



UNICEF-WHO Inter-Secretariat Meeting

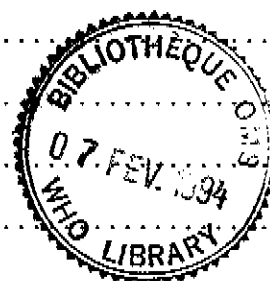
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REPORT OF THE MEETING

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1. INTRODUCTION

1. The UNICEF-WHO Inter-Secretariat Meeting, held in Geneva on 14 and 15 October 1993, was opened and chaired by Dr J.-P. Jardel, Assistant Director-General, WHO, who on behalf of Dr Hiroshi Nakajima, Director-General, welcomed UNICEF colleagues to WHO. He took the opportunity to reiterate some of the major points covered in the Director-General's statement on the occasion of the Roundtable of the Secretary-General of the United Nations "Keeping the promise for children", New York, 30 September 1993 in which he had reiterated his personal commitment, and that of the entire World Health Organization, to stand steadfastly with UNICEF and other responsible partners in the United Nations system, to cooperate with countries to ensure that the goals set at the World Summit for Children in 1990 move from aspirations to reality.

2. The health goals of the World Summit had a sound technical basis and were technically feasible. They reaffirmed the goals already set by the World Health Assembly as an integral part of the main social target adopted by the World Health Assembly 1979, and endorsed by the United Nations General Assembly in resolution 36/43, namely health for all peoples through sustainable primary health care in all countries.

3. To ensure that the work with countries to attain the World Summit goals had a clear focus and could be monitored, eight mid-decade health goals had been set for 1995 when the mid-decade review, called for by the Summit, would be made. The Executive Board of WHO had endorsed these eight mid-decade goals; they were ambitious, but could be achieved if all forces joined to do so.

4. All of these goals needed sustained political commitment and solidarity of effort if momentum towards their achievement was to be maintained in the present difficult socioeconomic conditions worldwide.

5. WHO and UNICEF colleagues had worked together to establish indicators so that progress towards the goals could be measured. Such instruments were also vital for adjusting strategies at national, regional and global level.

6. However, he also wanted to express the Organization's concern regarding the action taken by UNICEF to re-word some goals and to have some new goals added without consultation with WHO. Particular concern was expressed on: (1) the process, as WHO should have been consulted; and (2) the technical feasibility and realism of some of UNICEF's statements with which, therefore, WHO had difficulty in associating itself.

7. The present meeting, therefore, presented a strategic opportunity to get on to the right footing and to move on in the best possible way, and to set the scene for a successful, special session of the WHO/UNICEF Joint Committee on Health Policy, Geneva, 27 and 28 January 1994.

8. In reply Dr Nyi Nyi greeted the participants on behalf of Mr J. Grant, Executive Director of UNICEF, who had expressed his gratitude to WHO for taking the initiative to convene the special session of JCHP in January 1994, the timing of which was important in view of monitoring the strategies for reaching the mid-decade goals. Dr Nyi Nyi wished to stress the remarkable progress made in countries, despite differences of opinion and approaches between the two organizations and which were considered minimal compared to what the countries were going to achieve by the year 2000. Goals were not static and organizations had to keep up with the changes.

9. He agreed that there should be more consultations between the organizations as developments proceeded, the overriding objective being to avoid conflicting messages at the country level. He then reported on the Mayors' Colloquium in Mexico City, attended by over 70 mayors; the Ministerial Consultation of East Asia and Pacific region, in Manila attended by 17 countries and the meeting of the health ministers from 37 countries in Mexico City, discussing how to accelerate the reduction of child mortality. All these assemblies have strongly endorsed the mid-decade goals. He mentioned a great momentum being created now for primary health care and the mid-decade goals in different parts of the world.

10. In adopting the agenda it was proposed that some additional items (as listed in paragraph 68) be considered under agenda item 4 - Other matters.

11. Concerning the new goals with respect to water and sanitation this would be considered as an additional item, i.e. under 2.9.

2. WORLD SUMMIT FOR CHILDREN - MID-DECADE GOALS, 1995

Review of progress

2.1 Neonatal tetanus (NT)

12. The mid-decade goal is "elimination of neonatal tetanus by 1995". This means that a rate of less than one case of neonatal tetanus per 1000 live births will be considered as evidence of elimination in every district of every country.

Situation

13. Achieving this goal requires accelerated efforts. The progress in immunization of women of child-bearing age, and especially pregnant women, with tetanus toxoid is much behind the immunization of infants with childhood vaccines. Globally, the coverage rate for two or more doses of tetanus toxoid increased from 27% in 1989 to only 43% in 1992.

