Folder Title:	AIDS - World Health Organization [WHO] - Bank Cooperation
Folder ID:	30117078
Dates:	03/27/1987 - 10/21/1987
Fonds:	Records of the Population, Health, and Nutrition Sector
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AIDS: WHO/Bank Cooperation

FORM NO. 27 - GCR
(7/86)

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WORLD HEALTH ORGANIZATION

GENEVA, SWITZERLAND

FOR MRS. I. BRUGGEMANN, DIRECTOR, PROGRAMME FOR EXTERNAL COORDINATION AND DR. J. MANN, DIRECTOR, SPECIAL PROGRAMME ON AIDS. SUBJECT: WORLD BANK COMMENTS ON DRAFT MANAGEMENT AND COORDINATION DOCUMENTS FOR SPECIAL PROGRAMME ON AIDS (SPA). ENJOYED VISIT BY MR. T. MOONEY, WHO/SPA, DR. N. DRAGER, WHO/COR/HRM, AND MRS. M. DAM, WHO/DGO/AMRO, TO EXCHANGE VIEWS ON SUBJECT DOCUMENTS. THIS TELEX RESPONDS YOUR REQUEST FOR COMMENTS ON SUBJECT DOCUMENTS. FIRST, REGARDING JOINT MANAGEMENT STRUCTURE. WE VIEW PROPOSED JOINT MANAGEMENT STRUCTURE SUGGESTED FOR ADOPTION DURING NOVEMBER MEETINGS AS A STRONG FOUNDATION FOR UPON WHICH SPA CAN CONTINUE TO BUILD ITS IMPORTANT PROGRAM AND WE SUPPORT ADOPTION OF THIS STRUCTURE. HOWEVER, WE SUGGEST MODIFICATION OF THIRD TO LAST PARAGRAPH (BEGINNING QUOTE EXCEPT THOSE REPRESENTATIVES... UNQUOTE) TO REFLECT FACT THAT INDIVIDUAL PEOPLE WHO ARE QUOTE MEMBERS UNQUOTE OF COMMITTEE OF PARTICIPATING PARTIES ARE NOMINATED BY AND SERVE AT WILL OF GOVERNMENTS, MULTILATERAL AGENCIES, ETC. WHICH CONSTITUTE PARTICIPATING PARTIES. CURRENT LANGUAGE SUGGESTS TWO-YEAR TERM INDEPENDENT OF SUCH CONSIDERATIONS.

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SECOND, REGARDING COORDINATION OF GLOBAL AND NATIONAL AIDS ACTIVITIES. (AAA) BANK IS GENERALLY SYMPATHETIC TO GOAL OF COORDINATING ACTIVITIES OF DIVERSE DONORS ADDRESSED BY DOCUMENT DESCRIBING PROPOSED QUOTE COMPREHENSIVE COORDINATION OF GLOBAL AND NATIONAL AIDS ACTIVITIES UNQUOTE, WHICH WE UNDERSTAND IS TO BE REVISED BY NOVEMBER MEETING FOR DISCUSSION AT NEXT SUBSEQUENT MEETING OF COMMITTEE OF PARTICIPATING PARTIES. OUR COMMENTS REGARDING THIS DRAFT ARE PRESENTED IN FOLLOWING PARAGRAPHS. WE WILL PREPARE FURTHER COMMENTS ON RECEIPT OF REVISED DRAFT. (BBB) REGARDING DEFINITION OF WHO-APPROVED NATIONAL AIDS PLAN. WE NOTE THAT SUBJECT DOCUMENT ELIMINATES DISTINCTION BETWEEN SHORT, MEDIUM AND LONG TERM NATIONAL PLANS SEEN IN PREVIOUS WHO/SPA DESCRIPTIONS OF PLANNING PROCESS. THEREFORE WE ARE UNCERTAIN AS TO WHETHER REFERENCES TO NATIONAL AIDS PLANS IN PARAGRAPHS III.B.2 AND III.B.3 REFER ONLY TO SHORT-TERM WHO/SPA ACTION PLANS, WHICH, TO WHO/SPA'S CREDIT, ALREADY EXIST IN MOST SERIOUSLY AFFECTED COUNTRIES, OR TO LONG-TERM FIVE TO TEN YEAR PLANS WHICH, TO OUR KNOWLEDGE, DO NOT YET EXIST IN ANY COUNTRY. IF REFERENCE IS TO SHORT-TERM PLANS, PARAGRAPHS III.B.2 AND III.B.3 APPEAR INNOCUOUS, SINCE SHORT-TERM PLANS EXIST ALREADY

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AND EXCLUDE LITTLE IN MOST COUNTRIES OF CONCERN. (CCC) REGARDING WHO/SPA COORDINATION OF RESOURCE MOBILIZATION. IF REQUIREMENT OF CONSISTENCY OF DONOR CONTRIBUTIONS WITH NATIONAL PLANS IS STRENGTHENED TO THE POINT THAT IT COULD CONSTRAIN DONORS, WE SUGGEST THAT PROCEDURES FOR CONSULTATION, DISCUSSION AND RESOLUTION OF POSSIBLE CONFLICTS BASED ON REVISION OF NATIONAL PLANS AND/OR DONOR STRATEGIES BE EXPLICITLY INCORPORATED IN SUBJECT DOCUMENT. DONOR INVOLVEMENT IN ONGOING NATIONAL PLANNING PROCESS AS SUGGESTED BELOW MAY HELP AVERT SUCH CONFLICTS. (DDD) REGARDING DONOR MEETINGS ORGANIZED BY WHO/SPA. SUBJECT DOCUMENT MAKES NO REFERENCE TO INTERSECTORAL, GENERAL PURPOSE DONOR MEETINGS TYPICALLY ORGANIZED UNDER BANK OR UNDP AUSPICES IN INDIVIDUAL RECEPIENT COUNTRIES. MECHANISMS FOR THE EXPLICIT COORDINATION OF AIDS DONOR MEETINGS WITH MORE GENERAL AID COORDINATION ACTIVITIES NEED TO BE EXPLICITLY SPELLED OUT. (EEE) REGARDING CATEGORIES OF RESOURCES DESCRIBED UNDER RESOURCE MOBILIZATION. SUBJECT DOCUMENT SHOULD INCLUDE REFERENCE TO CONTRIBUTIONS IN-KIND (SUCH AS EXISTING CONTRIBUTION OF STAFF TIME TO WHO/SPA/HQ BY CERTAIN NATIONAL GOVERNMENTS AND BY BANK) AND TO POSSIBILITY THAT SOME AFFECTED COUNTRIES MAY CHOOSE TO

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SUPPLEMENT GRANT FUNDING OF NATIONAL AIDS PROGRAM BY REPROGRAMMING EXISTING FUNDS OR BY BORROWING. FURTHERMORE WE SUBMIT THAT THE TERM QUOTE BILATERAL UNQUOTE MAY BE CONFUSING IN SECTION III.C.2.B, WHERE IT APPARENTLY REFERS TO ACTIVITIES OF MULTILATERAL AS WELL AS BILATERAL AGENCIES. CONCERNING PROVISION OF QUOTE UNDESIGNATED CORE SUPPORT TO WHO/SPA UNQUOTE MENTIONED IN LAST SENTENCE ON PAGE 6 OF SECTION III.C.2.B, WE SUGGEST THIS SENTENCE BE WEAKENED TO EXPRESS THE POSSIBILITY OR DESIRABILITY OF SUCH SUPPORT, RATHER THAN AN UNDERSTANDING THAT IT WILL NECESSARILY OCCUR. (FFF) REGARDING NATURE OF NATIONAL PLANNING PROCESS. WHILE WE AGREE THAT ALL NATIONAL AIDS PROGRAMS COULD BENEFIT FROM A GOOD PLAN, SUBJECT DOCUMENT DOES NOT, IN OUR VIEW, MAKE ADEQUATE ALLOWANCE FOR POSSIBILITY THAT WHO-APPROVED PLAN COULD QUICKLY BECOME OBSOLETE DUE TO CHANGING INFORMATION. IN PLACE OF PREVIOUS DISTINCTION BETWEEN SHORT, MEDIUM AND LONG TERM NATIONAL PLANS, WE SUGGEST REFERENCE BE MADE TO WHO/SPA SUPPORT OF A PLANNING CYCLE OR A PLANNING PROCESS WHICH PERIODICALLY REVISES AND UPDATES A QUOTE ROLLING UNQUOTE THREE TO FIVE YEAR NATIONAL AIDS PLAN BASED ON CONTINUOUS EVALUATION OF ONGOING ACTIVITIES AND ON LATEST INTERNATIONAL TECHNICAL

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INFORMATION. SUCH REFERENCE WOULD REPLACE SUBJECT DOCUMENT'S CURRENT EMPHASIS ON A SINGLE FIXED PLAN. DONORS COULD THEN BE ENCOURAGED TO PARTICIPATE IN SUPPORT OF THIS PLANNING AND EVALUATION PROCESS IN EACH COUNTRY AS A MECHANISM FOR ENSURING THA THAT AIDS ACTIVITIES WOULD EVENTUALLY ENCOMPASS THEIR CONCERNS. WE SUGGEST THIS ALTERNATIVE VIEW OF PLANNING BE INCORPORATED IN ANNEX II AS WELL AS IN SECTIONS III.B, III.C.1 AND III.D.3. (GGG) REGARDING MANAGEMENT AND SUPPORT OF NATIONAL PLANNING PROCESS. IN ADDITION TO ESTABLISHMENT OF STREAMLINED MANAGEMENT SUBCOMMITTEE REPORTING TO MINISTER OF HEALTH AND TO NATIONAL AIDS COMMITTEE SUGGESTED IN SECOND PARAGRAPH OF SECTION III.C.3 (PAGE & (PAGE 7) OF SUBJECT DOCUMENT, WE SUGGEST ESTABLISHMENT OF SEPARATE PLANNING AND EVALUATION SUBCOMMITTEE TO BEAR RESPONSIBILITY FOR CONTINUOUS PLANNING AND EVALUATION PROCESS. FURTHERMORE IN DESCRIPTION OF WHO/SPA EXEERT SUPPORT IN FOURTH PARAGRAPH OF SAME SECTION (PAGE 8), WE SUGGEST ADDITION OF EXPERTISE IN HEALTH PLANNING AND EVALUATION TO FIVE SPECIALITIES MENTIONED IN FOURTH SENTENCE. WE LOOK FORWARD TO FUTURE EXCHANGES OF VIEWS WITH WHO/SPA AT NOVEMBER MEETING OF COMMITTEE OF PARTICIPATING PARTIES, IN THE COURSE OF ONGOING COLLABORATION IN ECONOMIC AND

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DEMOGRAPHIC ANALYSIS OF AIDS AND IN DESIGN OF NATIONAL AIDS PROGRAMS. SINCERELY, DEAN JAMISON, CHIEF, POPULATION, HEALTH AND NUTRITION DIVISION, POPULATION AND HUMAN RESOURCES DEPARTMENT.

