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Health and mortality

Report of the ACC Task Force on Basic Social Services for All

Summary

The present report has been prepared in response to resolutions 1995/55 and 1996/2 of the Economic and Social Council. It is based on the replies of 17 member organizations of the ACC Task Force on Basic Social Services for All to a request for information on the implementation of the Programme of Action of the International Conference on Population and Development with respect to the theme of the Commission on Population and development at its thirty-first session, "Health and mortality, with special emphasis on the linkages between health and development, and on gender and age".

The report presents an overview of the activities of the Task Force; discusses Task Force member organizations' work in the areas of primary health care, child survival and health, women's health and safe motherhood, and human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS); notes the technology, research and development work undertaken by Task Force member organizations; and concludes by highlighting key lessons learned through the experience of the Task Force.

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I. Introduction

1. The present report has been prepared in response to resolution 1995/55 of the Economic and Social Council, in which the Council endorsed the new terms of reference of the Commission on Population and Development, and resolution 1996/2, in which the Council welcomed the newly constituted Task Force on Basic Social Services for All of the Administrative Committee on Coordination (ACC), under the chairmanship of the United Nations Population Fund (UNFPA), and requested it to continue to report to the Commission on the implementation of the Programme of Action of the International Conference on Population and Development (ICPD). Under the topic-oriented and prioritized multi-year work programme of the Commission, the topic for 1998 is "Health and mortality, with special emphasis on the linkages between health and development, and on gender and age".

2. This report is based on responses received from 17 member organizations of the ACC Task Force[1] on Basic Social Services for All to a request for information on the implementation of the Programme of Action, with special emphasis on the theme of the year. Section II presents an overview of Task Force activities; section III focuses on primary health care and the health-care sector; section IV discusses child survival and health; section V examines women's health and safe motherhood; section VI focuses on human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS); section VII notes the technology, research and development work undertaken by Task Force member organizations; and section VIII concludes the report by highlighting key lessons learned through the experience of the Task Force.

II. Overview of Task Force activities

3. During 1997, the ACC Task Force on Basic Social Services for All focused its attention on producing the end products agreed to at its first meeting in February 1996. Using the modality of working groups with lead agencies, the Task Force has produced the following:

(a) Guidelines for the United Nations resident coordinator system on key areas of the Programme of Action — primary health care, reproductive health, national capacity-building in tracking child and maternal mortality, women's empowerment, basic education and guidance notes on international migration and development;

(b) A wall chart (available in United Nations languages) with key indicators to assist countries in monitoring progress in meeting conference goals in the provision of basic social services;

(c) An advocacy card on basic social services;

(d) A compendium of international commitments relevant to poverty and social integration;

(e) A report encompassing three country case studies on donor collaboration in assistance to the social sector and lessons learned/best practices.

The need for indicators

4. In response to the clear and felt needs of countries, the Task Force focused on developing a set of indicators to assist countries in monitoring their progress in achieving the goals agreed at the International Conference on Population and Development and other recent United Nations global conferences. In the first instance, the Task Force has developed and disseminated widely a wall chart on basic social services for all which can also be accessed via the Internet at **http://www.undp.org/popin/wdtrends/bss/bss.htm**, and all member organizations of the Task Force have been asked to link their websites to the wall chart website. In order to show where countries are currently and where they should aim to be in the future, the wall chart provides country data in six key areas: population; primary health care; nutrition; basic education; drinking water and sanitation; and shelter. The indicators pertaining to these will serve as a guide to assist countries in monitoring their progress in achieving conference goals. It should be noted that 8 of the indicators on the wall chart are the same as 8 of the 15 indicators in the Minimum National Social Data Set (MNSDS), endorsed by the Statistical Commission of the United Nations at its twenty-ninth session in February 1997.[2] Additionally, six of the seven ICPD-goal indicators selected by UNFPA for its revised approach to resource allocation to countries are the same as those on the wall chart. These indicators are related to access to reproductive health services; mortality reduction; and education, especially of women and girls.[3]

5. In April 1997, the World Health Organization (WHO), the lead agency of the Task Force's Working Group on Reproductive Health, organized a technical meeting on reproductive health indicators for global monitoring. The meeting, which brought together participants from developing countries, technical experts and representatives of United Nations agencies, focused on reaching consensus on 15 reproductive health indicators for national and global monitoring. The indicators meet certain essential criteria: they are considered to be ethical, useful, scientifically robust,

representative, understandable and accessible. They provide an overview of the reproductive health situation in different settings. It is not envisaged that they can provide all the information needed for national or global monitoring or for the evaluation of programme impact. For the latter, WHO advises that countries focus on strengthening national capacities for data generation, analysis and interpretation. To support countries in these endeavours, WHO has developed a guideline targeted to district health planners and managers which describes a process for the identification and selection of reproductive health indicators that meet essential criteria.

6. During 1996, UNFPA developed a list of quantitative and qualitative indicators that address the principal dimensions of reproductive health.[4] The list includes indicators that are primarily related to *outcome* (events) and *process* (delivery of services and management). The suggested indicators could be used for a variety of purposes, including monitoring the goals and targets set at the ICPD; assessing performance in delivery of reproductive health services; advocating for and developing policies in reproductive health; and programming and evaluating different components of reproductive health programmes. While the indicators are not intended to fulfil all possible data needs of policy makers and managers, those included have been selected so as to be manageable in most countries, though some may require complex collection instruments and procedures. A sub-set of indicators can be determined at the country level according to priority needs. Representatives from various bilateral agencies, United Nations agencies, non-governmental organizations and the UNFPA country support teams were involved in the process leading to the development of the set of indicators. In addition, UNFPA developed a framework of selected indicators to assess the impact of information/education/ communication (IEC)/advocacy activities in support of population and reproductive health programmes; and indicators for population and development. These indicators, which have been published by UNFPA[5] will assist countries in monitoring their progress in achieving the goals of the International Conference on Population and Development.

Collaboration with non-governmental organizations and civil society

7. All member organizations of the Task Force on Basic Social Services for All have focused attention on strengthening and expanding their collaboration with non-governmental organizations, civil society organizations and the private sector. Strategic partnerships and close collaboration between all development partners are necessary. Thus, the United Nations resident coordinator system is encouraged to share all the end products of the Task Force with national counterparts, bilateral agencies, non-governmental organizations, civil society organizations and the private sector, and to seek their collaboration in activities focusing on achieving the goals of the International Conference on Population and Development and other recent United Nations global conferences.

III. Primary health care and the health-care sector

8. The concept of primary health care was defined and given international recognition at the International Conference on Primary Health Care (Alma Ata ,1978). The Declaration of Alma Ata,[6] adopted at the Conference, has become the main focus for the promotion of world health and the instrument for achieving the goal of health for all. Four basic components underlie the primary health care approach:

(a) Universal accessibility and coverage;

(b) Community and individual involvement;

(c) Intersectoral action for health;

(d) Appropriate technology and cost-effectiveness in relation to available resources.

