing initiatives, empowerment of developing countries and meeting needs of the most vulnerable, and designing and implementing programmes consonant with both the right to development principles and right to health framework.

Dialogue with the Global Fund centered around the promotion of innovation, incentives for manufacturers to collaborate to improve access to intellectual property and medicines, sustainable funding, establishing principles and policies, providing technical assistance and capacity building towards strengthening countries' supplies and health systems, monitoring and evaluation of access to essential medicines for the poor and vulnerable populations, monitoring of procurement and quality data, and policy and market dynamics analysis, especially with regard to pricing.

United Nations Development Programme (UNDP)

Social and environmental factors play an important role in the achievement of health-related MDGs. UNDP's approach recognizes that development action outside the health sector – including governance, gender equality, human rights, and the environment – can impact health outcomes, especially for the poor. UNDP has been actively involved in the follow-up to the Ministerial Declaration, particularly in promoting policy consensus at the regional level and the strengthening of national health systems. UNDP's support is demand-driven and determined by the specific priorities of each region or country, covering a range of issues such as infant and maternal mortality, HIV and AIDS, and health care services in post-crisis countries.

As the principal recipient for the Global Fund for AIDS, Tuberculosis and Malaria grants in 26 countries (as of December 2009), UNDP is working with partners such as WHO, UNICEF, UNFPA, UNHCR and the

UNAIDS Secretariat to ensure that governments and civil society partners have access to the necessary technical support and policy guidance for effective programme implementation. Services include community outreach for HIV, TB and malaria prevention, HIV counseling and testing, ARV treatment for people living with HIV, prevention of mother to child transmission services, support to orphans, distribution of condoms, treatment for STIs; detection and treatment of TB cases, malaria treatment, and distribution of bed nets to protect against malaria. UNDP is also implementing a joint initiative with the World Bank (WB) and the UNAIDS Secretariat in addressing AIDS, human rights and gender equality through National Development Plans and Poverty Reduction Strategies.

To increase efficiency and cost-effectiveness of HIV and AIDS programmes, UNDP has developed an Integrated Framework for HIV Planning, Resource Estimation, Budgeting and Financing which calculates minimum levels of funding required for a comprehensive National AIDS response, and supports countries in developing robust resource estimates for MDG planning. Such planning and estimation tools may be timely given the uncertainty and fluctuation of national resources due to the economic crisis.

Asia and the Pacific Region: In partnership with other UN organizations, UNDP is supporting countries to mitigate the impact of multiple crises on health. A study in five countries – Cambodia, China, India, Thailand and Vietnam – calls for social protection schemes that prioritize poor households living with HIV. In partnership with UNAIDS and the Asian Development Bank (ADB), UNDP developed a tool to help national authorities estimate short, medium and long-term resources needed for comprehensive HIV responses, as well as per unit costs. The tool is applicable to other areas of the health sector.

In 2009, UNDP, IOM, ILO, UNAIDS and UNESCO organized a high-level regional consultation with ten Association of South East Asian Nation Member States to assess the impact of the recent economic crisis on migrants. The consultation resulted in a set of recommendations that seek to protect the rights, health and well-being of migrants. UNDP conducted another study in seven countries to address issues of unsafe movement, gender-based violence and the rights, dignity, and well-being of Asian migrant women, which led to the formulation of joint UN country level responses in the Philippines and Sri Lanka.

A UNDP/ESCAP/ADB Sub-regional Workshop on Aligning Policies and Strategies to Achieve the MDGs in South Asia in 2009 resulted in a set of recommendations which include: (i) increasing public investment in the health sector, (ii) reducing out-of-pocket expenditures on health care and moving towards universal health-care coverage, (iii) ensuring financial protection of the poor. Participants included government representatives and NGOs. UNDP also launched the Asia-Pacific Community of Practice (CoP) on HIV, Gender and Human Rights in partnership with UNAIDS, OHCHR, UNIFEM and the Asia Pacific Network of Positive People (APN+) in 2009. The CoP provides a platform for practitioners and stakeholders to engage on HIV, human rights and gender.

Eastern Europe and the Commonwealth of Independent States (CIS): Following the H1N1 influenza outbreak in 2009, the UN Kosovo Team developed an information and awareness raising plan as part of the UN's Pandemic Contingency Plan. This Plan was discussed and shared with OSCE, EULEX and health institutions representatives to foster a coordinated response should a pandemic occur. UNDP also supported a regional consultation on "Access to essential medicines, HIV and intellectual property" to promote a better

understanding of the implications of the economic crisis for trade and intellectual property rights, and to consider access to essential medicines in the context of potentially declining health budgets.

In Latin America and the Caribbean, five UN agencies are coordinating their support through a project on *"Comprehensive sexuality education in Latin America and the Caribbean"* as a follow-up to the 2009 Mexico Ministerial Declaration. Through the project, the Mexico Declaration has been widely disseminated in the Region, including a kit about the Declaration and its principle (in both Spanish and English), as well as other advocacy materials (including a video about challenges of sexual education in school). Under the Chair of UNDP, the LAC Regional Directors' Team's (RDT) Working Group on HIV/AIDS produced a Guidance Note on monitoring of UN coordination at country level, which has been distributed to all UN Country Teams and HIV focal points.

Arab States: UNDP has been working with its partners in the Region to produce the Arab Human Development Report (AHDR), a key publication on development in the Region. The AHDR advocates that health outcomes are negatively impacted by conflict and that some traditional practices and attitudes can hamper progress on health. The AHDR further points out that while the Arab States have had a low HIV prevalence, the 90,500 new cases of infection between 2001 and 2007 suggest a shift in this trend. The report calls for increased policy and social attention to the challenges posed by HIV and AIDS, and calls for a policy approach that addresses the underlying causes of the spread of HIV through multi-sector, multi-tiered development policies.

United Nations Education, Scientific and Cultural Organization (UNESCO)

The continuous functioning of the UNESCO Inter-Sectoral Platform on HIV and AIDS has facilitated the in-house coordination, harmonization and collaboration across the sectors at the headquarters, regional and national levels.

Water and health issues are closely linked, as safe drinking water and sanitation are essential for reducing water-borne diseases. UNESCO has an important role to contribute to the internationally agreed health-related goals—in particular, to the attainment of the MDG on water and sanitation to "halve by 2015 the proportion of the population without sustainable access to safe drinking water and basic sanitation". UNESCO aims to achieve this goal by promoting science, knowledge and capacity building on water and health; water quality; and water and sanitation. UNESCO's International Hydrological Programme addresses water and health issues in the context of protecting water quality, and providing safe drinking water and sanitation through activities aimed at awareness-raising of the importance of good water quality to human and ecosystem health, and promoting science-based approaches and policy strategies for protecting water quality, with specific emphasis on developing countries.

There is also international acknowledgement of a strong inter-dependence between human health and health of the ocean. This relates to habitat protection as a precondition for sustainable development; this entails securing seafood safety and quality, and for example discovering new drugs and products from the sea. Ocean observation systems and early warning systems that forecast threats to human and ocean health are a critical in this perspective. The Intergovernmental Oceanographic Commission (IOC) of UNESCO is supporting the development of such observation systems through its lead in the Global Ocean Observing System (GOOS). An

increasing proportion of the world's population is living in the coastal zone, and this increases the inter-dependence between ocean health and public health. The IOC of UNESCO is developing tools for integrated coastal area management to secure coastal ecosystem health, sustainable development and resource exploitation in the coastal zone. Such integrated management of coastal resources enhances the living and health conditions for coastal communities. Harmful algal events are phenomena which directly relate to seafood safety and toxic aerosols in the coastal zone and thus to public health. The IOC has for nearly two decades supported its Member States in establishing research capacity and management systems to forecast harmful algal events, to secure seafood safety, and to minimize beach closures. As a key element in these efforts IOC-UNESCO is developing an international Harmful Algal Information System which will include harmful algal event-related illness surveillance data.

Within the field of bioethics, the adoption of the UNESCO *Universal Declaration on Bioethics and Human Rights* (2005) is of particular relevance to the discussion on the implementation of the international agreed development goals and commitments with regard to global public health. In its Preamble, the Declaration – the first instrument of international scope in the field of bioethics - expresses the desirability of "developing new approaches to social responsibility to ensure, whenever possible, that progress in science and technology contributes to justice, equity and to the interest of humanity" and devotes an entire article – Article 14[22] – to the issue of social responsibility and health. By including Article 14, the Declaration opens up perspectives for action that go beyond medical ethics and reiterates the need to place bioethics and scientific progress within the context of reflection opened to the political and social world.

Article 14 is designed to draw the attention of policy makers in the field of medicine and life sciences to the practical concerns of bioethics, contributing to re-orienting bioethical decision-making towards issues that are urgent for many countries. Even though the list is not exhaustive, five specific elements are singled out as priority and universal areas of decision to be taken into account: a) access to quality health care and essential medicines, especially health of women and children; b) access to adequate nutrition and water; c) improvement of living conditions and the environment; d) elimination of the marginalization and exclusion of persons on the basis of whatever grounds; e) reduction of poverty and illiteracy.

This article formulates an ethical framework for policy making in health care. The stakeholders are numerous and include governments, and groups of people organized within societies, such as communities identified, for example, by religious beliefs or ethnic characteristics, commercial companies, political organizations, educational institutions, law enforcement agencies and others.

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[22] Articled 14 : 1. The promotion of health and social development for their people is a central purpose of governments that all sectors of society share.
2. Taking into account that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition, progress in science and technology should advance: (a) access to quality health care and essential medicines, especially for the health of women and children, because health is essential to life itself and must be considered to be a social and human good; (b) access to adequate nutrition and water; (c) improvement of living conditions and the environment; (d) elimination of the marginalization and the exclusion of persons on the basis of any grounds; (e) reduction of poverty and illiteracy.

Article 14 is complex and it is why the UNESCO's International Bioethics Committee –an advisory body of 36 independent experts– decided to focus on the principle of social responsibility and health immediately after the adoption of the Declaration in 2005. Without duplicating the work or the debates on public health-policy issues already addressed in other international bodies, in particular the WHO, IBC attempted to address those questions from a bioethical standpoint by developing the ethical and legal dimensions of the principle of social responsibility and its relations to health.

After almost 4 years of reflection, the *Report of IBC on Social Responsibility and Health (Rev. SHS/EST/CIB-15/08/CONF.502/3 REV. 3 of 26 November 2009*,) was finalized by IBC at the sixteenth (ordinary) session of IBC, held in Mexico City, Mexico, in November 2009 and transmitted to the Director-General of UNESCO at the beginning of 2010.

After a descriptive part on the social determinants of health and constraints on health access, and a specific section devoted to the elaboration of the ethical and legal dimensions of the principle of social responsibility and health, the Report presents a sample of possible concrete strategies and courses of action in order to translate the principle of social responsibility and health, as set forth in Article 14 of the Declaration, into specific policy applications, with a view to promoting the highest attainable standards of health for all.

It might be added that the report makes a link between the concept of social responsibility and the role of National Bioethics Committees. UNESCO capacity-building assistance to NBCs through the ABC project (Assisting Bioethics Committees) is contributing to the national debate about sustainable research priority policies within the domain of pubic health in the countries concerned, as well as about optimizing public health services for increasing coverage and enhancing the quality of services.

- **Initiatives of the UN system organizations to adopt new modalities for action as promoted by the Ministerial Declaration (widening the circle for partnerships, enhancing financing for health and development, engaging other sectors and promoting health in all policies, etc.)**

Economic Commission for Asia and the Pacific (ESCAP)

As part of a combined effort by the entire UN system to work together with countries on building capacities to address MDG gaps, including on heath, water and sanitation and hunger, ESCAP in conjunction with the Asian Development Bank (ADB) and UNDP, organized a subregional workshop for South-Asia, in Katmandu on 4-6 November, that focused on health, water and sanitation and hunger. The meeting was attended by delegates from the ministries of planning, health and water and sanitation from 8 countries in the South Asian subregion. The meeting was also attended by UNFPA, WHO, UNICEF, UNIFEM and FAO and a number of non-governmental organizations. The meeting exemplified a combined effort by the entire UN system to work together with countries on building capacities to address MDGs gaps.

Economic Commission for Europe (ECE)

The regional interagency programmes in the ECE region that address several environmental health related factors are the most promising UN system activities related to health, such as, the next Ministerial conference under the Environment for Europe (EfE) process will focus on sustainable management of water and water-

related ecosystems. The EfE process is a successful example of joint UN system processes allowing active participation across the UN system and other international organizations, but also by many NGOs working in the region.

A promising example to ensure safe drinking-water from source to tap and to improve the management of water demand and to take full advantage of supportive policy instruments is the UNECE/ WHO Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes.

The Transport, Health and Environment Pan-European Programme (THE PEP) was set up in 2002 as a joint policy platform of UNECE and the WHO Regional Office for Europe to achieve more sustainable transport patterns and more closely integrate environmental and health concerns in transport policies. In January 2009, at the Third High-level Meeting on Transport, Health and Environment, representatives of all three sectors adopted the Amsterdam Declaration – Making THE Link: Transport choices for our health, environment and prosperity. It recognized the opportunity provided by the current economic downturn to rethink investments in transport policies and to leverage opportunities for economic growth provided by investment in sustainable transport policies.

Under UNECE auspices, five multilateral environmental agreements (MEAs) serve as a framework in which countries can agree on common solutions to the transboundary problems affecting health and the environment. Under the Convention on Long-range Transboundary Air Pollution, governments carve out strategies and policies to abate pollution across the UNECE region. The Aarhus Convention supports the public's access to environmental information, and the Industrial Accidents Convention helps countries prevent accidents and prepare and respond to them.

UNECE has also promoted global initiatives in this field. The Global Energy Efficiency 21 is a program that the UN regional commissions have recently undertaken that focuses on financing energy efficiency investment projects for climate change mitigation, based upon the UNECE's experience gained over the last several years under its Energy Efficient 21 project. This is a capacity building program that provides technical assistance in helping countries identify and develop bankable investment projects. It also assists municipal and national authorities in introducing economic, institutional and regulatory reforms that support investment projects.

Another significant UNECE activity in collaboration with UN-HABITAT concerns urban and building design that improves daily living conditions and is environmentally sustainable.

Food and Agriculture Organization (FAO)

Proposed input from the One Health Agenda

The Food and Agriculture Organization of the Untied Nations (FAO), working closely with the World Health Organization (WHO) and the World Organisation for Animal Health (OIE), seeks to redress the global challenge posed by the emergence of disease at the animal-human-environment interface. The main call in this regard is to move beyond emergency assistance immediately after a crisis, to more clearly encompass disease

prevention, introduce safer food distribution and marketing practices, and adopt sustainable animal agriculture and natural resource management.

FAO envisages greater emphasis on preventive safety measures and sustainability across the continuum given by natural resource management, land use, farming practices, food supply and marketing channels. In practical terms, the focus remains with the strengthening of veterinary-public health systems, building on the early warning, early detection and early response capacities and platforms established over the recent years. The greater emphasis on prevention extends to safer practices in the production environment and food chain. Food safety considerations extend to live animal marketing, bush-meat trade and wildlife conservation.