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TELEX NO.: 27821 OMS

DATE: OCT.23,1987

SUBJECT:

DRAFTED BY: MOver:ck

EXTENSION: 33451

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cc: Harbison, Husain, McGreevey, Mahar, Pachter, ter Weele, van der Gaag, Hamilton, Measham, Bulatao, Over

AUTHORIZED BY (Name and Signature): Mead Over Mead Over

DEPARTMENT: Population & Human Resources

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WORLD BANK/INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM

DATE: October 21, 1987

TO: R. Harbison, EMTPH, I. Husain, AFTPN, W. McGreevey, LATHN, D. Mahar, EAS, L. Pachter, SPRIE, A. ter Weele, ASTPH

FROM: Dean Jamison, Chief, PHRHN

EXTENSION: 33226

SUBJECT: AIDS: Bank Response to WHO's Draft "Joint Management Structure"and "Comprehensive Coordination of Global and National AIDS Activities" for the WHO Special Programme on AIDS

1. The attached telex is a draft Bank response to WHO's request for comments on the two documents cited above. WHO has requested the receipt of our response by Monday, October 26, to permit revisions prior to the Fourth Meeting of Participating Parties scheduled for November 12-13, 1987.

2. The document entitled "Joint Management Structure" constitutes a revision of the current oversight structure for the Special Programme on AIDS (WHO/SPA). It will be proposed as a replacement for the current structure at the Fourth Meeting of Participating Parties scheduled for November 12-13, 1987.

3. The document entitled "Comprehensive Coordination of Global and National AIDS Activities" is intended as a detailed description of WHO/SPA's role vis à vis affected countries and other donor agencies. WHO/SPA is currently soliciting comments from donors, after which it will solicit comments on a revised draft both from affected countries and from donors. The subsequent revision will be distributed at the November meeting, but will not be scheduled for discussion and approval until the next meeting of "participating parties," perhaps in February. I will distribute this revision, when received, for further comment.

4. If you have additional comments or suggestions for WHO, please send them to Mead Over, S-6111, in this division by C.O.B. Thursday, October 22.

MO:ec

Attachments

cc: Wadi Haddad, Acting Director, PHR
Ann Hamilton, Director, PHR (o/r)
Anthony Measham, PHRHN (o/r)
Mead Over, PHRHN
R. Bulatao, PHRHN

October 21, 1987

D R A F T T E L E X

WORLD HEALTH ORGANIZATION
GENEVA
SWITZERLAND

FOR MRS. I. BRUGGEMANN, DIRECTOR, PROGRAMME FOR EXTERNAL COORDINATION AND DR. J. MANN, DIRECTOR, SPECIAL PROGRAMME ON AIDS. SUBJECT: WORLD BANK COMMENTS ON DRAFT MANAGEMENT AND COORDINATION DOCUMENTS FOR SPECIAL PROGRAMME ON AIDS (SPA).

ENJOYED VISIT BY MR. T. MOONEY, WHO/SPA, DR. N. DRAGER, WHO/COR/HRM, AND MARJORIE DAM, WHO/DGO/AMRO, TO EXCHANGE VIEWS ON SUBJECT DOCUMENTS. THIS TELEX RESPONDS YOUR REQUEST FOR COMMENTS ON SUBJECT DOCUMENTS.

FIRST, REGARDING JOINT MANAGEMENT STRUCTURE.

WE VIEW PROPOSED JOINT MANAGEMENT STRUCTURE SUGGESTED FOR ADOPTION DURING NOVEMBER MEETINGS AS A STRONG FOUNDATION FOR UPON WHICH SPA CAN CONTINUE TO BUILD ITS IMPORTANT PROGRAM AND WE SUPPORT ADOPTION OF THIS STRUCTURE. HOWEVER, WE SUGGEST MODIFICATION OF THIRD TO LAST PARAGRAPH (BEGINNING QUOTE EXCEPT FOR THOSE REPRESENTATIVES ... UNQUOTE) TO REFLECT FACT THAT INDIVIDUAL PEOPLE WHO ARE QUOTE MEMBERS UNQUOTE OF COMMITTEE OF PARTICIPATING PARTIES ARE NOMINATED BY AND SERVE AT WILL OF GOVERNMENTS, MULTILATERAL AGENCIES, ETC. WHICH CONSTITUTE PARTICIPATING PARTIES. CURRENT LANGUAGE SUGGESTS TWO-YEAR TERM INDEPENDENT OF SUCH CONSIDERATIONS.

SECOND, REGARDING COORDINATION OF GLOBAL AND NATIONAL AIDS ACTIVITIES.

(AAA) BANK IS GENERALLY SYMPATHETIC TO GOAL OF COORDINATING ACTIVITIES DIVERSE DONORS ADDRESSED BY DOCUMENT DESCRIBING PROPOSED QUOTE COMPREHENSIVE COORDINATION OF GLOBAL AND NATIONAL AIDS ACTIVITIES UNQUOTE, WHICH WE UNDERSTAND IS TO BE REVISED BY NOVEMBER MEETING FOR DISCUSSION AT NEXT SUBSEQUENT MEETING OF COMMITTEE OF PARTICIPATING PARTIES. OUR COMMENTS REGARDING THIS DRAFT ARE PRESENTED IN FOLLOWING PARAGRAPHS. WE WILL PREPARE FURTHER COMMENTS ON RECEIPT OF REVISED DRAFT.

(BBB) REGARDING OF WHO-APPROVED NATIONAL AIDS PLAN. WE NOTE THAT SUBJECT DOCUMENT ELIMINATES DISTINCTION BETWEEN SHORT, MEDIUM AND LONG TERM NATIONAL PLANS SEEN IN PREVIOUS WHO/SPA DESCRIPTIONS OF PLANNING PROCESS. THEREFORE WE ARE AS TO WHETHER REFERENCES TO NATIONAL AIDS PLANS IN PARAGRAPHS III.B.2 AND III.B.3 REFER ONLY TO SHORT-TERM WHO/SPA ACTION PLANS, WHICH, TO WHO/SPA'S CREDIT, ALREADY EXIST IN MOST SERIOUSLY AFFECTED COUNTRIES, OR TO LONG-TERM FIVE TO TEN YEAR PLANS WHICH, TO OUR KNOWLEDGE, DO NOT YET EXIST IN ANY COUNTRY. IF REFERENCE IS TO SHORT-TERM PLANS, PARAGRAPHS III.B.2 AND III.B.3 APPEAR INNOCUOUS, SINCE SHORT-TERM PLANS EXIST ALREADY AND EXCLUDE LITTLE IN MOST COUNTRIES OF CONCERN.

(CCC) REGARDING WHO/SPA COORDINATION OF RESOURCE MOBILIZATION. IF REQUIREMENT OF CONSISTENCY OF DONOR CONTRIBUTIONS WITH NATIONAL PLANS IS STRENGTHENED TO THE POINT THAT IT COULD CONSTRAIN DONORS, WE SUGGEST THAT

PROCEDURES FOR CONSULTATION, DISCUSSION AND RESOLUTION OF POSSIBLE CONFLICTS BASED ON REVISION OF NATIONAL PLANS AND/OR DONOR STRATEGIES BE EXPLICITLY INCORPORATED IN SUBJECT DOCUMENT. DONOR INVOLVEMENT IN ONGOING NATIONAL PLANNING PROCESS AS SUGGESTED BELOW MAY HELP AVERT SUCH CONFLICTS.

(DDD) REGARDING DONOR MEETINGS ORGANIZED BY WHO/SPA. SUBJECT DOCUMENT MAKES NO REFERENCE TO INTERSECTORAL, GENERAL PURPOSE DONOR MEETINGS TYPICALLY ORGANIZED UNDER BANK OR UNDP AUSPICES IN INDIVIDUAL RECIPIENT COUNTRIES. MECHANISMS FOR THE EXPLICIT COORDINATION OF AIDS DONOR MEETINGS WITH MORE GENERAL AID COORDINATION ACTIVITIES NEED TO BE EXPLICITLY SPELLED OUT.