The primary health-care approach received new impetus and reaffirmation at the International Conference on Population and Development. In keeping with the Declaration, the Programme of Action called on all countries to reduce mortality and morbidity and seek to make primary health care, including reproductive health care, available universally by the end of the current decade. The Programme of Action established specific time-bound goals, *inter alia,* for life expectancy, mortality, the provision of reproductive health and family planning services, and universal primary education.

9. The Programme of Action called on all countries to give priority to measures that improve the quality of life and health by ensuring a safe and sanitary living environment for all population groups. The expanding number of marginalized, underserved groups is a growing concern that needs to be addressed more carefully. Among those groups are the elderly, adolescents, poor women, the unemployed, the homeless, single mothers, indigenous people, and individuals and families in post-crisis or emergency situations. Special efforts are required to identify these groups and to meet their specific needs. Although some progress has been made, the current situation is that health-care services often remain inaccessible to vulnerable groups, are fragmented and of poor

quality, and do not meet the expectations of the clients. Moreover, in many developing countries there is still a strong urban bias in access to potable water, adequate sanitation and health clinics.

10. One encouraging development is that the focus is shifting from drinking-water quality alone towards overall environmental improvement involving water supplies, sanitation, hygiene education and general community involvement in environmental management. Another positive development is the notion of "healthy public policies" aimed at creating a healthy environment. WHO has undertaken a healthy cities programme which adopts a holistic approach to health development, focusing on the availability of clean water, sanitation, housing, environmental conditions and disease control. Already there are more than 2,500 healthy cities initiatives in action around the world. The healthy cities movement has proliferated to embrace healthy villages, healthy islands, health-promoting schools, healthy workplaces (with the accent on safety) and baby-friendly hospitals. These intersectoral projects lay great emphasis on health promotion and seek to make health issues understandable and relevant to the work of local governments and other bodies.

11. Migrants are not only a rapidly growing urban population but also a group with special health needs, including reproductive health and family planning needs. Research indicates that migrants and their families face greater health problems than long-term residents. Providing adequate reproductive health care to migrants requires more focused communication and service delivery. One way to serve migrants better is through community-based programmes that provide health care, including reproductive health care and family planning services, at locations where migrants work and congregate. International cooperation is also necessary to protect and promote the human rights of migrants.

12. The United Nations Centre for Human Settlements (Habitat) focuses on the identification and demonstration of viable solutions for integrated human settlements improvements at household and community levels aimed at improving health and the environment. Shelter-related hazards exact a heavy toll on human life, health and productivity in developing countries. The Settlement Infrastructure and Environment Programme (SIEP) of Habitat seeks to improve the interdisciplinary understanding of housing and health and to develop human settlements interventions that could promote community health and productivity. SIEP is working closely with the United Nations Children's Fund (UNICEF) in promoting child-friendly cities in developed and developing countries. This initiative aims at building capacity in authorities, local communities and non-governmental organizations with the aim of improving the well-being of children, especially in relation to basic services. The Habitat Agenda[7] identifies the well-being of children as the single most important indicator of good governance and healthy cities.

13. The United Nations International Drug Control Programme supports alternative development projects which aim to prevent, reduce or eradicate illicit drug production, while simultaneously offering alternatives and increased quality of life. They often include health components targeted at the general population, particularly women and children. Accompanying measures can include improvement of the nutritional base of the area and alternative agricultural development. Support is also provided for the training of health and social work professionals in the area of drug abuse treatment.

14. The International Labour Organization (ILO) provides technical assistance on the improvement of safety and health at work and on the design and management of health cost insurance schemes. Recently, ILO started an interregional project on social security in the informal sector. In one pilot project in Dar es Salaam, United Republic of Tanzania, for one dollar per person per month, participants are insured for primary health care and some secondary and tertiary-level health-care costs. This experiment, covering 1,500 workers, is self-financing and will be extended to other areas in the United Republic of Tanzania and to various areas in Benin, El Salvador and India. Similarly, the Bamako Initiative[8] has demonstrated that even poor families will pay modest charges for health care if the services needed are available and of good quality.

15. An important basic issue, which provides the framework within which all subsidiary issues in the health sector have to be addressed, is that of health sector reform. Health sector reform implies fundamental change in health-care systems and is a process of redefining the approaches required to achieve the objectives of primary health care and to improve and sustain health status. It must involve institutional change, as existing organizational structures and management systems have failed to address the major health sector problems in most developing countries. Reform is thus concerned with redefining priorities and policies and reforming the institutions through which the policies are implemented. There is no consistent, universal package of measures that constitutes health sector reform. Its agenda should therefore be country-specific, since different developing countries are at widely different stages in terms of health reform.

16. Selected key issues related to health sector reform are discussed in the guidelines on primary health care, prepared by the Task Force on Basic Social Services for All. They include the role of the ministry of health; planning and priority setting; decentralization of authority; health-care financing; human resource development; and capacity-building. Future action in the area of primary health care should build on opportunities provided in each country through governmental reform programmes in health, education, agriculture and other sectors; the mobilization of civil society and non-governmental organizations; and the initiatives of various United Nations theme groups at the country level. The Task Force guidelines highlight specific actions that can be undertaken at the country level through the United Nations resident coordinator system.

Elderly people and persons with disabilities

17. Declines in fertility levels and in mortality levels are producing fundamental changes in the age structure of the population of most societies, including, most notably, record increases in the proportion and number of elderly people. This steady increase of older age groups in national populations has significant implications for countries, particularly with regard to the future viability of existing formal and informal modalities for assistance to elderly people. In most societies, women, because they live longer than men, constitute the majority of the elderly population and, in many countries, elderly poor women are especially vulnerable. Since they live longer, women are more likely to be left without spousal or family support and face higher risks of health problems and disability. Also, as a result of their limited access to education and employment, women have fewer opportunities than men to earn and save money. Consequently, in old age many women are poor and without support or safety nets.

18. The Ageing and Health Programme of the World Health Organization has recently reviewed the health condition of ageing women in the world and has proposed a framework for action under the guidance of the WHO Global Commission on Women's Health. Together with WHO, the Division for the Advancement of Women of the United Nations Secretariat will hold an expert group meeting in June 1998, focusing on women and health. The meeting, which will develop proposals for gender-sensitive management systems in health care, will consider five themes: occupational health, environmental health, mental health, ageing, and nutrition. The Commission on the Status of Women will discuss the situation of elderly women at its forty-second session in 1998 and will focus on women and health at its forty-third session in 1999. To contribute to the International Year of Older Persons (1999), the Division for the Advancement of Women is carrying out a study on ageing women and development, based on country profiles. Recommendations emerging from the study will be made for policies to improve the situation of older women. With the United Nations programme on ageing of the Department of Economic and Social Affairs, an expert group meeting on gender and care giving was recently organized (Malta, 30 November-2 December 1997). Experts analysed current care giving patterns and policies from a gender perspective and explored innovative approaches to meeting the needs of women both as caregivers and as receivers of care.