Clean delivery

14. Increasing the number of deliveries conducted by trained and supervised birth attendants will make a significant contribution to the elimination of neonatal tetanus, as well as reducing other causes of maternal and newborn mortality.

15. However, the combined initiatives for elimination of neonatal tetanus and reduction of maternal mortality will require greatly accelerating the levels of coverage by trained birth attendants which in 1992 reached a level of 55%.

Surveillance

16. Assessment of elimination of neonatal tetanus needs more effective and sensitive surveillance systems. Data on neonatal tetanus should be collected through routine reporting systems and be complemented by active surveillance defined as a search for NT based on a review of vital event data (when available), health facility record review, and community based search for neonatal tetanus (e.g. using focus groups or key informants).

ACTION

1. All countries where neonatal tetanus is a health problem should start to carry out district assessment of their neonatal tetanus elimination status, to identify high-risk districts/areas for priority activities to achieve neonatal tetanus elimination, and to start implementation of control measures.
2. By the end of 1995:
 - all countries should achieve in each district at least 80% protection of newborn against neonatal tetanus through immunization or clean delivery or both;
 - all countries will have established a system for at least monthly routine reporting of neonatal tetanus from all districts. The system should include a capacity to investigate cases and take appropriate action in response to a case.
3. The provision of a long-lasting immunity against tetanus with the use of 5-dose tetanus toxoid schedule should be promoted in countries where neonatal tetanus poses a serious public health problem.
4. Attainment of the clean delivery component of the strategy will require decentralized district-based action to ensure that health centres provide quality care and training, supervision and supporting materials to birth attendants.

2.2 Measles deaths and cases

17. The mid-decade goal is "Reduction by 95% in measles deaths and reduction by 90% of measles cases compared to pre-immunization levels by 1995, as a major step to the global eradication of measles in the longer run."

Situation

18. A global reduction in measles deaths by 95% may well be achieved by 1995 if current trends are maintained. Indeed many countries have already achieved 95% reduction in deaths. However, measles is still responsible for more deaths than any other vaccine-preventable disease. It is estimated that one million children die annually due to measles. Many countries in Africa and in other regions (Haiti, Afghanistan) report immunization coverage with measles vaccine below 50%.

Strategy

19. The main strategy is to raise and sustain high coverage (at least 90%) with measles vaccine in all districts and communities in the first year of life.

20. Special immunization activities should be used in high-risk areas/groups of children living in poor urban areas, displaced children, HIV-infected children, and children admitted to hospitals.

ACTION

1. Raise and maintain at least 90% coverage with measles vaccine in children below one year of age.
2. Reduce mortality from measles using standard case management and aggressive treatment of complications.
3. Improve vitamin A status of young children in vitamin A-deficient areas by provision of vitamin A supplements and treating all cases of measles with vitamin A.

2.3 Poliomyelitis-free status

21. The mid-decade goal, 1995, is "to achieve poliomyelitis-free status in the American, European, and Western Pacific Regions of WHO as well as selected countries in other regions, comprising at least 60% of the world population".

22. The goal is the global eradication of poliomyelitis by the year 2000.

Situation

23. In 1992, the most encouraging indication of progress towards a polio-free world by the year 2000 was the further development of geographic areas in which polio is either absent or at low incidence. The countries in the American Region had been free of poliomyelitis due to wild polio virus for more than two years. The countries in the Western Pacific Region have set a target to eradicate poliomyelitis by 1995 and are aggressively pursuing the strategies needed to achieve this target. In the European Region, although wild polio virus transmission continues in several of the New Independent States, incidence was sharply down.

24. Progress in both the Western Pacific and European Regions is threatened by shortage of vaccine. In countries suffering from war or social unrest the immunization activities are reduced.

Strategy

25. The main strategy for polio-endemic countries remains achieving and sustaining a high immunization coverage (at least 90%) with four doses of OPV given to children below one year of age. This should be the primary objective in countries or areas affected by conflicts or social unrest and in those where health systems are currently least developed.

26. Routine immunization **alone** may not be sufficient to interrupt transmission of wild polio virus and supplementary immunization activities may be necessary. These strategies include: national or sub-national immunization days, "mopping up" immunization activities in selected high-risk areas, conducted on house-to-house basis, and outbreak immunization where suspected cases are detected.

ACTION

1. Raise and sustain 90% immunization coverage with four doses of oral polio virus in children below one year of age, including a dose of OPV at birth.
2. Improve disease surveillance systems to measure progress toward the 1995 intermediate goal and the year 2000 eradication goal.
 - Acute flaccid paralysis surveillance should be implemented in all countries to pick up all potential cases of paralytic poliomyelitis.
 - The global/regional laboratory network should be strengthened to ensure that stool specimens from suspect cases are tested for the presence of polio virus in an accurate and timely manner.
 - The leading effort for improving surveillance for poliomyelitis should also directly and effectively strengthen surveillance activities for measles and neonatal tetanus.
3. Continuous close collaboration with Rotary International, national rotary clubs and other partners should be strongly encouraged and sustained.