(EEE) REGARDING CATEGORIES OF RESOURCES DESCRIBED UNDER RESOURCE MOBILIZATION. SUBJECT DOCUMENT SHOULD INCLUDE REFERENCE TO CONTRIBUTIONS IN-KIND (SUCH AS EXISTING CONTRIBUTION OF STAFF TIME TO WHO/SPA/HQ BY CERTAIN NATIONAL GOVERNMENTS AND BY BANK) AND TO POSSIBILITY THAT SOME AFFECTED COUNTRIES MAY CHOOSE TO SUPPLEMENT GRANT FUNDING OF NATIONAL AIDS PROGRAM BY REPROGRAMMING EXISTING FUNDS OR BY BORROWING. FURTHERMORE WE SUBMIT THAT THE TERM QUOTE BILATERAL UNQUOTE MAY BE CONFUSING IN SECTION III.C.2.B, WHERE IT APPARENTLY REFERS TO ACTIVITIES OF MULTILATERAL AS WELL AS BILATERAL AGENCIES. CONCERNING PROVISION OF QUOTE UNDESIGNATED CORE SUPPORT TO WHO/SPA UNQUOTE MENTIONED IN LAST SENTENCE ON PAGE 6 OF SECTION III.C.2.B, WE SUGGEST THIS SENTENCE BE WEAKENED TO EXPRESS THE POSSIBILITY

OR DESIRABILITY OF SUCH SUPPORT, RATHER THAN AN UNDERSTANDING THAT IT WILL NECESSARILY OCCUR.

(FFF) REGARDING NATURE OF NATIONAL PLANNING PROCESS. WHILE WE AGREE THAT ALL NATIONAL AIDS PROGRAMS COULD BENEFIT FROM A GOOD PLAN, SUBJECT DOCUMENT DOES NOT, IN OUR VIEW, MAKE ADEQUATE ALLOWANCE FOR POSSIBILITY THAT WHO-APPROVED PLAN COULD QUICKLY BECOME OBSOLETE DUE TO CHANGING INFORMATION. IN PLACE OF PREVIOUS DISTINCTION BETWEEN SHORT, MEDIUM AND LONG TERM NATIONAL PLANS, WE SUGGEST REFERENCE BE MADE TO WHO/SPA SUPPORT OF A PLANNING CYCLE OR A PLANNING PROCESS WHICH PERIODICALLY REVISES AND UPDATES A QUOTE ROLLING UNQUOTE THREE TO FIVE YEAR NATIONAL AIDS PLAN BASED ON CONTINUOUS EVALUATION OF ONGOING ACTIVITIES AND ON LATEST INTERNATIONAL TECHNICAL INFORMATION. SUCH REFERENCE WOULD REPLACE SUBJECT DOCUMENT'S CURRENT EMPHASIS ON A SINGLE FIXED PLAN. DONORS COULD THEN BE ENCOURAGED TO PARTICIPATE IN SUPPORT OF THIS PLANNING AND EVALUATION PROCESS IN EACH COUNTRY AS A MECHANISM FOR ENSURING THAT AIDS ACTIVITIES WOULD EVENTUALLY ENCOMPASS THEIR CONCERNS. WE SUGGEST THIS ALTERNATIVE VIEW OF PLANNING BE INCORPORATED IN ANNEX II AS WELL AS IN SECTIONS III.B, III.C.1 AND III.D.3.

(GGG) REGARDING MANAGEMENT AND SUPPORT OF NATIONAL PLANNING PROCESS. IN ADDITION TO ESTABLISHMENT OF STREAMLINED MANAGEMENT SUBCOMMITTEE REPORTING TO MINISTER OF HEALTH AND TO NATIONAL AIDS COMMITTEE SUGGESTED IN SECOND PARAGRAPH OF SECTION III.C.3 (PAGE 7) OF SUBJECT DOCUMENT, WE SUGGEST ESTABLISHMENT OF SEPARATE PLANNING AND EVALUATION SUBCOMMITTEE TO BEAR RESPONSIBILITY FOR CONTINUOUS PLANNING AND EVALUATION PROCESS. FURTHERMORE

IN DESCRIPTION OF WHO/SPA EXPERT SUPPORT IN FOURTH PARAGRAPH OF SAME SECTION (PAGE 8), WE SUGGEST ADDITION OF EXPERTISE IN HEALTH PLANNING AND EVALUATION TO FIVE SPECIALTIES MENTIONED IN FOURTH SENTENCE.

WE LOOK FORWARD TO FUTURE EXCHANGES OF VIEWS WITH WHO/SPA AT NOVEMBER MEETING OF COMMITTEE OF PARTICIPATING PARTIES, IN THE COURSE OF ONGOING COLLABORATION IN ECONOMIC AND DEMOGRAPHIC ANALYSIS OF AIDS AND IN DESIGN OF NATIONAL AIDS PROGRAMS. SINCERELY.

DEAN JAMISON (CHIEF, POPULATION, HEALTH AND NUTRITION DIVISION, POPULATION AND HUMAN RESOURCES DEPARTMENT).

(Document for the DAC Informal Meeting on AIDS, 2nd November 1987)

WANG DOC. 4698F

Draft proposal

WHO

SPECIAL PROGRAMME ON AIDS

JOINT MANAGEMENT STRUCTURE

The Special Programme on AIDS (SPA) is attached directly to the office of the Director-General of WHO. The scope and complexity of the issues confronted by SPA necessitate the creation of two advisory bodies to the Programme. The purpose of this paper is to provide suggested terms of reference for each of these bodies. However, these terms of reference may, on the recommendation of these two bodies, change, as the programme progresses and experience is gained.

1. GLOBAL COMMISSION ON AIDS

A. Functions

The Global Commission on AIDS shall have the following functions:

- to review and interpret global trends and developments related to HIV and other human retrovirus infections;
- to review and evaluate, from a scientific, technical, socioeconomic and behavioural standpoint, the content and scope of the Programme;
- to provide scientific and technical advice for SPA's plan of action for its global activities;
- to advise the Director-General of WHO regarding short-, medium- and long-term priorities in the research and operational components of the SPA, including the establishment and disestablishment of scientific working groups; and
- to provide the Committee of Participating Parties and the Director-General of WHO with a continuous evaluation of the scientific and technical aspects of SPA activities.

For these purposes, the Global Commission on AIDS may propose and present for consideration by the Director-General of WHO and the Committee of Participating Parties such technical documents and recommendations as it may deem appropriate. To assist it in its endeavours, WHO shall provide the Commission with whatever secretariat and other support services may be considered necessary and reasonable.

B. Composition

The Global Commission on AIDS shall comprise 18-24 biomedical and social scientists, legal and economic experts, technical and administrative specialists, who will serve in their personal capacities, to represent the broad range of disciplines required for review of SPA's activities. Members of the Global Commission on AIDS shall be appointed by the Director-General of WHO to serve for a

period of three years, and will be eligible for further reappointment. They will be nominated with due consideration given to obtaining an optimum diversification and balance of personal experience, professional background and international standing. The Chairperson of the Commission shall be selected from and by members of the Commission for a period of two years and shall be eligible for re-election. The Chairperson shall preside over meetings of the Commission and shall undertake whatever additional duties may be assigned by the Commission. To maintain continuity of membership, the expiration of the initial terms of office of members of the Commission shall be staggered.

SPA shall maintain a list of nominees for the Commission for the purpose of ensuring that each of the major disciplines among the broad range required for the review and evaluation of the Programme's activities is represented, as well as to ensure an appropriate geographical distribution of Commission members. The Director of SPA will be pleased to receive, from WHO member states, members of the Committee of Participating Parties, and Collaborating Centres, names of possible Commission members, with an up-to-date curriculum vitae. All suggestions will be added to the list of nominees but their inclusion does not necessarily imply future appointment to the Commission.

C. Operation

The Global Commission on AIDS shall meet at least once a year and may meet more often at the request of its Chairperson or the Director-General of WHO. It shall prepare an Annual Report for submission to the Director-General of WHO and to the Committee of Participating Parties. The Chairperson of the Commission or, in his or her absence, a member of the Commission designated by the Chairperson, shall present this Report to the Committee of Participating Parties and attend its sessions to answer any questions that may be directed to the Commission.

2. COMMITTEE OF PARTICIPATING PARTIES

A. Functions

The Committee of Participating Parties shall, for the purpose of co-ordinating the interests and responsibilities of the parties cooperating with SPA, have the following functions:

- to review and recommend policies for the planning and execution of the Programme: for this purpose the Director of SPA shall keep the Committee informed of the Programme's development and implementation, and the Committee shall receive and consider all reports and recommendations made to it by the Global Commission on AIDS;

- to review and make recommendations on the proposed annual plan of action for SPA's global activities;

- to review and make recommendations on the proposed medium-term programme and biennial and annual budgets prepared by the Director of SPA;

- to annually review the arrangements envisaged by the Director-General of WHO for financing and managing SPA;

- to review the financial statements submitted by WHO on SPA;

- to review periodic reports evaluating the progress of SPA toward the achievement of its objectives;

- to recommend ways in which the activities of SPA could be coordinated with those of other relevant organizations; and

- to consider any other matters relating to SPA referred to it by the Director-General of WHO or the Director of SPA.

For these purposes, the Committee of Participating Parties shall be assisted in its endeavours by the provision, by WHO, of whatever secretariat and other support services may be considered necessary and reasonable.

B. Composition

The Participating Parties of SPA shall be:

- governments contributing to SPA's financial resources;

- governments providing technical and/or scientific support to SPA and governments of countries within which SPA is operating;

- multilateral agencies and organizations contributing to SPA's financial resources, providing technical and/or scientific support or participating in any of the global or national activities of SPA; and

- non-governmental and voluntary organizations contributing to SPA's financial resources, providing technical and/or scientific support or participating in any of the global or national activities of SPA.

The Committee of Participating Parties shall be composed as follows:

- government representatives from the fourteen countries which financially contributed the most in the previous fiscal year to SPA's resources;

- fourteen government representatives appointed by the Director-General of WHO: Africa 4, America 2, Europe 1, South-East Asia 3, Eastern Mediterranean 1 and Western Pacific 3 - from among those countries within which SPA is operating, or from among those providing technical and/or scientific support to SPA;

- four representatives from the multilateral agencies and organizations contributing to SPA's financial resources, providing technical and/or scientific support or participating in any of the global or national activities of SPA, which shall be nominated by SPA's Director and appointed by the Director-General of WHO; and

- four representatives from the nongovernmental and voluntary organizations contributing to SPA's financial resources or providing technical and/or scientific support to SPA, which shall be nominated by SPA's Director and appointed by the Director-General of WHO.