Apart from directly enhancing health protection FAO proposes greater transparency and improved traceability in food production and supply, involving less transactions and where applicable, also more localness. The agro-ecological drivers of disease emergence have to be identified and confronted. The risks posed by the mix of traditional and industrial production systems coinciding in the same farming landscape and sharing the same distribution and marketing channels have to be addressed with some urgency. The same applies to conflicts that arise at the meeting points of rural economies and natural ecologies and the encroachment of the latter. It is here where expertise in socio-economics, communications and related disciplines becomes indispensable. FAO endeavors to assist all stakeholders concerned to place animal and human health concerns in a broader development perspective. This entails a continual sharing of views between health professionals and the public at large.

Whilst disease intelligence and emergency campaigns orchestrated by centrally coordinated public health institutions remain key, these efforts require to be complemented by social awareness and mobilization efforts, involving the community at large, from consumers to farmers, family level entrepreneurs, vendor networks, industry, hunters, tourist agencies, environment agencies, local administrators and other stakeholders with the aim to integrate the different disease technical, environmental, livelihood and rural development concerns.

There is a need to move beyond the conventional health protection measures. Efforts will have to build on the platform established over the recent years. Bottom-up approaches may bring local level integration and streamlining of prevention measures, safety and sustainability. Medical, veterinary, socio-economic, agricultural and other disciplines may jointly engage in risk and impact assessment, and formulate more comprehensive risk management and prevention packages. FAO seeks to support the emerging One Health initiatives seeking to redress disease flare-up at source through tackling the drivers and through placing people at the centre stage.

Apart from introducing a multi-sector and multi-disciplinary approach, the success of the One Health initiative relies on continued efforts to build effective partnerships and joint ventures. Importantly, FAO has to synergize with WHO and OIE, bridging their respective regulatory and other efforts in international human and animal health, extending, blending or integrating these health risk pre-occupations with socio-economic development, natural resource management and sustainable agriculture and rural development. FAO's core mandate neatly coincides with these challenges.

International Bank for Reconstruction and Development (IBRD)

In 2008, the Taskforce on Innovative International Financing for Health Systems (Taskforce) was launched with the objective of identifying and promoting innovative financing mechanisms to bridge the financing gaps which are compromising attainment of the health-related MDGs. The Taskforce highlighted the need to raise up to an additional US$ l0 billion per year to spend on health in low-income countries. To make better use of new and existing funds, low-income countries could focus on strengthening health systems as part of a national health strategy to improve governance and finance the scaling up of services required to reach the health MDGs. In its Report, the Taskforce presented innovative financing options that countries and other stakeholders can choose to support to help fill health systems financing gaps.

In line with the recommendations of the Taskforce, a common health systems platform is being established between the Global Fund, GAVI Alliance, and the World Bank. The intent is to coordinate, mobilize, streamline and channel the flow of existing and new international resources to support national health strategies. The three agencies have made important progress on this recommendation and have sought input from the global health community throughout the process. An inter-agency working group has established a number of principles for the Joint HSS work and made suggestions on how the three agencies may be able to harmonize their work in this area. Key principles for joint HSS work include a country led and country focused process in keeping with IHP principles.

RBF for Health is a national-level tool for increasing the quantity and quality of health services used or provided based on cash or in-kind payments to providers, payers, and consumers after predetermined health results (outputs or outcomes) have been achieved. It combines the use of incentives for health-related behaviors with a strong focus on results, and can support efforts to achieve the MDGs.

Essentially, results-based approaches aim to increase efficiency and effectiveness of health systems spending and improve outcomes by rewarding improvements with grants or paying off loans.

The World Bank, through the Health Results Innovation Trust Fund[23], currently supports eight governments to design, implement, and learn from RBF. Programs complement larger development efforts (by partners), including concessional IDA (International Development Association) credits. All eight RBF program-supported projects target the poorest segments of the population. They also target reproductive and child health the "neglected" MDGs 4 & 5 increasing the attention on interventions such as assisted deliveries and family planning services.

RBF is used increasingly by national health programs as a tool to strengthen delivery systems and accelerate progress towards national health objectives, particularly those linked to MDGs 4 and 5. RBF can help focus government and donor attention on outputs and outcomes. RBF mechanisms may reinforce efforts to improve the timeliness, credibility and accuracy of national reporting and monitoring; and may even help spur creative

[23] US$100 million contributed by the Government of Norway in 2008. As of September 2009, the Government of Norway committed to continue to support this work through an additional contribution of NOK 1.5 billion; the Government of the UK will join in supporting this work, contributing £100 million to results-based programmes through the World Bank Health Results Innovation Trust Fund.

reforms that confer authority and flexibility to local, service-delivery levels, fostering problem-solving where it is most needed.

In FY09 the World Bank created a new "Health Systems for Outcomes" (HSO) Program which is anchored in the Africa Region HNP Unit of the World Bank. The program is key to supporting the implementation of the Bank's 2007 HNP strategy, and rose from the realization that the Millennium Development Goals in Health in Africa are unlikely to be achieved if the underlying Health Systems that deliver services to the poor remain weak and underdeveloped. Central to the operation of HSO is the creation of two technical hubs, currently composed of 12 experts, located in Dakar and in Nairobi, both designed to provide technical and analytical support and operational expertise to governments and country TTLs working on health systems strengthening (HSS). HSO Program team members function as one team in three locations (Washington, Dakar, and Nairobi) and collaborate with health colleagues both across the Africa Region, the World Bank and many partner organizations.

The HSO Program is designed to primarily support IHP+ countries (or soon to be IHP+ countries). The current HSO focus countries in Africa include: Benin, Burundi, Eritrea, Ethiopia, Ghana, Kenya, Madagascar, Mali, Mozambique, Nigeria, Rwanda, and Zambia. Some support is also provided to nonIHP+ countries on a case by case basis (based on prioritized need). During Phase J, activities were jumpstarted at both country and regional levels: the program management structure was established, regional technical hubs were created, and health system strengthening activities started at both country and regional levels. The program was able to quickly respond and mount several missions to countries, initiating the policy dialogue on health systems and producing country IHP+ deliverables such as the production of a health system diagnostic in Benin and Rwanda, the signing of an IHP+ compact in Mali and the development of Results Based Financing (RBF) pilots in several countries. A regional capacity building and knowledge management component also delivered regional conferences, workshops, and analytical products as well as a website. Finally, an operational and monitoring structure was created and country and individual work-programs and results frameworks developed.

International Maritime Organization (IMO)

In cooperation with the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Philippines, the World Health Organization (WHO) and national maritime stakeholders, a series of in-house seminars on HIV/AIDS in the workplace were carried out to promote prevention and care among the seafaring community. The IMO regional coordinator in Manila was instrumental in the establishment of a women's association "Women in Maritime Philippines" (WIMAPHIL), which aims to promote the empowerment of women in the maritime sector. This association has placed HIV/AIDS issues high on its agenda and aims through its programmes to involve all the stakeholders, e.g. wives of seafarers, employees of maritime agencies and port authorities, manning agencies and shipping operators, in enhancing awareness, prevention and care, as well as human rights issues.

International Telecommunications Union (ITU)

- ITU is developing an "m-Health Initiative" to promote the coordinated introduction of cost-effective mobile e-Health applications in developing countries.

- ITU is strengthening its coordination with WHO, the World Bank, and other national, regional and international organizations to organise a series of e-Health Roadmaps Regional Forums to support the development or update of National e-Health Strategic Plans and help shaping an effective regulatory, governance and policy context for further e-Health development and investment.

- ITU Secretary-General is co-chairing with the President of Novartis Foundation for Sustainable Development, the Advisory Board for the *Digital He@lth Initiative.* This initiative facilitated by the UN Office for Partnerships is a unique multi-stakeholder collaboration between the ICT and healthcare sectors and an implementation of the health related Millennium Development Goals. The initiative aims to harness digital health care solutions in the most resource poor settings. In practice, it will map the current state of play in this emerging field, develop an economic model for policy-makers and practitioners, and put in place a partnership platform for country-specific projects of regional importance.

United Nations Development Fund for Women (UNIFEM)

The two global commitments on HIV/AIDS, which governments are required to report on, are the 2001 UNGASS Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS. The former is a powerful tool helping to guide and secure action, commitment, support and resources for the AIDS response[24]. The latter reaffirms the UNGASS agreement and provides a strong mandate that will help move the AIDS response forward, particularly with regards to scaling up towards universal access to HIV prevention, treatment, care and support[25].

Recently, UNAIDS, and UNIFEM have developed a strategy/framework to promote greater action on women, girls, and gender equality in the context of HIV/AIDS. The Action Framework: Addressing Women, Girls, Gender Equality and Operational Plan[26] has been produced and endorsed for implementation by the UNAIDS Programme Coordinating Board[27]. This Framework and Plan holds UNAIDS, UNIFEM, and others to account for supporting countries to deliver better on women's rights and gender equality in the context of the HIV/AIDS epidemic.

The Global Fund to Fight AIDS, TB and Malaria Board has also adopted a new Gender Equality Strategy, designed to expand investments in programmes focused on women and girls and those most at-risk. This may lead to increased investments in strategies which address the structural drivers which lead to women's increased vulnerability to HIV/AIDS. UNIFEM has been involved in consultations with the Global Fund and UNAIDS, to develop strategies for supporting the implementation at country level of this strategy.

World Food Programme (WFP)

WFP continues to work closely with partner agencies to implement its new Nutrition Improvement Approach. This includes UNICEF, WHO and UNHCR. WFP works closely with WHO to continuously adjust nutrition

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[24] http://www.unaids.org/en/AboutUNAIDS/Goals/UNGASS/default.asp.
[25] http://www.unaids.org/en/AboutUNAIDS/Goals/2006Declaration/.
[26] UNAIDS, 2009, http://data.unaids.org/pub/Report/2009/jc1794_action_framework_gender_equality_en.pdf.
[27] UNAIDS, 2009, 24th Meeting of the PCB, Decisions, Recommendations and Conclusions. http://data.unaids.org/pub/InformationNote/2009/20090603_pcb_24_decisions_en.pdf.

standards for people receiving antiretroviral treatment. In 2009, WFP has joined WHO in starting a process of defining similar nutritional standards for TB patients.

WFP continues to be an active cosponsor of UNAIDS. HIV and AIDS go far beyond what any single UN agency can do. WFP fully endorses the 2009 UNAIDS Joint Outcome Framework and intends to live up to its responsibilities under outcomes 3, 4 and 9[28].

WFP works closely with it's UNAIDS partners at the regional and country level to help national governments address the epidemic in a comprehensive manner. In Rwanda, Mozambique and Tanzania, WFP provides leadership on food and nutrition issues within joint UN programmes following the '1-UN' pilot initiatives, highlighting strategic priorities, operational requirements and funding needs. Through the one UN Fund, funds have been made available for Food and Nutrition interventions for the coordinated response and liaison with Governments. Other non-pilot countries are increasingly engaging in joint programme initiatives; in Kenya, Lesotho, Madagascar, Malawi, Swaziland, Uganda and Zambia, WFP ensures adequate focus on food and nutrition matters in joint programme development efforts.

World Meteorological Organization (WMO)

Health in the GFCS

The World Climate Conference-3 (WCC-3) saw an unprecedented response by world leaders and the international scientific community to the call by the World Meteorological Organization and its long-standing partners in the World Climate Programme for the establishment of a framework to provide society with the climate services it needs to address the challenges of climate variability and change, now and in the future. Climate has emerged as one of the most challenging issues for the global community in the twenty-first century. Coping with the impacts posed by climate variability and change will require countries and societies to be equipped with new tools and capacities, including better observation and understanding of climate variability and risks; increased awareness, education and dissemination of information; as well as improved prediction and information services to enable the identification and management of a wide variety of climate risks and opportunities, including for nationally appropriate mitigation actions and adaptation.

The United Nations System is committed to delivering as one on climate change. As the two United Nations specialized agencies assigned convening responsibility for the "climate knowledge" component of the United Nations System-wide strategy, the World Meteorological Organization (WMO) and the United Nations Educational, Scientific and Cultural Organization(UNESCO) were delighted to receive this strong support.

WMO and UNESCO have greatly welcomed the recent scientific advances to inter-annual prediction and multi-decadal climate projection and the developments in high-resolution regional climate models which offer a sound basis for the continued development and application of new tools and climate services. It is recognized that improved climate prediction and information services and broad assessment of climate impacts are

[28] UNAIDS Joint Outcome Framework: Priority Area 3: Treatment: Nutritional support in HIV treatment and care programmes, Priority Area 4: TB: Nutritional support in tuberculosis (TB) programmes and Priority Area 9: Social Protection: Social safety nets for people affected by HIV.

essential for targeted adaptation and risk management measures and strategies, and would facilitate the mainstreaming of adaptation into sustainable development strategies at local, national and regional scales.

The Global Framework for Climate Services (GFCS), initiated by WCC-3, will address the challenges of climate variability and change both today and into the future. Successful implementation of the Framework will lead to enhanced climate observations, research, monitoring and modeling, a transformation of that information into sector-specific products and applications, and their widest possible use by all sectors of society in decision-making. This will contribute to disaster risk reduction and socioeconomic development, including achievement of the United Nations Millennium Development Goals and be another concrete illustration of the United Nations System delivering as one.

WMO and UNESCO are committed to following up the WCC-3 decisions, taken by over 150 governments, through the mechanism set down in the Conference Declaration. In this, the support of governments and strong partnerships across all sectors will be essential. Collaboration at all levels will be necessary to foster the development of sector-targeted climate services for decision-making.

The executive summary of the WCC-3 session on Climate and Human Health presents recommendations that will be considered by a High-Level Taskforce, the composition of which having been adopted at an Intergovernmental meeting help in Geneva on 11 & 12 January 2010. After wide consultation with governments, partner organizations and relevant stakeholders, the High-Level Taskforce will prepare a report, including recommendations on proposed elements of the Framework, to the Secretary-General of WMO within 12 months of the task force being set up. The report should contain findings and proposed next steps for developing and implementing the Framework, and shall be circulated by the Secretary-General of WMO to Member States of the WMO for consideration at the next WMO Congress in 2011, with a view to the adoption of the Framework and a plan for its implementation.

Health in MHEWS projects

Epidemics, floods, droughts and wind storms account for over 80 % of the disasters that afflict Africa. Epidemics of weather- and climate-sensitive infectious diseases, such as malaria, meningitis, cholera and Rift Valley fever, cause massive disruption to societies and overburden the health system.

Developing an effective early warning system is essential to help national health services cope with the impacts of normal seasonal variability in the occurrence of health hazards and diseases, and scale up interventions in time to prevent a disaster when one threatens, thus, dramatically reducing morbidity and mortality.

The Project of elaboration of techniques of information about the risks of meningitis in the ambient environment (MERIT) developed thanks to the active collaboration of the WHO and a certain number of members of the following sectors: Environment, Public Health and Research. This project aims at strengthening the current capacities to be able to make a more effective synthesis of the environmental information and the knowledge relative to the meningitis in meningococcal epidemic on the basis of an analysis taking into account the information and the data on the distribution of the cases of meningitis, the

demography, the environment and the climate, the situation in vaccination and the characteristics of the various strains.

Through the MERIT project, opportunities exist to integrate valuable information into meningitis prevention and control activities through the development of:

-Risk maps of the current situation and future scenarios, based on projected changes in climatic and environmental factors

-Early warning systems

-Improved impact assessment methodologies for prevention efforts

For example, combining routine epidemic surveillance data including information on previous epidemic history and control measures, with information on historical or current climatic and environmental conditions may improve the targeting of preventative and reactive vaccination efforts.

