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FOR ACTION

IMPLEMENTATION PLAN OF THE HEALTH STRATEGY FOR UNICEF

SUMMARY

The present report was prepared in response to Executive Board decision 1995/28 (E/ICEF/1995/9/Rev.1) on the UNICEF health strategy. The strategy (E/ICEF/1995/11/Rev.1) responds to changing requirements for effective approaches to health that can realize the health rights outlined in the Convention on the Rights of the Child and consequent gains in health status. UNICEF health actions take place within the overall principles of the Convention as the guiding force for programmes, the Mission Statement, the primacy of country-level programming in support of government policies and coordinated action with partner organizations.

The Executive Director recommends that the Executive Board adopt the draft recommendation contained in paragraph 66.

* E/ICEF/1997/2.

CONTENTS

I. PRINCIPLES OF IMPLEMENTATION FOR THE HEALTH STRATEGY

A. Programming principles

1. The following programming principles provide the overall basis for intervention that seek to accelerate implementation of the Convention on the Rights of the Child, with subsequent gains in health status. First, the Convention provides the basis for assessing the major health issues in a country, planning strategic interventions, monitoring the action taking place and evaluating efficiency and impact. UNICEF will focus on children, young people and women in the context of the family and household. As households and families do not divide themselves along sectoral lines (health, education, water), activities designed to support actions that will improve health status need to be intersectoral and coordinated. Health policy dialogue has to be emphasized, with a clear involvement of communities in the improvement of their health status. In order to play a strategic role in seeking to achieve the universality which is a core principle of the Convention, UNICEF actions in health will focus on the poorest and most vulnerable. To give coherence and focus to programming, the UNICEF interventions will involve a dynamic relationship between three priority populations - children, young people and women - and three major intervention methodologies - monitoring, services and health promotion.

B. Implementation principles

2. The overall approach to implementing the health strategy will focus on activities within the categories of country programming, partnerships, advocacy, staffing and organizational support, as follows:

(a) Building on and working from the comparative advantages UNICEF enjoys within health, particularly the strong country-level presence and a culture of responding to country needs in challenging and ground-breaking ways;

(b) A close working and mutual learning relationship between UNICEF country offices to review and transform their approaches to health;

(c) A structured, peer review process that will identify, based on country experience, best practices in health;

(d) Using an area-based approach for piloting innovative activities and supporting national authorities in defining mechanisms for going to scale;

(e) Increasing UNICEF engagement at community, national, regional and global levels in the policy dialogues required for implementation of the Convention and consequent achievement of gains in health status;

(f) Providing up-to-date, easily accessible and user-friendly information on health problems and programming trends;

(g) Working with an expanded partnership base of people and organizations from within and outside the health sector to mobilize the coordinated cross-sectoral approach necessary for overall gains in health.

II. COUNTRY PROGRAMMING

A. Programming in the context of the Convention on the Rights of the Child

3. The organization of health actions around the Convention on the Rights of the Child (and the Convention on the Elimination of All Forms of Discrimination

Against Women) will modify the approach to programming at country level. It will facilitate UNICEF going beyond the specific health objectives of child survival and infant/child mortality reduction to the broader objectives of improving the quality of life and addressing health concerns of infants, children, adolescents and women, especially taking the following key aspects into consideration:

(a) Non-discrimination with regard to gender, minority, ethnic, socio-economic and religious factors;

(b) The best interests of the child. Health programmes should aim at protecting the interests of women and children, especially in the context of financial constraints that tend to hurt them more than others;

(c) Participation. Health programmes will emphasize information, quality of information and participation of stakeholders, especially women and children;

(d) Universality of rights. UNICEF health programmes have to focus particularly on the most disadvantaged and at-risk women and children, the unreached, the poorest and victims of organized violence and emergency situations.

B. Establishing a typology of countries

4. A number of regional networks in the field of health already facilitate the exchange of ideas, experiences, resource people and materials. However, geographical location is not the only factor; also important are socio-economic status, level of urbanization, literacy, infrastructure capacity, religion, type of health system, demography of health professionals, etc. In terms of these indicators, countries in the same region may be rather dissimilar (e.g., Mauritius and Mozambique), and countries in different regions may have many similarities and much to contribute and learn from one another (e.g., Brazil and South Africa). Countries in emergency situations provide specific experiences across regions as well, and these best practices should be used beyond regional boundaries. Thus, UNICEF will prepare a typology of countries by June 1997, in coordination with other United Nations agencies and bilateral donors.

C. Revision of programming instruments

5. Improving the situation analysis. In the past, the situation analysis tended to be a UNICEF exercise focusing on UNICEF priorities and goals within the country in the field of health, and did not fully reflect the multisectoral approach which is one strong advantage of the organization. These documents have improved markedly in recent years, but although the situation analysis targets women and children (and recently young people), it rarely considers the household in totality. The situation analysis seldom analyses the sustainability of initiatives listed, tends to limit its analysis of health services to primary care, and generally does not pay enough attention to specific urban issues. Finally, situation analyses tend to consider health indicators in a national way, without disaggregating data enough to fully identify the households most in need of specific support.

6. To address those issues, it will be important to involve to a greater extent not only other United Nations agencies, but local institutions and administration in the design of the situation analysis documents. Such an approach, already adopted by several country offices, improves ownership of nationally agreed priorities and strengthens relationships with key national

partners. It also facilitates raising of sensitive issues (sexual exploitation of children, drug abuse, HIV/AIDS) and builds an environment where open discussion creates a supportive atmosphere for additional programmes. The situation analysis should be considered as a dynamic document to be reviewed through the cycle of the country programme as the situation changes. Health has to be analysed using a multisectoral approach in order to highlight the socio-economic determinants of health and to support advocacy at the highest levels of decision-making. By the end of 1997, new guidelines, reflecting this multisectoral approach, will be developed and synthesized from country experience for improving the process of situation analysis in the health sector.

7. Improving the organization of country programmes. In many countries, the health programme is structured around a set of activities that are implemented vertically, and the budget allocation tends to reflect this vertical structure of the programme. Many programmes do not fully support the emergence of sustainable centres of excellence and competence in the country. In particular, few programmes address the issues of training doctors, pharmacists and nurses in spite of activities that require a deep change in their day-to-day behaviour and more involvement of national institutions.

8. Often, the flexibility of UNICEF programmes and the organization's strong field presence allow experimenting with new approaches and activities on a pilot basis. In several cases, such "pilots" have become a strong basis for new activities and policy reforms. It is essential that country programmes keep and expand that possibility in the health sector. For instance, in the context of "health reform" in many developing countries, UNICEF programmes should test policies and approaches that preserve equity and the interests of the most vulnerable.

9. Programming in a gender-sensitive way. Health programmes have always been targeted towards improving the conditions of children and women, but more effort has to be made to take a stronger approach to gender issues in health programmes. Women's education, women's participation in the management of community health services, advocacy programmes targeted towards women, women's access to adequate reproductive health care and girls' education all contribute to reducing child mortality and improving the health status of children. Gender sensitivity will be one of the criteria of evaluation of programmes by the regional management teams.

D. A stronger integration of UNICEF health programmes

10. UNICEF country programmes should be integrated with national policies, and health interventions integrated within the country programme. Activities such as immunization, control of diarrheal diseases or acute respiratory infections (ARI), baby-friendly hospitals, etc., should no longer be considered through a "vertical" approach, but should become integrated into the ongoing activities of the health system to ensure systematization and sustainability. Furthermore, issues such as a difficult economic environment, rapid population growth, malnutrition, the growing impact of HIV/AIDS, etc., require a strong health policy base to address them, with the support of UNICEF programmes. The emerging environment of democracy, transparency and community involvement in a growing number of developing countries provides an important background.

11. This requires adequate sectoral analysis and assistance in the formulation of policy goals and strategies. UNICEF can help Governments to engage in a participative policy dialogue with other stakeholders at the national level. Through training and capacity-building activities, UNICEF must support better integration of health programmes using the priorities outlined in

the health strategy: strengthening of basic health services and health systems; health promotion and communication; and monitoring and evaluation of the population's health, notably regarding end-decade goals. Guidelines to improve and measure the sustainability of health programmes will be produced in 1997.

E. Strengthening health response in emergencies

12. Since the health problems and diseases that arise in emergencies are the same ones that children and women encounter in normal life, UNICEF will ensure that the same approaches and strategies are applied in emergencies, but with additional speed, flexibility and innovation. Applying the key strategies of assessment and monitoring, health promotion and service delivery, UNICEF will strive to reach the greatest number of children and women in emergency situations through training, collaborative and stand-by agreements with partners, and alliances to create the required management and technical skills to respond more effectively to an emergency in an integrated fashion. The special health problems of girls and women generated by gender-related violence in emergencies will be addressed through a combination of care and protection strategies.

13. UNICEF will rely on its continuous country presence (emergency preparedness and contingency planning), its development-oriented country programming process and partnership with Governments, communities and non-governmental organizations (NGOs). Partnerships with international organizations have already been established, including the International Committee of the Red Cross and the United States Centers for Disease Control and Prevention. Before May 1997, a Memorandum of Understanding will be signed with the World Health Organization (WHO) on better coordination between the two organizations in emergency situations.

F. Improving data collection, monitoring and evaluation

14. A framework for community-based monitoring systems will be developed by June 1998. Country programmes will support national capacity-building in epidemiology and surveillance and develop community capacities. By the end of 1999, community-based monitoring systems should be in place in most health districts supported by UNICEF programmes. Guidelines for monitoring the utilization of district health facilities have been developed and implemented in over 10 countries in Africa (in the context of implementation of the Bamako Initiative). An evaluation of the process and expansion to other countries after adaptation to specific local conditions will take place by the end of 1998.

15. Guidelines for the new situation analysis process will be developed by the end of 1997 (see paras. 6-7 above), and a wide consultation with regional and country offices and Governments will take place regarding their implementation in all country programmes by the end of 1999. Regarding progress towards the end-decade goals, a consultation and prioritization process will be initiated in 1997, together with a thorough review of the multi-indicator cluster survey (MICS) methodology used at mid-decade. By early 1998, a consensus will be sought on the most appropriate methodology for end-decade goals in terms of precision, reliability, cost and sustainability.

16. A geographic information system (GIS) has been developed in cooperation with WHO to provide a graphic and precise approach to monitoring. Several African countries already use this tool at the national level for their own planning and monitoring processes. This powerful monitoring tool will be developed further in the context of the United Nations System-wide Special

Initiative for Africa, and will be used for monitoring of progress towards the goals of the World Summit for Children, using detailed and disaggregated data. Developed for dracunculiasis (guinea worm disease) eradication, the GIS will be extended to polio and neonatal tetanus cases, as well as to other disease and/or process-oriented surveillance. By the end of 1998, most African countries will be able to use the GIS as a monitoring tool.

17. At the global level, broader dissemination and utilization of health monitoring information will be undertaken through such instruments as the State of the World's Children report and the Progress of Nations. Data from the State of the World's Children report are distributed to all field offices in spreadsheet form, and all the basic indicators and the State of the World's Children will be accessible through the Internet by the end of 1996.

G. Establish greater support between country programmes

18. Progress in child health development, especially in the context of reaching the unreached, is an objective common to all countries, as expressed through national plans of action for children, the Convention on the Rights of the Child and other instruments. Thus, countries are struggling with similar sets of problems in service extension, financing, vaccine and drug supply, communication, health staff development, user participation, etc. Both effective experience exchange and increased networking between countries are necessary. In the late 1980s, UNICEF was instrumental in supporting joint work by Benin, Guinea and Nigeria to develop management training modules which increased the effectiveness of the Bamako Initiative. The evolution of technical support groups, grouping key actors from a number of countries to focus on a particular health problem, has been particularly effective in the drive to eliminate dracunculiasis and in establishing effective responses to HIV/AIDS and problems of adolescent health.

19. The increased role of regions in the technical support to country programmes will not only be based on using resources in the regional offices. Mechanisms will be created to strengthen intercountry support within a same region without creating heavy regional bureaucracies. Such mechanisms may involve loans of personnel, short technical assistance missions, exchange of consultants, etc. Databases describing the specific skills of UNICEF health personnel will be established at regional and global levels by January 1997 to increase opportunities for improved mutual support, and will later include health staff in country offices.

III. PARTNERSHIPS

20. The health strategy has a broader and more global approach to health programmes than in the past, and its implementation will involve strengthening and widening of partnerships at both institutional and programme levels. Partnerships have to be developed with new actors, such as private entities and decentralized authorities in various countries. Many of these have already started and are in a development process.

21. There is a traditional and strong partnership between WHO and UNICEF, and the Joint Committee on Health Policy (JCHP) provides a high-level framework for that cooperation. In recent years, joint approaches have been developed to address integrated management of the sick child, polio eradication, young people's health and development, maternal mortality and emergencies. Furthermore, there is a strong and permanent exchange on more traditional topics for collaboration such as immunization, child survival and development, the

promotion of breast-feeding and monitoring of health status. In 1996, closer collaboration has been initiated in the fields of health promotion and essential drugs. The GIS for surveillance and monitoring in Africa was developed jointly by the two agencies.

22. UNICEF is one of the key members of the Children's Vaccine Initiative, and there is a very strong interaction between UNICEF and WHO on the economics of immunization, the strategy for vaccine purchase, quality control of vaccines, the evaluation of vaccine production facilities, the organization of national immunization days, etc. The two agencies published jointly in 1996 the first report on the State of the World's Vaccines and Immunizations. A closer interaction between the two agencies will be necessary in the coming years for the evolution of the expanded programme on immunization (EPI), the introduction of new antigens and injection devices, and the improved sustainability of immunization.

23. The partnership of UNICEF and WHO has not been limited to headquarters. Excellent relations have been developed with WHO regional offices. In most countries, there is a coordination mechanism in place, and closer ties will be developed (strengthened by both agencies' involvement in the Joint United Nations Programme on HIV/AIDS (UNAIDS)). Finally, UNICEF has been associated with the renewal of the WHO "Health for All" approach, and will continue to support this process. By June 1997, it is expected that the two agencies will decide on the need for a joint international conference (a follow-up to the International Conference on Primary Health Care, held at Alma-Ata in 1978) to discuss and firmly establish the renewed Health for All concept.

24. The United Nations Population Fund (UNFPA), in association with WHO, is a crucial partner in the field of sexual and reproductive health. The three agencies regularly hold a high-level inter-secretariat meeting, resulting in cooperative work to support women's and adolescent health programming in a selected number of countries. Further cooperation will be developed at the regional level. UNICEF has also developed and is strengthening partnerships with the United Nations International Drug Control Programme; the United Nations Educational, Scientific and Cultural Organization (school health and health education); and the Office of the United Nations High Commissioner for Refugees (emergencies and health of refugees).

25. UNICEF will continue to collaborate with and provide a process of peer support for the other co-sponsors of UNAIDS. UNICEF has been an active co-sponsor of UNAIDS, under which a strategic advantage has been identified for UNICEF in the fields of school-based interventions, programming for especially vulnerable young people, health communications and prevention of transmission through injections. In the future, UNICEF will focus on improving the efficiency of UNAIDS and improving its efficiency at field level.

26. In recent years, the World Bank has become the most important source of public financing for the health sector in developing countries. A strong partnership has developed with UNICEF in several countries, notably in procurement and supplies; immunization; essential health services (the Bank has financed the development of the Bamako Initiative in several countries); and training and technical assistance. In some countries, UNICEF has gone beyond developing new programme approaches for Bank health sector loans; it has had responsibility for implementation of all or part of several World Bank-financed health projects. An evaluation of this approach is currently under way. (A more comprehensive overview of UNICEF collaboration with the Bank is contained in the report on follow-up to decisions by the Economic and Social Council (E/ICEF/1997/4).)

27. UNICEF will continue to be a special partner of the World Bank, with full respect for the mandate, policies and approaches of UNICEF. UNICEF will continue its dialogue with the Bank and government partners to ensure that the projects it funds take into consideration the groups most at risk and address issues of poverty reduction and equity. Discussions will be held with the Bank during 1997 to streamline reporting mechanisms and to improve administrative and financial arrangements.

28. Traditionally, UNICEF has worked closely with bilateral cooperation agencies, both at field level and for policy dialogue. A large number of health programmes at country level could not be implemented without the financial support of bilateral cooperation agencies. Recently, closer relationships have been developed with a whole range of bilateral agencies, involving direct support to UNICEF programmes through joint programming and shared implementation; financing of bilateral or national experts to help implement UNICEF country programmes in health; secondment of national experts at headquarters; joint research and development; and common training mechanisms.

29. In the future, these new forms of partnerships between UNICEF and bilateral agencies will be developed further, to the advantage of recipient countries. Such partnerships will be sought for innovative approaches (urban health, community-based health insurance, integrated sick child management, etc.). By the end of 1998, UNICEF will prepare a review of new partnerships with bilateral cooperation agencies in the field of health, and will evaluate their impact on the quality of country programming.

30. UNICEF has a long history of collaboration with international NGOs in the field of health. In some cases, this collaboration has resulted in mobilizing financial resources (Nippon Foundation, Rotary International and Kiwanis International). It has also mobilized partnerships for key programmatic elements (World Organization of Scouts, International Federation of Red Cross and Red Crescent Societies) and mobilized competence for policy design and implementation (Rockefeller Foundation, Carnegie Foundation, McConnell Clark Foundation). More agreements will be concluded in the field of health with such large international NGOs in the coming years, and these partnerships will be strengthened.

31. Collaboration with local NGOs has been extremely useful for the implementation of health programmes in several countries, and this will be further developed. Local NGOs have been precious partners in advocacy and social mobilization and the strongest expressions of community participation. They represent one of the best options to help reach unreached women and children. Their support is essential in sensitive areas (e.g., child prostitution, early age of marriage). By January 1998, UNICEF will establish criteria for the evaluation of local NGOs so that partnerships are developed with the best and most efficient NGOs.

32. Partnerships with the private sector are extremely promising and are being developed in two directions. First, active long-term partnerships have been organized, mostly under the responsibility of Supply Division, with manufacturers of such products as vaccines, auto-destruct syringes and fortified foods. Improved coordination between Supply Division and the Health Section will be developed in the future to secure more long-term agreements that make essential products accessible for children of developing countries. Partnerships with global companies will be strengthened and refined.

33. Secondly, there has been support to UNICEF activities through financial mobilization and communication for health messages. The image of UNICEF is very attractive to private corporations, which often seek to be associated with it,

as in the case of producers of goods (e.g., oral rehydration salts, iodized salt, bed-nets) and medical devices. It is also the case for several mass media and communication companies. Such partnerships are handled mostly at regional and country levels. In 1997, guidelines will be established for such partnerships, to ensure that they are developed with respect for transparency, competition and the best interest of UNICEF.

34. UNICEF has always had partnerships with foundations and universities at the global level for a wide range of activities, including situation analysis, advocacy, planning, mobilization, monitoring, evaluation and global policy design. However, this area has not been fully explored at the local level, although cases of collaboration exist in some countries, often with local institutions that UNICEF programmes helped to create and develop. With the growing emphasis on decentralization, local capacity-building and institutional strengthening, it is important to make better use of the local connections of such institutions which provide high-level competence together with an excellent understanding of local cultural and socio-political processes

35. To implement the health strategy, collaboration with local universities and foundations will be used for situation analysis; programme advocacy; programme planning; monitoring and evaluation; mobilization; and training. Collaboration with medical colleges, nursing schools and technical institutes will be emphasized, as training financed by UNICEF to improve local capacities will be strengthened. Emphasis will also be placed on training in communication and social mobilization, and UNICEF programmes will support local capacity-building in this field.

IV. ADVOCACY AND COMMUNICATION

A. Promotion of health strategy approaches with Governments

36. To ensure that the ambitious objectives of the UNICEF health strategy can be realized in the field, Governments must be convinced that this approach supports the health and well-being of women and children and that it should be fully integrated in their national policies. Advocacy should also target regional and municipal authorities. Ultimately, the use of national resources for an adequate health policy will be the best indicator of the sustainability of UNICEF involvement. One useful tool for greater integration has been the synchronization of UNICEF programming with the country's programmatic cycle.

37. Many international agencies, including bilateral donors and NGOs, support a systemic change in the health systems of developing countries, based on an analysis of the sector. The experience gained by UNICEF through dialogue on child survival programmes and the promotion and implementation of the Bamako Initiative has placed it in a good position to discuss policy issues with Governments. Its support for capacity-building (training of national counterparts, support to health institutions) have provided opportunities for dialogue about health policy and strategy issues. UNICEF country offices will have to better explain the health strategy to Governments to make sure that its holistic approach is shared and supported at the national level.

B. Increasing dialogue with the private sector of health care delivery and financing

38. Partnerships will be sought in the field of private health care delivery and private financing of health care services. One of the keys to the strengthening of more equitable and efficient essential health services is the development of adequate financial mechanisms (pre-paid and health insurance

services). Already, private health insurance companies are operating in developing countries, as are many community-based insurance systems. The importance of pre-paid health financing mechanisms will be studied on a multi-country basis in 1997. UNICEF country programmes will maintain an active dialogue with these new actors in the health system to make sure that they understand the main messages of the health strategy and adhere to principles of equity, non-discrimination, protection of women and children, and approaches to a better health status and life style.

39. In many countries where private providers are people's contact of choice for primary care, UNICEF health programming will have to involve partnerships with these important actors to ensure that they participate in improving the survival and quality of life of children. Private health care providers can contribute to the efficiency of essential health services as they complement public sector services and sometimes offset its shortcomings. However, private providers tend to focus more on purely curative care, and to neglect prevention, health education and promotion, and monitoring. Country programmes will increase their advocacy towards private care providers over the next three years.

C. Mobilization of major communication channels

40. Communication strategies provide a powerful means to accelerate action towards health achievements. There is growing evidence of the effectiveness of communication in mobilizing social and individual change. Communication through news, entertainment, marketing and distribution of popular goods and services, community-level communication, interpersonal interactions and awards programmes provide national-scale channels that are compelling and influential. In the future, situation analyses will include the evaluation of health promotion and communication approaches, and country offices will have to strengthen the skills of relevant staff (not always health staff) to become better analysts and communicators.

41. In seeking to implement this aspect of the plan, the emphasis will be on accelerating the development - at community, national, regional and global levels - of partnerships with private, public and non-governmental organizations with extensive communication capacities. The implementation of the health strategy will draw on country-based experiences that identify ways to expand the numbers of partnerships with organizations that have significant communication capacities and to increase their focus on health issues for gains in health.

D. Support to fund-raising

42. Full implementation of the health strategy will require more funds than are actually available today. Even in a context where UNICEF is less in charge of direct programme execution and acts more as an advocate and a coordinator, it is important that the level of resources for health activities remain high enough for country programmes to make a significant contribution to the implementation of the health strategy. UNICEF will support Governments in their advocacy for financial support for health system reform and improvement of the health of women, infants, children and adolescents. This support will be provided at country level and in regional institutes. It will also be provided in facilitating dialogue with the Bretton Woods institutions (Paris Club) over health priorities.

V. STAFFING

43. Implementation of the health strategy requires highly committed staff, with a different mix of skills, since it mostly depends on the capabilities of UNICEF health staff. At present, UNICEF has more strength in specific interventions (such as the control of diarrhoeal diseases (CDD), ARI control or immunization) than in the broader aspects of monitoring, promotion, health services development and health policy dialogue. A gradual transformation of current health staff will have to be achieved through deployment and training so that all are able to handle the strategy development, programme implementation and general decision-making associated with these main strategic areas of UNICEF health work.

A. Improving recruitment in the health sector

44. Many of the health officers currently designing and implementing health components of country programmes were recruited in the 1980s. In many cases, they were recruited to contribute to the intense immunization effort and the recommendations of the World Summit for Children. They were trained to implement programmes rather than mobilize for their implementation. Many do not have enough of the new requirements, including policy dialogue, inter-agency coordination, advocacy, social mobilization, negotiation with new partners and monitoring and evaluation.

45. These emerging disciplines in the health field, in terms of staffing levels, would require a wider pool of positions at the P-2 and P-3 levels for highly qualified graduates with advanced skills, but relatively limited experience. At the same time, policy dialogue and promotion of partnerships should be the responsibility of staff with longer and broader experience than is often the case at present. A recruitment policy, covering international and national staff, will be discussed with the Division of Human Resources and finalized by May 1997.

B. Broadening and strengthening skills of existing health staff

46. Numerous training activities have already been developed, organized for the most part in three traditional forms: training workshops; printed training packages; and study leave, either short- or long-term. In 1997, each country office will evaluate the skills of its health personnel and submit a training plan to the regional office, which will evaluate its financial and technical consequences. Furthermore, better use will be made of existing internal expertise (inter-country cooperation) and the expertise of national counterparts.

47. The establishment of training mechanisms will be guided by the two principles of flexibility and interactivity. UNICEF has to grasp the current cost-effective technological opportunities brought by telecommunications and Internet services now available to most UNICEF offices. Headquarters will organize global agreements for training of health personnel and design some of the training programmes. In country offices, training programmes will be organized for both health officers and government and NGO national health staff, in association with local training facilities.

48. The following mechanisms will be used for upgrading the skills of field staff:

(a) Regional conferences and seminars under the leadership of the regional office and regional management team, with resource persons inside the institution to facilitate some of these training sessions;

(b) Specialized workshops at country level, with the participation of both local institutions and experts from outside the country, involving national staff;

(c) Distance learning to train UNICEF field staff on specific issues requiring in-service methods, for such topics as health economics, health insurance, etc., through a combination of courses, case studies, tests and audio-video conferences;

(d) Internet services for individual consultation by health staff for skills updating on technical issues such as immunization, integrated child care management, malaria control, HIV/AIDS, etc.

C. Increasing the involvement of health professionals

49. In recent years, it has been a consistent policy of UNICEF country offices to increase the participation of national health experts in the design and implementation of health programmes. This policy will be systematically encouraged through easier access of national staff to UNICEF information and training facilities and improved mobility from one country programme to another.

VI. ORGANIZATIONAL SUPPORT

50. The centrality of the country programme has been reaffirmed strongly, and the health strategy will be implemented taking into full consideration the particular settings and priorities of each country, in the context of its programme. General policies and goals will be adapted to local conditions, and diversified approaches will be utilized by country programmes to implement the health strategy in accordance with local conditions and in agreement with local policies. Each location (headquarters, regional and country offices) brings added value to the country programme according to its comparative advantage. The overall purpose of this process is to produce an efficient and sustainable development process at country level.

A. The role of the Health Section at headquarters

51. Knowledge centre. The role of knowledge centre means having access to the best sources of information, keeping the best possible record of people with information and technical capabilities, collecting and synthesizing information from country and regional offices, in addition to producing knowledge through the analysis and dissemination of best practices, using the following specific tools:

(a) Databases with bibliographic information, to be operational by December 1997;

(b) Bulletin boards on the Internet;

(c) CD-ROMS on specific issues, providing comprehensive information on technical issues. The first one (on oral rehydration) will be produced by June 1997;

(d) Agreements with outside knowledge centres to get direct access to their data, including universities, foundations and various institutions in the health sector;

(e) Commissioning and analysis of specific interregional studies from which it is possible to compare and extract best practices of direct use for country programmes.

52. Policy setting. The Health Section advises the Executive Director on the health policy of the institution, within the framework of the health strategy and informed by organization-wide experience. Before the end of 1997, important policy decisions will be taken regarding the introduction of new antigens into EPI, integrated management of the sick child, the role of UNICEF in the management of malaria, measures that can boost equity in essential health services, future activities for the prevention and alleviation of the consequences of HIV/AIDS, integration of nutrition activities into health programmes, prevention of accidents in children, etc. Policy orientations will be proposed to regional and country offices and adapted to their specific national contexts.

53. Resource mobilization. The Health Section proposes criteria for the allocation of resources in the health sector, regarding both general resources and the types of supplementary funding that can be accepted and mobilized. Guidelines will be established by January 1998 for the use of various types of supplementary funding.

54. Relations with the United Nations system and the Executive Board. The Health Section has the responsibility of organizing meetings of JCHP (dialogue with WHO) and of keeping an active interaction with the other agencies of the United Nations system, including the World Bank, the Executive Board and National Committees for UNICEF.

55. Quality control. The Health Section will propose mechanisms for quality assurance of country programmes and will provide input into the quality control that will be established at the regional level and that of the Programme Division. Guidelines will be established by the end of 1998, in liaison with regional and country offices, on the launching of a total quality management approach in programming for health.

B. The role of regional offices

56. Centres of competence and support. The regional health advisers provide direct support to country programmes using several mechanisms. They participate in the preparation and follow-up of country programmes, maintain a database of consultants and technical assistants, and maintain contacts with local and regional institutions that can support country programmes. Regional health advisers (and key health personnel in the country offices) organize trans-country studies in their regions and synthesize experiences learned in the region. They promote sharing of experience and expertise between country offices.

57. Policy development. Regional health advisers provide regional input into the planning process and contribute to the development of the UNICEF health policy. They interpret the health strategy to best fit the requirements of their regions. The regional health adviser maintains an active dialogue with representatives of bilateral and multilateral donors, and remains in contact with representatives of WHO and major NGOs. At least once a year, the regional health adviser organizes a meeting of all health officers in the region to discuss policy issues.

58. Supervision of the performance of country programmes. In the context of regional offices clearing country notes and country programme recommendations for submission to the Executive Board, the regional health advisers evaluate and comment on the health component of the country programme. The regional health advisers also participate in the assessment of the implementation of the country programme to ensure that it reaches the highest possible standards.

C. Formal processes

59. Core team in the Health Section. The Health Section relies on the support of networks outside the institution. Already, technical support groups, comprised of experts from various knowledge centres, have been formed to support programming in HIV/AIDS and youth health. Independent assessments of the technical support groups have found their work to be of high quality to UNICEF. To disseminate information gathered and synthesized at headquarters, a forum on the Internet, restricted to UNICEF health officers and their national partners, will be established by May 1997.

60. Regional health teams. Regional health teams, facilitated by regional offices, will gather individuals from among UNICEF staff and partners (Governments, the United Nations system, bilateral agencies, technical partners, knowledge-based institutions, national and international NGOs) to discuss and interpret the strategy in each regional context and establish quality norms and indicators. These regional health teams will also use electronic media and should be in place by the end of 1997.

61. Lead UNICEF offices. Regions have to identify "lead" countries that function as centres of excellence, innovation, training and programme development, and consider them as direct partners of the regional office in improving the quality of all regional health programmes. These "lead" countries will help to develop policies and strategies as well as to identify technical developments that can best be achieved through the mobilization of global partners and that involve country programmes.

VII. IMPLEMENTING THE HEALTH STRATEGY: PROGRESS TO DATE

A. Improvement of structural approaches to health

62. At headquarters, the system has been consolidated into one single Health Section, which operates like a team and provides leadership and support to country programmes. Strengthening of regional offices has led to better coordination of country activities, an improved quality control mechanism and the operation of efficient regional networks. At country level, several programmes have evolved from providing support to specialized activities to a broader rights approach, an active health policy dialogue (e.g., in Brazil, Mali and South Africa) and effective coordination with international partners (e.g., in Ethiopia and Zambia). Steps have been taken to support improved sustainability and capacity-building in the countries, and a growing emphasis has been placed on community involvement and participation. A large set of training materials has been produced and disseminated beyond the organization. Regional offices have developed a range of approaches for keeping countries connected and informed, such as the regional networks in Eastern and Southern Africa, the interchange of resources between country offices in West and Central Africa and the regional HIV/AIDS Mekong Delta project in East Asia.

B. Better focus on target groups

63. During the past few years, UNICEF has learned many lessons from the contributions that it has made to the impressive improvements in child health and development outlined in the Secretary-General's recent report on progress at mid-decade towards the goals of the World Summit for Children. UNICEF has developed significant capacity at global, regional and national levels to advocate for planning and monitoring of the implementation of key child health interventions from supplies to social mobilization. Support has been provided

to countries for an integrated approach to child health, and studies have been conducted (and their results implemented) on the sustainability of immunization, the participation of private sector partners in CDD programmes and improved access to essential drugs for sick child management.

64. In recent years, UNICEF has developed its programming approaches to the health and development of young people, children in their second decade of life. Guidelines, produced in partnership with several international organizations and NGOs, have been disseminated and adapted at field level. They are based on the experiences of countries that are accelerating adolescent health programme activities and include a joint UNFPA/UNICEF/WHO study group on programming for adolescent health. Much of the UNICEF contribution to UNAIDS is focusing on young people, including through school-based interventions (as in Uganda and Zimbabwe).

65. Maternal health has been a growing focus for UNICEF, with key interventions being directed to the reduction of maternal and neonatal mortality, including improvements in perinatal care, maternal nutrition and access to expanded reproductive health care. Process indicators for the reduction of maternal mortality are presently developed in partnership with WHO, bilateral donors and experts in developing countries. Programmes aiming at reducing maternal deaths are under way in Bangladesh, Viet Nam and several African countries. UNICEF has also been very active in the serious problems of female genital mutilation and gender-base violence in the household in order to develop effective advocacy and interventions.

VIII. DRAFT RECOMMENDATION

66. The Executive Director recommends that the Executive Board adopt the following draft recommendation:

The Executive Board,

Having reviewed the "Implementation plan of the health strategy for UNICEF" (E/ICEF/1997/3),

Endorses the overall approach for implementing the health strategy as contained in the report, taking into account the comments made by delegations at the present session.