Except for those representatives of countries contributing financially to SPA's resources, whose membership shall be ascertained annually, members of the Committee of Participating Parties shall serve for a period of two years and may be reappointed. The Chairperson of the Committee shall be elected from and by members of the Committee for a period of two years but while eligible for re-election, may not serve concurrent terms. The Chairperson shall preside over meetings of the Committee and undertake whatever additional duties may be assigned by the Committee, in agreement with the Director-General of WHO.

Other interested governments or parties, cooperating with SPA, or in which SPA is operating, may request the Director-General to invite them to attend as observers at meetings of the Committee.

C. Operation

The Committee of Participating Parties shall meet at least once a year. The Committee may also meet more often upon the proposal of either its Chairperson or the Director-General of WHO, and with the latter's agreement.

TM/dla: 30.9.87

(Document for the DAC Informal Meeting on AIDS, 2nd November 1987)
WANG DOC 4951F

WHO

SPECIAL PROGRAMME ON AIDS

COMPREHENSIVE COORDINATION OF GLOBAL AND NATIONAL AIDS ACTIVITIES

I. INTRODUCTION

The World Health Organization (WHO) has the constitutional responsibility to direct and coordinate international health activities and has been mandated to develop and implement a global strategy for AIDS prevention and control. That mandate explicitly recognizes the global scope of AIDS, the health, social and economic dimensions of the problem; and the need for a global approach that makes optimum use of the broad range of scientific, public health and socioeconomic resources that will be needed for its prevention and control. The need for such a coordinated approach, under the global leadership of WHO, has been recognized by the 40th World Health Assembly in May 1987 in its Resolution WHA 40.26, the Venice Summit of June 1987, and the July 1987 Meeting of ECOSOC (Resolution E/1987/76). In order to meet this challenge the Director-General of WHO established a Special Programme on AIDS (SPA), which became operational on 1 February 1987. The creation of this programme was requested by the 39th World Health Assembly in May 1986 and endorsed by WHO's Executive Board in January 1987.

Broad agreement on a framework for coordination, including clear and practical guidelines, is now required at two levels of complementary activity within the Global Strategy on AIDS:

(i) support for comprehensive national AIDS programmes; and
(ii) mobilization and structuring of global action.

The Third Meeting of Participating Parties held in Geneva in April 1987, explicitly recognized these needs and requested SPA to develop specific proposals for the comprehensive coordination of global and national AIDS activities.

II. GLOBAL COORDINATION

WHO/SPA provides global leadership, helps ensure international cooperation, and pursues global activities of general value and importance. In this respect, WHO/SPA's global priorities are numerous and wide-ranging, (Annex I). In pursuit of these global priorities, WHO is guided by the concept that only a worldwide effort can stop AIDS. This concept dictates the following objective and principles:

A. OBJECTIVE

All governmental, intergovernmental and non-governmental efforts, whether scientific, technical or financial, must be consistent with and supportive of WHO's Global Strategy on AIDS as approved by the World Health Assembly.

B. PRINCIPLES

1. WHO has the mandate to lead, direct and coordinate AIDS prevention, control, research, education and public information at the global, inter-regional and regional levels, in conformity with its Global Strategy on AIDS as approved by the World Health Assembly; and

2. Policy and programme coordination, with governmental, intergovernmental and non-governmental agencies, must be assured by WHO, if all available and potential resources are to be effectively mobilized and utilized in accordance with the Global Plan of Action.

C. GLOBAL IMPLEMENTATION MEASURES

To achieve the basic objective and adhere to the principles governing its global activities, WHO/SPA will implement the following Planning, Resource Mobilization and Management measures:

1. Planning

Based on the policies agreed upon by the World Health Assembly, WHO/SPA will submit, annually, to the Committee of Participating Parties, for its review and advice, a global plan of action, which will have benefited from guidance from the Global Commission on AIDS.

In the design of this global plan of action, international scientific, technical, socioeconomic, behavioural and programmatic expertise, experience and resources, provides the basis for:

(i) SPA's identification of global priorities;
(ii) the elaboration of its control, monitoring and evaluation strategies; and
(iii) its formulation of guidelines, consensus statements, prototypes and models.

SPA will undertake the promotion and coordination of scientific research, involving, but not limited to, the global network of WHO Collaborating Centres on AIDS, under the overall guidance of the Global Commission on AIDS. This facilitates international scientific progress, especially in such areas as the development, evaluation and testing of diagnostic methods, therapeutic agents and vaccines. The development, promotion and coordination by SPA of international social and behavioural research, epidemiological studies, and demographic and economic impact assessments in collaboration with selected Collaborating Centres and national participating institutions in developing and developed countries, also contributes to developing SPA's global plan of action.

2. Resource Mobilization

To comply with the principles previously stated that WHO has the mandate to lead, direct and coordinate AIDS activities and to ensure that all available and potential resources are effectively mobilized and utilized in accordance with the Global Plan of Action, WHO/SPA in collaboration with the WHO Programme for External Coordination will assume responsibility for the mobilization and allocation of resources in support of major global and regional activities for AIDS prevention and control. In addition, it will assume responsibility for resource mobilization for global and regional activities specifically undertaken by SPA. The establishment and activities of the interregional positions, which SPA is establishing for the support of national, as well as regional, activities, will also be funded from this budget.

Support for the WHO/SPA Global Plan of Action may be provided in the form of undesignated financial contributions. It may also be provided as contributions in kind and as seconded staff. All such contributions are recorded in the WHO Voluntary Fund for Health Promotion, Special Account for AIDS, and are subject to normal WHO accounting and reporting procedures, including Programme Support Costs of 13%.

Review of the budget for SPA's global activities will be carried out at the annual meeting of the Committee of Participating Parties. At this time, donors will be requested to indicate the planned level of their contributions to SPA.

3. Management

To ensure that the Global Strategy to combat AIDS is effectively implemented by all levels of WHO, the Director-General has decided that the Special Programme on AIDS shall be directed from SPA/HQ and, for this purpose, has made the Director of SPA directly responsible to him. SPA headquarters in Geneva has been made directly responsible for programme formulation and direction, with WHO regional offices providing operational support. Within that relationship, management of SPA is invested in the Director of SPA, who operates within the policies agreed upon by the World Health Assembly, the guidance provided by the Global Commission on AIDS, and the recommendations of the Committee of Participating Parties. It is against these policies that the decision will be made by the Director of SPA, on the advice of the relevant Programme Unit Chief, as to whether global and/or regional activities are consistent with and supportive of the Global Plan of Action on AIDS.

D. GLOBAL IMPLEMENTATION GUIDELINES

The accelerating scope of global demands will challenge the ability of WHO/SPA to respond and to engage simultaneously in all of them. This underscores the need to ensure the coherent and complementary cooperation of other international organizations. WHO/SPA may initiate joint programmes of cooperation with relevent organizations for the purpose of advancing its global priorities. Joint programmes will also extend the influence and benefits of SPA's financial resources by permitting SPA to take advantage of the tested skills and resources of other organizations.

In addition to the establishment of joint programmes, there will be opportunities for WHO/SPA to 'piggy-back' on relevant programmes of other organizations, i.e. to utilize their proven delivery systems to, inter alia, disseminate global messages and prototype materials on AIDS - its prevention and control; or to 'add-on' to existing or future programmes of WHO and other organizations an AIDS component to assist in, for example, education, epidemiology and impact assessment, research activities and laboratory work.

In its cooperation with other organizations, multilateral, bilateral or non-governmental, WHO will work toward developing and promoting an international consensus on key issues which are of interest and use to a multiplicity of organizations. The creation by WHO/SPA of a global AIDS prevention and control network, designed to ensure collaboration, information exchange and full access, by all interested parties, to new data, strategies, materials and technology, will greatly assist the international community in its efforts to cope with AIDS.

Therefore, WHO/SPA will:

- undertake joint programmes of cooperation, wherever appropriate and feasible, with other technical and development assistance agencies;
- avoid unnecessary duplication of efforts by seeking to utilize the relevant personnel skills and resources of other agencies in an agreed and appropriate fashion; and
- place itself at the disposal of other agencies for whatever support it can provide to maintain or enhance the coherence of their programmes within the Global Strategy on AIDS.

III. NATIONAL COORDINATION

WHO/SPA supports and strengthens National AIDS programmes throughout the world (Annex II). The overall objective is to coordinate AIDS-related activities to enable national authorities, WHO and development agencies, to most effectively use national and international resources in the service of national AIDS prevention and control, within WHO's Global AIDS Strategy. Coordination by SPA on behalf of, and in collaboration with governments, in support of national programme activities, will have the following objective and principles.

A. OBJECTIVE

All governmental, intergovernmental and non-governmental efforts must be consistent with and supportive of, individual National AIDS Plans which, in turn, must be consistent with WHO's Global Strategy on AIDS.

B. PRINCIPLES

1. SPA supports member states in designing, strengthening, implementing, monitoring, and evaluating national AIDS plans;
2. Existence of a WHO approved National AIDS Plan is a prerequisite for the provision of external support except for limited and short-term urgent support. Consistent support of this principle by development assistance agencies is critical to the integrity of the national planning and implementation process carried out in collaboration with WHO; and
3. All external support - scientific, technical or financial - must be consistent with and supportive of the National AIDS Plan as well as being supportive of the government's primary health care and its long-term health policies. WHO's role in identifying, assessing, and mobilizing such support for governments, is indispensible to maintaining the integrity of National AIDS Plans.

