

FOURTH MEETING

Tuesday, 24 January 2006, at 14:00

Chairman: Mr M.N. KHAN (Pakistan)

TECHNICAL AND HEALTH MATTERS: Item 4 of the Agenda (continued)

Eradication of poliomyelitis: Item 4.4 of the Agenda (Documents EB117/4 and EB117/4 Add.1) (continued)

Mr SHUGART (Canada) said that the poliomyelitis eradication strategy's links with routine immunization and micronutrient supplementation should be mentioned in reports to the governing bodies as evidence of its integrated nature. WHO's staff working on the poliomyelitis programme had valuable experience, in surveillance for example, which could be transferred to influenza and other communicable diseases as poliomyelitis activities were wound down. That might help to alleviate the problem of human resources discussed the previous day in relation to influenza.

Dr BRUNET (alternate to Professor Houssin, France) said that the eradication of poliomyelitis was a key commitment of the international community. The Secretariat's activities were highly effective, being based on a high level of technical expertise, a swift response and a flexible and intelligent approach. France had increased its financial support for the eradication of poliomyelitis since 2004, and offered technical assistance where WHO considered necessary. He supported the draft resolution.

Dr SHINOZAKI (Japan) commended the Director-General's leadership in the effort to limit the international spread of wild-type poliovirus transmission since 2003. He supported the draft resolution, but observed that it referred only to action to be taken when wild-type poliovirus was detected in a previously poliomyelitis-free country; preventive action, such as maintaining a sufficiently high coverage of routine immunization, was also important. Was the recommendation that an oral poliomyelitis vaccine should be used also intended to apply to those poliomyelitis-free Member States which used inactivated vaccine? If not, WHO should develop further guidelines for the Member States concerned. It should also draw up a timetable for the eradication of poliomyelitis.

Dr PHOOKO (Lesotho), speaking in English, followed by Dr SÁ NOGUEIRA (Guinea-Bissau), speaking in French, on behalf of the Member States of the African Region, said that, as at the end of September 2005, 524 laboratory confirmations of wild-type polioviruses had been reported in eight countries of the Region, a decrease of 26% compared with the same period in 2004. Wild-type poliovirus transmission had re-emerged in five countries in 2004, owing to a failure to eradicate imported wild-type polioviruses. However, 29 of the 46 Member States of the African Region had been poliomyelitis-free for more than three years, despite improvements in their acute flaccid paralysis surveillance leading to the detection of more cases. By the end of June 2005, 35 countries in the Region had met the standards to qualify for certification. Almost all countries had established national expert committees and national certification committees, and most had established national task forces for the biocontainment of wild-type poliovirus.

The main challenge to eradication was the resurgence of wild-type poliovirus transmission in the Region since 2003, fed by intensified transmission in Niger and Nigeria, the scaling-down of supplementary immunization in recently poliomyelitis-free countries, low coverage of routine immunization and persistent shortfalls in funding. Health systems, including human resources, should be strengthened for the sake of greater vigilance and increased routine immunization coverage. The eradication of poliomyelitis called for a high degree of commitment.

Professor PEREIRA MIGUEL (Portugal) said that, as a partner in the Global Polio Eradication Initiative, his country strongly supported action to interrupt the final chains of wild-type poliovirus transmission worldwide. Member States must agree on a date when they would all stop using oral poliomyelitis vaccine, while maintaining their political and financial commitment to eradicating poliomyelitis. His country's health authorities had prepared a post-eradication action plan, designed to maintain high immunization coverage, sustain clinical, epidemiological and laboratory surveillance of acute flaccid paralysis and guarantee laboratory biocontainment of wild-type poliovirus. Portugal was committed to cooperation both directly with the Secretariat and through the European Union, to ensure that children in all countries were protected from poliomyelitis. He supported the draft resolution.

Dr ALI MOHAMMED SALIH (Iraq) thanked WHO for its support, which had enabled his country to build up its immunization capacity and remain poliomyelitis-free since 2000, despite its critical situation. Two urgent vaccination campaigns had been conducted in June and September 2005, achieving a coverage rate of more than 96%. As the national immunization programme covered only 85% of demand, he called on WHO to support at least two immunization campaigns annually. The country was building up its infrastructure, relying on primary health care and improving security. Environmental surveillance of the last remaining areas of endemic wild-type poliovirus was an essential part of the eradication process.

Dr SHANGULA (Namibia) supported the draft resolution, with the following amendments: paragraph 1(2) should be amended to read: "... three large-scale rounds of immunization using a type-specific monovalent oral poliomyelitis vaccine including, where applicable, house-to-house immunization. The first round ...". Paragraphs 1(3) and 1(4) should be combined and amended to read "targeting all children aged less than five years in the affected and adjacent geographical areas and using independent monitoring ...".

Dr ABDULLA (alternate to Dr Botros Shokai, Sudan) said that he too was concerned that insufficient attention was being given to poliomyelitis-endemic countries and those in which the disease had recurred. Three years' freedom from poliomyelitis was not enough to guarantee that a country would remain free of the disease permanently, as the experience of his country showed. He called for greater support of endemic countries and those where poliomyelitis had recurred, in the form of better surveillance systems, effective national immunization days, strengthening of routine immunization services, and improving immunization rates among hard-to-reach children. He supported the amendments to the draft resolution proposed by the member for Thailand.

Dr ANTEZANA ARANÍBAR (Bolivia), observing that the Americas had been declared free of poliomyelitis, expressed concern about the statement in the report that 57% of cases of poliomyelitis reported in 2005 had occurred in supposedly poliomyelitis-free countries. States must avoid complacency, remain vigilant and maintain their capacity, in terms of both laboratory facilities and human resources, to keep track of circulating wild-type polioviruses. He supported the draft resolution, but wanted sufficient emphasis on the need for vigilance in countries declared free of poliomyelitis.