2.4 Oral rehydration therapy/diarrhoea case management

27. The mid-decade goal endorsed by JCHP, February 1993, was to "Achieve at least 80% use of oral rehydration therapy (increased fluid) and continued feeding in selected countries, and 80% of the following in all countries: capability for and proper case management in health facilities; access to oral rehydration salts (ORS) and provider compliance with ORS use; and mothers knowing three rules of home case management." The revised mid-decade goal is to "Achieve at least 80% use of oral rehydration therapy (increased fluid) and continued feeding." WHO, however, considers that given the current level (around 20% in 1992) this target is not achievable globally. In working towards this goal, monitoring will also include 80% capability for proper case management in health facilities, access to oral rehydration salts (ORS) and mothers knowing three rules of home case management.

CURRENT SITUATION

28. In discussing document IS/UNICEF-WHO/93.5, it was recalled that the intermediate World Summit for Children goal related to the control of diarrhoeal disease called for high levels of use of oral rehydration therapy (ORT) and continued feeding for diarrhoea in children, based on improved family knowledge as well as proper case management by health care providers, both public and private for acute diarrhoea, dysentery and persistent diarrhoea. As part of these aims it is essential that the now widespread acceptance and increased availability of oral rehydration salts be converted into their consistent and correct use.

29. Although significant progress had been made in these areas, the goal cannot be achieved without a very significant increase in commitment of governments and supporting institutions, including international and bilateral agencies. This must be brought to bear to improve the skills of health workers, to ensure that health services function at a level that can assure quality of care and to achieve effective communication within families about the dangers of diarrhoea and how to respond to it. WHO and UNICEF must play a forceful and unified role to promote and support such commitment.

ACTION

30. The essential components of diarrhoea case management should be clearly reiterated to all WHO and UNICEF staff in the field to ensure a common approach in their support to governments.

31. Within their National Plans of Action, governments should be encouraged to set ambitious but achievable targets in keeping with the above statement of the mid-decade goal.
32. Consideration should be given to recommending the use of jointly agreed indicators and the adoption of targets related to ARI case management. This is in recognition that many countries are doing this already and progressively combining CDD and ARI related activities.
33. The indicators for CDD (and ARI control) agreed by UNICEF and WHO should be made widely known and both organizations should assist countries in the measurement of these indicators for the monitoring and improvement of their national control programmes.
34. 1993 marks the 25th year of the discovery of "ORT". International and national meetings in 1993 and 1994 should be used to widely publicize ORT and other components of the diarrhoeal disease control programme, so as to take this technology to the hands of people, and establish correct case management as a norm of practice. The occasion should also be used to further promote ORT especially where it is lagging and in need of further acceleration.
35. The stated mid-decade goal and the required action will not be possible without a major intensification of effort. This implies increased political will at all levels as well as a major increase in financial resources. Every effort should be made to obtain the additional required funding.

2.5 Baby-friendly hospital initiative (BFHI)

CURRENT SITUATION

Introduction

36. The formulation of the two mid-decade goals relevant to breast-feeding were clarified. The combined and complementary action of WHO and UNICEF with its major partners, particularly governments and nongovernmental organizations, has resulted in a high level of awareness, interest and commitment to the two goals.

Goals

37. (1) "Ending the distribution of free or low-cost breast-milk substitutes (BMS) in all maternity centres and hospitals in developing countries by June 1993, and in all countries by June 1994; and (2) having by 1995 all health facilities which provide maternity services achieve 'baby-friendly hospital' status by following the BFHI global criteria based on the Ten Steps to successful breast-feeding recommended by WHO and UNICEF."¹

Situation

38. All but three developing countries have initiated the necessary procedures to effect the goal on ending free and low-cost supplies. Progress in a number of developed countries is being effected through a combination of actions, often in a broader context of an overall programme in support of breast-feeding. The European Community's directive on infant formula will come into effect in June 1994, while the policy commitment has been conveyed to WHO by the infant food industry stating that they will not initiate the distribution of free or low-cost supplies of BMS in the newly emerging market economy countries of eastern Europe and the former republics of the Soviet Union.

39. The implementation of the goal on the BFHI has involved several complementary activities, above all the strengthening of the partnership of governments with the network of nongovernmental organizations which have extensive experience in the areas of advocacy and training. Criteria and guidelines for the designation as

¹ The summary list of "intermediate goals for 1995" appended to the report of the twenty-ninth session of JCHP, February 1993, did not correspond with the agreed shift of the goal from end 1992 to June 1993, as reflected in the body of that report and agreed to and confirmed by the two Secretariats. Hence the newly worded intermediate goals.

BFH have been established. The relevant training has been developed and applied for lactation management and breast-feeding, and assessing institutions as BFH.

Strategy

40. WHO and UNICEF are actively supporting government action to implement measures, such as regulations, ministry of health circulars, monitoring systems, and agreements with manufacturers and distributors of breast-milk substitutes, to end the distribution of free and low-cost supplies. Countries need to set up monitoring mechanisms to ensure the implementation of these measures. The process of turning the health care systems toward implementing the principles of the baby-friendly hospital initiative requires government commitment, training of health workers and hospital assessors, setting up assessment and designation mechanisms and follow-up support to the designated hospitals, including reassessment.

2.6 Iodine deficiency disorders (IDD)

41. The mid-decade goal endorsed by JCHP, February 1993, was "Achieve full implementation of universal salt iodization in most of the countries where iodine deficiency disorders (IDD) are a public health problem; where full salt iodization is not possible in areas where IDD is a severe public health problem, supplementation with oral or injected iodized oil will be recommended as a temporary measure."

42. The proposed modification of the mid-decade goal is "Iodize all salt used for human and animal consumption (including salt used for food processing) (Universal Salt Iodization) in all countries where iodine deficiency disorders (IDD) are a public health problem; where full salt iodization is not possible in areas where IDD is a severe public health problem, supplementation with oral or injected iodized oil will be recommended as a temporary measures." Short title of the mid-decade goal, 1995: Universal iodization of salt in IDD-affected countries. Mid-decade goal process indicators for use at global, regional and country level: Proportion of salt for consumption which is adequately iodized according to agreed criteria.

PRIORITY ACTIONS

43. The priority actions by UNICEF/WHO for achieving the mid-decade goal will be:

1. All countries to establish whether there is IDD at a level of public health significance.¹
2. Advocacy and Information, Education, Communication (IEC) for action to eliminate IDD through universal consumption of iodized salt by all the people and livestock.
3. Ensure that all salt imported into or produced in the country for human and livestock consumption is adequately iodized at the factory, at entry into the country, at retail sale and at household level. This implies establishing appropriate standards or regulations for iodized salt, monitoring procedures and measures for enforcement.
4. Where salt is produced domestically, work with the salt industry, including co-operatives and associations of small-scale providers, and mobilize essential resources if necessary to:
 - install iodization equipment if not yet in place;
 - ensure access to lowest-cost potassium iodate;
 - develop quality control procedures including monitoring at production sites by producers;
 - support sustainable methods of financing the extra costs involved in salt iodation.

¹ WHO/UNICEF/ICCIDD (1993): Indicators for assessing iodine deficiency disorders and their control programmes. Document WHO/NUT/93.1, Geneva.

5. Help organize a national monitoring and information system for process indicators (salt iodization) and epidemiological indicators (primarily, goitre rates and urinary iodine in subsample); ensure that appropriate action is taken whenever salt iodine levels are insufficient.
6. Ensure appropriate training of health, information, salt sector and other personnel involved, both in-country and abroad.
7. Ensure adequate education of salt traders to minimize iodine losses between producer and consumer, and of consumers to minimize losses during home storage and cooking.
8. Support or cooperate in the national intersectoral mechanism for management of IDD control and elimination.

Monitoring guidelines

1. **Indicator:** Proportion of households (in a representative sample of households) consuming adequately iodized salt, according to agreed criteria: (i) in the whole country; (ii) in areas known to be at high risk of IDD.
2. **Procedures:** Appropriate procedures for monitoring salt iodization, criteria for assessing adequacy of iodization and techniques for measuring salt iodine levels are indicated in the WHO/UNICEF/ICCIDD (1993) document: Indicators for assessing iodine deficiency disorders and their control programmes, paragraphs 83-91 and Tables 8 and 9 (document WHO/NUT/93.1, Geneva).

2.7 Vitamin A deficiency (VAD)

44. The mid-decade goal recommended by JCHP in February 1993 and endorsed by the World Health Assembly in May 1993:

"Achieve a significant increase in dietary intake of vitamin A in children from 6 months to 6 years of age, through food and/or fortified products, where diets are deficient in vitamin A. Where clinical vitamin A deficiency is a public health problem, vitamin A supplementation for preschool children every 4 to 6 months will be urged, as a time-bound short-term measure, until dietary intakes reach basal requirements." The revised 1995 goal is as indicated in paragraph 48 below.

CURRENT SITUATION

45. Vitamin A deficiency as defined in the document (IS/UNICEF/WHO/93.8) (both clinical and subclinical forms) was a likely problem in up to 75 countries and may afflict as many as 80-90 million children.
46. The goal for the year 2000 is the virtual elimination of vitamin A deficiency and all its consequences, as established both by an absence of signs of clinical deficiency and by adequate levels of biochemical indicators.
47. By 1995, all countries would have identified whether they have a problem of vitamin A deficiency and will have established approaches to ensure elimination of the problem by the year 2000. By 1995 steps would be taken to ensure adequate vitamin A intakes in the group of children at highest risk of the consequences of deficiency - those under 24 months of age and those in areas where clinical vitamin A deficiency is recognized.

48. The revised 1995 goal therefore is:

"Ensure that at least 80% of all children under 24 months of age living in areas with inadequate vitamin A intake¹ receive adequate vitamin A² through a combination of breast-feeding, dietary improvement, fortification and supplementation."

ACTION

49. Ensure that all children under 24 months of age receive an adequate intake of vitamin A through an appropriate combination of dietary diversification, fortification and supplementation. Establish a foundation for a sustainable programme that will ensure adequate vitamin A intakes for all children under five years of age by the year 2000.

- Establish prevalence of vitamin A deficiency using existing information and rapid assessment procedures. Identify major sections of country where inadequate intakes of vitamin A exist and where action is required.
- Establish and implement strategy for improving vitamin A intakes of children by 1995 and by 2000 using combinations of dietary diversification, fortification and supplementation based on local circumstances.
- Identify major local food sources of vitamin A and implement ways of ensuring these are consumed in adequate quantities by young children and lactating women.
- Identify processed foods widely consumed by at-risk young children and lactating women and where appropriate support fortification of these foods with vitamin A.
- Establish a strategy to ensure that children for whom adequate intakes of vitamin A cannot be met through dietary means receive periodic supplements.
- Supplements targeted to case management of high-risk sick children, particularly those with measles, prolonged diarrhoea and severe protein energy malnutrition, should be a strategy implemented in all countries where inadequate vitamin A status is suspected.

2.8 Guinea-worm transmission

50. The mid-decade goal, 1995, is to "Interrupt guinea-worm transmission in all affected villages".³

51. The collaboration between UNICEF and WHO in the dracunculiasis eradication programmes was most satisfactory. Global level interagency meetings, held together with the NGOs concerned, two or three times per year, ensure the coordination in overall policy and technical approaches. The subregional station jointly operated by the two agencies, the Interagency Technical Team (ITEC) in Ouagadougou, Burkina Faso, should stand as a model for other joint operational programmes. UNICEF had recently seconded a professional staff member to WHO headquarters for the geographic monitoring of surveillance data and progress in control.

52. The programme is progressing well, with remarkable results in Ghana, Nigeria (75% reduction in incidence achieved in only a few years), Cameroon and Uganda (50% reduction). It is clear that those countries troubled by warfare or serious internal political upheavals cannot be expected to participate effectively until such problems have been solved. There would be serious challenges to meet the 1995 deadline in Chad, Ethiopia and Sudan.

¹ Evidence of inadequate dietary intake from rapid dietary surveys, high under five mortality rate, high level of poverty, illiteracy, low sanitation or evidence that clinical VAD is a public health problem.

² Adequate vitamin A is defined as the equivalent of at least 350 micrograms retinol equivalents ($\mu\text{g RE}$ or 1200 IU) daily or 2450 $\mu\text{g RE}$ weekly (8400 IU).

³ Change in wording proposed at Intersecretariat Meeting, October 1993 (earlier the wording had been to "stop guinea-worm transmission ...").

53. WHO's major contribution to the programme is the country by country certification of eradication by 1999. In some 10 countries (8 in Africa) monthly surveillance systems have been established already. WHO is being supported financially in this undertaking by OPEC and UNDP. In addition WHO's regular budget contribution has been increased by the provision of an additional professional staff member. A brochure for publicity purposes has recently been issued.

54. It is hoped to attract the necessary further voluntary contributions for this programme.

CURRENT SITUATION

55. Dracunculiasis had been the object of a global campaign that was initiated in 1980, in conjunction with the beginning of the International Drinking Water Supply and Sanitation Decade (1981-1990).

56. The basic strategy for eradication is to:

1. Identify infected villages.
2. Establish village-based surveillance.
3. Initiate health education and community mobilization.
4. Provide safe drinking-water.
5. Integrate monthly surveillance of major preventable diseases.
6. Certification of eradication.

57. Owing to political upheavals in certain endemic countries, as well as the shortage of funds, it was reported that the achievement of the mid-decade goal would be a challenge. However, with the political will, now manifested in the majority of the endemic countries, the surveillance system recently becoming operational in over 68% of endemic villages and with community participation increasing, the final goal - global eradication of dracunculiasis in the 1990s - should be attained.