C. NATIONAL IMPLEMENTATION MEASURES

To achieve the basic objective and adhere to the principles governing its support of governments and their National AIDS Plans, WHO/SPA undertakes to implement the following Planning, Resource Mobilization and Management measures:

1. Planning

Involvement by WHO/SPA in a member state's efforts to combat AIDS is predicated on the expression of political willingness by the government concerned to deal effectively with AIDS through the establishment of a National AIDS Committee and National AIDS Plan. There should be a clear expression of the government's acceptance of WHO's responsibility for leadership and coordination as stated in Resolution WHA 40.26 of the 40th World Health Assembly and further elaborated in this document. The list of criteria (Annex III), developed by WHO/SPA to help ensure the success of National AIDS Plans, will be used by WHO/SPA to prioritize requests for collaboration from member countries.

Governments which have adopted National AIDS Plans prior to passage of this document will be asked to incorporate a clause in the Plan expressing their agreement with this document.

The initial country visit by a WHO/SPA team to a Member State will normally be for the purpose of making an initial assessment of the AIDS situation and identifying the immediate technical and/or financial support needed to combat the spread of HIV infection. The team will present its findings to the government for review and seek agreement on any immediate action proposed. On agreement with the government, the team will also share its findings with the country representatives of interested development assistance agencies and make an initial sounding of their interest in participating in the design and support of National AIDS Plans for the countries concerned.

Subsequent visits by WHO/SPA to the countries will, in general, be to advance the development of medium-term National AIDS Plans. The WHO may, with prior agreement by the government, include experts from interested development agencies. The team will also review existing in-country aid coordination arrangements with the coordinating ministry of the government, representatives of the World Bank, UNDP and other UN agencies, as well as major bilateral and NGO representatives. The purpose of this review is to ensure that all National AIDS Plans are formulated within the context of a country's overall development policy and programme, with specific reference to the country's primary health care policy. WHO may make recommendations regarding the composition of the National AIDS Committee to help ensure that it has immediate access to the necessary governmental decision-making authority and the ability to speak on behalf of governments as a whole.

2. Resource Mobilization

For most developing countries, the implementation of National AIDS Plans will require external, technical and development, cooperation inputs in addition to available domestic resources and direct WHO support. Consequently, once the National AIDS Plan is finalized, approved by the government and sanctioned by WHO, WHO/SPA will field a negotiating team to support the government in convening a meeting for the purpose of mobilizing resources for the Plan. Following this meeting, certain development agencies wishing to support one or more components of the Plan, may offer to field teams to elaborate more detailed proposals. If desired, WHO/SPA would be prepared to undertake this task on behalf of an agency or lend WHO experts to assist such a mission. WHO would wish to be kept informed of the activities and findings of all such missions.

As considerable pressure exists in many countries to launch their National AIDS Control Programmes as soon as possible, it will be important that confirmation and delivery on pledged contributions to WHO and/or to the Governments be as rapid as possible. It must be understood that WHO (and most governments) cannot undertake commitments until funds are received. This calls for understanding on the part of the donors, and may require exceptional measures to shorten the processing and decision-making time for reaching agreement on proposals in emergency situations.

National AIDS Plans may be supported in three ways:

A. FUNDS THROUGH WHO: In general, SPA will receive undesignated funding, intended for global and national support activities of the programme. National support activites would include initial visits, urgent support, support for preparing Medium-term Plans, monitoring and evaluation, as well as support for the successful launching of National AIDS Plans by funding various elements or components of such Plans to alleviate any perceived inequities in international support for individual plans. Additionally, donors may, if they wish, designate which National AIDS Control Programmes, they want their contributions to support. It is understood that donors, utilizing the latter method, given the interdependence between the Global Plan of Action and National AIDS Plans, will also provide undesignated core support to WHO/SPA. All contributions of the former sort will be recorded in the WHO Voluntary Fund for Health Promotion, Special Account for AIDS (Member State). These funds will be administered and disbursed at the country level by WHO/SPA, according to WHO procedures. These contributions will be inclusive of Programme Support Costs, and will be subject to WHO accounting and reporting procedures.

B. FUNDS DIRECT TO MEMBER STATES: In some cases, donor requirements/preferences may dictate that support be given bilaterally to a National AIDS Control Programme. Some donors may designate their contribution simply by identifying a component(s) in the National AIDS Control Programme and stipulating that their contribution be dedicated to that area. Other donors may need to develop more detailed bilateral proposals. Elaboration of such proposals may be done by the Government, WHO, and/or the donor agency. Proposals "packaged" in this manner for bilateral support would also be eligible for supplementary funding through WHO/SPA for execution with the Government. It is also understood that donors, utilizing bilateral channels for their contribution to National AIDS Control Programmes will, given the interdependence between the Global Plan of Action and National AIDS Control Programmes, also provide undesignated core support to WHO/SPA.

Financial support provided bilaterally should include a reasonable amount for "contingencies" to provide the Government with the means of assuring central management of the National AIDS Control Programme as well as meeting unexpected demands which will undoubtedly arise as implementation progresses. Furthermore, as there will be cash requirements to assure sustainability; difficulties may arise if a contribution consists only of commodities or with a grant designated exclusively for the purchase of commodities. It would, therefore, be desirable that bilateral projects be accompanied by an additional 10-15% of the total monetary equivalent of the contribution as cash (which may be designated for the realization of that component). As inequities can arise from designating funds for a specific component or country region, donors are requested to contribute a percentage of the totality of such contributions, usually 25%, to the pool of non-designated funds provided to the government.

C. WHO AS A PURCHASING AGENT: Governments receiving bilateral funding may wish, under a Trust Fund Arrangement, to request WHO to be the purchasing agent for certain supplies/commodities which are required for the National AIDS Control Programme. In such instances, the Government will deposit with WHO, in advance, the estimated cost of the purchases to be made, inclusive of an amount for Programme Support Costs equivalent to 3% of the purchase order.

3. Management

WHO/SPA's management of its support provided to governments for their individual National AIDS Control Programmes is bound by the following requests stated in WHA Resolution 40.26:

- to assert WHO's international directing and coordinating role in support of National AIDS Programmes;

- to support national AIDS prevention and control programmes in due balance with other health programmes by ensuring adequate coordination and cooperation of the governments concerned, WHO, and other external partners.

- to reinforce the Organization's support to Member States in designing or strengthening, implementing, monitoring and evaluating national programmes for AIDS prevention and control; and

- to issue guidance on the prevention and control of AIDS on a continuing basis as new information comes to light and the Special Programme evolves.

Experience has taught us that the National AIDS Committes are too large and their members too busy for day to day management of National AIDS Control Programmes to be invested in them. Consequently, it is deemed advisable to give such responsibilities to smaller Management Committees. These Committees will consist of representatives from the Ministries of Health and WHO/SPA; will be directly responsible to the Minister of Health; and will receive guidance and advice from the National AIDS Committee. They will be responsible for the overall management of, and allocation of resources within, the National AIDS Control Programmes.

The principal duty of such a Committee would be to maintain the integrity of National AIDS Plans and, in keeping with the principles described in this paper, ensure that all external support - scientific, technical or financial - is consistent with and supportive of the National AIDS Plan as well as the Government's primary health care policy and is in conformity with its long-term health development policies and objectives. In this respect, it makes recommendations regarding external support to the Minister of Health and the National AIDS Committee. Consequently, all external support for AIDS-related activities must be submitted by donors to it for review before negotiations are initiated with the Government. The Committee would also be responsible for any national and international liaison and coordination necessitated by the National AIDS Control Programme including review over, and coordination of, all externally-led AIDS-related research conducted in the country. As part of its management role, the Committee would also hold preliminary consultations with all interested donors concerning the provision of adequate funding for the Natonal AIDS Control Programme. In all of these activities the Management Committees and the National AIDS Committees would, with the agreement of the governments concerned, receive the direct support of WHO/SPA.

In order to provide such support, WHO/SPA undertakes to provide a strong field presence to National AIDS Committees, their Management Committees and National AIDS Control Programmes. WHO/SPA, with the agreement of the government concerned, will field advisors from WHO's regional offices. In some cases, these advisers would, for a particular time, be responsible for a particular country programme, in others they would advise several governments. These would include: an epidemiologist, public health specialist, health education specialist, laboratory specialist and administrative/technical officer. One of these would be responsible for overall management of WHO/SPA's involvement in National AIDS Plans and for liaison and coordination with National AIDS Committees, on whose Management Committees they will sit; Governments and the international donor community.

Due to the rapidly evolving nature of AIDS and the knowledge and methods to combat it, the Director-General of WHO has directed that SPA be a centrally-managed programme that reports directly to the Director-General's Office. Thus, WHO/SPA's activity at the regional and national levels and the work of its field personnel will be under the technical guidance of WHO/SPA/HQ. However, the strong support of the National WHO Representative will be sought to ensure that, as requested by the WHA in Resolution 40.26, the global strategy to combat AIDS is effectively implemented by all levels of the Organization and that adequate coordination and cooperation exists within WHO to accomplish this objective.

As implementation of National AIDS Plans progresses, there will likely be a need for re-planning and re-programming which, with the agreement and under the leadership of the governments concerned, WHO will support in the same fashion as it has supported the initial design of National AIDS Plans. Similarly, it would advise the Governments concerned as to whether there then existed any requirement for a further donors meeting, the holding of which it would support as it did the first such meetings.

In addition, WHO/SPA will strive for an effective division of labour among donors to:

(i) preclude unnecessary duplication;
(ii) ensure all important components of National AIDS Plans are implemented; and
(iii) prevent the over-burdening of scarce national expertise.

To this end, WHO/SPA will, inter alia, make every effort to reduce the administrative burden of National AIDS Plans on recipient Governments by simplifying and harmonizing, in one format, the accounting, monitoring and reporting requirements of donors involved in the provision of support to National AIDS Control Programmes.

