Item 4.7

Draft Global Health-Sector Strategy for HIV, 2011-2015

Context of EB Discussions

Following the request to the Director-General in resolution WHA63.19 to submit a WHO HIV/AIDS strategy for 2011–2015, a broad consultation process has informed a draft global health sector strategy for HIV/AIDS structured around four main goals: improving HIV outcomes; improving broader health outcomes; strengthening health systems; and creating supportive environments. The Board is invited to consider the draft strategy (contained in Executive Board document EB128/10) and make a recommendation on its possible endorsement by the Sixty-fourth World Health Assembly.

Background

The draft strategy was developed through a consultative process (including a 7-week online consultation between July and September 2010). It was developed in parallel with UNAIDS 2011-2015 strategy, with the aim of guiding national health sector responses.

The draft strategy supports and reinforces the agreed division of labour among UNAIDS cosponsors. Among the UNAIDS cosponsors WHO is responsible for the health-sector response to HIV, taking the lead on HIV treatment and care and on HIV/tuberculosis co-infection, shares responsibility with UNICEF for the prevention of mother-to-child transmission of HIV, and collaborates with other cosponsors in supporting actions in all other priority areas.

Comments on the EB discussions

1). Collaboration and coordination: speaking on behalf of WHO-AFRO region, Uganda – recognising that there are multiple stakeholders in HIV/AIDS who are not always well coordinated – called for WHO to consider including the role of coordination in the draft strategy, as WHO's constitution gives it that mandate for health. The USA believes WHO needs to work more closely with other partners, eg in terms of working with vulnerable groups, WHO can provide guidelines and Technical Assistance, since others are better placed in dealing with these group (eg UNAIDS). Hungary and Norway recommended that WHO should work with UNAIDS in organising the New York summit.

2). Balancing HIV Prevention and Treatment: On behalf of WHO-AFRO region, Uganda reported that the draft strategy puts more emphasis on care and treatment than on prevention of HIV, and this needs to be revised to give equal attention to prevention. Similarly, Norway and Hungary (on behalf of EU), believe prevention needs to be emphasised in the draft strategy. Specifically, the EU suggests stronger focus on the empowerment of young people, stronger linkages with human rights, ensuring greater linkages between HIV and SRH, TB and malaria, health workforce strengthening, and sustainable financing; whilst Norway mentioned the need for gender empowerment and work with marginalised groups. The NGO, Consumers International aligned with this view, and specifically alluded to the importance of nutrition in HIV prevention and treatment, and also for child survival yet nutrition was only mentioned twice in the strategy. Consumers International also called for the need to put in place

norms which industry needs to comply with in collaborating with WHO on the strategy. Thailand called for the strengthening of laboratory capacities especially where civil registration systems are weak (as the incidence in such contexts is most possibly higher than reported). Switzerland called for the Greater Involvement of Persons with HIV.

3). Decline in HIV/AIDS funding: Uganda and MSF separately expressed concerns at the decline in funding for HIV. MSF expressed worry that in 2012, for the first time, the Global Fund may not issue a funding round. Brazil promised to support the implementation of the strategy with USD 500,000 through WHO, whilst Barbados and Bangladesh called for increased public private partnerships.

4). Geographical representation of technical experts: Uganda, on behalf of WHO-AFRO region; and Zimbabwe, called for the involvement of experts from regions affected by diseases to be included in the development of strategies for those diseases. In particular, that there should have been a better representation of members of the WHO-AFRO region in the Technical Committee that drafted the strategy.

5). Workplan and M&E components of strategy: PHM's detected that the draft strategy did not include an Action Plan. And that according to WHA59.12, the DG is requested to prepare a plan of action for the implementation of the recommendations of the Global Task Team, and to provide effective technical support at national level. In the progress report (para. 92), there is mention of a UNAIDS technical support strategy to which the WHO has contributed, and is "elaborating a plan to outline WHO's role and contributions". Therefore, PHM recommended that Member States ask for this plan of action (on WHO's role and contributions) to be developed and set a deadline for this.

During the EB discussions, Brazil, Japan, Morocco, Uganda (on behalf of AFRO) and Hungary (on behalf of EU) called for the inclusion of an M&E plan and a Workplan in the draft strategy before it is presented to the WHA. Japan called for coherence with the MDG targets when developing the M&E plan. Thailand called for caution in comparing different countries' progress (for political reasons) as suggested in page 54 of the strategy. Rather, Thailand suggests the strategy should call for comparisms within countries. Russia is of the view that the strategy needs to emphasize more on country-specific situations eg on SO1 regarding harm reduction for IDUs, Russia thinks lifestyle changes need greater focus. Russia said it doesn't support methodine substitution as a strategy as it has been proven to increase spread of HIV in Russia.

6). Increasing access to ARVs: PHM's comment was that strict enforcement of intellectual property rights is resulting in unaffordability of HIV diagnosis and treatment, and this should be acknowledged as a barrier to reaching the ultimate objective of implementing the Three Ones principles. Furthermore, PHM argues that access to affordable HIV-related medicines is hampered by the failure of countries to use safeguards available in the TRIPS agreement. However, there is no reference to the failure of the para 6 system of the Doha Declaration in helping LDCs with no pharmaceutical manufacturing capacity access medicines (Canada-Rwanda case), and of its review process at the TRIPS council. Yet, there is no mention of TRIPS-plus provisions in bilateral trade agreements through which developing countries give away their TRIPS safeguards.

During the EB discussions, the USA stated that with regards to access to ARVs, **differential pricing** has been proven not to work. Therefore, it is important to use **patent pools** to allow for more generic drug manufacturers. Meanwhile, MSF called for the use of **TRIP flexibilities** to ensure low cost drugs.

7). Document too complex: Zambia, Brazil, Norway and Hungary (on behalf of EU) believe the document is too complex and hence leading to some overlaps. The Norway and Hungary expressed their endorsement of the strategy but suggests it needs more revisions to make it more precise.

ADG – Dr. Hiroki Nakatan

Division of labour followed (using document developed with UNAIDS); Nutrition captured under the division of labour with WFP taking lead on it; Strategy not suggesting one size fit all; Prevention (both in general population and with MARPs included); Accessibility to drugs included as per previous strategy; ME uses previously agreed universal targets – such as MDGs etc

DG

HIV/AIDS is multi-dimensional. Progress has been made but not victory. Sceptics have been proven wrong – funding on HIV and AIDS has proven that Development Assistance is not that gloomy. WHO will continue do the science and leave the polemics to others. WHO can make the best recommendations but definitely countries have to make commitments (WHO can recommend that treatment begins when CD4 count is 350 but it's up to countries to take action).

Other PHM Comments include:

- The Draft HIV/AIDS strategy should inform AIDS coordination and vice versa, with clear links established between the two. The two items should not be discussed in isolation from one another.

- The close cooperation between WHO and the GF on technical support issues should not be confined to countries who succeed in receiving GF. There are developing countries which are in need of technical support, but which often fail the GF "application process". They should not be deprived of such support.

- There is a need for technical assistance on health-related IP matters, which should be specified under the implementation section (Table 6, p. 52), where the WHO collaborates with the UNDP. This is being called for at other UN organisations such as WTO and WIPO, and developing member states are also questioning the content of existing technical assistance programmes provided to developing countries. The WHO should take the lead on such health-related discussions, and there is also a need for more information about specific ways in which the WHO will contribute.

- Under Health financing (p. 27) the draft strategy calls for the adoption of approaches to minimize out-of-pocket expenditure, but places mobilisation of donations for adequate funds as

a first element, further reinforcing a vertical donor-centred approach. The immediate interpretation is that prices, hence big pharma commercial interests, are not to be negotiated. The vertical approach, which is criticised for being unsustainable, should be addressed through strengthening national capacity, namely health regulatory and legislative capacities. Investing in local pharmaceutical manufacturing capacity also provides a sustainable solution away from the vertical approach.

Advocacy issues

- Coordination (WHO's role in the UNAIDS strategy)
- HIV prevention largely influenced by health systems – therefore need to have health systems strengthened.
- Link with global financial crisis; the future of WHO financing; health a public good; collective good, not from charity;
- The collapse of the replenishment of the global fund an illustration of the failure of charity....

Priority

This draft strategy is important because it charts the framework for the health sector response to HIV at the global level for the next five years, and serves as a guide for country level health sector strategies for the same period.

Advocacy

Event: 2011 UN General Assembly High Level Meeting on AIDS in New York, June 8-10.

> Thirty years into the AIDS epidemic, and 10 years since the landmark UN General Assembly Special Session on HIV/AIDS, the world will come together to review progress and chart the future course of the global AIDS response at the 2011 UN General Assembly High Level Meeting on AIDS from 8 –10 June 2011 in New York. Member States are expected to adopt a new Declaration that will reaffirm current commitments and commit to actions to guide and sustain the global AIDS response.

Messages

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Who else is interested?

- Section 27
- Stony Point group

What slogans might lead the advocacy?

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