ACTION

58. It is recommended that:

- (1) All efforts are made taken to fully implement the recommendations on Integrated Surveillance in Dracunculiasis Eradication Programmes within the Joint Statement by WHO, UNICEF, Global 2000 and the WHO Collaborating Centre.
- (2) The integration at field operational levels between dracunculiasis eradication programmes and immunization programmes should be facilitated and strengthened.
- (3) All dracunculiasis endemic villages should be mapped and data bases should be established at WHO, UNICEF and CDC, and the status of programme interventions within those villages monitored by mid-1994.
- (4) Control measures should be initiated within the dracunculiasis endemic villages by the end of 1994.
- (5) The appropriate organs of the United Nations should be advised of the status of the dracunculiasis eradication effort, with particular attention to those areas where existing armed conflict substantially constrains those efforts.

2.9 Water and sanitation

59. Reference was made to the mid-decade (1995) target for water supply and sanitation established by UNICEF: "Increase water supply and sanitation so as to narrow the gap between the 1990 levels and universal access by the year 2000 of water supply by one-fourth and of sanitation by one-tenth".

60. Any consideration of such an interim goal had to be considered in relation to the sectors' past performance on the one hand and what had to be done to achieve universal coverage by the year 2000 which was the ultimate objective.

61. Firstly, countries had established water supply and sanitation programmes during the 1980s within the context of the International Drinking Water Supply and Sanitation Decade (IDWSSD) and were able to adapt these on the basis of the progress achieved by the end of 1990 to develop the sector plans within the World Summit for Children framework. From this standpoint, the sector was ahead of other programme areas. In addition, monitoring had been established on a routine basis to monitor progress towards national IDWSSD goals.
62. The second point to be considered was what remained to be done to achieve the Summit Goals for the Year 2000 if the interim goals were achieved.
63. A quick analysis of these considerations appeared to indicate that the mid-decade goal for water supply called for some additional effort than the level achieved at the end of the IDWSSD; the sanitation mid-decade goal, although appearing more modest, called for a doubling of the effort which had been achieved in the past. Looking to the future to achieve the ultimate Summit Goals for the Year 2000, it was recognized that a significant acceleration of programmes has to be achieved.
64. Overall, the value of having interim/mid-decade goals was recognized, since they served to focus attention on concrete objectives and were therefore welcome. The task which remained was to develop a rationale for them and to document this. The goals as set by UNICEF could be strengthened by support from such a document.
65. It was agreed that an information document be prepared supporting the water supply and sanitation mid-decade goals for presentation to the JCHP, January 1994, realizing that this would not be an easy task since it would have to be completed by the end of October, and that consultation with the relevant technical staff in UNICEF would be required.

3. WORLD SUMMIT FOR CHILDREN - HEALTH INDICATORS AND THE MONITORING PROCESS

66. A status report (IS/UNICEF/WHO/93.10) had been prepared by WHO on the process to date to establish indicators for monitoring health goals of the World Summit for Children, recommended by WHO and UNICEF for national monitoring and programme management and international reporting, particularly relating to the mid-decade goals.
67. UNICEF and WHO had agreed upon a list of indicators for monitoring the health goals of the World Summit for Children. These indicators were largely consistent with those proposed for monitoring Health for All, but also included some additional indicators. The agreement between UNICEF and WHO to work together in support of countries' health monitoring efforts needed to be communicated to countries and to the country and regional offices of both organizations.

NEXT STEPS

68. Given the progress to date and the above issues, the Intersecretariat Meeting agreed to the following actions (with responsibilities as indicated) being undertaken:
1. Issue a joint statement expressing the two organizations' commitment to the monitoring process for the Summit goals and their cooperation at the country level, including the monitoring of the mid-decade goals. The statement would include the agreement reached on those indicators for monitoring progress. It would be transmitted to the regional directors and representatives of the two organizations and to their country and field offices.
 2. Accelerate work on the comprehensive health indicator guidelines (WHO and UNICEF technical programmes with the support of HST/WHO), with priority given to early completion of those related to the mid-decade goals (see paragraph 4 below).
 3. The Global Programme on AIDS noted that the indicator "Knowledge of HIV" had not been included among the mid-decade goals and requested that this be taken up at the JCHP in January 1994. It was noted, however, that this indicator for basic health knowledge of HIV was only one of the indicators addressed

to the goal on Basic Education. UNESCO and UNICEF have developed a set of indicators for the full array of basic education goals, which are not listed here.

4. UNICEF will bring to the attention of all its regional and country offices the opportunities offered by national reporting on Health for All to strengthen overall capacity to monitor progress towards the Summit goals for children and women at the mid-decade level.

5. Form a WHO-UNICEF Working Group to develop the process of reporting at mid-decade on global progress on the health goals contained in the World Summit Plan of Action. During the meeting the technical programme staff of the two organizations confirmed the Summit indicators related to the mid-decade goals to be used for global reporting. It would also strive to see that the indicator guidelines for reporting on the mid-decade goals (see paragraph 2 above) were completed by 15 November.

6. Proceed with further support for improving certain indicators and measurement methods, for example, child mortality by cause.

7. Convene an informal review meeting in 1994 immediately preceding the Intersecretariat Meeting to review progress on indicators and revise, if necessary, the Summit indicator table to include progress on those indicators currently listed as under development.

4. OTHER MATTERS

69. It was proposed that the following recommendations be submitted for consideration by JCHP. However, the present meeting thought that items 1 and 2 below deserved serious consideration, but that they needed to be discussed at other echelons of WHO:

1. The importance to highlight maternal and child health in the 1995 World Summit for Social Development, and to this end the JCHP should be encouraged to commend the goals of the World Summit for Children to the Social Summit.

2. To recommend that the Executive Boards of WHO and UNICEF consider and endorse the proposal of UNDP for "20/20", already endorsed by the 1993 Summit of the Organization of African Unity (OAU) and the East Asia and Pacific Ministerial Consultation, which encourages donor countries to earmark 20% of their Official Development Assistance (ODA) and developing countries 20% of their government budgets to meet basic human needs, including health, hygiene, nutrition and basic education.

3. To recommend that the Secretariats of WHO and UNICEF are encouraged to direct special attention and support to countries in greatest need in order to achieve the World Summit for Children health goals for the year 2000 and the mid-decade health goals, 1995, for example, countries in armed conflict or other significant political crisis, New Independent States, and countries where health systems are currently least developed.

4. The JCHP to encourage the Secretariats of WHO and UNICEF to accelerate their efforts to assist in strengthening the capacities of countries in achieving the year 2000 health goals, concurrently with efforts to achieve the mid-decade goals, and to strengthen their efforts in those areas for which goals do not yet exist, but which impact substantially on the achievement of the World Summit for Children goals, among them HIV/AIDS and malaria.

UNICEF-WHO Inter-Secretariat Meeting

Geneva, 14-15 October 1993
WHO Headquarters, Salle D

IS/UNICEF-WHO/93.1
3 August 1993

AGENDA

1. **ADOPTION OF AGENDA AND TIMETABLE** IS/UNICEF/WHO/93.1

2. **WORLD SUMMIT FOR CHILDREN - MID-DECADE GOALS, 1995**
 - 2.1 Neonatal tetanus IS/UNICEF/WHO/93.2
 - 2.2 Measles deaths and cases IS/UNICEF/WHO/93.3
 - 2.3 Poliomyelitis-free status IS/UNICEF/WHO/93.4
 - 2.4 Oral rehydration therapy IS/UNICEF/WHO/93.5
 - 2.5 "Baby-friendly" hospitals IS/UNICEF/WHO/93.6
 - 2.6 Iodine deficiency disorders IS/UNICEF/WHO/93.7
 - 2.7 Vitamin A deficiency IS/UNICEF/WHO/93.8
 - 2.8 Guinea-worm transmission IS/UNICEF/WHO/93.9
 - 2.9 Water and sanitation No paper

3. **WORLD SUMMIT FOR CHILDREN - HEALTH INDICATORS AND THE MONITORING PROCESS** IS/UNICEF/WHO/93.10

4. **OTHER MATTERS**

ANNEX II

UNICEF-WHO Inter-Secretariat Meeting

Geneva, 14-15 October 1993

WHO Headquarters, Salle D

IS/UNICEF-WHO/93.1

11 October 1993

LIST OF PARTICIPANTS

UNICEF

Dr Nyi Nyi, Special Adviser to the Executive Director
Dr D. Alnwick, Senior Adviser, Micronutrients
Dr L. Bisharat, Director, Planning and Coordination Office
Ms M. Kyenkya-Isabirye, Adviser, Infant Feeding
Mrs B. Ogun-Bassani, Deputy Director, UNICEF/Geneva
Dr A. Paganini, Chief, BIMU
Mrs M.-P. Poirier, Public Affairs Officer, NGO, UNICEF/Geneva
Dr M. Sharma, Senior Adviser, CDD/ARI
Dr J. Sherry, Chief, Health Cluster
Dr C. Voumard, Senior Health Adviser, UNICEF/Geneva

WHO

Mr V. Abramov, Public Information Officer, Office of Information (INF)
Dr F. Antezana, Assistant Director-General (ADG)
Dr A. Ball, Programme on Substance Abuse (PSA)
Dr K.V. Bailey, Nutrition (NUT)
Mr M. Barton, Programme Manager, Office of Information (INF)
Dr M. Belsey, Programme Manager, Maternal and Child Health (MCH) - also representing Director,
Division of Family Health (FHE)
Dr D. Benbouzid, Nutrition (NUT)
Ms P. Brice, Global Programme on AIDS (GPA)
Dr M. Carael, Global Programme on AIDS (GPA)
Dr G.A. Clugston, Chief, Nutrition (NUT)
Dr R. Cumming, Office of International Cooperation (ICO)
Dr P. de Raadt, Director, Control of Tropical Diseases (CTD)
Mr H.S. Dhillon, Director, Division of Health Education (HED)
Mr H. Dixon, Chief, Epidemiological and Statistical Methodology (ESM)
Dr A. Galazka - representing Director, Expanded Programme on Immunization (EPI)
Dr E.H.T. Goon, Director, Division of Development of Human Resources for Health (HRH)
Mrs D. Halvorsen, Division of Interagency Affairs (INA)
Dr H.R. Hapsara, Director, Epidemiological Surveillance and Health Situation and Trend Assessment (HST)
Dr S. Holck, Global Programme on AIDS (GPA)
Dr J.-P. Jardel, Assistant Director-General (ADG)
Dr Y. Kawaguchi, Director, Division of Interagency Affairs (INA)
Dr A.G. Landi, Programme for Resource Mobilization (RMB)
Dr S. Levine, Medical Officer, Cabinet of the Director-General (CDG)
Dr Maaza Bekele, Division of Interagency Affairs (INA) and Coordinator, Inter-Secretariat Meeting
Dr L.J. Martinez, Associate Director, Division of Communicable Diseases (CDS)
Dr N. Napalkov, Assistant Director-General (ADG)
Dr S. Orzeszyna, Monitoring, Evaluation and Projection Methodology (MEP)
Dr G. Quincke, Director, Division of Food and Nutrition (FNU) - also representing Dr F. Antezana, ADG

Mrs M. Raymond, Division of Interagency Affairs (INA)
Dr J. Rochon, Director, Health Protection and Promotion (HPP)
Mrs R. Saadeh, Technical Officer, NUT
Dr S. Sapirie, Chief, Monitoring, Evaluation and Projection Methodology (MEP)
Mr M. Subramanian, Chief, Global Health Situation Assessment and Projections (GSP)
Dr I. Tabibzadeh, District Health Systems (DHS)
Dr A. Tekle, Director, Division of Emergency and Humanitarian Action (EHA)
Mr L. Tillfors, Programme for Resource Mobilization (RMB)
Dr J.L. Tulloch, Director, Diarrhoeal and Acute Respiratory Disease Control (CDR) - also representing
Dr R. Henderson, ADG
Dr B.A. Underwood, Nutrition (NUT)
Dr G. Watters, Community Water Supply and Sanitation (CWS)

ANNEX III

UNICEF-WHO JOINT COMMITTEE ON HEALTH POLICY

Special session

Geneva, 27-28 January 1994

JCHPSS/94/1

November 1993

PROVISIONAL AGENDA

1. OPENING

1.1 Statement by the Director-General of WHO and the Executive-Director of UNICEF

1.2 Election of Chairman and Rapporteurs

1.3 Adoption of Agenda and Timetable

JCHPSS/94/1.1

2. WORLD SUMMIT FOR CHILDREN - MID-DECADE GOALS, 1995

2.1 Follow-up action

An overview of implementation of the mid-decade goals for achievement by 1995

JCHPSS/94/2

2.2 Progress made

Progress made in specific areas, including monitoring and further actions needed to ensure the achievement of goals and targets by the mid-decade

2.2.1 EPI Overview

JCHPSS/94/2.1

2.2.2 Neonatal tetanus

JCHPSS/94/2.2

2.2.3 Measles deaths and cases

JCHPSS/94/2.3

2.2.4 Poliomyelitis-free status

JCHPSS/94/2.4

2.2.5 Oral rehydration therapy

JCHPSS/94/2.5

2.2.6 "Baby-friendly" hospitals

JCHPSS/94/2.6

2.2.7 Iodine deficiency disorders

JCHPSS/94/2.7

2.2.8 Vitamin A deficiency

JCHPSS/94/2.8

2.2.9 Guinea-worm transmission

JCHPSS/94/2.9

2.2.10 Reduction of malnutrition

JCHPSS/94/2.10

2.2.11 Water and sanitation

JCHPSS/94/2.11

2.2.12 Knowledge of HIV/AIDS

JCHPSS/94/2.12

3. WORLD SUMMIT FOR CHILDREN - HEALTH INDICATORS AND THE MONITORING PROCESS

JCHPSS/94/3

4. OTHER MATTERS

5. CLOSURE

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