Existing resources could be dramatically improved through collaboration between national, regional and international institutions to refine research efforts, increase access to data and influence the development and enhancement of health-environment networks. WMO is supporting this project through the World Climate Research Programme.

The VigiRisC project, " Systems of Vigilance in front of Climate change in Africa ", costs 4 M€, will last a duration of 3 years, has the objective to design and develop products and services of vigilance in front of climatic risks. This project is co-financed for half by the French Fund for the World Environment (FFEM) and for the other half by a certain number of international institutions (World Meteorological Organization, International Federation of the Red Cross, African Development Bank, Economic Committee (Commission) for Africa, French Agency of Development, the Meteo France, and African Centre of Meteorological Application for Development (ACMAD)).

This project joins in the objectives of the "Program of climatic information for the development in Africa" (ClimDev in Africa) introduced by the Economic Commission for Africa, the African Union Commission and the African Development Bank, and in the conclusions of the fourth report of the GIEC (2007 - Group II Adaptation) who emphasizes the future effects of the climate change in Africa.

The climate change being translated at first by an increase of the climatic variability, the development of systems of vigilance can contribute to answer the immediate concerns of the decision-makers and to participate in the effort of adaptation in sectors sensitive to the climate.

The expected results of this project are:

- Products and pilot services of vigilance identified on the basis of an analysis of the needs of the end users and the actors of the community of the development, the available data and the good practices

- Products and pilot services of vigilance developed, implemented and integrated into the plans of risk prevention

- Capacities and African skills for the vigilance in front of climate change developed by networking and through the dialogue between the meteorological community and the communities of the development

Products and pilot services of vigilance will take into account the climatic risks and following sectors, identified by the GIEC as potentially vulnerable in Africa, and in particular in the health domain, the role of the climatic factors in the epidemiology of the malaria, the meningitis and the other emergent diseases not passed on by mosquitoes.

WMO will participate in the first quarter of 2010 to the official launch of this project.

- **The coordination of UN efforts and approaches in this field – progress and obstacles**

Economic Commission for Africa (ECA)

In response to the challenges of global public health highlighted above, and specifically mentioned in the 2009 Ministerial Declaration, ECA, together with its partners such as the UNFPA, ILO, and the African Union Commission, embarked on a number of activities within its mandate.

- ECA collaborated with the UNFPA and WHO for the delivery of the programme on Enhancing the Capacity of African member States to address maternal mortality. A number of workshops are being held to: identify the priority problems to enhance maternal and neonatal survival in countries where mortality areas are very high, e.g. Southern Sudan, Liberia and Sierra Leone; and identify training needs to scale up current interventions.

- ECA is developing a Tool to track the implementation of the recommendations of the Commission on HIV/AIDS and Governance in Africa (CHGA) that countries pledged to implement and to report on. The programme is called "Implementation of Securing our future: follow-up to the report of the Commission on HIV/AIDS and Governance in Africa and development and operationalization of an accountability index for monitoring commitments on HIV/AIDS in Africa". It will be delivered through collaboration with UNAIDS, UNFPA, WHO and the African Union Commission (AUC).

-In 2010, ECA, together with UNFPA, AUC and the nonprofit organization IPAS, will research and produce a report called "Strengthening policy development on sexual and reproductive health – focusing on women's rights". The objective is to present member States with evidence-based policy options for addressing the critical challenge of sexual and reproductive health in Africa.

Economic Commission for Asia and the Pacific (ESCAP)

ESCAP is the chair of the Asia-Pacific Regional Coordination Mechanism (RCM), which consists of the regional offices of 27 Bangkok-based United Nations and affiliated organizations. Thematic Working Groups (TWGs) have been formed to address six critical focus areas, including health. In 2009-2010, the TWG on

health is focusing on the critical issue of maternal mortality, which is covered under Millennium Development Goal 5 (MDG 5).

As the regional arm of the United Nations, ESCAP has taken steps to ensure implementation of the 2009 Ministerial declaration on global public health in the region and to coordinate the UN efforts in this field. As the chair of the Asia-Pacific Regional Coordination Mechanism (RCM), the institutional platform to ensure a combined effort by the entire UN system to work together with countries on building capacities to address MDG gaps, included those related to health, ESCAP has established a Thematic Working Group on Health, with members from other regional offices, to facilitate an integrated approach by regional UN system partners on health issues. In 2009-2010, the TWG has adopted a coordinated approach involving all its members for addressing maternal mortality in the region.

Economic Commission for Europe (ECE)

Acknowledging the importance of environmental factors for health, UNECE is promoting interagency actions within the framework of the Regional Coordination Mechanism (RCM) climate change working group. The RCM working group on Climate Change adopted a multi-sectoral approach to climate change adaptation and mitigations strategies in the region. In particular, it recognized that climate change is posing increasing challenges to health outcomes in the region which need to be addressed and are reflected in its working plan. In light of these considerations the RCM Climate Change Working group will participate in the Fifth Ministerial Meeting on Environment and Health organized by the WHO in March 2010.

International Bank for Reconstruction and Development (IBRD)

In recognition of the urgent need to improve coordination of development assistance in health, the International Health Partnership (IHP+) was launched in September 2007. The IHP+ aims to facilitate improved results for health by implementing the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action in the health sector.

-Country ownership and alignment with country systems and processes is key. Partners need to rally around country-led, country-owned national health strategies.

-Harmonization between agencies is necessary to minimize transaction costs and maximize efficiencies at all levels, but most importantly at the country level.

-Mutual accountability is critical. All partners need to be held accountable for the commitments they make. Civil Society has a strong role to play.

-Focus on results is needed. Without results, HSS has no meaning; yet, there will be no results without HSS.

Partners recognize that this approach requires substantial changes in the way donors and development actors have traditionally done business, with simplified aid architecture, stronger civil society involvement and a greater focus on mutual accountability that will reach far beyond the IHP+ partner countries.

Under the auspices of IHP+, partners have worked to develop a tool and guidelines for the Joint Assessment of National Health Strategies. Joint assessment is a shared assessment of the strengths and weaknesses of a national health strategy, strategic plan or national strategy for a specific health issue such as malaria. Joint assessment of national strategies is seen as a way to help make high level commitments such as the Paris Declaration on Aid Effectiveness, and the IHP+ principles -a reality.

International Labour Organization (ILO)

Initiatives of the ILO to implement the 2009 Ministerial Declaration in a coordinated manner include ILO's support to implement internationally agreed norms, frameworks, and initiatives through the following activities:

-The Global Campaign on Social Security and Coverage for All, mandated by the International Labour Conference in 2001, relates closely to the promotion of ILO Convention No. 102 and the Decent Work Agenda, which addresses social health protection.

-The Providing for Health Initiative (P4H), aims to coordinate technical cooperation, capacity development and advice on social health protection in numerous countries with a view to generating sustainable financing at the national level.

-The CEB Social Protection Floor Initiative, jointly led by ILO and WHO and endorsed as a part of the Global Jobs Pact, requests countries that do not yet have extensive social security to build "adequate social protection for all, drawing on a basic social protection floor including: access to health care; income security for the elderly and persons with disabilities; child benefits and income security combined with public employment guarantee schemes for the unemployed and the working poor, and "urges the international community to provide development assistance, including budgetary support, to build up a basic social protection floor on a national basis" .

-Joint efforts are being led by ILO to develop and apply globally agreed standards for measuring the status quo and progress of social health protection coverage, defined as effective access to essential health care.

-The ILO promotes the ratification of Convention No. 183 and the conformity of national legislation with its provisions; these are among the indicators of the global "Countdown to 2015" monitoring effort. This UN initiative monitors health systems and policy environments with a view to improving maternal, newborn and child health.

-The promotion of working conditions in health services include generally applicable labour standards such as the Labour Relations (Public Service) Convention (No. 151) and Recommendation No. 159, 1978, and the Nursing Personnel Convention (No. 149) and Recommendation (No. 157), 1977. These standards promote the general application of labour standards for nursing personnel, including education and training; practice of the nursing profession; career development; remuneration; working time and rest periods; occupational health protection; and social security.

-The ILO, in consultation with governments and with employers' and workers' organizations, and with UNAIDS and WHO, is preparing a new international labour standard on HIV at the workplace, scheduled for adoption in June 2010.

-The Joint ILO/WHO Guidelines on Health Services and HIV/AIDS cover HIV protection and training for health workers in occupational health and safety, strengthening health systems.

-Strengthening workplace HIV and TB prevention, and promoting TB treatment through workplace programmes, has proven a cost-effective way to capture a large segment of productive age population and reduce HIV and TB co-infection. ILO and WHO have jointly developed a guide on HIV and TB prevention for the business sector.

International Organization for Migration (IOM)

Initiatives of the UN system organizations to align their policies, programmes and activities across the relevant sectors identified by the Ministerial Declaration (communicable diseases, including HIV/AIDS, non communicable diseases, neglected tropical diseases, maternal health, health systems, health workforce, access to health services, vulnerable and marginalized groups including migrants, health literacy, e-health, etc.)

IOM is working closely with a number of partners within the UN system, especially WHO, UNFPA, UNAIDS, UNODC and ILO, to address migrants' health. Specific initiatives in 2009 have included:

-With the support of the United Nations Global Initiative to Fight Human Trafficking, and led by IOM and the London School of Hygiene & Tropical Medicine, the handbook "Caring for Trafficked Persons" was developed, which provides practical and non-clinical advice to help a concerned health provider understand the phenomenon of human trafficking, recognize some of the associated health problems and consider safe and appropriate approaches to providing healthcare for trafficked persons.

-The Global Partnership on HIV and Mobile Workers in the Maritime Sector was launched in 2009. It is an initiative among seven international organizations and global networks: the International Organization for Migration (IOM), the International Transport Workers' Federation (ITF), the International Committee On Seafarers' Welfare (ICSW), the International Labour Organization (ILO), the International Maritime Health Association (IMHA), the International Shipping Federation (ISF), and the Joint United Nations Programme on HIV/AIDS (UNAIDS). The overall objective of the global programme is to contribute to a reduction in the number of new HIV cases among seafarers[29].

-In particular, IOM has stepped up its partnership with WHO since the adoption of the 61st (2008) World Health Assembly Resolution *Health of Migrants.* In March 2010, WHO, IOM and the Ministry of Health and Social Policy of the Government of Spain, have taken the initiative to organize the Global Consultation on Migrant Health.

The Objectives of the Consultation are:

[29] More info at seafarers@iom.int, +41 22.717.9234.

1) To take stock of the actions taken by Member States and other? Stakeholders in the following areas:

   -Monitoring migrants' health

   -Policy- and legal frameworks on migrants' health or affecting migrants' health.

   -Migrant sensitive health systems

   -Partnerships, networks and multi country frameworks

2) Reach consensus on priority areas and strategies to improve the health of migrants and communities in today's increasingly diverse society

3) Initiate an operational framework to promote migrant health on the international health agenda and to work with Member States and stakeholders in their efforts to address health of migrants and health issues associated with migration.

IOM's role within this Global Consultation is to facilitate cross-sectoral partnerships and multi-country and regional cooperation as *migration by default connects communities and countries or regions as well as various sectors in society.*

Joint United Nations Programme on HIV/AIDS (UNAIDS)

In general, collaboration and coordination with partners in the UN system is an inherent part of a UNAIDS mandate as a Joint United Nations Programme on HIV/AIDS. As such, UNAIDS is an innovative joint venture of the UN family bringing together the efforts and resources of ten UN system organizations[30] and the UNAIDS Secretariat in the AIDS response. At the country level, coherent UN action on AIDS is coordinated through the UN theme groups, and the joint teams and programmes on AIDS. UNAIDS also helps mount and support an expanded response to AIDS beyond the UN system – one that engages the efforts of many sectors and partners from government and civil society.

Areas in the 2009 Declaration that are of particular relevance to the work of UNAIDS include:

Paragraph 17 (a) and (c) – communicable disease prioritized by MDGs:

(a) scaling up efforts to achieve universal access to HIV prevention, treatment, care and support by 2010 and the goal of halting and reversing the spread of HIV/AIDS by 2015; maximizing synergies between the HIV response and strengthening of health systems and social support;

(c) TB - strategies for dealing with new threats such as co-infection with HIV;

Paragraph 15 (d) – maternal and child health: Integration of services for HIV and primary health care, sexual and reproductive health, and mother and child health, including efforts to eliminate the mother-to-child transmission of HIV;

[30] Cosponsors: ILO, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, WFP, WHO and the World Bank

Paragraph 9 – health systems strengthening;

Paragraph 10 **–** social determinants of health and social protection;

Paragraph 12 – human rights and interrelationship with health;

Paragraph 13 and 14 – gender equality/access of women to health care, and violence against women;

Paragraph 33 – the impact of the financial and economic crisis;

The information below provides an update on UNAIDS activities with regard to the afore-mentioned issues:

-*UNAIDS Outcome Framework 2009-2011: Joint Action for Results* - developed by the UNAIDS Cosponsors and the Secretariat, establishes a set of specific and ambitious goals in 10 priority areas that will help achieve universal access to HIV prevention, treatment, care and support, and the MDGs. The priority areas are the following: 1) Reduce sexual transmission of HIV, 2) Prevent mothers from dying and babies from becoming infected with HIV, 3) Ensure treatment access for people living with HIV, 4) Prevent people living with HIV from dying of TB, 5) Protect drug users from becoming infected with HIV, 6) Remove punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS, 7) Stop violence against women and girls 8)Empower young people to protect themselves from HIV, 9) Enhance social protection for people affected by HIV, and 10) Protect men who have sex with men and transgender people from becoming infected with HIV.

Guided by the Outcome Framework, UNAIDS will continue to advocate for and support national efforts for comprehensive multi-sectoral country responses to the epidemic. The priorities constitute areas in which collective action by the UNAIDS Secretariat and the Cosponsors can make a difference, by maximizing their comparative advantage as per respective mandates and areas of expertise, more clearly identifying roles and responsibilities and promoting accountability for making resources work to deliver results.

-*Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV* – developed through a widely consultative process with representatives and experts from governments, UN system and civil society organizations, especially women's groups and networks of women living with HIV – the Agenda puts issues of women and girls at the center of AIDS response. The five-year plan (2010-14) calls on the UN system – including the UNAIDS Secretariat and Cosponsors, UNIFEM and the UN Joint Teams on AIDS[31], to accelerate joint and inclusive country action – in collaboration with governments and civil society – to address the persistent gender inequality and human rights violations that put women and girls at greater risk to HIV, and empower women and girls to protect themselves from the infection and cope more effectively with the impact of the epidemic.

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[31] UN Joint Teams on AIDS bring together all UN system organizations present in a given country (beyond UNAIDS Secretariat and Cosponsors).

-Maximising synergies between the HIV response and strengthening of health systems and social support

In the second half of 2009, UNAIDS Secretariat reviewed activities with cosponsors[32], GFATM and PEPFAR in order to develop a coherent approach to better support health systems strengthening. Work has been initiated to 1) bring evidence on the contribution of HIV response to health system strengthening, 2) better align HIV programming and health sector planning cycle in 10 countries in sub-Saharan Africa; and 3) develop better integrated health package that contributes to MDGs 4, 5 and 6.

With respect to the synergies between HIV response and social support, UNAIDS has set-up an inter-agency working group[33] in order to ensure national social protection strategies are inclusive of people and households affected by HIV. For 2010-2011, the group will develop an evidence-based, coherent approach to HIV-sensitive social protection by the UNAIDS Secretariat, the cosponsors and other partners. In addition, the group will contribute to national scale up of HIV-sensitive social protection systems and programmes in 20 countries by 2015, in relation with the UN Social protection floor initiative.