19. Since 1989, UNFPA has collaborated with and provided support to the International Institute of Ageing, which was established in Malta in 1988, in response to Economic and Social Council resolution 1987/41. The main objective of the Institute is to fulfil the training needs of developing countries in the area of ageing and to act as a practical bridge between developed and developing countries in promoting technical cooperation, exchanging skills and knowledge and providing advisory services. The proposed training programmes and activities of INIA for 1996-1999 take into account the objectives and recommendations of the ICPD and the World Assembly on Ageing. Over the years, UNFPA support has helped to facilitate and contribute to the training of over 1,000 participants from developing countries, for courses on such subjects as demographic aspects and implications of population ageing, income security for older persons in developing countries, and gerontology and geriatrics. UNFPA has also provided support for updating the Institute's library and for the publication of a gerontological quarterly entitled *Bold*. UNFPA is also providing support to the Korea Institute for Health and Social Affairs for an international symposium to be held in 1998, in collaboration with the Government of the Republic of Korea, on population and development policies in low fertility countries: the challenges of changing age structures. With rapidly declining fertility and mortality, several Asian populations are experiencing substantial changes in age structure. One of the consequences of the changes is an increase in the number and proportion of the elderly. How to support and care for them is a challenge now facing the region, which the symposium will discuss.

20. Due to population ageing and the breakdown of traditional family structure, formal and informal support systems for the elderly are a major concern. Key actions are needed to:

(a) Develop systems of health care and of economic and social security in old age, with special attention to the needs of women;

(b) Enhance the self-reliance of elderly people, promote their quality of life and enable them to work and live independently;

(c) Develop a social support system, both formal and informal, to enhance the ability of families to take care of elderly people within the family.

21. In 1996, the International Labour Organization published a study entitled *Combining Work and Elder Care: A Challenge for Now and the Future*, which examines the relevant international instruments and policies regarding elder care and compares the approaches to supporting workers with elder-care responsibilities in six industrialized countries. The Economic and Social Commission for Asia and the Pacific is currently supporting small-scale surveys of household structure and the elderly in Bangladesh, China, Indonesia, Pakistan, Sri Lanka, Thailand and Uzbekistan. The results will be published in 1998. The United Nations High Commissioner for Refugees (UNHCR), on the occasion of the International Day of Older Persons, noted the invisibility of older persons, even though, as in the Great Lakes area of Central Africa, they make up about 10 per cent of the refugee camp population. Particularly vulnerable are old people who are alone or who care for young children. UNHCR highlights the need for inclusion of the elderly and respect for their skills and knowledge. It encourages agencies to establish systems of home visits and neighbour support so that elderly people can be helped to obtain the basic necessities of life and access to health care.

22. The valuable contribution that elderly people make to families and society, especially as volunteers and caregivers, should be given due recognition and encouragement. As underscored in the Programme of Action, Governments, in collaboration with non-governmental organizations and the private sector, need to strengthen formal and informal support systems and safety nets for elderly people and eliminate all forms of violence and discrimination against elderly people, paying special attention to the needs of women. The United Nations system could provide assistance in these endeavours.

23. In spite of social, scientific and technological advances, there remains a pressing need for continued action to promote effective measures for the prevention of disability, for rehabilitation and for the realization of the goals of full participation and equality for persons with disabilities. The Programme of Action calls on Governments at all levels to consider the needs of persons with disabilities in ethical and human rights terms and to develop the infrastructure to address those needs, in particular with regard to education, training and rehabilitation. In 1996, WHO and UNHCR held a joint workshop in Uganda with the Norwegian Association of the Disabled. The workshop brought together representation from refugees, non-governmental organizations, UNHCR and governmental officials from several countries in the region to draw up plans of action on community-based rehabilitation. The ideas generated at the workshop have been taken back to Rwanda, Ethiopia, Kenya and the United Republic of Tanzania, where the inspiring Uganda model (the country even has a quota for disabled persons in Parliament) is being applied. The workshop highlighted the fact that while various health interventions are required for disability, one major problem is community acceptance of those with disability.

IV. Child survival and health

24. Globally, over the past 30 years, the average infant and under-5 mortality rates have dropped by half or more, in great part, through the control of childhood communicable diseases and reductions in perinatal deaths (see figure). Such extraordinary reductions in mortality are unmatched in recorded history. The current average global infant mortality rate (IMR) — the ratio of deaths of children under one year to annual total live births — is 61, down from 123 in the mid 1960s. Similarly, the under-5 mortality rate (U5MR) dropped to 90, from 191 in the mid 1960s.

25. However, despite significant gains made over the past few decades, childhood mortality risks remain high throughout the developing world, particularly in sub-Saharan Africa and South Asia. Most of the deaths are preventable. Diarrhoea and acute respiratory infections together account for 38 per cent, vaccine-preventable disease for 13 per cent, and neonatal and perinatal crises for almost 18 per cent, exacerbated in more than half the cases by malnutrition. HIV/AIDS has eroded or reversed many hard-won gains in sub-Saharan Africa and now threatens South Asia and South-East Asia. Experience has shown that community and household participation is crucial in activities for child survival. The quality of services has to be improved. District health systems need to be decentralized and strengthened. Health services and programmes must reach inaccessible and vulnerable groups, and gender bias in health services must be eliminated.

26. UNICEF estimates that about 7 million young lives are being saved each year as a result of the cumulative impact of several interventions that were begun after the 1990

Figure. Under-5 mortality rate, 1960 and 1995

Source: The State of the World's Children, 1997 (New York, Oxford University Press, 1997), table 10.

[a] Probability of dying between birth and exactly 5 years of age, expressed per 1,000 live births.

World Summit for Children and reinforced by the International Conference on Population and Development. This dramatic decline in the infant mortality and under-5 mortality rates is the outcome of a number of collective, reinforcing efforts. Governments have moved to accord high priority to child survival and health; the work of non-governmental organizations and of the private sector has expanded; community participation has increased, and families have been empowered by gaining greater knowledge and skills about utilizing low-cost, easily available life-saving technologies for their children; bilateral and multilateral agencies have mobilized greater resources for child survival and health interventions; and immunization, nutrition and reproductive health programmes have expanded. Many of these efforts were spearheaded by United Nations agencies, in partnership with Governments, non-governmental organizations, service organizations, and bilateral and multilateral donors.