The CHAIRMAN, speaking as the member for Pakistan, said that wild-type virus was still circulating in his country. However, there had been only 24 cases of infection in 2005, and it was hoped that mopping-up activities could begin in September 2006. Transmission had been interrupted in 100 of the country's 126 districts, and was expected to be stopped in the rest during 2006. Only one type of poliovirus was circulating at present. An efficient and sensitive surveillance system for acute flaccid paralysis was in operation, and a monovalent vaccine, three times more effective than other vaccines, had been used for the most recent round of immunizations. Coverage of 99.7% had been achieved. His Government was working with Afghanistan to ensure coverage of people who unofficially crossed the border between the two countries. Pakistan was fully committed, at the highest levels, to poliomyelitis eradication. It was conducted completely transparently and all data were shared

with WHO. He thanked the Secretariat and in particular the Regional Office for the Eastern Mediterranean, the Government of Japan and Rotary International for support.

Dr STEIGER (United States of America)¹ thanked Egypt, Niger, Pakistan, Afghanistan and Nigeria for their efforts to eradicate poliomyelitis in 2005. Much progress had been made, which was also to the credit of the Secretariat. The United States had long supported the campaign to eradicate poliomyelitis. WHO's contribution and such partnerships as those with the African Union and the Organization of the Islamic Conference were essential in mobilizing national commitment and political leadership. He observed that poliomyelitis due to wild-type poliovirus, after eradication, was listed as a disease requiring immediate notification under the International Health Regulations (2005), and urged all nations to adhere to that reporting requirement through voluntary compliance with the Regulations and to cooperate fully with the international campaign by reporting cases early and consistently. He supported the draft resolution and the proposed amendments. He called for contributions to make good the funding shortfall for 2006 and beyond.

Mr HÖRNDLER (Rotary International), speaking at the invitation of the CHAIRMAN, commended the dedication shown to the global eradication of poliomyelitis, to which he pledged his organization's continued commitment. Despite the many challenges in 2005, phenomenal progress had been made. Africa's efforts to eradicate poliomyelitis were back on track, after successful multinational, synchronized immunization campaigns. India, once accounting for more than 70% of the global poliomyelitis burden, had almost achieved eradication with only 65 cases reported in 2005. Egypt, one of the world's six poliomyelitis-endemic countries, had been poliomyelitis-free for over a year. By the time of global certification, Rotary International would have contributed more than US\$ 600 million, in addition to the countless hours its volunteers had spent immunizing over 3000 million children in 122 countries. The poliomyelitis initiative had been hailed as an example for other global health endeavours and, having come so close, must be brought to a successful conclusion.

The CHAIRMAN praised Rotary International for its highly commendable contribution to poliomyelitis eradication.

Dr HEYMANN (Representative of the Director-General for Polio Eradication) thanked Member States, on behalf of the other core partners in the Global Polio Eradication Initiative, UNICEF, Rotary International, and the United States Centers for Disease Control and Prevention, for their comments and poliomyelitis eradication efforts. He welcomed the proposed amendments to the draft resolution. Of the 21 poliomyelitis-free countries where reinfections had been detected since 2003, all but seven had been able to stop transmission of poliovirus, thanks to strong political support from such groups as the Organization of the Islamic Conference, the Commonwealth, the African Union and the G8. The availability of monovalent vaccines for types 1 and 3 polioviruses would enable responses to be tailored to countries' needs. In addition to its role in detecting disease and ensuring that children received vaccines, the poliomyelitis eradication infrastructure had contributed to other initiatives such as campaigns for the provision of vitamin A and for the supply of bednets to women and young children to prevent malaria, as well as strengthening country proposals to the Global Alliance for Vaccines and Immunization. The poliomyelitis surveillance network had also contributed to the response to major outbreaks and disasters, for example its assessment of the infectious disease situation after the earthquake in Pakistan, its work in Angola during the outbreak of Marburg haemorrhagic fever and its work during the outbreak of severe acute respiratory syndrome. Discussions were under way to determine the network's potential role in the area of communicable diseases, including avian influenza. The guidelines for response to outbreaks involved the use of monovalent oral poliomyelitis vaccine, but recommendations for inactivated poliomyelitis vaccine

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

would also be included. He thanked partners for their efforts in reducing the 2006 shortfall of US\$ 200 million to US\$ 150 million, and for the work they had done in general to eradicate poliomyelitis.

Mr AITKEN (Director, Office of the Director-General) read out the proposed amendments that members had supported. Two new preambular paragraphs had been proposed: “Noting that the majority of new cases have come from areas which had already stopped transmission of indigenous polioviruses;” and “Noting the significant support extended by partners, appreciating their continuous cooperation, and calling for their ongoing support to national programmes in this final phase of the global eradication effort;”. A new paragraph 1 would read: “URGES polio-endemic Member States to foster their commitment to interrupting transmission of wild polioviruses with the application of appropriate monovalent oral poliomyelitis vaccines;”. The original paragraph 1(2) had been slightly reworded to read: “implementing a minimum of three large-scale rounds of immunization using a type-specific monovalent oral poliomyelitis vaccine, including, where applicable, house-to-house vaccination, ...”. After informal consultations with members, the following merged version of paragraphs 1(3) and 1(4) was proposed: “targeting all children aged less than five years in the affected and adjacent geographical areas, using independent monitoring to determine whether at least 95% immunization coverage has been reached;”. Paragraph 1(5) would read: “ensuring that at least two full rounds of poliomyelitis immunization are conducted in the targeted area after the most recent detection of polioviruses”. Paragraph 2(2) would read: “to assist in mobilizing funds and ensuring adequate supplies of monovalent oral poliomyelitis vaccine to implement emergency response to an outbreak;” and a new final subparagraph should be added: “to report to the Executive Board at its 119th session on progress made in the implementation of this resolution”.