-Addressing HIV-TB co-infection

UNAIDS Secretariat has worked closely with the Stop TB Partnership, the WHO and other cosponsors to strengthen collaboration between the TB and HIV communities. In May 2010, UNAIDS Secretariat will sign a Compact with the Stop TB Partnership, to commit to halving TB deaths in people living with HIV by 2015, through increased political commitment, community mobilization, research investment and a strengthened rights-based approach to ensure universal access to integrated TB and HIV services.

-Prevention of mother-to-child transmission of HIV (PMTCT)

Following the call of UNAIDS Executive Director to eliminate mother-to-child transmission of HIV by 2015, and in the spirit of broadening its partnership circle, UNAIDS signed – in September 2009 – an MOU with the Millennium Villages Project (MVP), under the auspices of the Presidents of Uganda and Senegal. The aim of the partnership is to help local communities create "mother-to-child transmission (MTCT)-free zones" in the 14 "Millennium Villages" across ten African countries (Ethiopia, Ghana, Kenya, Malawi, Mali, Nigeria, Rwanda, Senegal, Tanzania and Uganda). The initiative will use the existing infrastructure and human capacity in the "Millennium Villages" to help rapidly expand family- and community-centered heath services with focus on the following four priority areas: (a) primary prevention of HIV among women of childbearing age; (b) prevention of unintended pregnancies among women living with HIV; (c) prevention of HIV transmission from a woman living with HIV to her infant; and (d) providing appropriate treatment, care and support to women living with HIV and their children and families. The partnership brings together the MVP, UNAIDS Secretariat and three co-sponsors: UNFPA, UNICEF and WHO.

-Weathering the impact of the global financial and economic crisis on the AIDS response

In December 2009, UNAIDS and World Bank prepared a report on the "Impact of the global financial and economic crisis on the AIDS response", which was based on findings from a series of studies, surveys and

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[32] UNFPA, UNICEF, WHO, World Bank
[33] ILO, UNFPA, UNICEF, WFP; WHO, World Bank

consultations conducted during the second half of 2009. These included: Case studies of 13 countries across all regions; Interviews with key donors; Survey of 63 UNAIDS Country Coordinators (UCC) in countries that account for two-thirds of people living with HIV globally; Survey of 457 Civil Society Organisations (CSOs); and two multi-stakeholder consultations. In implementing the recommendations of the report, UNAIDS, inter alia, provides a comprehensive package of technical support to countries, especially to high-burden countries, to contain and mitigate the negative impact of the crisis on the AIDS response, and will use its convening power to bring HIV donors together, where possible in coordination with GFATM, and other innovative financing mechanisms including UNITAID. The technical assistance is focused on the following areas: (1) priority setting within national HIV plans; (2) raising programme efficiency; (3) designing safety nets that include people living with HIV; and (4) securing and mobilizing funding.

-Addressing HIV-related stigma and discrimination and promoting human rights

A protective legal environment - comprising law, law enforcement and access to justice –is essential in addressing HIV-related stigma and discrimination and guaranteeing access to a wide range of HIV-related health and support services for people living with HIV, vulnerable groups and members of key populations at higher risk. However, analyses of the legal environment related to HIV in many countries reveal lack of protective measures and/or the existence of punitive laws and policies that hinder access to HIV services.

The judiciary has an important role in providing a protective legal environment in the context of HIV. In December 2009, UNAIDS together with UNDP, the International Association of Women Judges and the International Commission of Jurists, brought together some 30 judges from the highest national and regional courts from 15 countries in sub-Saharan Africa, as well as members of regional parliamentary institutions, people living with HIV, representatives of groups of sex workers and men who have sex with men. During the meeting the judges agreed upon a statement of principles aimed at guiding and inspiring members of the judiciary throughout Africa in the context of the AIDS response. The statement of principles addresses the following issues: 1) the role of the law in responding to the HIV epidemic; 2) science and evidence-informed decision-making; 3) stigma and discrimination; 4) protecting and empowering women: the links between HIV, gender based violence and property rights; 5) protecting and empowering marginalized and criminalized communities; 6) ensuring proper application of criminal law; and 7) court proceedings and access to justice.

Great strides have been made in recent years in understanding *HIV-related stigma and discrimination*. However, due to the lack of standardized indicators at the programme, national and global levels to measure stigma, it is difficult to compare its prevalence across setting and populations and to scale up stigma reduction programmes. On 23-25 November 2009, UNAIDS in collaboration with the Global Network of People Living with HIV (GNP+), International Center for Research on Women (ICRW) and the International Planned Parenthood Federation (IPPF), held consultations in Washington DC to share lessons learnt on stigma measurement, to review existing measurement tools and to lay the ground to develop a set of common, standardized indicators on HIV-related stigma and discrimination.

Following the presentation at the 2009 ECOSOC Innovation Fair, UNAIDS continued to expand the roll-out of *The People Living with HIV Stigma Index*[34] in a number of countries: Argentina, Bangladesh, China,

[34] See www.stigmaindex.org

Colombia, El Salvador, Ethiopia, Fiji, Kenya, Mexico, Myanmar, Nigeria, Pakistan, Papua New Guinea, Paraguay, Philippines, Russia, Rwanda, Thailand, UK, and Zambia. The Stigma Index is a new research and advocacy initiative, which brings together efforts of the International Planned Parenthood Federation (IPPF), the Global Network of People Living with HIV (GNP+), the International Community of Women living with HIV (ICW) and UNAIDS. The initiative - driven and implemented by people living with HIV – utilises rigorous quantitative and qualitative research to help measure stigma and discrimination relating to HIV; build an evidence base for improved policies and programmes and increased advocacy; as well as provide an empowering experience for the people living with HIV involved in the process.

United Nations Education, Scientific and Cultural Organization (UNESCO)

UNESCO contributes to the internationally agreed goals and commitments in regard to public health through promotion of research capacity building in the basic sciences, where the focus is on fostering applications for societal needs, including areas of importance to public health such as HIV and AIDS, emerging infectious diseases, neglected diseases of poverty, and water quality. Partnerships have been developed to this end with international scientific unions, non-governmental organizations and other UN organizations for cost-sharing training programmes or cooperative advocacy activities. In addition, as a scientifically literate population is important for increasing global public health, strengthening of science education at all levels is a priority with considerable focus on activities to promote careers for women and girls in science.

As a UNAIDS Cosponsor, UNESCO has fully engaged in UNAIDS processes and actions, including in meetings of the Committee of Cosponsoring Organizations, Cosponsor Global Coordinators for HIV and AIDS, and the Programme Coordinating Board. Significant results achieved through such coordinating efforts include the development and finalization of the UN joint business plans that operationalize the UNAIDS Outcome Framework, to which UNESCO has contributed and committed to the following common goals of the UN family: empowering young people to protect themselves from HIV infection; reducing sexual transmission of HIV; stopping violence against women and girls; and preventing people living with HIV from dying of tuberculosis. UNESCO has also contributed to the second independent evaluation of UNAIDS (for the period 2002-2008). UNESCO convenes the UNAIDS Inter-Agency Task Team (IATT) on Education, and is a member of the UNAIDS IATT on HIV and Young People and a co-convenor on the working group for the UNAIDS Outcome Framework business case on Young People, together with UNFPA and UNICEF.

UNESCO has strengthened its leading role in the UNAIDS Global Initiative on Education and HIV & AIDS, known as EDUCAIDS, that provides support for the implementation of comprehensive national education sector responses to AIDS. Since its launch by the full Committee of Cosponsoring Organizations of UNAIDS in 2004, EDUCAIDS is now operating in more than 50 countries with collaboration between UNESCO and UNAIDS Cosponsors, ministries of education, civil society and other development partners. The EDUCAIDS Framework for Action, which provides overall guidance on how to formulate appropriate country-level responses, and other technical materials have been compiled into a single resource pack, which is now available in the six official UN languages as well as in Portuguese. An external evaluation of EDUCAIDS completed in 2009 has further highlighted the instrumental role of UNESCO in mobilizing partners and in advocating for comprehensive education sector responses at country-level and the significant achievements attributable to UNESCO and EDUCAIDS in some of the countries and regions most affected by the epidemic.

UNESCO's partnership with UNAIDS, UNICEF, UNFPA and WHO to develop the International Technical Guidance on Sexuality Education brought together the technical leadership from all the agencies in a sustained and very productive process. The process has resulted in a high quality technical publication in December. Based on a rigorous and current review of evidence on sexuality education programmes, the International Technical Guidance sets new international benchmarks for standards in sexuality education and is aimed at education and health sector decision-makers and professionals.

The UNAIDS IATT on Education, convened by UNESCO, is now a mature and well-established structure contributing to accelerated and improved education sector responses to HIV and AIDS, with recent progress that includes: a renewed commitment and shared vision, mission and strategic priorities as documented in "A Strategic Approach: HIV & AIDS and Education"; the enhanced availability and accessibility of the evidence base in HIV & AIDS and education as a result of stock-taking exercises supported by the IATT; the expansion of the IATT membership network to include strategic partners in different aspects of the response, including more than 30 multilateral organizations, private foundations, bilateral agencies and civil society partners; established and maturing mechanisms for coordination, alignment and harmonization among the IATT members, strengthened with a recent mapping and analysis of the IATT member updates; and numerous policy and technical guidelines and tools developed by the IATT to guide HIV mainstreaming in education at the country-level.

As part of the Coordinating Group and leader of three thematic working groups (education, the environment, HIV and AIDS and sexual and reproductive health) of the FRESH (Focusing Resources on Effective School Health) Partnership, UNESCO has contributed to and participated in the initiation and implementation of concerted action by a wide number of agencies, experts and stakeholders to produce clear, robust sets of indicators for the monitoring and evaluation of School Health and Nutrition (SHN). The development of common standards for monitoring and evaluating SHN programmes will act as a resource to countries and programmes and also enable better evidence-based programming by improving planners' ability to compare different interventions and their impact. In turn, it is hoped that governments will adopt and support interventions that will contribute towards reaching their EFA objectives.

United Nations Population Fund (UNFPA)

Significant work has been undertaken to further strengthen coordination between and beyond the UN Agencies addressing the health-related MDGs (UNAIDS, UNFPA, UNICEF, WHO) with the aim to further enhance synergies, linkages, build momentum, scale-up efforts and boost progress. Numerous global health initiatives have been established that focus on supporting national ownership, alignment with national systems, mutual accountability, harmonizing between agencies, managing for results while strengthening mutual accountability. Most initiatives explicitly recognize that strengthening health systems and demand for services are critical to improving health outcomes, including maternal health.The most notable initiatives include the Global Campaign for the Health MDGs, the H8, the H4 and initiatives such as the IHP+ and the Harmonisation for Health in Africa (HHA). It also includes partnerships focused on MDGs 4 and 5, such as the Partnership for Maternal, Newborn and Child Health and the associated campaign 'Deliver Now for Women and Children. In addition, other critical partnerships which also contribute and impact on global public health include among others the UN Social Protection Floor Initiative and the UN Interagency Taskforce on Adolescent Girls.

United Nations University-International Institute for Global Health (UNU-IIGH)

UNU-IIGH since its inception in 2006 has been involved in supporting a number of developing countries to develop and implement the case-mix system which can be used as a prospective payment mechanism in the social insurance scheme. Three countries namely Indonesia, Mongolia and the Philippines have benefited from training programmes conducted by UNU-IIGH. In Indonesia, UNU-IIGH conducted a series of workshops to train health care workers of Department of Health (DEPKES) to develop the Indonesian DRG (INA-DRG) which is currently being used as a tool to implement the national hospital tariff under the Social Insurance Scheme for the Poor or JAMKESMAS. JAMKESMES provides coverage of more that 80 million people in Indonesia. In 2009, 900 hospitals in the country had implemented the INA-DRG. Around 350 healthcare workers from the Department of Health, Indonesia and provincial and district level hospitals received training from UNU-IIGH.

Universal Postal Union (UPU)

The main action to be underlined in the framework of the Secretary General report is the worldwide awareness campaign on how to prevent HIV, launched on 7 July 2009 under the leadership of the UPU in partnership with the Joint United Nations Programme on HIV/AIDS, the International Labour Organization (lLO) and UNI Global Union (organization representing postal sector employees worldwide).

This coordinated effort between UN organisations and sector partners aims at raising awareness on HIV/AIDS prevention especially in developing countries by involving national postal operators, governmental authorities and social partners.

The campaign comprises three phases:

Phase I: raising awareness among post office customers.

This first phase will be carried out in two stages:

1. Pilot phase

On the basis of the presence in the field of partner organizations (UNAIDS, ILO and UNI Global Union) and UNAIDS statistical data, a list of seven pilot countries were drawn up (Brazil, Burkina Faso, Cameroon, China (People's Rep.), Estonia, Mali and Nigeria) for the launch of the campaign, which took place on 7July 2009.

The campaign in the seven pilot countries covered some 16,000 post offices and their customers.

For the campaign's first phase, the communication material prepared by UNAIDS with the help of the other partners was used (posters, leaflets, postcards, facts sheets).

A communication kit prepared by the UPU International Bureau's Communication Programme was made available to the seven pilot countries.

A survey conducted in the pilot countries showed that the campaign has been very successful indeed.

In this connection, the information collected for the following two African countries deserves special mention:

Cameroon

The country's postal operator, CAMPOST, held a number of press conferences and sent out press releases appearing on national and community TV and broadcasted on national and regional radio. The campaign was also featured on the CAMPOST website.

CAMPOST also distributed hundreds of T-shirts and thousands of leaflets and displayed campaign banners. With the assistance of Cameroon's National Anti-AIDS Committee (CNLS) in particular, free testing clinics were organized and female condoms handed out. CAMPOST has also introduced a support and assistance programme for its staff infected with HIV/AIDS.

Some figures:

Post offices involved: 258

Posters displayed: 1,300 UNAIDS posters and 300 CNLS posters

Leaflets distributed: 15,000

Persons reached by the campaign: some 40,000

Nigeria

Nigeria's postal operator (NIPOST) also made use of the media to launch its campaign and prepared a communication plan based on the model developed by the UPU International Bureau Communication Programme.

Governmental authorities (Ministry of Information and Communication, National Action Committee on AIDS) played an active role in the campaign.

Some figures:

Post offices involved: 3,871

Posters displayed: 10,000

Leaflets distributed to the public: 30 million

Persons reached by the campaign: 60 million

2. Extending the campaign to all UPU member countries

All UPU member countries will be invited to participate in this campaign during the second half of 2010. The objective is to have around 150 participating countries in order to achieve a global reach.

Phase II – AIDS prevention campaign aimed at postal employees

In many countries, the national postal operator is the biggest employer. The distribution of training guides, brochures and posters for the postal staff awareness-raising campaign is scheduled for the second half of 2010. In this second phase, the role of the ILO and UNI Global Union will be critical.

Phase III – Commemorative stamp issues in 2011

In June 2009, the International Bureau asked UPU member countries to include in their stamp programmes postage stamp issues commemorating the 30th anniversary of the fight against AIDS in 2011.

This campaign is part of the UPU's ongoing effort to promote sustainable development and social responsibility among postal administrations.