D. NATIONAL IMPLEMENTATION GUIDELINES

WHO/SPA's efforts in support of governments and their individual National AIDS Control Programmes, through its planning, resource mobilization and management activities, will be carried out according to the following guidelines:

1. Strengthening the Coordinating Role of National Governments

The Government must be at the centre of the coordination process and play the leading role in initiating and sustaining effective coordination arrangements. In those cases where a government may lack the capacity to carry out this function effectively, the international community must rally its efforts to strengthen its national aid management capacities and institutions. Where AIDS Plans and related health activities are concerned, WHO will play a critical role. The World Bank and UNDP have a particularly important role to play in these efforts as well.

2. Developing a Flexible Approach to Coordination

Coordination arrangements should be responsive to the real needs of external partners and the requirements of the National AIDS Plan. Thus, they may vary greatly among countries. No particular model is suited to all situations. Experience continues to be gained by WHO/SPA in country-specific coordination arrangements, which may influence the mechanisms that will be established by future National AIDS Committees and their Management Committees.

3. Constructing a Dialogue on National AIDS Plans

A thorough, constructive and continuing dialogue on AIDS policies, objectives and aid use options for a given country is essential to the coordination and effective use of external support. There is room for experimentation and different approaches, but it is in the interest of a broad and coherent policy framework for aid-supported measures, that a National AIDS Plan be drawn up, sanctioned and supported by WHO/SPA, to become the vehicle for cooperation between the government, WHO, and the technical and development cooperation agencies involved.

4. Facilitating Consultation and Information Exchange

In addition to providing the means for technical and development cooperation agencies to gain a clearer perspective on country needs and priorities, coordination arrangements will include full and frank exchanges of relevant information among participating agencies, and between the agencies and the country. This will also serve as a framework enabling the government and the agencies to raise problems in aid programming and implementation, the resolution of which would contribute to the more effective use of resources. Such arrangements for coordination and consultation will also be strengthened through the mutual confidence which is most likely to result when technical and development cooperation is provided on a harmonized and predictable basis, coherent with national priorities.

5. Developing effective monitoring and evaluation procedures

Effective coordination requires that all involved parties strengthen their joint efforts to monitor and evaluate aid activities to help identify and resolve implementation problems and bottlenecks, and to ensure that conclusions reached through consultation are, in fact, being acted upon.

IV CONCLUSION

The growing complexity of economic and social development and development cooperation has increased the need for improved coordination and dialogue among international aid institutions and developing countries. The issues and problems raised by the AIDS pandemic are also complex. Hence, there is a deeply felt need to ensure effective and humane coordination of all AIDS, and AIDS-related, activities globally and at the national level. Such coordination is the primary responsibility of the recipient Goverment. However, active cooperation, such as described in this paper, with and between governmental, intergovernmental and non-governmentral agencies, in support of the countries concerned, is needed to achieve the objectives foreseen for such coordination.

To fulfill its mandate to direct and coordinate global AIDS prevention and control measures, in a way that is most supportive of national and international activities, WHO will need continued, strong commitment by all its Member States to the principle of global leadership, direction and coordination, as well as consistent, firm support for the specific and practical application of this principle at the national, regional and global levels. In the final analysis, however, the success of these efforts will depend primarily on the goodwill of all interested parties.

TM/JM/dla: 30 September 1987

ANNEX I

GLOBAL PRIORITIES OF THE SPECIAL PROGRAMME ON AIDS

(i) Develop and disseminate global messages and prototype materials on AIDS and its prevention and control;

(ii) develop and promote international consensus in the following areas:

- clinical trials for AIDS vaccine
- therapeutic trials in an international context
- HIV and international travellers
- HIV and employee health issues
- HIV screening issues and programmes
- exchange of scientific reagents (viruses and sera)

(iii) establish active information exchange system to support Member States (Ministries of Health, national AIDS committees);

(iv) epidemiology and impact assessment:

- expand international surveillance for AIDS and HIV infections
- develop modelling capability to improve estimates and tools for national and international analysis of the HIV pandemic
- promote international collaborative surveys of HIV infection

(v) promote, coordinate and support research on:

- sexual behaviour, including condom use
- operational aspects of HIV screening of blood
- new HIV screening technologies
- prevention of HIV infections among intravenous drug users
- HIV epidemiology, modes of transmission, risk factors
- counselling strategies
- epidemiological modelling
- methodology for assessment of social and economic impact of HIV
- vaccines and therapeutic agents
- health care and patient management issues
- community knowledge and attitudes

(vi) laboratory support for research and prevention:

- establish network ("banks") for storage and exchange of geographically and temporally representative retroviralisolates and reference sera
- establish laboratory performance criteria for HIV screening tests in developing world, protocols for evaluation of new tests, and required serum panels

(vii) consolidate and publish guidelines and supporting materials:

- national plan development
- initial epidemiological assessments
- serosurvey methodology
- educational strategies for prevention of sexual transmission of HIV
- prevention of sexual transmission
- medical assessment and follow-up of HIV seropositives in developing countries
- counselling of HIV infected persons, their sexual partners, family and others
- sterilization techniques vis-à-vis HIV
- revention of HIV transmission for health care workers at all levels
- information/education of general public about AIDS and HIV

(viii) organizational development:

- recruit core staff in Headquarters, regional offices and for assignment to Member States
- develop organizational capability for:
- identification and training of consultants
- provision of immediate support to Member States, including HIV
- laboratory equipment and supplies and condoms
- organize Global Commission on AIDS and Committee of Participating Parties
- establish management information system
- strengthen linkages within WHO and with UN agencies and other international agencies, including NGOs
- fund-raising
- establish public information system

ANNEX II

NATIONAL PRIORITIES OF THE SPECIAL PROGRAMME ON AIDS

A. URGENT ACTIONS

- confirm and reinforce political commitment for national AIDS programme
- provide guidance on, and if necessary support for, establishment of national AIDS committee;
- identify and provide immediate technical and/or financial support in the following areas:

  - initial epidemiological assessment
  - initial resource assessment
  - strengthening and prompt implementation of existing programmes foreducation of health care workers
  - strengthening and prompt implementation of existing programmes for public education and information

B. SHORT-TERM SUPPORT

- assist in developing and strengthening the national plan for AIDS prevention and control;
- based on the national plan, provide technical and/or related financial support in the design and implementation of the following activities:

  - further epidemiological assessment
  - epidemiological surveillance
  - laboratory capability for diagnosis and support of epidemiological surveillance and studies
  - educational programmes for health-care workers at all levels
  - prevention programmes:

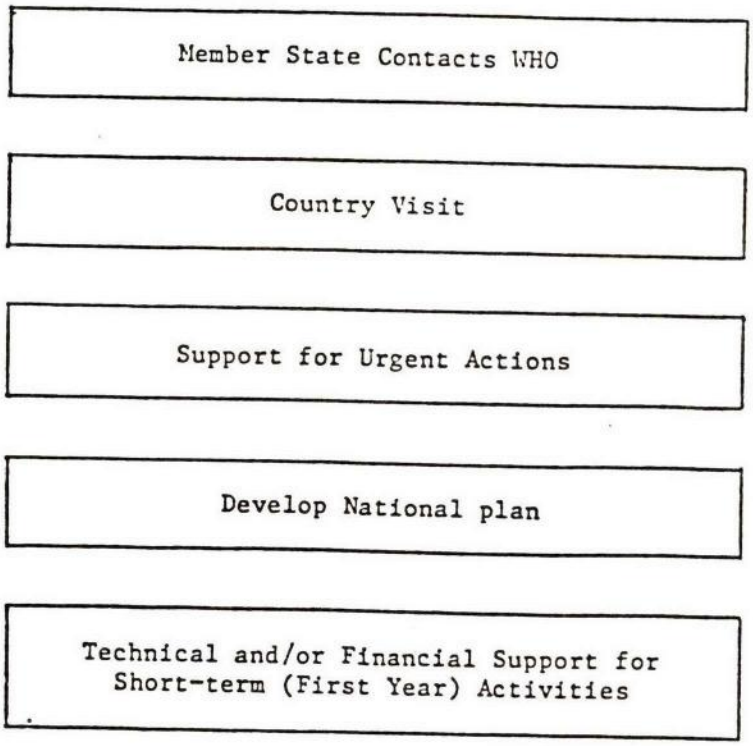
    - sexual transmission: public health communication programmes, including condom promotion and distribution
    - blood: HIV screening for blood transfusions; programmes to ensure sterilization of needles, syringes and otherskin-piercing instruments; programmes to prevent HIV transmission among intravenous drug users

Annex II cont'd.

- programmes to reduce impact of established HIV infections:
  - counselling programmes for HIV infected persons, their sexual partners, household members and other persons in their social environment
  - educational programmes for health-care workers
  - identification and more extensive support of "model prevention programmes" at the national or local level will also be considered in the areas of public health communication, blood transfusion, injections/skin-piercing instruments, counselling and maternal and child health care.

The National Programme Support unit, in close association with regional offices, provides technical and related financial support to Member States. Collaboration with the national AIDS programme begins immediately following agreement between the Member State, the Regional Office, and SPA (often crystallized during a rapid on-site visit by SPA and/or Regional Office staff).

In summary, initial WHO action proceeds as outlined below:



Annex II cont'd

C. MEDIUM-TERM PLANNING AND SUPPORT

The national plan also provides the basis for medium-term (3-5 year) strategies and activities. According to national capability and resource availability, the national AIDS programme will be supported to ensure:

(i) strengthening and consolidation of major Programme components:
- surveillance
- laboratory support
- education of health-care workers
- prevention programmes:
  - sexual, blood and perinatal transmission reduction of impact of established infections

(ii) evaluation capability for major Programme components;

(iii) extension and broadening of prevention programmes to include:
- integrated public health communication programme
- effective linkages with all relevant primary health care sectors and NGO activities;

(iv) development of methods to assess and monitor the economic and social impact of HIV;

(v) participation in regional and global AIDS prevention and control network, to ensure collaboration, information exchange and full access to new data, strategies, materials and technology.