The resolution, as amended, was adopted.¹

HIV/AIDS: Item 4.5 of the Agenda

- **Universal access to prevention, care and treatment** (Document EB117/6)
- **Nutrition and HIV/AIDS: draft resolution** (Documents EB117/7 and EB117/7 Add.1)

The CHAIRMAN drew attention to a draft resolution on implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, proposed by Austria, Belgium, Canada, the Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Luxembourg, Madagascar, Malta, Mexico, Monaco, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, South Africa, Spain, Sweden, Switzerland and the United Kingdom of Great Britain and Northern Ireland, which read:

The Executive Board,

Having considered the report on HIV/AIDS: universal access to prevention, care and treatment,²

RECOMMENDS to the Fifty-ninth World Health Assembly the adoption of the following resolution:

The Fifty-ninth World Health Assembly,

¹ Resolution EB117.R1.

² Document EB117/6.

Taking note of the report on HIV/AIDS and universal access to prevention, care and treatment;

Recognizing the role of WHO as a cosponsor of the Joint United Nations Programme on HIV/AIDS (UNAIDS);

Recalling the decisions of the Seventeenth Programme Coordinating Board of UNAIDS (27-29 June 2005, Geneva);

Commending the final report of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors;¹

Noting, in that regard, that improved coordination and harmonization of efforts and a clear division of responsibilities between UNAIDS and its cosponsors will be required, together with coordination with national and global partners;

Noting the emphasis placed on support for action at country level and on developing the national response,

1. ENDORSES the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors;

2. REQUESTS the Director-General:

(1) to implement the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, to prepare appropriate plans of action, in collaboration with UNAIDS and the other cosponsors, and to maintain the momentum created by the Global Task Team, within the deadlines set;

(2) to report to the Health Assembly on progress made in implementation of the recommendations of the Global Task Team and to use that report to inform the Programme Coordinating Board of UNAIDS;

(3) to provide effective technical support to national governments and, in conformity with the agreed division of work, to focus on those areas in which WHO has an advantage compared to other bodies.

Ms TOR DE TARLÉ (France), introducing the draft resolution, summarized the main recommendations of the Global Task Team. It was important that WHO join other international bodies in officially endorsing those recommendations. The draft resolution should have no administrative or financial implications; on the contrary, implementation of the recommendations would, through the resulting synergy achieved between the different international players, lead to optimal use of resources.

Mr GUNNARSSON (Iceland) endorsed the report on universal access and strongly agreed that treatment and care should go hand-in-hand with prevention. To that end, primary health-care systems must be strengthened. His country, together with the Nordic countries, welcomed the proposal in the report to establish a rapid and participatory process at country level for setting country-specific targets on prevention, treatment, care and support services to be reached by 2010. He supported the draft resolution.

Dr WINT (Jamaica) commended the report. Thanks to the “3 by 5” initiative 60% coverage with antiretroviral treatment had been achieved in his country in just more than one year since its introduction. Jamaica was still working towards full implementation of the Three Ones principle, and recognized the importance of involving multiple stakeholders and networks of people living with

¹ Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors: Final Report 14 June 2005, Geneva, UNAIDS, 2005.

HIV/AIDS. Jamaica's experience was testimony to the reported "lessons learnt", in particular the decentralization of the programme and its greater integration within other local level programmes. Control of sexually transmitted infections was closely related to HIV/AIDS control, and he noted the importance of training in voluntary counselling and testing at community level. Access for vulnerable groups in particular needed to be improved, and the stigmatization and discrimination concerning HIV/AIDS constituted an additional major challenge for his country, hindering achievement of universal access to prevention, care and treatment. Nutrition was a crucial element in treatment. He welcomed the draft resolution.

Dr ALI MOHAMMED SALIH (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that, in the area of universal access, those countries had shown increasing political commitment in their response to HIV/AIDS. Some had been offering free antiretroviral treatment to all in need for several years. Others were having difficulty fulfilling their commitments, owing to weak health systems and infrastructure. The high cost of antiretroviral treatment and laboratory tests was halting the expansion of services, and stigmatization was a major obstacle to the uptake of prevention and treatment services. In September 2005 the Regional Committee for the Eastern Mediterranean had endorsed the regional strategy to strengthen the health-sector response to HIV/AIDS. He therefore welcomed the global commitment to universal access. There was a growing need, however, for technical assistance to support capacity building, advise countries about antiretroviral treatment costs and provide tools and guidelines for ensuring greater prevention, treatment and care.

Mr AZIZ (alternate to Dr Ali Mohammed Salih, Iraq) said that measures to prevent transmission of HIV must be taken within the context of the International Health Regulations (2005) and treaties. The media had to be used to raise popular awareness about the disease. Strategies needed to be regularly reviewed over the 10 years ahead in order to assess and control transmission, and be set within the framework of the Millennium Development Goals.