At the press conference on 7 July 2009 organised at the Palais des Nations (Geneva) with the Executive Heads of ILO, UNI Global Union and UNAIDS , Mr. Edouard Dayan, Director General of the UPU International Bureau, summarized the UPU's desire to take a position on health issues as part of its overall mission:

"With 660,000 post offices around the world, the postal network is the ideal partner for this campaign. This is the biggest health-related awareness-raising campaign ever launched worldwide by the postal sector, a perfect example of its ability to communicate to millions of people and the value of the universal services that it provides. The campaign is an excellent example of what UN partners and the Post can do to help achieve a Millennium Development Goal – to check the spread of HIV/AIDS and begin to reverse the current trend by 2015."

World Intellectual Property Organization (WIPO)

WIPO has a central role in the international policy debate on intellectual property (IP) in the context of public health. In cooperation with its international partners, WIPO serves as a source of solid, technically sound and neutral information on current policy issues.

WIPO has been actively assisting countries in the implementation of their intellectual property (IP) legal system, which also includes examination in respect of the multilateral legal framework, such as the Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS) and its developments, namely, the Doha Declaration on the Agreement on TRIPS and Public Health, and the Decision of the World Trade Organization (WTO) General Council of August 2003. In this context, during the period from October 2006 to September 2009, legal advice, comments and draft laws were provided in response to requests from the authorities of 49 countries[35]. During the same period, advisory missions and outreach missions on IP laws were undertaken

[35] Afghanistan, Andorra, Angola, Argentina, Bangladesh, Bhutan, Bosnia & Herzegovina, Botswana, Brunei, Cambodia, CARICOM, Central African Republic, China, Colombia, Costa Rica, Djibouti, Dominican Republic, Ecuador, El Salvador, Equatorial Guinea, Grenada, Honduras, Indonesia, Lebanon, Maldives, Marshall Islands, Montenegro, Nepal, Nicaragua, OAPI, The Pacific Forum Islands, Pakistan, Panama, Paraguay, Peru, Rwanda, the S.A.D.C. Countries, Senegal, Seychelles, South Africa, St. Lucia, Thailand, Trinidad and Tobago, Turkmenistan, Ukraine, United Arab Emirates, Uruguay, Viet Nam and Zanzibar.

in 15 countries[36], mainly to discuss new or revised legislation with the government authorities concerned, or to consult on specific topics of IP law. Special attention has been given to the role played by patents as a component of innovation policies, and their relationship with other policy areas, such as health and health research policies and, in particular, policies aiming to improve access to medicines.

The legislative implementation process and, particularly, how policy options and flexibilities[37] have been incorporated into the national laws of Members, vary from one region to another, and within one region from one country to another. Implementation of the TRIPS Agreement in an important number of developing and least-developed countries (LDCs) started before the Agreement entered into force. For example, in respect of the 2000 deadline, 28 developing country Members completed their implementation process in advance, 22 developing country Members introduced outstanding legislative reform, and 13 LDCs implemented legislative reforms in advance of the mid-2013 deadline applicable to them. Some developing countries had TRIPS compatible legislation in place well in advance of the 2000 deadline, such as Chile, Mexico and South Korea. In the case of LDCs, the situation varies markedly: while some countries who have the right to use the transition period have not yet adopted implementing legislation, others passed implementing legislation ahead of the initial 2006 transition period (for example, 12 Francophone Member States of the *Organisation Africaine de la Propriété Intellectuelle* – OAPI, which are bound by the revised Bangui Agreement (2002)). It may further be noted that Cambodia and Nepal committed themselves to apply the TRIPS Agreement before the 2013 deadline.

In order to sensitize policymakers, stakeholders and users of those policy options, WIPO has organized a number of national, regional and international seminars and workshops on flexibilities and public policies in the patent field[38], occasionally in association with other international organizations, such as WTO.

To facilitate factual exchange of views and experiences and to further develop relevant studies, WIPO has convened and will continue to convene a series of highly topical public policy symposia focused on current cross-cutting issues dealing with the interface of intellectual property and the global challenge of public health. Among those meetings the following can be highlighted:

-Symposium on Current Issues in Intellectual Property and Public Health[39], September 19, 2007;

-Symposium on Intellectual Property and Life Sciences Regulation[40], November 16, 2007;

-Symposium on Public Policy Patent Landscaping in the Life Sciences[41], April 7 and 8, 2008;

-Symposium: Public Sector Intellectual Property Management[42], December 15, 2008; and

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[36] Afghanistan, Botswana, Colombia**,** Costa Rica, Dominican Republic, India**,** Maldives, Pakistan, Panama, Peru, Rwanda, Spain, Syria**,** Uruguay and Trinidad & Tobago.
[37] For further information, see at http://www.wipo.int/ip-development/en/legislative_assistance/advice_trips.html.
[38] From October 2008 to October 2009, 8 national and 3 regional seminars were organized on the issue of flexibilities, as well as the Conference on Intellectual Property and Public Policy Issues, held in July 2009, in Geneva.
[39] at http://www.wipo.int/meetings/en/2007/lifesciences/sym_health/.
[40] See at http://www.wipo.int/meetings/en/2007/lifesciences/sym_regulation/.
[41] See at http://www.wipo.int/meetings/en/2008/lifesciences/patent_landscaping/.
[42] See at http://www.wipo.int/meetings/en/2008/lifesciences/ip_lss3_ge/.

-Symposium on the Evolution of the Regulatory Framework of Test Data – from the Property of the Intellect to the Intellect of Property[43], February 8, 2010.

WIPO has the goal to provide unique insights into this area of significant policy concern, *i.e.* through promoting the analysis of patent landscapes[44] with the view to make information stemming from the IP system more widely and easier available and through explaining how the tools provided by the IP system may work for the benefit of public health and where may be the limitations. Tailored briefings and policy analysis are provided upon request on numerous occasions for diplomats, officials of cooperating inter-governmental organizations (IGOs), regional bodies, postgraduate students and academics, national experts and industry groups. For example, WIPO contributes extensively to WTO capacity building workshops dealing *inter alia* with intellectual property aspects of public health in the context of the implementation of the WTO TRIPS Agreement.

Following a proposal by the Standing Committee on the Law of Patents (SCP) at its 12th session held in June 2008, WIPO organized an international Conference on Intellectual Property and Public Policy Issues held in Geneva on July 13 and 14, 2009. The Conference had the objective of addressing issues relating to the interface of IP with other areas of public policy, such as public health, the environment, climate change and food security. It also aimed at serving as a forum for public policy debates on the role of IP and the balance between innovation and access to new technologies. The Conference also created opportunities for WIPO to deepen collaboration with other IGOs, such as Food and Agriculture Organization (FAO), the United Nations Framework Convention on Climate Change (UNFCCC), the World Health Organization (WHO), the World Meteorological Organizations (WMO), WTO as well as with private sector stakeholders, NGOs and academia.

WIPO is committed to providing judicious input to international policy processes, responding to growing demand. In this regard, the cooperation and the dialogue with WIPO's international organization partners, such as WHO, WTO and the United Nations Conference on Trade and Development (UNCTAD), and also with regional and national organizations as well as with NGOs, the private sector and academia is an important aspect of WIPO's work in the area of public health.

WIPO has engaged actively with WHO in the context of the adoption of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (GSPOA). WIPO works actively with WHO and WTO to identify and provide its contribution to the implementation of the GSPOA. To this effect and following a meeting of the Directors General of the three Organizations held in 2009 and an exchange of letters in regard of cooperation for the GSPOA, the three Secretariats have established an informal work plan and are meeting regularly with a view to pool resources and efforts in that direction.

Furthermore, WIPO supports with its IP expertise the Intergovernmental Meeting (IGM) on Pandemic Influenza Preparedness: Sharing of Influenza Viruses and Access to Vaccines and other Benefits, and upon request by WHO pursuant to WHA Resolution 60.28, WIPO has contributed a "Working paper: Patent issues

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[43] See at http://www.wipo.int/meetings/en/2010/wipo_ip_lss1_ge_10/.
[44] For further information on patent landscapes at WIPO, see at http://www.wipo.int/patentscope/en/dbsearch/analysis.html.

related to influenza viruses and their genes". The working paper is published on WIPO's website, and is also available from the WHO Avian Influenza Website.

WIPO is equally engaged in providing IP expertise to the initiative of the Special Programme for Research and Training in Tropical Diseases (TDR) to set up the African Network for Drugs and Diagnostics Innovation (ANDI), the African Union Pharmaceutical Manufacturing Plan for Africa, and the UNITAID Medicines Patent Pool Initiative that aims at establishing a voluntary patent pool for medicines with an initial focus on increasing access to newer antiretroviral medicines (ARVs) and encouraging the development of new formulations.

World Meteorological Organization (WMO)

WMO participated in setting up of the Social Protection Floor initiative, one of the nine Chief Executives' Boards for Coordination (CEB) initiatives elaborated within its High Level Committee on Programmes (HLCP) to addressing the global financial and economic crisis.

ILO and WHO are lead agencies at the global level. Leading and cooperating agencies may vary at the country level based on which agencies are best equipped to lead the SPF Initiative in concrete country contexts.

WMO stressed the importance of linking disaster risk management and SPF initiatives at national level, so that various vulnerabilities are appropriately taken into account when identifying communities to be targeted in priority. WMO also highlighted the benefits of educating those communities to optimally use the information on risks they should receive, including early warnings related to disasters caused by natural hazards or climate conditions as determining factors for increased exposures to health threats like epidemics.

UN Resident Coordinators will be responsible for the initiation of a national SPF task force where governments have requested assistance from the UN System to support the development of national SPF plans. In countries where a Social Protection country team already exists, the UN Resident Coordinator should advocate for the group to pursue the SPF approach and integrate the national SPF tasks force with the existent group. WMO will sensitize the Permanent Representative with WMO of pilot countries to this initiative, to associate National Hydro-Meteorological Services to the set up and implementation of the project, so that proper and timely weather, water and climate information, products and services are made accessible.

Chapter III Analysis of UN country-level experiences

Food and Agriculture Organization (FAO)

FAO has joined the UN country teams on HIV and AIDS in a number of countries, in order to provide technical support to member governments for capacity-building, and policy formulation to meet national development objectives and mitigate the impacts of AIDS on agriculture and the wellbeing of farmers. Countries that have received such assistance from FAO include the Lao PDR, Malawi, Myanmar, Nepal, South Africa, Tanzania, Zambia and Zimbabwe.

The task of promoting rural residents' health is often much more complicated than promoting health of urban people. In addition, to lower density and poorer quality of rural health infrastructure, key challenges include inadequate funding for health services in rural areas and the continued lack of institutional and technical capacities within national Ministries of Agriculture and Ministries of Health to effectively dovetail agriculture-based interventions with public health measures.

Proposed input from the One Health Agenda

Country level support will focus on capacity development and improved cross-discipline cooperation. National capabilities are required to ensure that disease emergence events are addressed in conjunction with the challenges posed by poverty reduction, natural resource management, sustainable agriculture and rural development. Thus, disease emergence is not just about the risk that a pathogen jumps from the animal to the human host. Disease emergence, viewed in the continuum of natural resource management, land utilization pattern, farming systems, food distribution and marketing, will reveal the options available to address the root causes of aggressive pathogen spread and host species jumps.

In practical terms, FAO seeks to assist its Member Countries, both on an individual basis and as regional clusters, in accordance with their trans-frontier ecosystems and market links, in generic One Health capacity building, expanding on the improved infrastructure and staff capabilities established in recent years in both early detection of and response to influenza viruses. Apart from disease transmission dynamics, risk assessment now comprises disease impact profiles and identification of drivers of disease emergence. Risk management will have to rely on the blending of insights obtained from epidemiology, agro-ecology, socio-economics and communications, so as to duly incorporate the notion that poor people are often disproportionately affected both by emerging diseases as well as chronic disease burdens.

Some farming landscapes are innately more resilient to disease invasion. Farming systems and the agricultural intensification process play a main role in pathogen evolution. Increases in host abundance select for pathogens displaying enhanced transmission. Epidemic forms of disease go hand in hand with viral jumps and spill-over to novel host types. Smallholder herds or flocks do not usually trigger the new emergence of aggressive pathogens. Neither do isolated industrial animal production plants. However, the reality usually entails a mosaic of farm types and holding sizes, generating complex networks of off-farm food chain interactions supporting new emerging pathogen transmission.

Disease emergence results from human action. Comprehensive risk management implies that adequate attention goes to the nexus of sometimes conflicting health, socio-economic and environment related objectives. Where disease control and prevention become integral components of wider development efforts, people rather than pathogens take the centre stage.

International Labour Organization (ILO)

The work of UN country-teams to promote health at the country-level provides opportunities for a more comprehensive and integrated response in support of national efforts. Governments and employers' and workers' organizations worldwide are taking innovative and far reaching steps to make maternity protection,

social health protection, and decent work for health workers a reality. This includes ILO participation in the One UN reform process.

In China and Nepal, ILO forged public and private partnership that mobilized civil society organizations to raise HIV awareness and promoted employment skills for people living with HIV.

In the United Republic of Tanzania (URT) and *Mozambique*, ILO addressed maternity protection issues and the working conditions of health care workers through the application of practical workplace tools and approaches to the improvement of working conditions. As part of a joint UN programme on maternal and newborn health, materials for raising awareness of the legal framework of maternity protection were developed, as well as occupational safety and health profiles for pregnant and nursing women working in the textile sector, agriculture and street cleaning.

In Jordan, the ILO provided technical assistance and worked closely with the government, employers and workers to provide guidance on the feasibility of a fair and affordable maternity cash benefits scheme within the national social security system.

In India, the government is set to provide women with maternity benefit during pregnancy and six months after, while they are lactating. The scheme is intended to promote health and partly offset the wage loss women may incur during the prenatal period, and is part of a larger effort to reduce maternal and infant mortality.

In Cambodia, garment factory owners are working with employers' organizations and the ILO to strengthen awareness and promote implementation of maternal protection, health, and breastfeeding measures through factory-based training, information materials and a nationally televised soap opera series on workers' rights and responsibilities.

In Peru, trade unions and the ILO are working to raise awareness and build capacity on maternity protection with the aim of promoting social security reform. Extending maternity protection to atypical forms of dependent labour, in accordance with Convention No. 183 is a key component of the proposed reform.

In Uruguay a tripartite commission on equal treatment and opportunities was created in 2008 and committed to promoting guarantees for maternity rights and measures to promote a balance between economic activities and maternity and paternity.

In Sierra Leone, the ILO and its constituents have developed a Decent Work Country Programme and worked with the National AIDS secretariat to increase awareness and access through the workplace to services on the prevention of mother to child transmission of HIV/AIDS (PMTCT). Through these efforts healthcare workers in workplace clinics have been trained to offer complete HIV services, including voluntary confidential testing, antiretroviral therapy and PMTCT services.

International Maritime Organization (IMO)

The Pacific Islands have an estimated 4,000 seafarers and over 40,000 fishermen serving on various types of ships and fishing vessels. With regard to MDG 6, seafarers, fishermen, their families and those associated with the industries, are among the most vulnerable groups at increased risk of HIV/AIDS infection in the

Pacific Islands region. In addition, seafaring/fishing ports have been clearly identified as risk settings in many countries within the region.

United Nations Development Fund for Women (UNIFEM)

UNIFEM brings gender equality and human rights perspectives to its work on women and HIV/AIDS. Highlighting the contributions and perspectives of HIV-positive women, and with an emphasis on reducing discrimination, the fund spearheads holistic strategies that make clear links to violence against women, feminized poverty, security and women's limited voice in decision-making. UNIFEM works with UNAIDS and other UN partners, national AIDS councils and civil society organizations, particularly networks of HIV positive women, to secure gender-responsive policies, strategies and plans to address the pandemic. In 2008, UNIFEM contributed to the integration of gender equality and women's rights into National Strategic Plans and/or Frameworks on HIV/AIDS in 19 countries. Of the 19 countries supported in 2008, UNIFEM provided 8 National AIDS Councils with gender experts to ensure on-going technical support for the review of their National Strategic Plans. In 12 countries, UNIFEM supported policy and programme staff in national AIDS coordinating authorities to identify the specific actions required to implement gender-responsive national AIDS plans; provided support to four countries to include gender equality priorities in proposals to the Global Fund to fight AIDS, Tuberculosis, and Malaria; and helped build linkages between national women's machineries and national AIDS coordinating authorities in four countries where these links were weak or nonexistent. UNIFEM's support to HIV+ women's networks and organizations is geared towards amplifying the voices of these organizations in shaping policies, programme, and resource allocations in the AIDS response. Working towards highlighting the contributions and priorities of women living with or affected by HIV/AIDS, UNIFEM provides technical support to enhance the leadership and participation of women in the response. As the voices and participation of women are vital to programme development, implementation, and monitoring UNIFEM has worked directly with HIV positive women's groups and networks in over 20 countries and has shaped their priorities, and created, for them, access to spaces to meaningfully participate in national responses. Some specific examples of results include:

1) Example of HIV+ women advocating for free diagnostic tests and services in hospitals in Tamil Nadu, India:

HIV-positive women's groups in Tamil Nadu India have been working to address stigma and discrimination in healthcare facilities. Through their leadership and participation in policy-making bodies, when government hospitals privatized a range of diagnostic and screening services, obliging people to pay special fees, PWN+ (Positive Women Network) advocated with the Tamil Nadu State AIDS Control Society to address this issue. Such fees were far beyond the reach of many people living with HIV, who are particularly vulnerable to infection and disease requiring such screening. PWN+, supported by UNIFEM, was successful in their efforts. The Tamil Nadu State AIDS Control Society issued a policy directive that charges be waived for people living with HIV, and arranged to pay the costs themselves. PWN is monitoring the situation closely, making sure that hospital personnel receive copies of the Society's directive and do not seek to demand the fees. In an ILO study in conjunction with national and state AIDS organizations in Maharashtra, Tamil Nadu, Delhi and Manipur to study the impact of HIV/AIDS on the affected households, it was found that 37% depleted their

savings for treatment, 23% borrowed money and 2% resorted to selling their physical assets as a final resort[45]. In Tamil Nadu, networks and organisations of Positive People have been actively involved in providing inputs in policy planning to better management and adherence to ART. TNSACS has aggressively promoted the participation of all those affected," says S. Vijayakumar, former Project Director, TNSACS. NGO representatives agree. "Tamil Nadu is one state where there is good involvement of Positive People in policy making," says Dr. Suniti Solomon, director of YRG Care, Chennai, a pioneer in HIV and AIDS care and support. "The administration involves Positive People in the technical advisory meetings and the joint appraisal committees which go through all project proposals submitted for state support and funding[46]."

2) Example of increasing men's involvement in care and support through "Gender Empowerment Zones" in Zimbabwe

In Zimbabwe, through targeted advocacy, with traditional male leadership and raising awareness of the gender and human rights dimensions of HIV/AIDS, the initiative in the Nyahunure community of Mutoko district succeeded in transforming gender relations, evidenced by a 40% increase in the enrollment of men as care-givers in home-based care programmes for community members infected with AIDS. In 2002 the Nyahunure ward, a rural community in Mutoko District in Zimbabwe, was selected as the location of the UNIFEM-supported Gender Empowerment Zone. The ward had previously participated in a UNIFEM-funded economic empowerment project that revealed the effects of HIV/AIDS on women's economic security and rights, an issue addressed by the GEZ initiative. When UNIFEM began the programme, men did not participate in home-based care programmes at all. Support by the traditional, male leadership for addressing the issue of gender-based violence in schools resulted in the establishment of the Girl Child Network in the community, which promoted peer-to-peer learning for girls within district-level schools. Women's roles and participation in leadership positions in the community also improved with the inclusion of 3 women living with HIV/AIDS in the Ward AIDS Action Committee (at the community level) and a woman living with HIV/AIDS being elected to the District AIDS Action Committee. Over a period of three years, the community saw a reduction in stigma and discrimination, evidenced by the increase in women and men requesting voluntary counseling and testing of their HIV status; an increase in male participation in community mobilizing on HIV/AIDS; and increase in women's role as decision-makers in the response to HIV/AIDS.

United Nations Development Programme (UNDP)

UNDP's efforts to strengthen health systems within the broader context of systems that include education, social protection and development planning are cost-effective because it leads to benefits not only in health but across multiple MDGs.

To help the Kosovo Government use the MDGs as a tool for improving mother and child health, UNDP and the UN Team prepared a baseline MDG Report. A subsequent report provides an analysis of the probability of Kosovo achieving the MDGs by 2015. Another joint initiative of UNDP/UNV, UNFPA, WHO, OHCHR and

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[45] UNAIDS and ILO Report 2003. *Socio-economic Impact of HIV/AIDS on People Living with HIV/AIDS and their Families*, Study conducted by Delhi Network of Positive People, Manipur Network of PLWHA, Network of Maharashtra by PLWHA and Positive Women Network of South India. Quoted in "The Impact of HIV/AIDS on Women Care Givers in Situations of Poverty: Policy Issues", Aasha Kapur Mehta and Sreoshi Gupta, Indian Institute of Public Administration, 2006

[46] Panos India 2007 "Antiretroviral drugs for all? Obstacles in accessing treatment Lessons from India"

UNICEF provides support to local authorities, civil society and local communities in using a bottom-up and rights-based approach to restore basic services, rebuild local economies and increase social cohesion and stability. In Croatia, the UNDP-based Theme group on HIV/AIDS has three programmatic pillars: (1) supporting National AIDS Commission in implementing a National AIDS Strategy; (2) Strengthening HIV and AIDS surveillance nationally and regionally; and (3) human rights. Together with the UNCT in Macedonia, UNDP is supporting an assessment on the health impacts of climate change which will be used to develop a national health adaptation strategy to climate change.

Through its post-conflict recovery programmes, UNDP is supporting the reconstruction and rehabilitation of health facilities in several African countries. In Eritrea, UNDP is assisting with the provision of shelter, sanitation, and safe water through its integrated multisectoral programme for the resettlement of internally displaced people. In Burundi UNDP is working with national partners to develop an early recovery program that mainstreams HIV activities into broader economic development and recovery efforts. The programme is also focusing on reducing food insecurity, improving access to basic social services, and strengthening local governance and human rights. Other countries that are benefiting from UNDP support in the mainstreaming of HIV/AIDS into national development strategies include Rwanda, Botswana, Lesotho, Kenya, Mozambique and South Africa.

UNDP, in partnership with the EU, is implementing an initiative to strengthen integrated primary health systems and service delivery in Bangladesh. In Indonesia, UNDP has assisted the formulation of a National HIV/AIDS Strategy and supporting legislation. People living with HIV/AIDS are also benefiting from training opportunities that equip them with business skills. In Myanmar, UNDP is providing training programmes that educate villagers on family planning, HIV/AIDS, the use of contraceptives, preventing malnutrition and common diseases. Schoolchildren are trained in the use of latrines and the importance of clean water and hands in preventing diseases. The project also helps communities' access safe drinking water by upgrading existing supply systems or building new ones.

In Morocco, WHO, UNICEF and UNDP are collaborating to support a $2 million joint- programme which will strengthen the Ministry of Health's ability to monitor and evaluate aid coordination, partnership and resource mobilization components of the National Health Action Plan 2008-2012. UNDP is supporting the Tunisian Ministry of Health in the implementation of the national maternal health strategy while WHO, UNICEF and UNFPA are facilitating national and region-specific data on maternal mortality to facilitate the monitoring of MDG5, improve the quality of prenatal and neonatal care and reinforce the capacities of health workers in terms of communication methods, and innovative training.

Also noteworthy are the efforts in Serbia to ensure health security for UN staff and their dependents. Through the UNCT's Health in Emergencies Theme Group, the UNCT is reviewing and assessing health hazards and risks and developing tools on prevention and available treatments during emergencies, crises and disasters.

Governments and employers' and workers' organizations worldwide are taking innovative and far reaching steps to realize decent work and make maternity protection, social health protection, and decent work for health workers a reality. This includes ILO participation in the One UN reform process.

United Nations Education, Scientific and Cultural Organization (UNESCO)

To strengthen UNESCO's capacity to respond to Member States in coordination with other UNAIDS Cosponsors and other key stakeholders, UNESCO has strengthened its technical capacity at the country-level by recruiting and training additional national staff working on HIV and AIDS. Orientation and guidelines have been developed to assist the newly recruited national staff to improve understanding of EDUCAIDS, identify country-level priority actions to support comprehensive education sector responses to HIV and AIDS, identify technical support needs, and develop and strengthen coordination, collaboration and partnerships with other key stakeholders at country level.

United Nations Population Fund (UNFPA)

National processes, priorities and plans increasingly form the basis of United Nations Country Teams (UNCT) programming. UNCTs are increasingly aligning their Common Country Assessments (CCAs) and United Nations Development Assistance Frameworks (UNDAFs) with national processes which are a process that catalyzes harmonization among the various UN agencies as well. In practice, increasing alignment and harmonization at the country level has resulted in a shift from project-based approaches towards joint support for country owned programs and a corresponding focus on strengthening national systems. In terms of modalities, it has involved pooled-funding arrangements (e.g., UNFPA, UNICEF and WHO jointly contributing to the health-sector pooled fund in Tanzania); sector budget support, harmonized technical assistance and joint missions. In particular, it has also involved specifically joint UN-programming, notably in the context of initiatives such as the Health 4, the International Health Partnership, Harmonizing Health in Africa and the Social Protection Floor.

In terms of the Health 4 Agencies, strengthening collaboration and coordination in the area of Reproductive, Maternal and Newborn health has involved joint work in Ethiopia with the development of a 2-year work-plan (2010-2011) together with the Ministry of Health to support the national health plan to address the three pillars of maternal mortality reduction strategies. In Bangladesh, this has resulted in carrying out a preliminary analysis of maternal and newborn health (MNH) and reproductive health (RH) situation and the current support provided by the four agencies. Further activities will include identifying and analyzing MNH/RH gaps as well as required interventions and remedial actions and potential support from the H4 Agencies. In light of the devastating earthquake in Haiti, the Health 4 Agencies are working collectively together to further coordinate activities, complement efforts and synergize initiatives in support of MNH/RH with a focus on re-building and re-enforcing the health system. The emphasis is on the delivery of a comprehensive package of services (MNH/RH, Nutrition, Adolescent & Youth, HIV/AIDS, Immunization, etc) and multi-sectoral approach to escalate efforts.

The lessons and experiences to further scale-up existing activities are well acknowledged and documented, including in the 2009 ECOSOC Ministerial Declaration. The issue is rather how to further escalate efforts and translate actual commitments into actions that are tangible and can be implemented. This includes investing in high-impact interventions and linking resources to actual needs, which are substantial in many countries, while at the same time they require a long-term investment and commitment, particularly in the area of Health System Strengthening. Development Partners need to fulfill their existing commitments to Health, including those made at Monterrey and Gleneagles while countries need to ensure that sufficient and increasing domestic

resources are programmed to the health sector to deliver better health outcomes. The emphasis on nationally-led processes and supporting national health plans and strategies is critical, while at the same time ensuring that such plans and strategies can be implemented with transparent budgeting, effective monitoring & evaluation and inclusive, that is, involving all stakeholders, including civil society organizations. In terms of strengthening national capacity, more emphasis and documenting of experiences on South-South collaboration and the strengthening of regional and national institutions in support of country needs is also important. Addressing aspects of equity while promoting the role of young, poor and vulnerable populations within existing activities and strategies and at the same time ensuring that communities are fully engaged in their own health care is critical in bridging the substantial blockages between the supply and demand-side. The issue of fragile States and post-conflict countries and their specific needs requires better positioning within the global health agenda.

World Food Programme (WFP)

Adding a preventive approach to WFP's traditional curative one for moderate acute malnutrition is challenging. The costs and benefits of preventive approaches are often not well understood. WFP and others often struggle to quantify the benefits from preventing malnutrition as opposed to treating it. Donors and others at times misinterpret prevention as poor targeting.

WFP has observed that in countries with HIV care and treatment services in early stages, such as Congo, that the achievements and effectiveness of food assistance, being an integrated and complementary component to basic health services, is highly dependent on the roll-out of the health services themselves. Where national/government efforts are lagging behind, food assistance cannot, as a stand alone intervention, provide a useful contribution.

In countries with significant coverage of treatment for HIV and TB, referral to nutritional support is usually made through the health sector. Operationally interventions are carried out under the umbrella of or outside the health sector. An already stretched health sector often struggles with the logistics of food distribution.

There is a need for coordinated advocacy and consultation on issues around HIV, food and nutrition to create common understanding of linkages and priority actions. WFP's engagement in innovative initiatives such as food fortification (Tanzania), and introduction of voucher systems to provide social (food security) assistance to clients in health programmes (Zambia, Mozambique), is an important avenue to introduce new perspectives.

A lack of basic appreciation of linkages between HIV, food and nutrition among national stakeholders hinders effective consultation on strategic intervention priorities. The national strategy/plan for development has to be grounded in formative/learning activities to ensure adequate and equal knowledge/insights among all involved stakeholders including NACs and those who control the national budget.

WFP programmes in Eastern and Southern Africa are increasingly modeling approaches that reflect the national implementers' realities in terms of mandates, costs, institutional and human resource requirements, and other such determining factors such as to advocate national ownership, replicability and scalability.

Finally, there still is too little evidence on what products are best suited to address the nutritional needs of people on HIV and TB treatment. It is still not fully understood, for example, why TB patients struggle to rebuild lean body mass even after they have been treated and cured. As of now, there are no food products which have been specifically developed for people treated for HIV and TB. For treatment of malnutrition among HIV and/or TB infected adults, the same nutrient intake guidelines are used as for non-infected malnourished adults.

WFP's Executive Director, Ms. Josette Sheeran, has clearly stated WFP's commitment to being a leading force in helping affected countries fight hunger and under-nutrition. REACH is the name of the WFP-, UNICEF- and WHO-led partnership to accelerate progress towards MDG 1 in countries of highest under-nutrition burden and prevalence. The goal of REACH is a documented reduction, by 2015, in the proportion of underweight children globally, in line with MDG1. In late 2008, the four heads of these agencies signed a joint letter to all offices worldwide, confirming their commitment to this broad partnership and promising full support for coordinated efforts to make a durable impact on child under-nutrition. An inter-agency team hosted by WFP in Rome has been formed to support coordination among REACH partners, and includes in-kind contributions of staff from WFP, UNICEF, WHO, FAO and NGO partners, working with private sector and other civil society partners and in alignment with the World Bank. During 2008 the REACH partnership achieved the following:

-refined promoted interventions according to new evidence;

-developed methods and tools to support countries in situation and readiness analysis, intervention prioritization, costing and action planning;

-launched pilots in the Lao People's Democratic Republic and Mauritania to demonstrate that significant, immediate impact on under-nutrition is possible;

-created knowledge products capturing country experience and lessons learned for implementing interventions at scale;

-developed a vision for knowledge-sharing among countries about what works in addressing under-nutrition, and how countries can replicate successes;

-convened key partners to coordinate international and regional nutrition efforts.

WFP will continue during 2010 to host the REACH partnership, with a focus on extending support to additional countries for action planning and practical knowledge-sharing, as well as broadening the partnership further.

WFP has become a key partner in the international dialogue between nutrition scientists and programming experts, and part of joint statements on nutrition with WHO and UNICEF. This global dialogue and agreement is essential for advocacy and seeking permission from host governments for the use of new products and delivery modalities. WFP's recently published *'10 minutes to learn'* series about new topics in nutrition are also good advocacy tools and explain nutrition relevant issues to donors, programming professionals and decision makers. However, further evidence with respect to the cost-effectiveness of specific approaches and

/or commodities needs to be collected in order to convince donors and governments to support a full-fledged scaling up of such activities.

At the regional level, WFP has engaged in consultations with FANTA and the supply chain management system project to explore increase procurement, handling and quality assurance of Fortified Blended Foods for use in expanding Food-By-Prescription programmes. WFP Tanzania, Zambia and Uganda have actively explored, with local USAID missions, WFP's operational and technical support to strengthening local supply systems for provision of specialized food products to health sector based programmes. WFP also needs to continue to pursue local production of such food products to add to its successful experiences in a number of countries.

WFP's lead role in nutritional support in the UNAIDS Division of Labour (DoL) and in accordance with outcome areas 3 and 4 of the UNAIDS Joint Outcome Framework (JOF) will involve continued leadership in the delivery of food assistance and nutritional support and in enhancing national actions through advocacy, guidance and technical support. WFP colleagues have provided technical and operational insights relevant for the development of national strategies and intervention protocols. Specific areas of engagement include national HIV/AIDS strategic plans and HIV and nutrition protocols and guidelines. HIV, food and nutrition considerations are also increasingly reflected in PRSPs and national food security and nutrition strategies in East and Southern Africa (Burundi, Congo, Djibouti, Ethiopia, Kenya, Madagascar, Mozambique, Rwanda, Swaziland, Uganda, and Zimbabwe).

To overcome resource constraints, WFP is focusing on the inclusion of food and nutrition in global funding streams. At the country level, multilateral funding through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) are new opportunities for expanding food and nutrition support for HIV programmes. For example, in Burkina Faso, WFP has implemented a food support programme with the GFATM.

WFP has been actively engaged in developing implementation plans for the roll out of activities under Round 7 grants such as the expansion of food assistance programmes in Ethiopia, transport sector HIV/AIDS awareness and support services in DRC, and in Somalia, WFP provides complementary food assistance to activities funded under Round 7.WFP has also played a critical role in the preparation of proposals for Round 8 and Round 9 of GFATM, ranging from technical assistance and backstopping to intense engagement in the proposal writing and Country Coordinating Mechanisms (CCMs) process.

WFP can help advance the debate on and deepen understanding of the nutritional needs of PLHIV and their family members, working together with UNAIDS and advocating with major funding mechanisms such as PEPFAR and the Global Fund. WFP can help ensure that national and community-level HIV and AIDS programmes, especially treatment programmes, include gender-responsive nutritional components. WFP is also supporting and aims to promote more scientific studies that look at the efficacy and effectiveness of specially formulated food products for the nutritional needs of PLHIV.

Chapter IV Conclusions and recommendations

- **Next steps to promote the coordinated implementation by the UN system of the 2009 Ministerial Declaration and to advance health related MDGs**

Economic and Social Commission for Western Asia (ESCWA)

At the Western Asia Ministerial Meeting on "Addressing non-communicable diseases and injuries: major challenges to sustainable development in the 21st century" organized by UNESCWA in cooperation with ECOSOC and the WHO, in Doha on 10-11 May 2009, the ministers made several recommendations on how to address the problems of NCDs and injuries in the region. As these diseases and injuries, and their risk factors and determinants, are closely related to poverty and mutually reinforce each other, instruments such as the Millennium Development Goals and their indicators, if adequately expanded to reflect accurately the current burden of NCDs and injuries, provide opportunities for synergy between health promotion and development efforts.

According to health related priorities identified in the region, the UN system should support the countries in the Western Asia region in their efforts to integrate health into national sectoral strategies in all sectors (transport, trade, taxation, education, social planning and development, agriculture, urban planning, mass media, food and pharmaceutical production) instead than through health policies alone and to place NCDs at the forefront of efforts to strengthen health systems.. Prevention and control of NCDs and injuries can be achieved through low-cost, cost-effective approaches and should be mainstreamed into primary health care.

A very specific step the UN system could take is supporting the establishment of a Regional Ministerial Multisectoral Task Force to provide strategic and technical input and conduct external reviews of the progress made by the region with regards to NCDs and injuries, and the impact of initiatives on the prevention and control of NCDs and injuries. This establishment was recommended at the Ministerial Meeting.

Economic Commission for Africa (ECA)

Particularly in Africa, epidemics begin and endure as regional affairs, with infections criss-crossing poor-country boarders in difficult times, often emerging from isolated endemic zones. This reflects the underlying poverty and associated deprivation in many countries of Africa – also most prone to civil war and failed state conditions – in which disease flourishes while public-health capacity withers. Helping these "weakest-link" countries strengthen their within-country systems and capacities is clearly in the international public interest, alongside the more traditional Global Public Good (GPG) concerns about research on infectious diseases and early warning systems.

Economic Commission for Asia and the Pacific (ESCAP)

Preparing for the 2010 MDG Summit: Specific steps that the UN system should take to support developing countries, including LDCs and special needs countries (post-conflict and disaster-affected countries), in strengthening health systems in the context of current and emerging challenges. Taking into consideration that a multidisciplinary approach is imperative in strengthening health systems in the context of current and emerging challenges for achieving progress, the representatives of governments gathered at the above

mentioned meeting in Katmandu adopted a multi-sectoral framework for action that the UN system should support in the Asia and the Pacific region to address MDG's gaps. It includes the following:

-additional and sustained public investment to strengthen infrastructure, human resources and service delivery, especially at the primary health-care level;

-movement towards universal health-care coverage based on equitable and sustainable systems of financing, ensuring financial protection of the poor and excluded, as well as adequate attention to preventive and promotive health services;

-investing in developing comprehensive human resource strategies in order to ensure the availability of an adequate, skilled and motivated health workforce; these should include strategies for recruitment, deployment and retention in the public sector;

-generating reliable data on indicators, particularly at sub-national level to support evidence-based policy making;

-fiscal and administrative devolution as an important strategy for improving governance, performance and accountability in the health sector;

-engagement of both the private sector and civil society in a manner that contributes to national health goals.

Economic Commission for Europe (ECE)

The health effects of the environment remain a common and growing concern in the ECE region especially in relation to access to safe drinking-water and sanitation, air pollution, and injuries. While the burden of disease due to known environmental factors varies up to fourfold between countries, often a regional or sub-regional coordinated action is more suitable to tackle the socio- environmental factors influencing health.

Positive regional experiences in collaboration with other agencies suggest that wide participation across the UN system, the member States, the civil society and other international organization enables more efficient and successful outcomes in social-economic and health outcomes. Health risk factors are deeply intertwined including drinking water, poor sanitation and hygiene and air pollution, thus a multisectoral approach is essential for improving health outcomes. The presented existing programmes and the RCM working group on climate change address several environmental health related factors and are the most promising UN system activities to address health related issues in the ECE region.

Food and Agriculture Organization (FAO)

Recognition of the two-way relationship between human health and agriculture is vital. Morbidity and mortality of smallholder farmers affect patterns of agricultural production, while agriculture can also play a significant role in the emergence and spread of infectious diseases.

Coordination between the agriculture and health sectors is essential for an effective response to the challenges posed by ill-health in rural areas. In this regard, it is important to bring agriculture into the health agenda, and likewise health into the agriculture agenda.

Although AIDS is and will remain an important factor in shaping rural societies, it should be recognized that it is one of several critical factors affecting rural livelihoods. The scope of the epidemic goes beyond being solely a public health challenge, and highlights many of the social and economic inequalities that persist in rural areas of many poorer countries.

It must be recognized that despite the HIV prevalence rates are stabilizing or declining in many countries, the impact of AIDS will persist for many years to come. Thus, the epidemic must remain a priority on the international agenda and prevention, care, treatment and mitigation efforts must continue.

Inter-agency, as well as multi-sectoral, collaboration between the health and agriculture sectors is essential for an effective response to global public health challenges in order to reach the internationally agreed goals and commitments.

Proposed input from the One Health Agenda

FAO with its diverse disciplinary strength and mandate on food, nutrition and agriculture should be offered as a global One Health hub.

International Labour Organization (ILO)

The health workforce shortage limits governments' capacity to provide social health protection. Calculations based on the ILO Global Staff Related Access Deficit Indicator reveal that one-third of the global population has no access to health care due to gaps in the health workforce.

Public and private partnerships involving government, employers and workers help ensure the sustainable impact of investments in social health protection while protecting health and non-health sector workers.

Other measures should include:

-Improving the focus on effectiveness of joint efforts to generate sustainable national resources for extending social health protection, including tripartite governance in the context of the providing for Health and the Social Protection Floor initiatives.

-Improving maternity protection and health through the workplace, including the promotion of effective maternity protection for all women workers during pregnancy, childbirth and breastfeeding.

-Promoting decent work for health workers that are essential to improve the quality of and access to health services.

International Maritime Organization (IMO)

The Secretariat of the Pacific Community (SPC) has, through a partnership agreement with IMO, established seafarer centers in Tuvalu, Kiribati, the Marshall Islands, Solomon Islands, and Vanuatu, as part of a prevention and capacity development project. The centers provide a supportive and comfortable environment for seafarers and their families to receive assistance, guidance and information on HIV/AIDS and other Sexually Transmitted Diseases (STDs). The seafarer centers also act as an interface with national non-governmental organizations providing information and support on HIV/AIDS, other STDs and sexual health issues. Links with counseling and testing centers have been established to facilitate access to these services.

United Nations Development Fund for Women (UNIFEM)

Much is at risk, particularly for women who already account for half of all people living with HIV worldwide. In order to sustain and intensify the positive trends and move forward, programmes must be grounded in a commitment to the protection of the human rights of girls and women, must seek to empower them to protect themselves from infection, must meaningfully engage men and boys as partners in this effort, and should reflect HIV-positive women's voices and leadership. National AIDS responses must deliver on commitments that governments have already made, particularly in the 2001 *Declaration of Commitment on HIV/AIDS,* reaffirmed in the *2006 Political Declaration on HIV/AIDS,* as well as in various human rights treaties, especially CEDAW and international commitments on women's rights and development such as the Beijing Declaration and Platform for Action and Cairo ICPD Programme of Action.

The context of the economic and financial crisis makes it more important than ever for gender equality goals to be at the centre of responding to global health goals. The paucity of resources at this stage demands an emphasis on the quality of their use. Specifically, structural drivers which increase women's vulnerability of contracting HIV will be exacerbated under the current financial climate and thus prevention, treatment and care strategies should be adapted accordingly.

Recommendations:

1. Eliminate barriers to women's access to prevention, treatment and care: Barriers and constraints to accessing services that stem from women's socio-economic status in society need to be recognized and addressed. For example, due to family responsibilities, such as: child care, often women cannot travel distances to access free treatment; stigma and discrimination by health care workers affect women disproportionately; women do not control income in the household which lessens their ability to pay for costs associated with accessing treatment (i.e. user fees, costs for tests, transportation costs etc.[47]) Health care systems can employ a variety of measures in order to reach these women such as: provide mobile health centers, integrate services so that health care centers that are accessible (such as family planning clinics) provide broader treatment and care options; sensitize and train health care workers to the particular constraints and stigma facing women; eliminate user fees and costs for diagnostic tests; providing child care at health centers, and ensuring all members of a family receive necessary treatment (not just men).

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[47] See the following source for evidence: Nanda, Priya. 2002. .Gender dimensions of user fees: Implications for women's utilization of health care.. *Reproductive Health Matters.*
Elsevier. 10(20): 127-134.

2. Eliminate Violence Against Women (VAW): Violence against women is a fundamental violation of human rights and is a cause and consequence of HIV infection. Violence against women undermines progress in stopping HIV/AIDS transmission; directly affects women's access to services, including methods of protection; jeopardizes informed choice; and poses serious challenges to sexual negotiations, including the use of condoms. Women living with HIV are also subjected to violence as a result of their disclosure of their status, and often times are "blamed" for bringing HIV into the family. Stigma and intense discrimination result in women being forced out of their homes, and rendered homeless. Women in Kenya and Uganda, for example, told Human Rights Watch that they could not reach HIV testing and treatment centers because they had no money to travel or pay for care and were too afraid to ask abusive husbands for funds, or were not allowed to leave the home[48]. Information from NGOs and partners on the ground in countries like Thailand, Cambodia and Vietnam indicates that there are many women and girls whose knowledge of HIV prevention is good; who may be aware of the health care services available to them but yet they cannot take any action because violence or the threat of violence exists. It is increasingly difficult to ignore that fact that violence against women is both a cause and a consequence of HIV infection. HIV prevention efforts, therefore, must include strategies to address the inter-linkages between violence against women and HIV and ensure that violence against women is addressed as an integral priority of national AIDS responses and included in national AIDS plans and actions.

3. Support women affected by HIV and AIDS who are providing care: Caregivers, particularly women and girls, need more economic, technical, and social support for providing this essential yet too often unrecognized service – and this support must be made central to AIDS strategies. Concerted advocacy must call for governments to implement commitments to scale up and broaden social protection, strengthen health systems, provide resources and support to caregivers, and implement legal mechanisms to protect women's rights. A study of 15 African countries conducted by Helpage International suggests regular cash payments can improve the lives of the millions of children and older people affected by HIV/AIDS in Africa. The value of cash payments ranged from less than US$3 per month in Mozambique to US$111 a month in South Africa. In Zambia, for example, the monthly US$8 payment is targeted at the poorest 10 per cent of the population. More than half of these are older people, mainly older women, caring for orphans. One-third of those receiving the payment use it to generate more money, for example by buying chickens to breed or weaving baskets for sale[49].

4: Support Women as 'agents of change': There is a need for major investments in women's groups who can and do effectively transform agendas in ensuring women's rights are upheld. It is essential that all programmes, policies and strategies incorporate the experiences and voices of positive women – who are living the reality of HIV and AIDS. Their activism and leadership is what will lead to transformation needed to combat HIV/AIDS. National Strategic Plans on HIV/AIDS should ensure that stakeholder consultations include diverse representatives of women, including those living with HIV, and that women fully participate in making decisions and formulating policies. This will improve national AIDS responses, promote women's rights to participate and reduce the impact of HIV on women.

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[48] Human Rights Watch. 2005. "A Dose of Reality: Women's Rights in the Fight against HIV/AIDS.
[49] http://www.helpage.org/News/Latestnews/RegularcashpaymentshelpfamiliesaffectedbyHIVAIDS.

United Nations Development Programme (UNDP)

Strategic multisectoral action and promotion of governance and leadership are key elements for strengthening systems for health. The UN has a particularly important role to play in supporting governance and leadership in health particularly at country level. The UN can also play a key role in supporting governments in the formulation and implementation of national strategic health plans as the basis for the overall management of the public sector while ensuring that such plans are linked to appropriate multi-sectoral action.

Strengthening the national health system is a key to progress. If there is no nationally endorsed health sector strategic plan, the UN often faces a gap on how to move forward in a coordinated way. While support to governments in defining goals, strategies, donating drugs and vaccines, or acquiring technologies is important, these must be complemented by adequate infrastructure and appropriate systems to ensure timely and effective transfer of knowledge, management of medical supplies, and effective use of technology.

The success of strategies, investments or programmes is highly dependent on the quality of national leadership, which should ideally encompass technical expertise, political skills and high ethical standards – all of which are requisite for effective policy development and implementation. Emerging health challenges such as H1N1 require coordinated communication and health information management systems which many developing countries do not have. The UN should step up its efforts to organize training and emergency preparedness of these countries.

United Nations Education, Scientific and Cultural Organization (UNESCO)

The UNAIDS Outcome Framework and UNAIDS IATT on Education have been instrumental to the alignment of the policies, programmes and activities across the relevant agencies and sectors.

A monitoring and evaluation framework, accompanied by a set of core indicators, needs to be improved to measure the progress and outcomes of the coordinated education sector response to HIV and AIDS.

United Nations Population Fund (UNFPA)

-There is a strong need to maintain the momentum and ensure that global public health remains high on the international agenda, particularly in support of the health-related MDGs which require a substantial scale-up of efforts and resources.
-Strengthening health systems calls for a “continuum of care” and life cycle” approach, providing a full range of services that meets the individual’s needs, including adolescents, in an effective, efficient and affordable way, integrated into an essential Primary Health Care package. This would include maternal, newborn, and child health, sexual and reproductive health, HIV, malaria and tuberculosis which is costed and budgeted, and delivered by the health system. Integrating approaches to health service delivery and strengthening the linkages are critical for improving health outcomes and for lasting reductions including maternal mortality, HIV/AIDS, tuberculosis, malaria and under nutrition.
-Creating further opportunities to enhance the role, engagement and creatively partnering with civil society, including community leaders, and the private sector to strengthen health systems, in all spheres, including

provision, access and demand for services. This will facilitate a more inclusive approach for scaling-up and harmonizing efforts in the delivery of universal access and better health outcomes.
-Advance and escalate the harmonization and alignment agenda in support of national processes, building on the positive experiences which have resulted in stronger ownership, robust health plans, transparent budgetary processes, innovative financing and enhanced implementation.
-More concretely address the crucial role of gender equality, equity and equitable access to health services for the poor, and marginalized, in particular women, young people, and ethnic minorities, in accessing health services, including sexual and reproductive health, will be critical. This includes developing, strengthening and scaling-up efforts in support of social protection mechanisms and putting in place strategies that protect a minimum level of access to essential services and income security for all.
-Intensify efforts to strengthen governance, stewardship and mutual accountability anchored in a multisectoral approach and community-based involvement.

World Food Programme (WFP)

WFP needs to continue to advocate for the need to scale-up and improve existing nutrition interventions. To reach MDG 1, it is critical we break the intergenerational cycle of under-nutrition, which is being passed down from generation to generation due to poor nutrition in the early year's of a child's life with irreversible, life-long consequences. WFP and its UN partners need to make a better case for the cost-effectiveness of preventive approaches to address chronic hunger.

In HIV and TB, WFP needs to push for collecting more evidence on how nutritional support contributes to nutritional recovery and treatment success and what products are best suited to achieve those goals. This is a joint endeavor with many of WFP's UN partners, NGOs and private sector partners.

In order to effectively combat under-nutrition, WFP needs to continue to expand its collaboration with the private sector. WFP also needs to continue to raise awareness that the challenges are too big for governments, the UN and civil society alone to address them. Adequate private sector contributions are critical to achieve the MDGs.

Chapter V Other

United Nations Children's Fund (UNICEF)

Health

The Joint UN initiative to improve maternal and newborn health (H4), which was signed by the Heads of the four agencies (UNICEF, UNFPA, WHO and the World Bank) in 2008 to accelerate country support for improving maternal and newborn health (MNH), has become a key entity to reckon with in the achievement of MDGs 4 and 5. The H4 are active members of the Partnership for Maternal, Newborn and Child Health (PMNCH) Board, with the muscle to influence decisions and lead responsibility for the various work streams of the PMNCH work plan. UNICEF's Executive Director has been actively engaged in the Maternal Mortality

Campaign and participated actively in several related activities during the past year. Maternal health has certainly gained status as an organizational priority.

Although the H4 is prioritizing action in 25 priority countries with the highest burden of maternal and newborn deaths, it has decided to focus on 6 countries with the largest burden of maternal and newborn deaths as a first step. The six countries which account for 50 percent of maternal deaths include Afghanistan, Bangladesh, DRC, Ethiopia, India and Nigeria. Baseline assessment and mapping of on-going H4 activities in all 25 countries have been documented and further discussions held with the 6 high priority countries to discuss the development and/or operationalization of existing national strategic plans and technical support needs to facilitate the scale up of MNH interventions to achieve MDG 5. An operational plan has been developed and joint missions have been organized to support the development of national strategic plans for MNH in Ethiopia, DRC and Nigeria, working closely within the IHP+/HHA framework. Similar joint missions are being planned for Afghanistan, Bangladesh and India in the first quarter of 2009.

A partnership forum was organized on the fringes of the UN General Assembly to inform Partners about the activities of the H4. The Forum which was attended by about 40 agencies alluded to the critical leadership role of the H4 in achieving MDG 5 and the desire expressed by Partners to be aligned with H4 activities, joint planning and missions at all levels.

The H4 is increasingly working as a team at global, regional and country levels, as envisaged. Key challenges include the availability of resources to support country level implementation and scale-up. Strengthening organizational capacity at all levels with adequate human and financial resources will be critical to the achievement of MNH goals.

In accordance with the signed MOU with UNFPA and AMDD to support countries in improving emergency obstetric and newborn care, the three agencies in collaboration with WHO organized three regional orientation workshops for needs assessments in Accra, Ouida and Kuala Lumpur for Anglophone and Francophone Africa and Asia Pacific countries respectively in 2009. Subsequently, 12 countries have been supported in the conduct of EmONC Needs Assessments which are at various stages of implementation. Early implementers, such as Ethiopia, have used the outcome of the needs assessments to inform the development of their national strategic plans for MNH.

The joint WHO, UNICEF and UNFPA statement on Home Visits for The Newborn Child was launched during the July 2009 ECOSOC high level segment. The launch has been followed by the development of the relevant tools to support implementation in countries and regional training of trainer workshops. Training of community health workers in countries is ongoing as part of the roll out of the community newborn care program. Early implementers include Malawi, Uganda, Zambia and Zimbabwe.

Nutrition

The REACH partnership (Renewed Efforts against Child Hunger and Under-nutrition) aims to renew efforts against child hunger through addressing challenges to eliminating under-nutrition and accelerating progress towards achievement of the under-nutrition target of MDG 1. REACH was jointly established by FAO, WHO, UNICEF and WFP. It is a multi stakeholder partnership between the UN, civil society and the private sector.

The UNICEF Executive Board formally endorsed UNICEF's role in this initiative in 2007 after which UNICEF has continued to be a lead agency in this effort.

The partnership works at two levels: (1) at country levels to promote a facilitated, systematic process for joint action planning and implementation to scale-up proven interventions and identify synergies across partners; and (2) at a global level to create a knowledge-sharing platform for field practitioners to capture and disseminate successful operational practices from countries to effectively scale-up and integrate delivery of a package of interventions. By composition of its membership, the Initiative will demonstrate the importance of a multi-sectoral approach, through involvement of the health, agricultural, population, education and other sectors.

REACH has proven to be an effective initiative in improving nutrition programming in Laos and Mauritania. In Mauritania, a working group of government, United Nations and international non-governmental organizations, supported by a facilitator, developed a detailed nutrition action plan using REACH as a platform. Coordinated distribution of vitamin A and mebendazole (a de-worming drug) in the south, for example, has reduced resource waste and duplication of efforts. Another positive outcome has been the launch of an improved referral and monitoring system for supplementary and therapeutic feeding. The direct impact on nutritional status is shown by improvements in specific indicators. Preliminary results of data collected in 2008 indicate substantial improvements in household consumption of adequately iodized salt and in rates of exclusive breastfeeding between 2007 and 2008. There is optimism that the programmatic efforts made through REACH will ultimately lead to improved growth, survival and development for Mauritania's children.

The results achieved in Mauritania have also led to an urgent demand for rapid scale up of REACH in West Africa. As a result, a West African regional nutrition working group was developed to support country teams and help mainstream the REACH approach; specifically to assist in-country facilitators; provide tools, workshops and advice; and foster advocacy, research and capacity-building in collaboration with such regional bodies as the Economic Community of West African States. Interest is also growing in other regions of Africa towards the REACH approach.

United Nations Office on Drugs and Crime (UNODC)

At the global policy level, the decisions made by the Commission on Narcotic Drugs, the Programme Coordinating Board of UNAIDS and the Economic and Social Council in 2009 indicate the existence of a common understanding within the United Nations about what a comprehensive package of HIV-related services for injecting drug users contains. As outlined by the World Health Organization (WHO), UNODC and UNAIDS in their target-setting guide[50], such a comprehensive package includes the following nine interventions, which should be provided in the context of a continuum of services that includes outreach, evidence-based drug dependence treatment and primary prevention of drug abuse and other health, social and legal services, including in prison settings:

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[50] WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users (World Health Organization,
Geneva, 2009).

-Needle and syringe programmes;

-Opioid substitution therapy and other kinds of drug dependence treatment;

-HIV testing and counseling;

-Antiretroviral therapy;

-Prevention and treatment of sexually transmitted infections;

-Condom programmes for injecting drug users and their sexual partners;

-Targeted information, education and communication for injecting drug users and their sexual partners;

-Vaccination, diagnosis and treatment of viral hepatitis;

-Prevention, diagnosis and treatment of tuberculosis.

These nine interventions should be complemented by other important health and social services, including overdose prevention and management, management of abscesses and food and shelter provision, depending on specific needs. Since drug use has been criminalized and is a hidden phenomenon in most affected countries, it is of critical importance to advocate and facilitate human rights-focused policies and legislation, to carry out outreach efforts, to involve, in a meaningful way, people who use drugs in policy and programme reviews and to provide legal aid to drug users.

Numerous evidence-informed technical papers and reviews have been made available to explain the effectiveness, including the cost-effectiveness, of the interventions listed above (in particular the needle and syringe programmes, opioid substitution therapy and antiretroviral therapy) for preventing HIV infection among people who inject drugs. However, that list of nine interventions should not be considered as definitive; new and emerging evidence regarding other possible interventions should also be taken into account. Normative guidelines, policy documents and good practice documents have also been produced and widely disseminated to stress the importance of harm reduction approaches and to encourage partners, including governments and representatives of civil society, to expand access to those services. For example, following the distribution of guidance provided by WHO, UNODC and the UNAIDS Secretariat on monitoring progress towards universal access to HIV prevention, treatment and care, in many countries people who inject drugs and harm reduction interventions are included in national policies and plans.

UNODC has assisted States in mobilizing resources, establishing multisectoral working groups, assessing programmatic needs and building capacity in collaboration with relevant national and international partners, including civil society organizations, for the development, implementation, dissemination, monitoring and evaluation of effective HIV/AIDS prevention, treatment and care services in prison settings, for injecting drug users, and for people vulnerable to human trafficking. For example, in the Russian Federation, UNODC has established several drug referral and case management programmes for injecting drug users and supported transitional case management programmes for prisoners in different areas. In Indonesia, UNODC has brokered partnerships between the Government and civil society, professional organizations and United Nations entities,

to address the needs of injecting drug users. Technical support in Viet Nam has helped expand the availability of harm reduction services, including opioid substitution therapy, in several provinces. Support has been provided for an HIV prevalence study in prison settings in Paraguay and for the introduction of opioid substitution therapy in a prison in India.

UNODC has helped to prepare proposals for the Global Fund to Fight AIDS, Tuberculosis and Malaria, for example in India, Indonesia, Nigeria, the Sudan and Viet Nam, where UNODC was the sub-recipient of a Global Fund grant for providing technical assistance for HIV programming in local drug treatment centers. UNODC has also assisted the Palestinian Authority in reaching out and engaging with injecting drug users in HIV prevention and care activities as a sub-recipient under the Global Fund.

UNODC has collaborated with WHO and the UNAIDS Secretariat to provide technical guidance on the establishment of targets for universal access to HIV prevention, treatment, care and support for injecting drug users. To this end, UNODC has organized regional workshops for national partners in Central Asia and a workshop for non-governmental organizations in the Islamic Republic of Iran. UNODC has supported skills building by organizing several study tours for law enforcement officers, provided guidance to civil society partners on needle and syringe exchange programmes (for example, in Thailand), generated evidence to support government efforts in India to develop a policy on opioid substitution therapy, assisted guideline development for methadone maintenance therapy and needle and syringe exchange programmes in Viet Nam, and translated United Nations technical guidelines in local languages in Indonesia.

In collaboration with relevant partners, UNODC has delivered technical support in countries to strengthen capacity to scale up the joint provision of HIV and tuberculosis-related services and provided prevention, care and support services with regard to HIV-related tuberculosis in prisons, for drug dependence treatment and in immigration detention settings.

For example, a needs assessment has been carried out on HIV and tuberculosis-related services for drug users, and training has been given for the provision of such services for injecting drug users in India and Bangladesh. In collaboration with WHO and the UNAIDS Secretariat, UNODC has developed and disseminated widely a technical paper on collaborative HIV and tuberculosis-related services for injecting drug users, which is now being translated into several languages.

UNODC has continued to work closely with representatives of civil society, national Governments and multilateral donors to address the uneven and often low coverage and quality of services among the populations most at risk of contracting HIV/AIDS and other blood-borne diseases. Such joint efforts have helped to develop comprehensive models for the appropriate delivery of HIV services, and facilitated greater resource mobilization to enable communities to provide evidence informed and human rights-based prevention, care and support services on a larger scale.

In particular, UNODC has further intensified its assistance to and work with civil society with the aim of advocating the adoption of non-stigmatizing, non-discriminatory evidence-informed approaches to HIV at the national, regional and global levels, and the further harmonization of laws governing HIV and drug use, both from a public health and a human rights perspective.

Over the past few years, action to address the dual epidemic of injecting drug use and HIV (and other infectious diseases) has increased worldwide. However, despite some improvements, much more needs to be done and the barriers that still hinder effective responses and negatively affect the availability, coverage, quality and impact of HIV prevention, treatment, care and support services for injecting drug users need to be addressed.

Among the gaps and remaining challenges are the following: (1) low access to services; (2) inconsistencies in policy approaches to support key activities in relation to drug use and HIV prevention, treatment, care and support services; (3) resource shortages; (4) stigmatization and marginalization of drug users; (5) legal and policy restraints on opioid substitution therapy; (6) low access to hepatitis C diagnostics and treatment; (7) extremely low access to services in prisons; (8) HIV prevalence among prisoners; (9) weak data and mechanisms for identifying emerging epidemics; and (10) lack of systematic attention to HIV and forms of drug use other than injecting.

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