ANNEX III

CRITERIA FOR ESTABLISHING PRIORITY COUNTRIES

Member States will be identified for priority action according to:

- national acceptance and awareness of the importance of AIDS and expressed commitment to create and maintain a national AIDS prevention and control programme;
- gravity of the HIV situation, based on available national data and knowledge of the regional epidemiological situation;
- potential for prevention of HIV infection (primary prevention) for large segments of national populations;
- the extent to which WHO's contribution will be essential in promoting national programme design and implementation;
- global representation, to ensure that all geographic areas may be assisted, including areas not yet faced with an HIV problem but with a need to develop the necessary alertness and prevention programmes;
- potential for evaluation of programme activities and impact on HIV transmission, in order to maximize knowledge gained from operational experience;
- ability and willingness of national authorities to utilize non-governmental organizations (NGOs) as well as a broad range of health, education and social service sectors as part of the AIDS prevention and control plan.

TM/dla: 30.9.87

Div file

THE WORLD BANK / INTERNATIONAL FINANCE CORPORATION
OFFICE MEMORANDUM

Date: 6 July 1987

To: Mr. Dean Jamison, Chief, PHRHN

From: R. A. Bulatao RAB

Extension: 61517

Subject: Visit to WHO Special Programme on AIDS (SPA/WHO), 18-30 June 1987: Back-to-office report

1. I visited SPA/WHO to develop collaborative arrangements regarding work on the demography of AIDS. (Attachment 1 contains terms of reference.) Progress was made on details, but not on the major objective. Drs. Mann and Carballo appeared reluctant to accept any Bank role in this area. In addition, both of them were too busy to see me for more than a few minutes and declined to discuss their objections.

2. Dr. Mann indicated he would instead contact Dr. Measham to arrange a discussion of the parameters governing the collaboration between the Bank and SPA/WHO. A copy of his message is Attachment 2. I recommend these steps:

2.1. We need to develop an understanding among Bank units of how we will handle and distribute responsibility for investigations of AIDS and what the rationale for the work is. We should meet with Dr. Measham, possibly Ms. Hamilton, and also others involved in the area, including Dr. Lamboray and Ms. Husain, in order to exchange information about work plans and develop a consensus about Bank needs and interests in the area. A partial statement of the rationale for demographic and economic work, which I provided to Dr. Mann, is Attachment 3.

2.2. In a subsequent discussion with SPA/WHO, arrangements for collaboration should be based on their understanding and acceptance of the basis and scope of our own interests, and should if possible be in writing.

2.3. Collaborative work with them--though not our own work--cannot proceed until the discussions come to a mutually satisfactory conclusion and appropriate arrangments at SPA/WHO for collaboration with Bank staff are worked out.

2.4. After a mutually satisfactory agreement is reached, a number of substantive questions need clarification. I prepared two lists of issues, first on the demography of AIDS (Attachment 4) and, second, a broader list covering demography and social research (Attachment 5), which I gave to Dr. Mann but to which I received no reply. A revised and expanded list could be prepared after our consultations within the Bank.

3. I was able to determine that SPA/WHO work on epidemiological-demographic modelling will be minimal. We should therefore plan to continue the program initially proposed of refining a model and applying it to three of four countries to determine demographic impact.

4. In the remainder of the memo, I cover my discussions and activities at WHO, focusing on these topics:

4.1. an overview of my discussions, with comments on organization and personnel at SPA/WHO, which at this point appears to be a major bottleneck

4.2. the status of epidemiological-demographic modelling at SPA/WHO

4.3. other areas of potential interest relating to AIDS, specifically areas of social research that SPA/WHO will pursue and a consultation on HIV and contraception

4.4. discussions with other units of WHO pertaining to topics on our work program (as of June), specifically work of the Special Programme on Human Reproduction (HRP) on contraceptive choice and work on adolescent fertility.

Overview of discussions with SPA/WHO

5. Of the four regular staff at SPA/WHO, I spoke with three, Drs. Chin, Carballo, and Mann. (Dr. Tarantola is in charge of national programs, and I did not have the opportunity to speak with him.)

Dr. Chin provided useful information, but raised no objections to our work, and left on mission three days after I arrived.

Dr. Carballo was in three meetings successively over the nine weekdays I was in Geneva. He did provide at my request a couple of documents on which I wrote him comments. He finally found time to see me after three days, but mainly to object to some of the comments and to question my presence there. At his request I sent him background material on our demographic work. He found a few minutes the next day, between sessions, for discussion of my written comments, but despite promises was unavailable for the rest of my visit. I was referred eventually to Dr. Mann.

As indicated above, Dr. Mann declined to discuss substantive issues, contending that our demographic work exceeded the limits of our collaborative arrangement with SPA/WHO. He indicated that higher-level discussions were necessary. After our discussion, I provided him the memo (Attachment 3) explaining the rationale for our work, but received no reply.

6. This account raises some questions. Had proper arrangements been made for the visit? Was SPA/WHO aware of the work on demographic modelling? If both questions can be answered affirmatively, what was the problem?

7. Arrangements for the visit were properly made at our end, but not at theirs. While visiting WHO in May, Ms. Nancy Birdsall explained to Dr. Mann our interests in demographic and economic work and arranged staff visits (as her Back-to-Office report, dated 15 May, indicates). I checked the dates personally with Drs. Chin and Carballo in Washington at the beginning of June, and they gave their approval. When I arrived, however, only Dr. Chin had time, and I found an office to use on my own.

8. An initial draft describing a demographic model was provided to Dr. Mann in May. Dr. Chin had a copy. Whether Dr. Carballo knew about it beforehand, I do not know.

9. Possibly SPA/WHO was under the impression that my visit was solely to assist them, and had no connection to Bank work. Clearly, also, personnel at SPA/WHO were extremely busy and unable to spend much time focusing on specific matters, providing information, or discussing issues.

10. Despite a progress report indicating success in meeting staffing targets, SPA/WHO does in fact have staffing problems. All professionals on the staff, except for the four noted, are temporary (including those assigned to regional and national offices), and no commitment has been made that any of them will stay with the program. The program officially started only in February, and positions were approved only in May. In addition, administrators have been very cautious in hiring and apparently reluctant to make personnel decisions without testing candidates first for an extended period. Authority and responsibility in the program are as a consequence highly centralized, in a way that overloads administrators.

11. Without a firm commitment, preferably in writing, it is unlikely that appropriate SPA/WHO staff will devote sufficient time to working jointly with Bank staff on specific problems.

Epidemiological-demographic modelling

12. SPA/WHO does not intend to play a major role in work in epidemiological-demographic modelling, but could be of some assistance. Drs. Chin and Carballo indicated that SPA/WHO does not intend to develop a capability for modelling, nor to provide major financial support for modellers (though they have about $200,000 to spend in this area). They will, however, support meetings, like the August meeting organized by the Institute of Medicine, for which they are covering some travel costs. They believe that other funders--USAID and the EEC were mentioned--are already sufficiently active.

13. The main assistance that can be expected from SPA/WHO is good epidemiological data. SPA/WHO still has considerable problems with such data--and the lack of any immediate interest in modelling on their part appears rational because of this. Some countries do not report to Geneva but to regional offices, which only provide Geneva with summaries; some countries provide reports from several different institutions; what the countries report is suspect, since the definition of AIDS cases is up to

each country; etc. Besides planning serosurveys, Dr. Chin is attempting to poll countries on their case definitions.

14. Epidemiological reports are kept in a DBase III file for processing on a PC-AT. The system is incomplete: data can be archived but reports cannot yet be produced. Separate reports are prepared regularly by Karen Estevez (who is in a different unit of WHO); she agreed to send regular updates.

15. I searched through the SPA/WHO collection of relevant materials, came across some studies I had not previously seen, but found nothing to indicate any institution with well-developed capacity in this area. I also discussed some substantive issues with Dr. Chin, like the changing infectivity of HIV seropositives and the possibility of reinfection, and modified the model I was working on appropriately.

16. My conclusion is that our working in this area should not conflict with any work of SPA/WHO. Their epidemiological data will eventually be useful, though at the moment it is suspect. We will need to keep track of other work in the area and may eventually want to adapt models produced by individuals or institutions other than SPA/WHO to Bank needs, to supplement or replace our own work.

Other work on AIDS

17. Social research on AIDS. I looked into social research for two reasons: because it was suggested to me that SPA/WHO could use some assistance in this area and in order to see what overlaps and linkages there were or could be with our own work program.

18. A consultation on this subject was held in May. Dr. Carballo was still writing the report, but he provided the background paper. This paper appears more theoretical than practical. (A social scientist at WHO who attended the consultation confirmed that the participants did not come to grips with practical research issues.) I provided Dr. Carballo with notes on what I labelled an alternative approach (Attachment 6).

19. Dr. Carballo indicated that many of the topics I identified for review papers were in fact covered or would soon be covered. Some topics, like the question of other sexually transmitted diseases, he found potentially interesting. On surveys of sexual behavior, he indicated that a meeting in late June, involving Dr. John Gagnon as a major participant, would begin drafting plans. He suggested that some collaboration might be possible, given our work on adolescent fertility in Africa. On public opinion, a later meeting is also planned.

20. HIV and contraception. Given the unavailability of the staff at SPA/WHO, I spent the last couple of days attending a consultation (organized by Dr. Susan Holck of HRP, and jointly sponsored by SPA/WHO) on interactions between HIV and contraception. The focus was mainly on oral contraceptives, other hormonal methods, and IUDs. A separate consultation (to be organized

by Dr. Patrick Rowe of HRP) is eventually intended to address issues relating to condoms and spermicides.

21. The meeting concluded that basic knowledge was lacking. Nothing known (specifically including Dr. Plummer's findings with Nairobi prostitutes) justifies any change in existing recommendations affecting contraceptive choice--but condoms should of course be used to prevent the spread of HIV, and HIV seropositives should avoid pregnancy. A partly marked-up draft of the short statement is Attachment 7.