Dr SHANGULA (Namibia), speaking on behalf of the Member States of the African Region, said that the HIV/AIDS pandemic remained one of the greatest public health challenges in the Region, with an estimated three million new infections and 2.5 million AIDS-related deaths in sub-Saharan Africa in 2004. It also had serious implications for national security and socioeconomic development. In many countries, access to prevention and care services remained elusive. Countries had responded positively to the global call to increase access to comprehensive care for people living with HIV/AIDS within the context of the "3 by 5" initiative, but the weaknesses of health systems meant that access to both prevention and treatment services remained insufficient to stem or reverse the epidemic. Nevertheless, considerable progress had been made in the provision of antiretroviral therapy. By June 2005, 500 000 people in sub-Saharan Africa were receiving antiretroviral treatment. Botswana, Namibia and Uganda had already met their "3 by 5" targets. Such results had been achieved through increasing advocacy and partnerships, the commitment of national governments and their ownership of control programmes, the provision of technical support and support for mobilization of funds from donor agencies.

Botswana, Burkina Faso, Côte d'Ivoire, Gabon, Gambia, Ghana, Guinea, Kenya, Lesotho, Madagascar, Malawi, Mauritania, Namibia, Nigeria, Seychelles, Swaziland, Uganda, Zambia and Zimbabwe had initiated comprehensive HIV testing and counselling services, but otherwise progress towards improving access to such services had been limited. Although access to services for prevention of mother-to-child transmission of HIV had improved, they still only reached 10% of those in need. Incipient declines in prevalence rates in pregnant women in Burkina Faso, Burundi, Kenya, Namibia, Uganda and Zimbabwe were encouraging. Among the challenges facing the African Region, Member States needed to ensure delivery of locally-defined essential prevention and care interventions, strengthen HIV prevention sufficiently to have an impact on the epidemic; to ensure universal access to comprehensive care; and to generate and better use strategic information. He urged WHO to continue its valuable contribution to partnerships, which were crucial to success.

Ms HALTON (Australia) affirmed Australia's commitment to the United Nations 2005 World Summit goal to come as close as possible to universal access to treatment by 2010. Her Government accepted that a package of interventions for HIV/AIDS must involve prevention, treatment and care but noted the absence of an internationally agreed target for universal access to prevention or care services. Defining universal access to prevention was also difficult. In working towards the goal of universal access to treatment, Member States should ensure that they did so without jeopardizing prevention and care programmes. Countries should aim to achieve a balance in their investment in prevention, care and treatment that was appropriate to national needs. In areas with rapidly emerging epidemics, such as the Western Pacific Region, it was crucial to maintain a strong preventive response while building capacity to meet increasing needs for treatment and care. National governments must provide the resources, funding and capacity to implement and maintain universal access to treatment in the medium to long term.

The "3 by 5" initiative had been an important catalyst, but problems remained relating to capacity, funding and human resources, on which the Organization should continue to focus. Implementing the recommendations of the Global Task Team had been promising, and WHO and other UNAIDS cosponsors should ensure the swift operationalization of the UNAIDS division of labour for technical support. Australia wished to be added to the list of sponsors of the draft resolution.

Mrs LE THI THU HA (Viet Nam) welcomed the process proposed by WHO and UNAIDS to enhance commitment to universal access by 2010, and the lessons that had been learnt from the "3 by 5" initiative. In March 2004, her Government had approved a national strategy for HIV/AIDS prevention and control up to 2010, with objectives and targets in line with universal access: 100% of urban dwellers and 80% of those living in mountainous and rural areas should understand about HIV transmission and how to prevent it; high-risk groups should have access to comprehensive harm-reduction measures, such as safe injections and condoms; 90% of infected adults, 100% of HIV-infected pregnant women and 100% of HIV-infected or HIV-affected children should receive appropriate treatment, care and counselling, and 70% of AIDS patients should be treated with specific medicines. The national strategy included harm reduction, care and support, surveillance, monitoring and evaluation. Insufficient funding created bottlenecks and her country would appreciate assistance to implement its national strategy, building on the "3 by 5" initiative. Additional practical guidance was needed in all those areas.

The continuing high cost of antiretroviral medicines posed a further problem. She requested information on the plans to expand the WHO Prequalification Project and further steps to promote prevention based on the progress made by the "3 by 5" initiative.

Coordination and harmonization of different initiatives in countries were crucial to expanding HIV services. WHO had supported countries in elaborating technically sound national guidelines and protocols. For injecting drug users, however, she asked whether general practical guidance was being issued. She supported the draft resolution.

Dr MUSTAFA (alternate to Dr Botros Shokai, Sudan) said that Sudan was the most affected country in the Eastern Mediterranean Region. Increased control of HIV/AIDS was needed. Although attitudes towards HIV/AIDS interventions were becoming more open, the response was still not equal to the challenge. The goal of universal access would entail strengthening the entire health system, from ensuring continuous supplies of antiretroviral medicines to training personnel and creating monitoring and evaluation systems. Sudan could achieve the present target to provide 4000 patients with antiretroviral medicines. So far 400 people were receiving treatment and medicines were available for a further 1500. The number of treatment sites had increased from 3 to 14 between 2004 and 2005.

Professor PEREIRA MIGUEL (Portugal), speaking on behalf of the Member States of the European Union, the acceding countries, Bulgaria and Romania, the candidate countries, Croatia, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates, Albania, Bosnia and Herzegovina, and Serbia and

Montenegro, said that the fight against HIV/AIDS was one of the biggest global health challenges. In 2005 the group of countries had made a commitment to developing and implementing a package for HIV/AIDS prevention, treatment and care to achieve near universal access by 2010. In only 12 months under the “3 by 5” initiative, the number of people in Africa receiving treatment had trebled. However, the target set had not been reached. Recent figures from UNAIDS showed that the number of cases of infection and death continued to increase; the Millennium Development Goal of halting and reversing the HIV/AIDS epidemic by 2015 was therefore still a long way off.

In Europe, high rates of HIV infection in some vulnerable groups were a continued threat for the spread of the disease in the general population and reignition of the epidemic among those groups. In December 2005, the European Commission had adopted a new Communication on combating HIV/AIDS within the European Union and in neighbouring countries for the period 2006 to 2009. The European Union strongly supported the work of the Global Steering Committee on Scaling Up towards Universal Access, which initiative should be a country-led process and cover the full range of necessary activities from prevention to treatment and care. It also placed great emphasis on the relevance of the final report of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, and on WHO being the implementor of the report's recommendations. Countries establishing a single United Nations team had been given priority. If United Nations agencies, including WHO, would focus on their core mandate and move from competition to coordination and collaboration, the global community would be better served. The United Nations High-level Plenary Meeting (New York, September 2005) had welcomed the recommendations contained in the Global Task Team report and several UNAIDS cosponsors had already endorsed its recommendations, as had the Global Fund to Fight AIDS, Tuberculosis and Malaria. The recommendations signalled a commitment to operational change. WHO also needed to give greater responsibility to its regional and country offices. The European Union encouraged the Board to endorse the recommendations. He invited other European Union Member States to sponsor the draft resolution.

During the Third Meeting of the Global Fund's Voluntary Replenishment Mechanism (London, 5-6 September 2005) the Union had emphasized its commitment to the Fund's role as a major mechanism for ongoing investment in the fight against HIV/AIDS, tuberculosis and malaria. Several European Union Member States, as well as the European Commission, had made significant pledges to the Global Fund for the 2006-2007 biennium.

The European Union had noted recent progress in connection with HIV/AIDS regarding nutrition and orphans and stressed the importance of such activities, which were vital in enabling both WHO's health targets and the health-related Millennium Development Goals to be met in the most affected regions. For World AIDS Day 2005, the European Union had adopted a Statement on HIV Prevention recognizing the need for a massive expansion of activities and emphasizing universal access to sexual and reproductive health information and harm-reduction commodities; provision of accessible and integrated health promotion and harm reduction services for drug users; reliable access to essential sexual and reproductive health; universal access to education and provision of life-skills and sex education; integration of prevention measures, including voluntary counselling and testing, into other health services; action to confront and address gender-based violence and to provide protection and support for victims of violence; support for investment in developing new biomedical prevention technologies, including microbicides and vaccines; and the promotion and adoption of good workplace practice.

The European Union recognized WHO's key role in the response to HIV/AIDS. The United Nations General Assembly special session on HIV/AIDS, to be held in September 2006, would review the status of implementation of its Declaration of Commitment.

Speaking in his capacity as the member for Portugal, he said that his country, where the incidence of HIV infection remained unacceptably high, accorded high priority to HIV/AIDS and had devised a national plan. The national policy focused on testing as an essential first step in prevention, treatment and care. However, there was consistent evidence of low prevalence among pregnant women; it also appeared that perinatal transmission was close to being controlled. Cases of infection among injecting drug users had decreased, but heterosexual transmission was rising. Managing

HIV/AIDS was part of a wider fight against sexually transmitted diseases, hepatitis C and tuberculosis. A new integrated policy approach could provide access to the necessary care.

Portugal was committed to promoting research and action on HIV/AIDS and nutrition, in particular, through a network of trained nutritionists in both hospital and outpatient services. Since nutrition was considered essential in education about the treatment of HIV/AIDS, a manual on antiretroviral adherence for people living with AIDS was being prepared in collaboration with several nongovernmental organizations.

Dr SOPIDA CHAVANICHKUL (adviser to Dr Suwit Wibulpolprasert, Thailand) said that Thailand wished its name to be added to the list of sponsors of the draft resolution.

The current increase in HIV incidence and the inadequacy of prevention services to meet the need represented a major threat to global AIDS responses. Universal access to treatment and care should not be at the expense of prevention efforts. According to UNAIDS data, fewer than one in five people at risk of contracting HIV had access to basic prevention services; only one in 10 people thought to be living with HIV had been tested for the virus. In South-East Asia, only 0.1% of people between 15 and 49 years had received counselling or been tested. In sub-Saharan Africa, only 5% of pregnant women living with HIV had access to services to prevent vertical transmission. Attention needed to be paid to overcoming operational barriers to effective management and delivery of prevention programmes. It would be beneficial to integrate prevention, care and treatment. A wider uptake of HIV testing could mean less stigmatization and denial. Intensified prevention was needed to make treatment affordable and sustainable. The cost of first-line medicines was still high in poor countries, and second-line antiretroviral medicines were unaffordable even in middle-income countries. Costs posed a major challenge for the years ahead.

Ms TOR DE TARLÉ (alternate to Professor Houssin, France) recalled that, with regard to universal access, several Board members had already emphasized the problems arising from funding and the high cost of medicines. The President of France was committed to the principle that everyone in need should have access to antiretroviral treatment and, therefore, the Declarations that had come from the Summit of the G8 group of countries (Gleeneagles, Scotland, 6-8 July 2005) and the United Nations High-level Plenary Meeting (New York, September 2005), both of which had emphasized the objective of ensuring universal access to treatment by 2010, had been extremely welcome. She drew attention to the link between prevention and care and the importance of mobilizing civil society and of integrating any new actions in existing primary care and reproductive health programmes. Six million people with HIV in the developing world urgently needed antiretroviral treatment, yet current production levels and market forces made it impossible to meet the demand.

