WORLD HEALTH ORGANIZATION

FIFTY-THIRD WORLD HEALTH ASSEMBLY **A53/6**
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HIV/AIDS

Report by the Director-General

BACKGROUND

1. At the end of 1999, 33.6 million people were living with HIV/AIDS, more than 95% of them in the developing world. The epidemic is continuing to spread globally, with 5.6 million newly infected people in 1999.

2. HIV/AIDS is the leading cause of death in sub-Saharan Africa, where two-thirds of all infections – more than 23 million people – and about 80% of all deaths have occurred. It is estimated that a cumulative total of 14 million people will have developed AIDS and died in this region by the year 2004. Studies conducted in nine countries in sub-Saharan Africa suggest that prevalence of HIV among women is now higher than among men, with 12 to 13 women currently infected for every 10 men.

3. In the worst affected countries of southern Africa, the HIV/AIDS epidemic is reversing the developmental gains of the past 50 years, including hard-won increases in child survival and life expectancy. In many of these countries, the cohort of individuals of reproductive age is dying, leaving behind grandparents to raise their grandchildren and children to raise their siblings.

4. The number of people living with HIV/AIDS doubled in the Newly Independent States between the end of 1997 and the end of 1999. The bulk of new infections was caused by unsafe injection of drugs. The climate for increased incidence of HIV is ripe, because sexually transmitted infections in this region have increased substantially among young people.

5. HIV is increasing rapidly in Asia, particularly in south and south-east Asia, with 6 million people infected. Much of this infection is among drug-injecting groups. In the Americas, although there has been a decline in mortality due to AIDS, HIV infection continues to increase among minorities and disadvantaged populations.

6. Resolution WHA45.35 (1992), the last adopted by the Health Assembly on the strategy for HIV/AIDS prevention and control, provided useful, practical guidance for the work of WHO. Many of its recommendations remain valid and continue to be pursued. Since then, however, many developing countries have experienced the unabated spread and growing impact of HIV, and the United Nations has changed its systemic approach. The Joint United Nations Programme on HIV/AIDS (UNAIDS) was launched in January 1996, WHO being one of its founding cosponsors.

7. UNAIDS has now seven cosponsors (UNICEF, UNDP, UNFPA, UNDCP, UNESCO, WHO and the World Bank). Its goals are to catalyse, strengthen and orchestrate the unique expertise,

resources and network of influence that each of the cosponsors offers. It has an annual budget of US$ 60 million and a staff of 129 professionals.

8. As a cosponsor, WHO's major responsibility is to strengthen the health sector's response to the HIV/AIDS epidemic. WHO's activities are concentrated in the fourth strategic objective of UNAIDS, namely, to identify, develop and advocate international best practices for HIV/AIDS prevention and control, including principles, policies, strategies and activities that worldwide collective experience has shown to be sound.

9. The United Nations Economic and Social Council resolution 1999/36 on HIV/AIDS stresses, *inter alia*, the responsibility of governments to intensify all efforts to combat AIDS using multisectoral approaches.

10. WHO provides specific technical support to national health sectors, with particular attention to UNAIDS thematic priorities: young people; mother-to-child transmission; community-based standards of care; vulnerable populations; human rights, gender issues and participation of people living with HIV/AIDS; and international efforts towards vaccine development.

11. Consultations were held during 1999 within WHO at all levels and with UNAIDS and its cosponsors, on updating the prevention and control strategy of WHO and national health sectors, taking into account the responses of UNAIDS and other cosponsors.

12. WHO participates actively in the governance of UNAIDS, through, for example, its membership on the UNAIDS Programme Coordinating Board and its Committee of Cosponsoring Organizations. WHO served as Chair of the Committee in the year 1998-1999, and in this capacity gave support to the design of a unified budget and work plan for UNAIDS. WHO also suggested publicity materials reflecting the joint nature of the Programme in order to strengthen cosponsorship.

13. WHO participates substantively in UNAIDS activities in its various areas of technical competence, together with other cosponsors. It has worked actively on the issue of HIV-related drugs (including those for reducing mother-to-child transmission), is cooperating on vaccine-related questions, and has produced joint documents, such as those on the latest epidemiological situation and on guidance for voluntary counselling and testing. WHO will continue its close cooperation in these and other new activities in the coming year, contributing directly through its own technical strengths. It will also participate in a broad range of working groups and task teams in order to bring the experiences of all levels of the Organization to bear upon developments within UNAIDS.

14. In response to the increasing burden of HIV/AIDS in Africa, UNAIDS and its cosponsors initiated the International Partnership against AIDS in Africa in order urgently to mobilize nations, civil society and international bodies in a concerted effort to curtail the spread of HIV infection, to reduce sharply the impact of HIV/AIDS in terms of human suffering, and to halt any further reversal in development of human and social capital in Africa. WHO is contributing to this partnership by strengthening the Regional Office for Africa so that it can respond promptly and effectively to country demands, and by identifying priorities at country level in terms of prevention, care and alleviation of impact.

15. The recent meeting of the United Nations Security Council on the impact of AIDS on peace and security in Africa further demonstrated the threat to political, economic and social stability that may face sub-Saharan Africa and Asia.

ISSUES

16. Where effective prevention strategies have been systematically implemented, the incidence of HIV infection has been reduced. Where they have not, HIV continues to spread with great speed in some countries.

17. The major challenge today is to apply what is known to be effective. In many countries this requires high-level commitment to tackling HIV/AIDS as a central development issue and to strengthening health systems with adequate resources so that the proven interventions can be applied safely and effectively.

18. Prerequisites for health sector development include: an enabling health policy environment; well-equipped health facilities; trained staff to provide prevention and care interventions; and involvement of the local community and people living with HIV/AIDS, in order to promote a sense of ownership and hence sustainability.

19. Developed and industrialized countries have human, physical and financial resources that enable them: (a) to provide access to care and treatment of HIV/AIDS-related illnesses; (b) to supply antiretroviral agents to prevent transmission of HIV from mother to child; (c) to improve the quality of life; and (d) to prolong life. Developing countries, on the other hand, lack such resources, yet 95% of people living with AIDS reside there.

20. Poverty and inequity between men and women in access to resources for prevention and care contribute to the spread of HIV and the development of AIDS.

21. Some key proven interventions for prevention are set out below:

- advocacy against stigma and fear in order to encourage open, accepting and compassionate attitudes towards people living with HIV/AIDS at community, political and administrative levels, with health institutions, in particular, providing an example;

- health education for prevention, including: raising awareness; promoting safer sex through provision of information; life-skills education for young people in and out of school; provision of protection methods such as male and female condoms, to enable people to change their behaviour and reduce transmission of infection; and targeting young people before they become sexually active;

- safe blood and blood products for transfusion, donor selection and the screening for HIV of donated blood being indispensable to ensure that health practice does not contribute to the spread of HIV;

- prevention and care of sexually transmitted infections, including syndromic management, in order to reduce substantially the risk of transmission of HIV and the burden of disease attributable to sexually transmitted infections

- voluntary counselling and testing as an entry point in order to facilitate prevention, and access to care – a major obstacle in developing countries is that most people do not know their HIV status;

- prevention of mother-to-child transmission of HIV – in the worst affected countries, between 20% and 45% of pregnant women are HIV positive and one-third of their babies are infected. Feasible and affordable interventions, including the use of antiretroviral drugs and counselling on infant feeding, are being pilot tested before wide implementation;

- prevention, care and rehabilitation for injecting drug users in order to avoid an explosive spread of infection in this vulnerable population;

- research and development of microbicides and a vaccine that is effective against virus strains prevalent in developing countries, in order to provide countries with a major primary prevention tool.

22. The key proven interventions for care include:

- the establishment of a continuum of care between home, community and institutions, in order to meet medical and psychosocial needs;

- the strengthening of counselling and support skills of health care workers in primary, secondary and tertiary care;

- the treatment and prophylaxis of common HIV-related illnesses – in particular tuberculosis – and palliative care, in order to increase quality and length of life;

- increased and sustained access to new therapies for HIV/AIDS through innovative mechanisms and partnerships, ensuring that these therapies are affordable and used safely and effectively;

- availability of suitable foods and micronutrients to restore and sustain adequate nutrition of people with HIV/AIDS.

23. Adequate surveillance of HIV/AIDS and sexually transmitted infections, and of behavioural patterns, with particular attention to women, are required for planning, implementation and evaluation of the response.

24. Discrimination and stigmatization impede effective prevention of the spread of HIV and present obstacles to care for people living with HIV/AIDS.

25. Individuals, families and communities in developing countries are spending vast amounts to meet the cost of remedies for the sick, to ensure the provision of acute, chronic and palliative care, and to cover burial costs. Effective drugs and medicines available for HIV/AIDS-related illnesses are beyond the reach of most people in developing countries because of the exceedingly high cost. A major obstacle to controlling the spread of HIV/AIDS is that the resources devoted to the epidemic, at both national and international levels, are not commensurate with the magnitude of the problem.

ACTION BY THE HEALTH ASSEMBLY

26. The Health Assembly is invited to consider the resolution contained in resolution EB105.R17.

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