27. Improving the health of the world's children is central to UNICEF's mission, and the reduction of infant, child and maternal mortality is the overarching goal of its health and nutrition programmes. UNICEF seeks to address the basic socio-economic causes of poor health and child deaths in a multisectoral way. With its direct programme interventions, UNICEF provides support to efforts to extend universal primary education, expand the availability of potable water and improve primary environmental care, and improve household food security and access to other resources. Through advocacy, it raises awareness about the situation of children, reinforces political will for action, influences policies and helps to establish a moral environment that puts the well-being of children high on the political agenda. The rights to survival and to the highest attainable standard of health, articulated in the Convention on the Rights of the Child, adopted by the General Assembly in 1989[9] and ratified nearly universally since then, provide the framework for UNICEF's work in mortality reduction. The UNICEF approach to health places the family and the household at the centre of health action and the child at the centre of the family. The focus is on helping to strengthen countries' capacities in health monitoring, health promotion and essential health services within the primary health-care approach so that children may enjoy the highest attainable standard of health and nutrition.

28. Child immunization has been one of the key public health interventions supported by UNICEF for the past 15 years. Over 80 per cent of the world's children are now covered by immunization services, up from 15 per cent or less

in many parts of the world just a decade ago. At current levels of immunization, almost 3 million children are saved annually. But there are still 2 million children dying because they are not immunized. The burden of immunizable/ preventable diseases is greatest in sub-Saharan Africa, a result of low immunization coverage and poor health infrastructure. Despite significant increases in immunization coverage in the past decade, measles remains a major cause of childhood death and ill health in many developing countries. WHO estimates that measles alone accounts for more children's deaths than any other vaccine-preventable disease. Acute respiratory infections, especially pneumonia, are another major cause of illness and childhood mortality, accounting for almost 2 million under-5 deaths and 30-40 per cent of paediatric visits to health facilities.

29. Oral rehydration therapy is being used in almost every country in the developing world to prevent dehydration and death from diarrhoeal diseases. Polio and guinea worm disease are on the verge of eradication. An additional 1.5 billion people have begun consuming iodized salt, protecting around 12 million infants each year from mental retardation. Over 12,000 hospitals are designated baby-friendly as a result of efforts to promote breastfeeding, which is fundamental to survival, health, nutrition and the development of children and is specifically recognized in article 24 of the Convention on the Rights of the Child as a major factor in ensuring the child's right to the highest attainable standard of health. Public communication and advocacy for breastfeeding have been carried out in collaboration with many Governments and non-governmental organizations.

the developing

30. countries are malnourished, measured by weight for age. Some 247 million are estimated to be stunted. A study funded by UNICEF, the results of which were endorsed by WHO, concluded that, globally, malnutrition contributes to about 56 per cent of under-5 mortality, both directly and indirectly, by lowering resistance to infectious illness. Malnutrition also results in poor physical and cognitive development. There is increasing evidence to suggest that malnutrition in the early years of life increases the risk in adulthood of diabetes, cardiovascular disease and other chronic illnesses.

31. Promotion of the improvement in the health and nutritional status of infants and children and pregnant and nursing mothers is the key operational feature of the work of the World Food Programme (WFP). The major form of WFP's intervention is supplementary feeding programmes and the incentive they provide for more regular utilization of mother and child health (MCH) services. To combat micronutrient deficiencies, WFP is providing low-cost blended foods fortified with essential micronutrients. The evidence indicates that supplementary feeding projects have clearly contributed to greater enrolment in MCH programmes and regular monitoring of pregnant women and children. Most projects are designed to reach between 20,000 and 100,000 beneficiaries per annum; seven projects target more than 200,000 people each year. The ongoing 27 supplementary feeding interventions carry a commitment value of over $300 million.

32. The Food and Agriculture Organization of the United Nations (FAO) provides technical guidance for promoting household and community action to improve dietary intake and nutritional well-being. FAO supports community-based participatory methods for achieving and sustaining nutritional improvements, especially among vulnerable population groups; increasing the utilization of locally available food crops; and improving the nutritional impact of post-emergency and agricultural rehabilitation programmes and food assisted projects. Training workshops are also supported to assist in national capacity-building for the execution of these activities at the community level in member countries.

33. UNDCP cooperates with WHO, UNICEF and the Joint United Nations Programme on AIDS (UNAIDS) in promoting comprehensive drug abuse prevention programmes that address the health and education needs of youth at risk. The target groups of such interventions — in- school and out-of-school youth, street children and young working adults — are individuals who have never used drugs; those who are occasional or frequent users; and those who abuse drugs regularly. Early preventive interventions aim at tackling the root causes of drug abuse by strengthening families and communities and providing basic social services.

34. The reproductive health needs of adolescents as a group have been largely ignored to date by existing reproductive health services. The Programme of Action underscores that information and services should be made available to adolescents to help them understand their sexuality and to protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility. This should be combined with the education of young men to respect women's self-determination and to share responsibility with women in matters of sexuality and reproduction. Since the International Conference on Population and Development, UNFPA has focused increasing attention on the key area of adolescent reproductive health, through collaboration with such non-governmental organizations as the International Planned Parenthood Federation. Recently, in collaboration with another non-governmental organization, the Centre for Development and Population Activities, UNFPA organized the African Youth Forum on Adolescent Reproductive Health, held in Addis Ababa, Ethiopia. UNFPA also sponsored an

international youth essay contest on promoting responsible reproductive health behaviour.

V. Women's health and safe motherhood

35. The Programme of Action calls on all countries to strive to effect significant reductions in maternal mortality by the year 2015 — a reduction in maternal mortality of one half of the 1990 levels by the year 2000, and a further one half by 2015. At the global level, it has been estimated that more than half a million women die each year of pregnancy-related causes, 99 per cent of them in developing countries. The gap between developed and developing countries is wide and should be narrowed. Programmes to reduce maternal morbidity and mortality should include information and reproductive health services, including family planning services. Priority should be accorded to improving the nutritional and health status of young women through education and training as part of maternal health and safe motherhood programmes. Programmes and education to engage men's support for maternal health and safe motherhood should be developed. Women should have access to quality services for the complications arising from abortion. Post-abortion counselling, education and family planning services should be offered promptly. Adolescent females and males should be provided with information, education and counselling to help them delay early family formation, premature sexual activity and first pregnancy. Strategies should be devised to ensure that men share responsibility for sexual and reproductive health, including family planning, and for preventing and controlling sexually transmitted diseases, HIV infection and AIDS.

36. Women bear by far the greatest burden of reproductive health problems but biological factors alone do not explain women's disparate burden. Their social, economic and political disadvantages and the denial of their reproductive rights have a detrimental impact on their reproductive health. The empowerment of women is a fundamental prerequisite for their reproductive health; women's reproductive health will not be significantly improved in the absence of gender equity and equality. Because men's social and sexual behaviour directly affects women's reproductive health, reproductive health programmes, while catering for the specific needs of women, will also need to pay special attention to the roles and responsibilities of men and the need for them to assume greater responsibility for their sexual and reproductive behaviour and their social and family roles.

37. The Task Force guidelines on primary health care, reproductive health and women's empowerment underscore the need for a gender approach in addressing women's health and safe motherhood issues. A gender approach to health (research, policies and programmes) examines how gender differences determine differential exposure to risk, access to information, services and benefits of technology and provides significant insights into the design of programmes and practical disease control interventions. A "gender lens" needs to be applied in viewing all aspects of primary health care, taking into account the multiple roles and the position of women and men, and how this affects the issue in question. Collecting sex- and age-disaggregated data is essential for this kind of analysis — for example, to determine whether there are differences in malnutrition or immunization rates between girls and boys, or to identify the problems related to accessibility to basic social services and to food and water.

38. The Safe Motherhood Initiative co-sponsored by WHO, UNICEF, UNFPA, the World Bank and two non-governmental organizations, the International Planned Parenthood Federation and the Population Council, focuses on five key areas of action: advocacy; epidemiological, social and operational research; information dissemination; human resource development; and health service improvement measures. In October 1997, a technical consultation on safe motherhood was held in Sri Lanka to review progress made to date on this important aspect of reproductive health.

39. Maternal health has been a growing focus for UNICEF, with key interventions directed at 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 currently being developed in partnership with WHO, bilateral donors and experts in developing countries. WHO and UNFPA have been partners in UNICEF's work related to maternal health and survival. WHO as the technical agency provides the standardized instruments (needs assessment, training modules). UNFPA is the lead agency for integration of reproductive health care, which includes sexual health and family planning, maternal and neonatal care, prevention and treatment of reproductive tract infections, sexually transmitted diseases, including HIV/AIDS, and elimination of harmful practices, including female genital mutilation (FGM) and violence against women.

40. The Programme of Action underscored that in a number of countries, harmful practices meant to control women's sexuality have led to great suffering. Among them is the practice of female genital mutilation, which is a violation of basic rights and a major lifelong risk to women's health. It is estimated that 85-115 million girls have undergone some

form of genital mutilation, and at least 2 million girls a year are at risk .UNFPA is addressing the issue of FGM. In 1996 it sponsored a technical consultation in Ethiopia, with representatives from 25 countries, to discuss, *inter alia*, the types of training, research and services needed to eradicate female genital mutilation. The recent dramatic success of a UNFPA-supported programme in Kapchorwa district in Uganda underscores the potential impact that advocacy can have. The Reproductive Educative and Community Health (REACH) Programme of Kapchorwa district uses an innovative and culturally sensitive approach in which community-based agents involve community leaders and people from all sectors of society in sensitization seminars and workshops to make them aware of the harmful aspects of FGM. The REACH Programme has witnessed a 36 per cent drop in female circumcision in less than one year.[10]

41. The view that violence against women is a universal obstacle to development and to empowerment of women underpins the work of the United Nations Development Fund for Women (UNIFEM). In support of actions to eliminate violence against women, the Administrator of UNDP has established a trust fund within the existing mandate of UNIFEM. The Governments of Australia, Denmark, Italy, Japan, the Republic of Korea, Malta and Mauritius have already contributed to the trust fund. Twenty-five initiatives in Africa, Asia and the Pacific and Latin America have been funded, with a total of over $850,000. UNFPA has pooled its gender advisers with UNIFEM, and UNDP is planning to do the same. UNICEF, UNFPA and WHO in partnership with other United Nations agencies and non-governmental organizations are developing strategies to address women's health problems such as domestic violence, women's vulnerability to HIV/AIDS, and harmful practices affecting women and girls, such as FGM.

42. Special efforts are needed to protect and promote the human rights of women migrants and refugees, who are especially vulnerable to violence and exploitation because of their gender. In 1996, UNFPA funded an emergency reproductive health-care initiative for refugees in the Great Lakes area of Central Africa to benefit some 200,000 women. The project was executed and coordinated by the International Federation of Red Cross and Red Crescent Societies, in full cooperation with UNHCR and non-governmental organizations. This collaborative effort marked the first time that reproductive health-care services for refugees had been planned at the beginning of an emergency operation.

43. The Department of Humanitarian Affairs of the United Nations Secretariat reports that the denial of access of girls and women to education and health services became prominent soon after the arrival in 1994 of the Taliban, in the Kandahar region of Afghanistan. In response to these clear violations of human rights, the United Nations resident and humanitarian coordinators for Afghanistan focused on the issue in the drafting of the country strategy note. The resident coordinator also provided funding for the creation of a gender advisory group, with the participation of non-governmental organization participation. At the meeting of the Afghanistan Support Group, held in Ashkabad, Turkmenistan, on 21-22 January 1997, the gender issue was singled out as the overriding problem affecting all aspects of the humanitarian assistance programme. Since then, donors, United Nations agencies and non-governmental organizations have intensified their efforts to take a common stand against the violation of the rights of girls and women to education and health care.

44. In 1999, when the International Labour Conference convenes, delegates will consider the revision of the Maternity Protection Convention (No. 103), 1952. Among the minimum standards set by the Convention are the right to 12 week's maternity leave with cash and medical benefits, the right to nursing breaks, and protection against dismissal while on maternity leave. ILO has prepared a law and practice report which examines the principal aspects of maternity protection provisions in countries around the world. The rights to maternity leave, to income replacement during leave, and prenatal confinement and post-natal care are fundamental to promoting the health, safe motherhood and economic well-being of pregnant and nursing workers. Ensuring that such workers are not subjected to discriminatory treatment in employment enables them to enjoy these rights.

45. The Programme of Action calls for recognizing and supporting the role of women as primary custodians of family health. Access to basic health care, expanded health education, the availability of simple cost-effective remedies, and the reappraisal of primary health-care services, including reproductive health-care services to facilitate the proper use of women's time, should be provided. It is critical that reproductive health programmes emphasize the empowerment of women and specifically address the special needs of girls and women as well as those of other underserved groups, such as youth and adolescents, rural and urban poor, persons in remote or neglected areas, and migrants, refugees and displaced persons. Increasing the role and responsibility of men in reproductive health, parenting and the prevention of STD/AIDS will also have a positive impact on the health of women. Attention must also continue to be focused on eradicating gender-based violence and other harmful practices detrimental to the health and well-being of girls and women. Women must also be afforded opportunities to be involved in the design, development, implementation and evaluation of reproductive health programmes. The United Nations

resident coordinator system can play a key role in ensuring that development programmes emphasize the empowerment of women and focus attention on promoting and enhancing their reproductive health. The guidelines developed by the Task Force on Basic Social Services for All provide a practical tool for such programming and advocacy.

VI. Human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS)

46. As underscored in the Programme of Action of the International Conference on Population and Development, the HIV/AIDS pandemic is a major concern for both developed and developing countries. Of the estimated worldwide total of 30.6 million living with HIV/AIDS, 29.5 million are adults and 1.1 million are children. According to recent estimates by the Joint United Nations Programme on AIDS (UNAIDS) and WHO, the epidemic continued to expand in 1997, with an estimated 5.8 million new HIV infections — approximately 16,000 a day. Over 40 per cent of the new infections among adults occurred in women. The majority of newly infected adults are under 25 years old. During 1997, HIV/AIDS-associated illnesses caused the death of an estimated 2.3 million people, including 460,000 children. This represents about a fifth of the total 11.7 million AIDS deaths since the beginning of the epidemic in the late 1970s.[11]

47. The HIV/AIDS pandemic is not just a serious health challenge; it is a critical human development challenge with complex socio-economic impacts and costs. Loss of experienced personnel and skilled labour, declines in productivity, the need for increased resources to hire and retrain replacements, increased absenteeism and labour turnover, increased health-care costs, coupled with the human and social costs endured by the individuals and communities affected by the pandemic are imposing heavy burdens, particularly on developing countries with limited resources.

48. In the absence of a vaccine, education and communication strategies, the provision of condoms, information and counselling, the promotion of safe and responsible behaviour and ensuring universal precautions in health settings are critical components of HIV/AIDS prevention and control strategies. In particular, special attention should be focused on reaching those at high risk of acquiring HIV infection, including adolescents and women, whose vulnerability is often greatest.

49. The Joint United Nations Programme on AIDS (UNAIDS), operational since January 1996, serves as the main advocate for global action on HIV/AIDS, pooling the experiences, efforts and resources of its six co-sponsors: UNICEF, UNDP, UNFPA, UNESCO, WHO and the World Bank. The strategic focus of UNAIDS is to strengthen the capacity of the United Nations system to assist Governments and civil society to respond to HIV/AIDS; to build worldwide political commitment and support to respond to HIV/AIDS; and to improve the content, access and use of the body of knowledge needed to accelerate the global response to HIV/AIDS. The six co-sponsors of UNAIDS are also members of the Task Force on Basic Social Services for All. In addition to collaborative efforts under the UNAIDS umbrella, the six co-sponsors carry out activities under their own mandates.

50. UNFPA, through its reproductive health and family planning programmes is providing assistance for HIV/AIDS prevention activities in 124 countries. This support focuses on four main areas: supply and distribution of condoms; training of reproductive health and family planning information and service providers; HIV/AIDS education, in and out of school; and HIV/AIDS information as part of broader population/reproductive health information, education and communication programmes. During 1996, in providing support to national AIDS prevention and control programmes, UNFPA collaborated with 115 non-governmental organizations and supported activities aimed at youth and adolescents in 95 countries. UNFPA estimated that the extent of its total support for HIV/AIDS prevention in 1996 was $20.5 million, and 95 per cent of that — i.e., $19.5 million — was at the country level. UNFPA continues to be an active co-sponsor of UNAIDS and works closely through the Programme Coordinating Board, the Committee of Co-sponsoring Organizations and various technical and theme groups which have been set up. At the country level, a number of the United Nations theme groups have been chaired by UNFPA representatives.

51. As a co-sponsor of UNAIDS, the World Bank is a leader in funding of HIV/AIDS programmes and links its efforts to broader initiatives in reproductive health and the control of communicable diseases, particularly reproductive tract infections and sexually transmitted diseases. The United Nations Educational and Scientific and Cultural Organization (UNESCO) is also a co-sponsor of UNAIDS; its initiatives on HIV/AIDS prevention are primarily focused on education, both in formal and non-formal settings. They include: development of new teaching/learning materials on HIV/AIDS prevention; revision of school curricula; teacher training; training of representatives of grass-roots women's organizations; and regional seminars for high-level decision makers. The United Nations Development Programme

(UNDP), also a co-sponsor of UNAIDS, is focusing on integrating HIV/AIDS prevention activities in key programming areas, including governance, gender and poverty. Training workshops have been organized in country offices to strengthen programming skills of national focal points. Meanwhile, the United Nations Development Fund for Women (UNIFEM) is working with other United Nations agencies and non-governmental organizations, at the field level, on women's empowerment aspects of HIV/AIDS projects.

52. The United Nations Children's Fund (UNICEF) is also a co-sponsor of UNAIDS. Using a rights-based approach, its focus is on strengthening capacity for measuring young people's health and development; protecting their rights to access information and services, including sexual and reproductive health services; identifying and developing resources to support country programmes; and improving the flow of information within UNICEF and with its partners. The main focus of UNICEF's global efforts is to distil and promote country and regional "best practice" experience in the use of communication for behaviour change in HIV/AIDS prevention, care and rights, and to mobilize partners to expand their priorities on HIV/AIDS issues. UNICEF is also very active in the theme groups at the country level.

53. The United Nations International Drug Control Programme, in collaboration with ESCAP, UNAIDS, local Governments and various non-governmental organizations is active in preventing HIV infection and providing care for injecting drug users, including those in the Golden Triangle area in South-East Asia. The United Nations Industrial Development Organization (UNIDO) has implemented HIV/AIDS prevention projects in sub-Saharan Africa, to meet the combined objectives of industrial development and the prevention of the spread of HIV/AIDS. UNIDO is supporting improved access to and affordability of products used in prevention programmes — condoms, latex gloves, syringes, HIV-1/2 test kits — through development of local manufacturing capability. Local manufacturers are also being encouraged to carry specific HIV/AIDS prevention messages on their product labels. HIV/AIDS prevention education is also being imparted to Palestinian school children, trainees at vocational centres, and refugee women, through a programme undertaken by the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA).

54. In the fight against HIV/AIDS, two key areas require critical attention: prevention among women and children — two of the most vulnerable groups; and increasing access to HIV/AIDS-related drugs and treatments in developing countries. The disastrous impact of HIV/AIDS on children needs to be urgently addressed. If the spread of HIV is not rapidly contained, the gains made in reducing infant and child death rates will be reversed in many countries. Estimates in a recent report, entitled *Children Living in a World with AIDS*, released by UNAIDS in June 1997,[12] indicate that by the year 2010, AIDS may increase infant mortality by as much as 75 per cent and under-5 child mortality by more than 100 per cent, in the most hard-hit countries in the world. According to the report, more children than ever before are contracting HIV, and there is no sign that the infection rate is slowing. Women of child-bearing age now make up an ever-increasing proportion of people with HIV worldwide; for example, AIDS kills more women than men in sub-Saharan Africa.

55. Reducing the vulnerability of infants to HIV infection also requires increasing women's control over their situations, improving their ability to negotiate with their male partners regarding their own reproductive and sexual health, increasing their access to health services and increasing the knowledge and sense of responsibility of both men and women about HIV prevention. It also requires increasing women's access to antiviral drug regimens which can cut the risk of mother-to-child transmission. In November 1997, UNAIDS launched the pilot phase of the UNAIDS HIV Drug Access Initiative, a collaborative effort between the public and private sectors to identify strategies to increase access to HIV/AIDS drugs in developing countries. The four developing countries involved in the pilot phase — Chile, Côte d'Ivoire, Uganda and Viet Nam — will work to adapt their health infrastructures to ensure effective distribution and uses of HIV/AIDS-related drugs, and participating pharmaceutical and diagnostic companies will subsidize purchase of the drugs. The overall objective of the initiative is to provide improved care and increase access to the newest and most effective drugs.

56. When an HIV diagnosis occurs, the family and the entire household often suffer from stigma, isolation, job loss and impoverishment because of discrimination, resulting frequently from fear and/or incorrect information and beliefs about HIV transmission. These prejudices and their cruel consequences must be combated and United Nations agencies and organizations are uniquely positioned to mount education and awareness-raising campaigns which will counter such discrimination. The Programme of Action specifically calls on Governments to develop policies and guidelines to protect the individual rights of persons infected with HIV and their families and eliminate discrimination against them. Special programmes should also be devised to provide care and the necessary emotional support to those who are affected and to counsel their families and near relations.

VII. Technology, research and development

57. Member organizations of the Task Force on Basic Social Services for All, in keeping with the call of the Programme of Action and their own mandates, are continuing activities pertaining to basic data collection, analysis and dissemination; reproductive health research, and social and economic research. The International Monetary Fund, recognizing the need to improve data collection on governmental spending in the social sector, particularly on health and education, has intensified its collaboration with the World Bank in monitoring public expenditures of member countries. This focus reflects a recognition of the crucial link between the level and efficiency of health and education spending and economic growth. The new emphasis was also prompted by the IMF Executive Board's request that staff pay particular attention to social indicators in the contexts of adjustment programmes supported by the IMF's enhanced structural adjustment facility and of the initiative to help heavily indebted poor countries achieve sustainable external debt positions. IMF has underscored that the proper mix of monetary and fiscal policies and the structural reforms needed to underpin them should also take into account the poor and the most vulnerable people in society. The second generation of reforms promoted by IMF seeks to enhance growth, accelerate human development, and ensure that the benefits of growth are widely shared. Thus, countries are encouraged to ensure adequate public expenditures for education and health to help individuals realize their potential to participate actively in a market economy and provide social protection to those who bear the brunt of the changes of a dynamic economy.

58. The Population Division (Department of Economic and Social Affairs, United Nations Secretariat) continually undertakes research and other activities related to health and mortality, monitoring levels and trends of mortality at the global level and studying its causes and consequences; monitoring country policies and programmes related to various aspects of health and mortality; and as part of the biennial revision of the United Nations world population estimates and projections, maintaining and updating the official United Nations estimates of life expectancy at birth and infant and child mortality for all countries of the world. For the thirty-first session of the Commission on Population and Development, the Population Division has prepared the 1998 edition of *World Population Monitoring* which covers health and mortality, with special emphasis on the linkages between health and development and on gender and age. As part of the biennial revisions of *World Population Prospects*, estimates are available of the effect of HIV/AIDS on deaths, life expectancy at birth, infant mortality and population growth. For the *1996 Revision*, the impact of the HIV/AIDS pandemic was measured for 24 African countries, two Asian countries and two Latin American countries. The Economic Commission for Latin America and the Caribbean collaborated with UNICEF and the Population Division in monitoring infant and child mortality rates in Latin American countries. Mortality estimates have been provided for urban and rural areas, disaggregated by level of education of the mother.

59. The Economic Commission for Europe (ECE) is carrying out a study of demographic change in European countries with economies in transition, which is part of the UNFPA-supported programme of data collection, analysis and research, focusing on selected aspects of the implementation of the Programme of Action in the ECE region, particularly in central and eastern Europe. The study is concerned, *inter alia*, with the trends and patterns in overall mortality, change in mortality by age and gender, and causes of mortality differentials. Early results indicate that during the transition to democracy and a market economy, the European Soviet successor States experienced losses in male and female life expectancy at birth, while as a rule, central European and Balkan countries witnessed gains. Deterioration in male survival in the former Soviet Union has been far greater than that in female survival, bringing about unprecedented sex differentials in mortality, particularly in the Russian Federation and the Baltic countries. Children and adolescents, both male and female, generally enjoyed improvements in survival during the transition years. Working-age adults and older persons were less fortunate. Their mortality declined in central Europe but generally increased elsewhere, particularly in the former Soviet Union. The mortality increases among adult males have been far greater than those among adult females, however, and the greatest mortality increases have taken place among older women and men.

60. The Programme of Action calls for the elimination of excess mortality of girls where it exists and for special education and public information efforts to promote equal treatment of girls and boys with respect to nutrition and health care. In response to those concerns and the need to identify measures aimed at eliminating excess and preventable mortality among young girls, a study was undertaken by the Population Division on the sex differentials in infant, child and under-5 mortality and the specific mechanisms that may lead to excess female mortality in childhood. The study *Too*

Young to Die: Genes or Gender, discusses the measurement and analysis of levels and trends of childhood mortality for boys and girls and explores the broad range of mechanisms that influence sex differentials in child mortality.

61. UNFPA, under its Global Initiative on Contraceptive Requirements and Logistics Management Needs, conducted a number of in-depth studies in developing countries, in collaboration with other United Nations agencies, bilateral agencies and selected international non-governmental organizations. The studies were carried out with the full cooperation of Governments in Bangladesh, Brazil, Egypt, India, Mexico, Nepal, the Philippines, Pakistan, Turkey, Viet Nam and Zimbabwe. Subsequently, studies were also undertaken in Burkina Faso, the Dominican Republic, Ethiopia, Haiti, and Morocco. In addition to projecting contraceptive requirements to the year 2005, the studies identified programme needs for logistics management, assessed the role of non-governmental organizations and the private sector in family planning activities and contraceptive delivery, reviewed the feasibility of local production of contraceptives, examined trends in the sources and uses of funds for contraceptive commodities and logistics management, and estimated condom requirements for the prevention and control of sexually transmitted disease/ acquired immunodeficiency syndrome. A facility has been established at UNFPA to assist countries in meeting their emergency needs for contraceptive commodities. Interim stockholdings have been established of all primary contraceptive methods in order to respond to envisaged emergency demand.

62. The WHO Special Programme on Research, Development and Research Training in Human Reproduction has developed and tested a new strategy to strengthen country capacity to broaden contraceptive choice. The Programme played a critical role in the identification of levonrgestrel as a novel method of emergency contraception. It is being implemented in model programmes in a number of countries. Ongoing activities include improving access to once-a-month injectable contraceptives and assessing the quality of contraceptives.

VIII. Conclusion

63. The ACC Task Force on Basic Social Services for All was established to galvanize the United Nations system around priority goals emerging from the recent global conferences and to strengthen the system's follow-up mechanisms for delivering coordinated assistance at the country and regional levels. A number of factors contributed to the synergistic collaboration and coordination achieved by the Task Force:

(a) All Task Force member organizations and agencies committed themselves to participating collaboratively on key issues and substance without being limited to representing only their individual agency interests;

(b) That commitment was also reflected in the time and resources (both staff and funds) provided by the Task Force members to organizing meetings, conducting follow-up and preparing the end-products;

(c) The selection of lead agencies to head the working groups was based not only on their mandates but also on their ability to contribute to and complete the tasks;

(d) The formation of informal networks of Task Force colleagues who could relate to each other in quick, informal, non-bureaucratic ways, frequently using electronic communication and sometimes linking up in connection with other duty travel, created synergy and kept the process moving forward with a focus on results;

(e) Task Force objectives were clear and well-defined, and a specific time-frame was set in which to achieve them;

(f) A spirit of cooperation prevailed (for example, some meetings were held in Geneva instead of New York to facilitate participation of Europe-based members; also some meetings were held back-to-back to save time and money; additionally, at the request of the Canadian International Development Agency, the Task Force discussed and subsequently provided feedback to it on its draft policy paper on meeting basic human needs;

(g) The secretariat organized meetings, prepared and distributed reports, tracked the meeting of deadlines and facilitated coordination and follow-up among the Task Force members.

64. Factors that proved to be constraints included limitations of time and resources, which also caused some delays. Also, the assigned mandate of the Task Force was relatively broad, and in-depth coverage of all areas in the limited time allotted was not possible. The Task Force addressed this constraint by focusing on areas of comparative advantage and producing specific outputs that would assist programming at the country level. For example, the wall chart provides indicators and data that will enable countries to monitor and measure progress in achieving Conference goals in such key areas as population, primary health care, nutrition, basic education, drinking water and sanitation, and shelter.

It should also be noted that the Task Force modality is generally effective for limited time-spans, and it may prove difficult to keep up the momentum beyond a certain time-period.

65. Lessons learned from the experience of the Task Force on Basic Social Services include the following: the mode of operation used by the Task Force — namely, working in a task-focused manner, frequently through informal networks, in addition to more established and formal inter-agency mechanisms, proved to be synergistic, quicker and more effective in producing results; clear and well-defined objectives and end-products allowed the Task Force to maintain a strategic focus and a specific timetable; Task Force working groups and member organizations demonstrated that they could work collaboratively in producing the agreed end-products in a timely manner and had no vested interests in establishing themselves as permanent structures; the Task Force experience, as well as that of the earlier Inter-Agency Task Force on Implementing the ICPD Programme of Action, demonstrates that within ACC, from time to time and as appropriate, the "task manager" approach can be used effectively for specific assignments. While this approach cannot replace established and permanent mechanisms which continue to have critical roles, it is important to recognize the value of the task force/ task manager approach which can empower a wider group of actors and engender co-ownership through increased sharing of responsibilities and closer collaboration. Naturally, the competence, ability and track record in delivering results will determine the selection of task force leaders and focal points and shape the final outcome.

66. After distribution of its end-products to the field, the work programme of the Task Force will have been accomplished. The emphasis will be at the country level where the United Nations resident coordinator system will use the end-products to assist countries in implementing programmes focusing on achieving Conference goals, including the provision of basic social services for all. It is envisaged that the Turin Training Centre in Italy will develop training modules for field staff to facilitate and optimize use of the Task Force end-products. Theme groups and ad hoc task forces within the purview of the United Nations resident coordinator would be a useful modality for enhancing inter-agency coordination and collaboration at the country level. Many countries have already organized such groups, modelled on the ACC Task Forces. Non-governmental organizations and groups in civil society and the private sector should be involved in the country-level theme groups and task forces, and all end-products of the Task Force should be made available to them. The United Nations resident coordinator system can use this modality to strengthen and expand linkages with bilateral agencies, non-governmental organizations, the private sector and civil society and to draw on their areas of comparative advantage. The outputs of the Task Force should be linked to the common country assessments, country strategy notes and the United Nations development assistance framework. The regional commissions also have a key role to play in promoting and advocating use of the Task Force end-products. Regular information sharing and exchange, through the Internet and other such technologies, will facilitate better coordination and collaboration among key actors and all development partners at the country level and will also help to engender a sense of co-ownership.

Notes

[1] The members of the Task Force are: United Nations (Department of Economic and Social Affairs, Department of Humanitarian Affairs, Economic Commission for Africa, Economic Commission for Europe, Economic and Social Commission for Asia and the Pacific, Economic Commission for Latin America and the Caribbean, Economic and Social Commission for Western Asia), the Food and Agriculture Organization of the United Nations, the International Labour Organization, the International Monetary Fund, the Office of the United Nations High Commissioner for Refugees, the United Nations Centre for Human Settlements, the United Nations Children's Fund, the United Nations Development Fund for Women, the United Nations Development Programme, the United Nations Educational, Scientific and Cultural Organization, the United Nations Environment Programme, the United Nations Industrial Development Organization, the United Nations International Drug Control Programme, the United Nations Population Fund, the United Nations Relief and Works Agency for Palestine Refugees in the Near East, the World Bank, the World Food Programme and the World Health Organization.

[2] *Official Records of the Economic and Social Council, 1997, Supplement No. 4* (E/1997/24).

[3] See also "A revised approach for the allocation of UNFPA resources to country programmes" (DP/FPA/1996/15).

[4] See *Indicators for Assessing the Performance of Reproductive Health Programmes: A Discussion Paper* (New York, UNFPA, April 1997).

[5] *Indicators for Population and Reproductive Health Programmes* (New York, UNFPA, November 1997).

[6] See WHO document ICPHC/ALA/78.10.

[7] See A/CONF.165/14, chap. I.

[8] See E/ICEF/1992/22.

[9] Resolution 44/25, annex.

[10] See United Nations Population Fund, *Annual Report 1996* (New York, UNFPA, 1997).

[11] See the UNAIDS fact sheet *HIV/AIDS: The Global Pandemic* (Geneva, December 1997).

[12] Geneva, 1997.