In order to combat AIDS, it was imperative to ensure drug security. France considered that official development aid would not be enough to generate sufficient and sustained resources needed by developing countries. It therefore proposed setting up an international solidarity fund by placing a tax on air tickets. A proportion of the revenue generated would be used to purchase drugs and encouraging increased production of antiviral and antimalarial drugs. It also proposed the creation of an international drug purchase facility that would mobilize resources over the medium- to long-term to facilitate the purchase of drugs and other medical products such as diagnostic kits necessary for the treatment of AIDS, tuberculosis and malaria. The facility would promote a restructuring of the market in medicines, particularly antiretroviral agents, enabling costs to be lowered through better-organized competition and a relatively long-term mutual commitment between manufacturers and purchasers. Quality would be ensured through prequalification by WHO and by approved agencies. The emphasis would be on making use of existing mechanisms rather than on creating new international systems.

Mr SHUGART (Canada) said that his country was deeply disturbed by the tenacity of the scourge of HIV/AIDS, the increase in new infections, the destabilizing potential of the disease and the human suffering it caused. It fully supported WHO's approach, in particular the principle of universal access to prevention, care and treatment. Canada also supported the emphasis given by UNAIDS to the need to ensure a human rights-based approach, which should also be adopted by WHO. Scaling up

universal access should be assessed in the context of strengthening health-care systems generally, notably in regard to human resources, and interventions should be closely linked to primary health care and to reproductive health services.

He proposed that paragraph 1 of the draft resolution introduced by France should be strengthened by the addition of the words “and furthermore endorses all the related decisions of the Programme Coordinating Board”. In paragraph 2(3) the word “agreed” should be deleted and the words “agreed among the UNAIDS cosponsors” added after “division of work”.

Dr SHINOZAKI (Japan) commended the Director-General’s leadership in launching the “3 by 5” initiative. It was important to identify the obstacles that had prevented the expansion of treatment services. He welcomed the approach to universal access outlined in the report and looked forward to an implementation plan. Monitoring and evaluation would be crucial.

Dr GASHUT (alternate to Dr Al-Keeb, Libyan Arab Jamahiriya), speaking on behalf of the Member States of the Eastern Mediterranean Region, proposed that the words “and the United Nations Framework on Priority Action in HIV and Infant Feeding” should be added at the end of paragraph 1(3)(a) of the draft resolution contained in document EB117/7. That would ensure a consistent approach to policy-making in that area, in the light of the fact that resolution WHA57.14 made reference to the Framework.

Dr ANDRADE GAIBOR (Ecuador) said that enough had been said about prevention: the emphasis should turn to finding and following up infected persons. The disease did not affect only the poor or the sexually promiscuous, but was found in all sectors of society: in his country, for instance, renal dialysis had caused the virus to be transmitted on a massive scale to people without other risk behaviours. The focus should be on education for the public, patients and the community. Laboratory services, antiretroviral medicines and hospital care had to be accessible to all; they were still too expensive for many people. He supported the draft resolution contained in document EB117/7.

Dr RAHANTANIRINA (alternate to Dr Jean Louis, Madagascar) said that HIV/AIDS was one of the principal causes of death in Africa, especially sub-Saharan Africa. Universal access to treatment was crucial, and the “3 by 5” initiative had done much to accelerate achievement of the Millennium Development Goals. Harmonization and coordination of interventions would allow more effective use of resources.

She too supported the draft resolution introduced by France and endorsed the draft resolution contained in document EB117/7 as amended.

Dr BUSS (Brazil) expressed regret that it had not been possible to achieve the targets of the “3 by 5” initiative and asked for an inquiry into whether non-availability of medicines, management problems in the Secretariat, or human resource problems in countries had been responsible for the failure. Unless lessons could be learnt from that experience, there was a risk that future efforts too would be unsuccessful.

Brazil had spent US\$ 400 million in the previous year on antiretroviral medicines, 67% of that sum on three drugs alone, but had experienced enormous difficulties in negotiating prices with the big pharmaceutical companies. The problem of AIDS would not be solved unless the issue of intellectual property rights was resolved, enabling governments to take action to defend public health, and an integrated approach taken that promoted solidarity between countries. He urged the Board to take a strong ethical stand in regard to the availability of medicines. Brazil had been obliged to take funds from other programmes to finance its AIDS programme.

Brazil supported the international solidarity fund proposed by France.

Dr ACHARYA (Nepal) said that the epidemic of HIV/AIDS in his country was concentrated in certain high-risk groups: 50% of injecting drug users were infected, as were 17% of female sex workers. In all, some 62 000 people were estimated to be infected, with up to 9000 needing

antiretroviral treatment, of whom only 450 were receiving it. Cross-border migration caused by insurgencies further compounded the risk of infection; in such situations, the solidarity between countries referred to by the previous speaker would be invaluable in controlling the spread of the disease. The HIV infection rate was rising rapidly, although it was difficult to gain reliable data, in part because of social stigmatization. Provision of antiretroviral medicines and community care was insufficient, and technical and financial assistance was still urgently required.

Dr TANGI (Tonga) thanked those governments that had been providing assistance in combating AIDS in the Pacific area. The Global Task Team had improved coordination between donor agencies and institutions.

Dr RUÍZ MATUS (alternate to Mr Bailón, Mexico) said that his country supported the commitment to tackle the epidemic by placing emphasis on prevention as well as treatment. In 2004, Mexico had reached the target, originally set for 2006, of providing antiretroviral medicines to those in need who were not covered by social security. It had also progressed in creating new models for those living with HIV/AIDS: from 2004, day-patient centres for prevention and treatment of AIDS and other sexually transmitted infections had been set up in various parts of the country. Mexico was also working to fight discrimination against people with AIDS, in conjunction with civil society bodies, and had become the Latin American representative in the Global Fund to Fight AIDS, Tuberculosis and Malaria. The draft resolution proposed by France and other countries would help to avoid poor resource use. Coordination was essential.

Dr SINGAY (Bhutan) also supported that draft resolution and welcomed the progress achieved towards universal access by 2010, which would help Member States to achieve the relevant Millennium Development Goals by 2015. The “3 by 5” initiative had made it possible for Bhutan, which was in the early stages of an HIV/AIDS epidemic, to render access to antiretroviral medicines universal. Coverage had risen and as a result people were living longer: that was a significant achievement of the initiative that ought to be recorded and appreciated.

Health systems particularly in primary health care must be strengthened in order to achieve universal access, and people living with HIV/AIDS should be represented in HIV/AIDS programmes. In view of the high cost of first-line and second-line drugs, prevention must be prioritized. For Bhutan, combating HIV/AIDS was going to be a major challenge.

Dr ANTEZANA ARANÍBAR (Bolivia), referring to the administrative and financial implications of the proposed draft resolution contained in the report,¹ asked for similar estimates for the implementation of countries’ HIV/AIDS programmes. He shared the concerns expressed by the members for Brazil and Canada.

The CHAIRMAN, speaking as the member for Pakistan, said that his Government was fully committed to the national strategic framework for HIV/AIDS control. Despite the apparent low prevalence of HIV in Pakistan, coordinated action was needed to prevent an epidemic. Eleven antiretroviral medicines had recently been included in Pakistan’s essential medicines list and free access to such drugs was available with the help of the Global Fund.

Young people had to be educated to realize that antiretroviral medicines did not provide a solution to HIV/AIDS and that promiscuous behaviour should be avoided. Pakistan fully supported the process proposed by WHO and UNAIDS for providing universal access to HIV/AIDS prevention, care and treatment by the year 2010. It was crucial to engage world leaders, the pharmaceutical industry and the general population on the issue of antiretroviral medicines. Further studies were needed on the links between HIV/AIDS and other diseases. Many countries had the capacity to produce antiretroviral

¹ Document EB117/7 Add.1.

agents, and a moral decision was needed on the issue of intellectual property rights in order to allow them to do so.

Dr STEIGER (United States of America),¹ endorsed the views of the previous speaker on prevention. On the question of treatment and universal access, his country, as a member of the G8 group of countries and under the President's Emergency Plan for AIDS Relief, was committed to near universal access to antiretroviral treatment by 2010. In the past two years, it had helped to provide such treatment for more than 400 000 people. Some challenges remained, such as the price of pharmaceuticals, and his country was working closely on that issue with generic drug manufacturers from many countries. The United States had an approval process to ensure that products from producers in developing countries were safe and effective and thus eligible for procurement under its programme. National governments should look to producers who had already received approval before using their resources to build up national companies; many safe and effective products were already available. Countries also had to help by reducing tariffs charged on imported medicines, and he appealed to WHO and governments to assist in breaking down regulatory barriers.

The three medicines mentioned by the member for Brazil were basically second-line therapies. Treatment was failing in many countries, and resistance to present drugs was growing. The question of who would be willing to make the third-line drugs if incentives were removed for the private sector to continue to invest in HIV therapy should be borne in mind.

He supported the draft resolution introduced by France, but pointed out that his country endorsed not a global action plan but the concept adopted by the United Nations General Assembly, namely the recommendation for consolidated action consistent with a country-driven process. The United States did not equate "country-driven" with "government-dominated"; it expected everyone to work with the private sector, nongovernmental organizations and civil society, and notably with faith-based and community organizations, as partners in the process. It supported and encouraged WHO's work in that regard.

Mrs FURMAN (Israel)¹ asked for Israel to be included among the sponsors of the draft resolution.

Ms MANE (UNAIDS) assured the Board that the process towards universal access was country-led and multi-partnered, aiming mainly at identifying major obstacles to access and practical solutions to overcome them. Prevention, treatment, care and support were equally important, but she particularly appreciated the attention paid by WHO to prevention. UNAIDS was working on an action plan to support accelerated prevention.

National authorities were holding consultations with stakeholders on how to work towards universal access in order to formulate regional strategies. The Global Steering Committee had met first in January 2006. It was likely to recommend that countries should establish their own targets for 2010 and that UNAIDS should assist by offering existing indicators that could be used in national target-setting and reporting. The targets would be finalized by 2006, and would include some interim progress targets for 2008.

Ms KEITH (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, supported the focus on universal access and the need to overcome barriers such as weak health systems, lack of human resources for health and payment for health services at the point of access. The subject related to other items on the agenda, and in relation to item 4.12, WHO's roles and responsibilities in health research, the Secretariat should, with UNAIDS and other stakeholder partners, commission research into the cost of providing an essential health-care package, including HIV care and treatment, that would be free at the point of access. Such research would update the

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

2001 figure, since it would need to take into account new treatments. Reference should be made to resolution WHA58.31, which dealt with such issues.

Her organization had carried out research, over a period of five years, on conditions in seven countries in east and central Africa, and specifically on the negative impact of chronic illness on household expenditure, and access to health care for poor families. Technical and financial resources should be allocated, both nationally and internationally, to determine what mechanisms could ensure that health and HIV services could be provided free at the point of access for all.

She welcomed the establishment of the Global Task Team.

Concerning the impact of HIV on children, she urged WHO and donors to support research into paediatric formulations of antiretroviral medicines. Programmes on the social determinants of health and HIV, such as gender, power relations, education and poverty, should also be supported. Further work should be done on health promotion, especially with regard to stigmatization and discrimination. She supported the statement by the European Union and the draft resolution introduced by France.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN, commended WHO's bold "3 by 5" initiative, which had acted as a catalyst in improving access to prevention, treatment and care. The millions of nurses that he represented would continue to collaborate with WHO in combating HIV/AIDS, striving to achieve the Millennium Development Goals, and supporting WHO's priority programmes.

The Council had undertaken much work on human resources in nursing, and for the past two years had shared all its information with WHO for inclusion in the planned progress report to the Fifty-ninth World Health Assembly on nursing and midwifery. It had therefore been distressing to learn that the matter had not been included on the agenda of that Health Assembly. During the discussion of strengthening of nursing and midwifery at the Fifty-sixth World Health Assembly, some 40 Members had spoken and a progress report had been requested for 2006.¹ Such a report had been promised by the then Executive Director, Evidence and Information for Policy, and he hoped that the promise would be honoured.

Dr ASAMOA-BAAH (Assistant Director-General), welcoming the tributes paid to the "3 by 5" initiative, said that in a few short years the conventional wisdom on AIDS treatment had mutated from hopelessness to hope, largely owing to the technical and financial support provided by international donors, especially Canada. As several speakers had pointed out, however, treatment remained expensive and elusive for many people, and the HIV/AIDS situation worldwide was deteriorating despite increased awareness. He had taken note of the concerns raised, such as the need for WHO to devote more attention to treatment and prevention and for practical guidelines on harm reduction for injecting drug users to be issued. WHO was evaluating the "3 by 5" initiative; the final report, by an independent team, would be issued in March 2006 and could provide valuable lessons for the future. He commended the work of the Global Task Team, in which WHO participated.

Mr SHUGART (Canada) proposed deletion of the final phrase of paragraph 2(8) of the draft resolution, contained in document EB117/7, which read "submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria".

Dr SHANGULA (Namibia), speaking on behalf of Member States of the African Region, said that good nutrition was vital for people infected with HIV; poor nutrition undermined immune systems and increased susceptibility to other infections. In sub-Saharan Africa, the rate of HIV infection and malnutrition had reached alarming levels. Following the consultative meeting on nutrition and HIV/AIDS in Africa held in April 2005, a regional training course in nutritional care and support for people living with HIV/AIDS had been organized for 11 countries. Plans had been developed to

¹ Document WHA56/2003/REC/3, summary record of the seventh meeting of Committee A, section 3.

implement the framework for priority action on HIV and infant feeding¹ by 20 countries in the African Region. He welcomed the proposed meeting on the inclusion of nutrition as a component for funding by the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria.

The African Region needed to reverse the current unacceptably high rates of malnutrition, HIV infection and food insecurity if it was to achieve the Millennium Development Goals. It also needed to ensure that adequate nutrition was available to optimize the effects of antiretroviral medicines, at the same time tackling the proliferation of untested diets promoted by those who sought to profit from people infected with HIV. The health and well-being of children infected or affected by HIV/AIDS, especially young girls, must be protected.

Good nutrition did not prevent HIV transmission; it was not an antiviral agent; it enhanced the capacity of the body to cope with infections. He therefore proposed that, in paragraph 1(1)(c) of the draft resolution contained in document EB117/7, the word “prevention” should be deleted. Secondly, a new paragraph 1(3)(e) should be added, to read “ensuring that institutions training health workers review curricula to be in line with current recommendations”.

Dr SOPIDA CHAVANICHKUL (adviser to Dr Suwit Wibulpolprasert, Thailand), supported by Mr GUNNARSSON (Iceland), endorsed the draft resolution as amended by the member for the Libyan Arab Jamahiriya.

Dr OROOJ (alternate to Mr M.N. Khan, Pakistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, urged the Board to consider the diversity of income, development, population size, health systems development and educational standards among the countries in his Region. They had in common relatively low access to health systems, even where epidemics were widespread. Despite commendable support from WHO, the Region lacked models and tools that took into account the experience of such countries, and they should therefore be included in global technical consultations so that appropriate tools and guidelines could be developed for them. WHO should work with governments to devise mechanisms to facilitate implementation and supervision strategies.

Mr ABDULLA (alternate to Dr Botros Shokai, Sudan) supported that suggestion.

Ms TOR DE TARLÉ (France), emphasizing an integrated approach, proposed the addition of the following preambular paragraph to the draft resolution in document EB117/7: “Underlining the importance of ensuring cooperation on this question with other United Nations agencies, including the World Food Programme, the Food and Agriculture Organization of the United Nations and the United Nations Children’s Fund”.

Dr LE GALÈS-CAMUS (Assistant Director-General) pointed out that WHO had always emphasized the importance of properly-structured cooperation with FAO, UNICEF and WFP. Such cooperation would continue in the interests of countries that lacked resources.

Mr AITKEN (Director, Office of the Director-General) read the amendments proposed to the draft resolution contained in document EB117/7. A new final preambular paragraph should read: “Underlining the importance of ensuring cooperation on this question with other United Nations agencies, including WFP, FAO and UNICEF,”. The word “prevention” should be removed from paragraph 1(1)(c), which should conclude: “... to incorporate nutrition into HIV treatment and care programmes;”. At the end of subparagraph 1(3)(a), the words “and the United Nations framework of priority action in HIV and infant feeding” should be added. A new subparagraph 1(3)(e) should be added, to read: “ensuring that institutions training health workers review curricula to be in line with

¹*HIV and Infant Feeding: Framework for Priority Action*, Geneva, World Health Organization, 2003.

current recommendations;”. Finally, paragraph 2(8) should end with the word “proposals”, the words “submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria” being deleted.

The resolution, as amended, was adopted.¹

(For adoption of the resolution on coordination, see summary record of the eighth meeting, section 3.)

The meeting rose at 18:15.

¹ Resolution EB117.R2.