22. A copy of my memo to Dr. Carballo regarding the background paper for the consultation is Attachment 8. Several of the issues raised are in fact more relevant to the upcoming consultation on barrier methods, but others concern family planning programs more directly.

Other matters

23. Contraceptive choice. Given our current task relating to contraceptive choice, I discussed this issue with Drs. Axel Mundigo and Iqbal Shah of HRP. They have recently launched a program of collaborative research on contraceptive choice involving nine countries. I obtained the basic questionnaire and made some recommendations regarding questions that might provide useful data for work on AIDS. We agreed to exchange information.

24. Adolescent fertility. Given our current interest in promoting surveys of adolescent fertility in Africa, I discussed this topic with Ms. Jane Ferguson (in the absence of Dr. Herbert Friedman, the officer in charge) in the maternal and child health unit. She outlined the WHO approach to the topic, which has been over the last few years to work with youth groups on adolescent health problems generally and to generate a variety of local projects. Most of the eight or so African countries in which they have projects are Anglophone. She indicated that WHO was now assigning this area high priority, would make it a major agenda item of a coming World Health Assembly, and would create a separate administrative unit. Assuming our interest in adolescent fertility surveys continues, we might consult with them further about relevant questions for surveys and about programmatic steps to take as follow-up.

cc.: Dr. Measham; Ms. Birdsall; Ms. Cochrane; Mr. Akin; Mr. Over; Dr. Lamboray

Attachments
1. Terms of reference
2. Dr. Mann's message to Dr. Measham
3. Memo to Dr. Mann concerning our demographic work
4. Issues to discuss on the demography of AIDS
5. Various substantive issues to raise with SPA/WHO
6. Comments for Dr. Carballo regarding social research on AIDS
7. Draft of statement of consultation on HIV and contraception
8. Memo to Dr. Carballo regarding HIV and contraception

THE WORLD BANK / INTERNATIONAL FINANCE CORPORATION

ATTACHMENT 1

O F F I C E M E M O R A N D U M

Date: 5 June 1987

To: Rodolfo A. Bulatao, PNHPR

From: Nancy Birdsall, Chief, PHNPR

Extension: 61581

Subject: Visit to WHO Special Programme on AIDS, Geneva, June 17-30, 1987

1. You will visit the WHO Special Programme on AIDS (SPA/WHO) to assist in the development of a collaborative work program on demographic issues relating to the AIDS pandemic in developing countries. You will work with Drs. Manuel Carballo and James Chin of SPA/WHO on defining such a program, with an appropriate role for the Bank.

2. You will also discuss with SPA/WHO efforts to date at demographic modelling of the impact of AIDS and collect such epidemiological and related data as they may have available--and arrange for receiving additional data as it is collected in the future--to allow parametrization of demographic models.

ATTACHMENT 2

WORLD HEALTH ORGANIZATION
CH – 1211 GENEVA 27 - SWITZERLAND

Telegr.: UNISANTE GENEVA
Tel.: 91 21 11 Telex: 27821
FACSIMILE: 910746

WHO FACSIMILE

Message No. ..... Page 1 of 1 pages Date: 26 June 1987

From: Dr J. Mann, Director, SPA To: Dr A. Measham, World Bank

Fax No.: (202) 4778164

Our ref.: A23/70/2 | Subject:

TEXT

Dear Tony,

I wanted to contact you regarding the relationship between the World Bank and the WHO Special Programme on AIDS.

My recent discussions with Dr Dean Jameson and Dr Randy Bulatao have led me to believe that there may be some uncertainty regarding the nature and scope of the World Bank/World Health Organization Special Programme on AIDS collaboration.

In order to ensure that we continue to work together as closely as possible, I should like to request your guidance on the composition and timing of a meeting between the WHO Special Programme on AIDS and World Bank representatives to advise on a clarification of the nature and scope of our collaborative relationship on AIDS.

In this regard, it might perhaps be advisable to delay Dr Over's visit to Geneva.

I would very much appreciate your guidance on these issues, as I am most anxious to continue the highly supportive and collaborative nature of the relationship we have thus far established.

Signed: Dr J. Mann

Copies to:

Dr R. Bulatao, World Bank
Dr J. Cohen, DGO
Dr H. Mahler, DGO

THE WORLD BANK / INTERNATIONAL FINANCE CORPORATION **ATTACHMENT 3**

O F F I C E M E M O R A N D U M

Date: 27 June 1987

To: Dr. J. Mann, Director, SPA/WHO

From: R. A. Bulatao, PHNPR

Extension: 61517

Subject: Rationale for the Bank's interest in studying aspects of the AIDS pandemic

1. Thank you for the copy of your message to Dr. Measham suggesting discussions of the Bank's collaborative relationship with SPA/WHO on AIDS. You indicated that, prior to this discussion, you do not wish to take up substantive issues. Nevertheless, given my instructions for this visit, I think I should make an effort to provide you what information I can about the rationale for our work on the demography and the economics of AIDS. This may, of course, be later supplemented by Dr. Measham or others at the Bank.

2. Our work on the demography of AIDS is in fact integral to the demographic projections we regularly produce in our division. As you may know, we publish annually medium- to long-term projections of the population of every country of the world. When making these projections, our choices with regard to the AIDS pandemic are (a) to ignore it, (b) to adapt other people's work to our own needs, or (c) to conduct some work of our own in order to determine how to factor in the effects of the pandemic.

3. So far, we have adopted alternative (a), but for some countries, I believe we should move to alternative (c). We will probably continue to ignore the demographic effects of AIDS for most countries, which do not appear so far to be affected in a major way. For those countries most affected, however, it is irresponsible for us to continue to ignore the phenomenon if there is something that can be done. Relying on other people's work (alternative b) is unsatisfactory at present. My understanding is that SPA/WHO cannot supply appropriate demographic statistics or an appropriate model for our demographic work, and does not intend to develop the capacity to do this or to directly support any institution that might provide such input. My contacts with modellers and review of various published and unpublished work indicates that no group is currently able to provide us with a satisfactory model for developing countries. We have been able to develop a simple approach that links directly to our demographic projection package. Until someone comes up with a better approach that we can adapt to our needs, therefore, I see the need to continue work on our own approach.

4. I have also tried to make the case to Dr. Carballo and you that good economic work will require some epidemiological-demographic modelling. Mr. John North, who has been our department director over this period, has

emphasized this to me several times in encouraging the work. You can indeed gather data on economic costs without worrying about a model (and gathering such data may in fact be the first priority). But if you want to do something with these data--to infer future costs, say, or to use the data for financial planning--then epidemiological-demographic projections will be needed. Without at least a primitive model, you can safely make statements only about current costs, not about future costs.

5. Other reasons might be given for the work, such as the relevance to our dialogue on population with governments in the main countries affected and our need to be prepared to respond to higher-level managers' and Executive Directors' inquiries. Again, some of these needs might be met simply be keeping track of what other researchers are doing--but at the moment that does not seem to be sufficient.

6. I should emphasize that it was never our intention to conduct demographic work on AIDS entirely independently of SPA/WHO. An early version of some work was provided to you about the time of the World Health Assembly. None of us had the impression that you had any reservations about our doing this work. My assignment here, therefore, was to discuss appropriate collaboration and to ensure that this work is satisfactory from your point of view. If you have now come to believe the Bank should not be doing any work on the demography of AIDS, Dr. Measham and Mr. Jamison will I am sure consider your arguments carefully, but will also have to take into account our own needs in the areas of demographic projection and economic work.

7. I believe similar arguments apply in the economic area. Not being an economist, I am not in the best position to make them. Roughly, however, I believe the argument is that we should factor the phenomenon of AIDS into our health sector work, both the cross-national work on health finance, which provides general guidelines, and the sector work on specific countries, which is used in project design and evaluation.

8. In this area, we have begun by attempting to respond to your request. If adequate economic work is to be done that will also be useful for our purposes, however, it will inevitably have to go beyond the simple collection of cost data. Again, there are various options for how this might be done, such as SPA/WHO hiring its own economist or asking the Bank or some other institution to handle the work. I think it would be prudent to try to think this through and to reach some agreement that ensures that your interests are preserved but our needs in this area will also be met.

9. As to other areas of social research, there are potential overlaps or linkages, like our work on adolescent fertility in Africa and the surveys of sexual behavior you are planning. It might be useful for us at some appropriate point to exchange further information on these matters.

10. We do agree that it is critical to maintain a constructive working relationship between our units. We may have been remiss so far in not giving you a complete picture of our interests and needs in this area, as well as in coming to the area relatively late. However, my visit here was

meant to partly remedy this, and it is unfortunate that I have not had the chance to discuss the issues with Dr. Carballo or you for more than a few minutes. (I did speak with Dr. Chin at some length before speaking with either of you, but he did not raise any problems with our demographic work.) I understand that you are all extremely busy, and I therefore do not take this personally. For the future, however, in the interests of our working relationship, I would recommend some adjustments.

11. If there is more information or explanation I can provide you, please let me know, either before I leave Wednesday or after I return to the Bank.

ATTACHMENT 4

Issues for a discussion of joint work on the demography of AIDS

This note updates the memo of 28 Feb 87, listing the issues involved in this work and posing some questions for consideration. (This note was prepared for J. Mann's visit to the Bank on 16 June 87, but was not taken up then because of limited time.)

Four possible objectives for the work are listed, and possible mechanisms for achieving each are noted.

1. First objective: To produce the best estimates possible in the shortest time of the demographic implications of AIDS in particular developing countries, and to develop mechanisms for continuous refinement of the estimates.

Possible mechanisms

1.1. Elaboration and application of a model developed in the Bank to several different countries

1.2. Support for modelling efforts in a variety of other institutions

1.3. Workshops to present and assess alternative models

1.4. