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Held at the Palais des Nations, Geneva, on Friday, 17 July 2009, at 10 a.m.

President: Ms. Gallardo Hernández (Vice-President) . . . . . (El Salvador)

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In the absence of Ms. Lucas (Luxembourg), Ms. Gallardo Hernández (El Salvador), Vice-President, took the Chair.

The meeting was called to order at 10.15 a.m.

Operational activities of the United Nations for international development cooperation (*continued*)

(a) Follow-up to policy recommendations of the General Assembly and the Council

Dialogue with United Nations country teams on strengthening the United Nations country team's coherent support to public health

The President said that with the economic crisis threatening to impact on public health spending and global health, a major system-wide effort must be made at every level to ensure that developing countries and least developed countries (LDCs) achieved the health-related Millennium Development Goals (MDGs). The crisis should be seen as an opportunity to reform the financing and organization of health services and to accelerate progress towards universal primary health care and community-based approaches. A substantial proportion of aid was currently channelled through multi-country projects, resulting in limited national ownership. National health plans should instead form the backbone for United Nations support at the country level.

The panellists might consider how global and national health partnerships could be better aligned with national priorities; how the United Nations system could work more effectively with key national stakeholders in the area of health; what coordination measures and resource mobilization strategies could be used to strengthen health services and achieve internationally agreed development goals; and how the United Nations might help strengthen programme countries' preparedness for future health crises.

Mr. Lashari (Secretary of Health, Ministry of Health, Pakistan) said that public health in Pakistan was chronically underfunded, accounting for less than 0.6 per cent of the country's gross domestic product (GDP). Fragmentation of actions at the national and international levels hampered progress on the health-related MDGs, as did the double burden of disease that resulted from changing lifestyles and demographics. Improved public health was also dependent on effective actions in other government sectors.

The High-level Panel on System-wide Coherence, co-chaired in 2005 by the Prime Minister of Pakistan, had affirmed that the United Nations must overcome fragmentation and "Deliver as One" by working collectively in pursuit of clearly articulated national goals. Greater efficiency and better utilization of resources would benefit everyone.

The "One UN" Programme in Pakistan comprised five joint programmes addressing Government-identified priority sectors for which United Nations technical capacities were readily available. The development process had been preceded by a situation analysis of each sector, which involved the Government, the United Nations country team and civil society organizations. Principles underpinning United Nations reform were now being applied to national health delivery, with the Government now also "delivering as one". Unless the international community's commitment to providing support was sustained, however, the programme would not achieve the desired results.

Dr. Bile (WHO Representative, Pakistan), accompanying his statement with an electronic slide presentation, said that a "One UN" programme had been signed in February 2009. The Government and the 19 specialized agencies working in Pakistan were committed to "Deliver as One" under a nationally owned initiative with one budgetary framework, one leader and one office. A major objective of the health and population programme was to harmonize United Nations and government action in order to improve delivery of essential care and promote universal access to health. There were also important synergies with the other four programmes under the "One UN programme", namely education; environment; agriculture, rural development and poverty reduction; and disaster risk management. The planned outlay of US$ 1.2 billion did have the ability to catalyse development. While Pakistan was not aid-dependent and made a significant State contribution to health, the need for additional resources continued to grow.

Despite the importance of a unified budget for the "One UN" programme, a large proportion of health funds continued to be channelled through civil society. Other operational challenges included disparities in the planning cycles of the various agencies, the Government and other stakeholders; difficulties in collectively aligning agencies' traditional zonal presence with government intervention; and the need to

streamline in-house business practices at United Nations Headquarters and in the regional offices.

"Delivering as One" meant that the Government and its development partners must share the same vision in the interests of enhancing aid effectiveness. It involved shifting from the current donor/recipient culture to a results-based, accountable partnership that put people at the centre.

Mr. Illo (Niger) said that his Government, which aimed to achieve the Millennium Development Goals and especially to reduce poverty, had committed itself to tackling its disappointing health record. One child in five was dying before the age of 5, and 5 per cent of pregnancies resulted in the mother's death. The country's high birth rate, an average seven children per woman, was a constraint on family well-being and held back socio-economic development. With a GDP per head of population of only US$ 280 a year, Niger also had to deal with the devastating effects of malaria, HIV/AIDS, tuberculosis and other chronic diseases.

Modest improvements had however been achieved through an effective partnership between the Government and Niger's technical and financial partners, the introduction of a national health information system, and technical assistance from the United Nations in its key strategic role. The current health development plan (2005-2010) had been drawn up to reflect Niger's poverty reduction strategy paper and the United Nations Development Assistance Framework (UNDAF). The next health development plan would cover the period 2011-2015, and would be aligned with Millennium Development Goals 1, 4, 5, 6 and 8. To achieve its goals, Niger intended to decentralize its health system, enter into regular contracts with its health workers, involve them in health outcomes and monitor the performance of its health system.

The financial plan for the system, within the medium-term budget, would raise health spending to US$ 17 a head, to reach US$ 27 by 2015. Given that almost half of health costs would have to be borne by households, the share of health in the budget would have to increase. Niger would therefore continue to rely on substantial additional resources from the international community. He welcomed the impetus given by the United Nations to achievement of the MDGs and to continued aid commitments from donor countries in spite of the economic crisis. In March 2009, Niger had joined the International Health Partnership (IHP+) with a view to improving the effectiveness of aid in its health sector.

Ms. Lo Ndiaye (United Nations Resident Coordinator, Niger) said that various obstacles hindered Niger's attainment of its development goals, in particular the MDGs. They included its extensive desert regions, poor maternal and infant health indicators, widespread poverty, a low human development index, uncontrolled demographic growth and the need for substantial investment in basic social services to improve access.

Three main approaches were being used to meet those challenges in her country: the United Nations Development Assistance Framework for Niger (2009 to 2013), based on Niger's national strategy for poverty reduction and accelerated development; reinforcement of joint programmes at the national level in the areas of gender, HIV/AIDS, nutrition and food security, and, at the regional level, focused on the Maradi region; and a government contingency plan, supported by the United Nations, in the field of emergency humanitarian assistance.

Niger worked with its partners within a coordination framework consisting of: a government-partners committee concerned with political dialogue, advocacy and mobilization of resources; second-level sectoral committees for coordination and dialogue, one of which focused specifically on health; and, at the third level, regional coordination frameworks set up in the field to ensure programme implementation, coordination and monitoring.

United Nations agencies and bilateral partners contributed to the health sector in Niger in various ways, including by helping to draw up sectoral health programmes and by reviewing the United Nations programming and monitoring cycle with a view to harmonizing it with Niger's national cycle. UNDP was the lead agency for ensuring aid effectiveness. Belgium facilitated the coordination between Niger and its partners and played a leading role in the area of health. Niger also participated in global and regional health initiatives in partnership with United Nations agencies and development banks. Niger's key instruments for managing its health resources were the medium-term expenditure framework and the common health fund, to which all Niger's partners contributed.

Mobilizing health resources was a great challenge for her country. While Niger allocated 11 per cent of its budget to health, a full two thirds of that allocation was needed simply to attain MDG 4. In order to reach all the health-related MDGs, Niger needed an enormous commitment in terms of financial resources, both on the part of its Government and external funding agencies. In that connection, Niger was among the first 10 pilot countries under the United Nations plan to accelerate progress towards the MDGs by increasing official development assistance. The Millennium Challenge Account, which provided assistance to developing countries, would also be of help in that regard. Other United Nations support for health in Niger included the formation of strategic partnerships, convening donor round tables to mobilize funds, and assisting the country in drawing up its medium-term expenditure framework and conducting public health expenditure reviews.

Niger had made progress in the public health sector. Among other measures, it had adopted an intersectoral strategic approach to the combat against HIV/AIDS, drawn up national plans for the prevention and control of epidemics, and produced a roadmap for reduction of maternal and newborn mortality. It was in the process of reforming its system for the provision and distribution of essential drugs. It had set up programmes to combat malaria and tuberculosis. With its partners, it was carrying out health programme reviews, and it had recently become a member of the International Health Partnership and Global Compact.

Yet, much remained to be done. Niger needed to move, in response to its structural problems, from the stage of emergency intervention towards that of medium- and long-term development. Efforts to mobilize resources, from both national and external sources, must be redoubled if Niger wished to attain the MDGs on time. The country's strategic planning framework had to be reinforced and, to that end, a strategic vision was being developed for the next 25 years. Another goal was to increase the national budget earmarked for health. Economic growth had reached 9.5 per cent in 2008 and it was vital to channel some of those resources into social sectors.

Dr. Sotelo (PAHO Area Manager of External Relations, Resource Mobilization and Partnerships), representing the United Nations Regional Directors Team (UNLAC RDT) and the WHO Regional Office for the Americas, said that while it had an extraordinary wealth of human and natural resources and had been experiencing positive economic growth over the past few years, the Latin American and Caribbean region was marked by inequality, with a large proportion of its population living in poverty, even in middle-income countries. United Nations agencies must pursue their efforts in those countries by encouraging them to draw up comprehensive cooperation policies to ensure that their achievements were sustained.

UNLAC RDT played an important role in the region through: the provision of strategic programme support, guidance and quality assurance for United Nations country teams; oversight of policy implementation at regional and country level; identification of specific regional priorities; integrated support for emergency and crisis prevention, preparedness and response; and provision of direct support to United Nations country teams. An important accomplishment by the Team had been the establishment of the Panama Regional Center, making possible the co-location of regional entities in Panama's City of Knowledge, thereby promoting increased inter-agency dialogue, cooperation and efficiency.

UNLAC RDT had four main achievements to its credit in the provision of public health support through United Nations country teams. The first had been the establishment of the Pan-American Alliance on Nutrition and Development for the Achievement of the MDGs, based on the recognition that malnutrition arose from the interaction of multiple factors. Traditional approaches to malnutrition had tended to downplay or ignore the importance of social determinants, including food security, the physical and social environment, education, access to information, maternal health status, the exercise of human rights, household income and working conditions. Efforts to implement a more complex approach to the problem of malnutrition called for simultaneous, coordinated and complementary technical cooperation among all the United Nations agencies and other actors involved.

The Team's second achievement had been its contribution to the Vaccination Week in the Americas campaign, the aims of which included promoting access to immunization, keeping the region free of polio and indigenous measles, supporting the introduction of new or underutilized vaccines, strengthening epidemiological surveillance and

promoting cross-border cooperation. The Team's leadership in that area, including its support for country-team involvement in Vaccination Week, had greatly contributed to the success of the campaign.

The third achievement had been the preparation and publication, in 2008, of an inter-agency report on health-related MDGs. Under the auspices of the Economic Commission for Latin America and the Caribbean (ECLAC), the Team had conducted a review of the progress made towards reaching health-related MDGs in the region, obstacles to their attainment, sustainable policies needed, and prospects for the future.

The fourth achievement had been the establishment, in June 2003, of the Regional Directors Group (RDG) of UNAIDS Cosponsors in Latin America and the Caribbean, bringing together the regional directors of the 10 agencies sponsoring the UNAIDS programme, and the UNAIDS Secretariat. The Group had been pursuing eight strategic lines of action, including advocacy for universal access to the prevention, care and treatment of HIV/AIDS, and guidance and support to United Nations theme groups and teams at the country level.

Most recently, the Regional Directors Team had been instrumental in disseminating the latest information on the influenza A(H1N1) pandemic, ensuring a supply of antiviral medication for United Nations staff in the region, and supporting inter-agency cooperation in the provision of technical assistance for controlling the spread of the disease, in accordance with national priorities.

On the basis of the work of the Regional Directors Team, the following conclusions could be drawn. First, a strong regional directors team was vital to ensuring that United Nations country teams were effective. Secondly, an effective strategy for ensuring communication between the different levels of the United Nations system was needed to accomplish the goal of "Delivering as One" at the country level. Thirdly, country teams needed effective support, including technical assistance and guidance on critical issues, from regional and global levels of the United Nations system.

Mr. Poinsot (France) emphasized the importance of close cooperation between all agencies working on the ground, whether United Nations agencies, private-sector entities or non-governmental organizations. In the health sector, WHO had a central role to play in coordination, and its country representative should be the contact point for the local authorities. The United Nations, other international organizations and donors must conduct their operations according to the needs identified in national plans. Work on the ground, and its coordination, should comply with the principles of harmonization and aid effectiveness defined in the 2005 Paris Declaration and the 2008 Accra Agenda for Action. Tasks should be clearly allocated among the various actors, and the countries where the operations were carried on should have ownership of the programmes.

The coherence of operations could be assured by using and developing the two principal coordination mechanisms. The International Partnership for Health was intended to improve health outcomes by mobilizing the eight principal agencies working in the health sector — WHO, the World Bank, UNAIDS, UNICEF, the International Monetary Fund, the GAVI Alliance, the Bill & Melinda Gates Foundation, UNDP and the African Development Bank — together with the donor countries and the developing countries, to meet the donor funding gap and improve coordination among the agencies in implementing national health plans. The coordinating effort would be led by WHO. Secondly, the SWAps system was a project whereby teams relied on existing coordination mechanisms and national plans to implement a single health policy, a single scheme of policy evaluation, a single means of coordination among donors and a single budget. Such projects were owned and directed by the government concerned, with all the partners supporting them. A good example was the SWAp which operated in Mozambique to reduce maternal and child mortality.

Mr. Goffin (Observer for Belgium) said that feedback from the field on the "deliver as one" concept, for example from Tanzania and Niger, was very positive. He wondered therefore why member States seemed somewhat hesitant to formally embrace the concept.

Mr. Lashari (Secretary of Health, Ministry of Health, Pakistan), in response to the representative of France, said that the Resident Coordinator was responsible for United Nations system efforts in Pakistan. In the health and population thematic group, the WHO representative played the leadership role. In order to strengthen coordination a framework had been established to bring together representatives of the

Government, the United Nations system and the many other bilateral and non-United Nations stakeholders who likewise provided assistance and grants. Since the "deliver as one" concept had only recently been introduced it was too early to suggest changes. With further experience however the system could be modified as needed to enhance coordination and integrate more agencies into the coordination effort.

With regard to the intervention by the representative of Belgium, he said that coordination was a challenge for all organizational structures, but it was important to persevere because coordination brought real benefits. At the national level his Government was in the process of realigning the work of its agencies and institutions to implement the "deliver as one" model, which would help reduce costs, make better use of resources, increase transparency and ensure value for money.

Dr. Bile (WHO Representative, Pakistan) said that in Pakistan the Government and the United Nations team had been able to make excellent progress on the important issue of coordination. Together they had established five thematic working groups each with two co-chairs. For each group there was one permanent co-chair, the representative of the relevant lead agency, for example WHO in the health sector, with the other partners sharing the second co-chair position on a rotating basis. That arrangement allowed for continuity in leadership while still taking into account the viewpoints of all partners. There was real unity of purpose within the groups and a willingness to ensure participation by all concerned stakeholders.

He recalled that there were more than 2 million internally displaced persons in Pakistan as a result of recent turmoil. Those people were starting to return to their homes. The United Nations system and the programme teams from various agencies would provide a collective "deliver as one" response to meeting their needs.

The United Nations system played an important role in coordinating health initiatives. There were however other non-United Nations health partners who provided significant health-related resources to Pakistan. That was why it was essential to broaden coordination efforts to include such partners as the World Bank. The Ministry of Health had recently established a coordination mechanism to bring together all partners, chaired by the Minister of Health or the Secretary of Health, to ensure implementation of the "deliver as one" model. Coordination tended to be a weak point in development efforts, which was why the "deliver as one" concept constituted a milestone in lending them added value.

Mr. Illo (Niger) said that the "deliver as one" model certainly seemed to be proving effective in the field, even if delegations seemed hesitant to fully endorse it as yet. In Niger coordination was essential to avoid fragmentation of development activities.

Ms. Lo Ndiaye (Resident Coordinator, Nigeria) recalled that Niger was not a "deliver as one" pilot country, but when resources were scarce, coordination was necessary to ensure the effectiveness of programmes. Niger was a vast country with insufficient human resources; it was impossible to be everywhere at the same time, hence the need for joint action in such areas as health and food security. Coordination added value to United Nations system efforts. Accordingly, there was a single United Nations office and one basic structure encompassing all staff. That reduced costs and strengthened coordination in the field, allowed for projection of a coherent United Nations vision and simplified relations with partners.

The situation was complex and resources must be allocated where they would be most effective. The United Nations had defined a national malaria eradication strategy and could for example supply bed nets, but it was an international NGO, Catholic Relief Services (CRS) which had been best able to distribute the nets. Such a division of labour made full use of the comparative advantage of the different partners. Coordination was an ongoing process. The Government provided leadership, and development partners, for example in the area of health, were committed to strengthening coordination.

Dr. Manzila (WHO Resident Representative, Niger) noted the leadership role played by Belgium in the health sector, in rotation with WHO. WHO was currently fully involved in implementing health programmes, strengthening the health system in the field, negotiating with partners and mobilizing resources for the health sector. It likewise played a lead role within the United Nations country team in coordination of health-related activities.

With regard to examples of work undertaken in Niger, he said that in the most recent meningitis season, there had been more than 12,500 cases, but

thanks to the efforts of the Ministry of Health, supported by WHO, resources had been mobilized and coordinated, keeping the number of deaths to 536, or less than 4 per cent. WHO had organized a meeting the previous week to review the H1N1 virus situation in response to the increased alert level announced by WHO; as a result measures had been adopted to improve screening at border posts with neighbouring countries, where cases had already been diagnosed. It would soon be cholera season and the Ministry of Health, in cooperation with WHO, had coordinated all partners with a view to being ready to deal with an initial 1,000 cases if necessary. WHO had also played a leadership role in formulating the new 2011-2015 sanitation health.

He recalled that Niger was a participant in the International Health Partnership initiative. As a result Niger would review health care and formulate a health compact defining the roles of the various partners. WHO would play a proactive leadership role in that effort. It was important to take advantage of and strengthen programmes that had proved effective. In Niger WHO worked closely with partners and played a leadership role in the health sector within the United Nations system and in partnership with the Ministry of Health.

Ms. Maitournam (Director of Statistics, Monitoring and Epidemic Readiness, Niger) said that ensuring coordination between the United Nations system and other bilateral and international partners was a complex task. The Ministry of Health played a leadership role in that regard and held regular monthly meetings with international and technical partners. A cooperation framework had been established; all partners were involved in evaluation of health programmes and follow-up. The strengths of different partners were used to best advantage in order to promote synergy. Full coordination and coherence would take time but steps had already been taken to create focal points and ensure coordination in the field.

Dr. Sotelo (PAHO Area Manager of External Relations, Resource Mobilization and Partnerships) said the region of the Americas had its own framework for health-related activities for the next 10 years. The primary task of the country teams, comprising WHO, PAHO and other agencies, was the continuing fight against endemic diseases such as tuberculosis and malaria, while also dealing with new threats such as the A(H1N1) virus, SARS or the health consequences of domestic violence. It was also important to keep down the rates of maternal and infant mortality. The representative of France had mentioned the importance of coordination and cooperation among the agencies working on the ground. It was also important to respect the internal arrangements within countries; in the federal system prevailing in some countries in the Americas, provincial governments had a different role from central government. In addition, the Americas had their own regional intergovernmental organizations such as MERCOSUR and the Andean Community. The international health agencies endeavoured to work both with government structures and with non-governmental organizations and civil society, in order to ensure coherence between local health agendas and those set for the Americas region as a whole.

The representative of Belgium had drawn attention to the importance of active participation by member States in improving results. That reflected the approach of WHO and PAHO, which followed a results-based strategy aiming to show what had been achieved by “delivering as one” with the United Nations country teams.

Ms. Emevy (New Zealand) referred to decision 2008/7 (b) adopted by the Executive Board of the United Nations Development Programme/United Nations Population Fund (document E/2008/35), in which the Board invited the Council to recommend to the General Assembly that the appointment of the Executive Director of UNFPA be regularized. UNFPA had originally been a fund within UNDP, until the General Assembly decided to grant it independent status, but no provision had been made for appointing its Executive Director. Since that decision of the General Assembly, two Executive Directors of UNFPA had been appointed, following the same procedure as for UNICEF. She intended to introduce a draft decision of the Council along the lines of paragraph 3 of Board decision 2008/7 (b), and she urged Council members to support it.

Ms. Schwabe-Hansen (Norway) endorsed those remarks.

The meeting rose at 12.15 p.m.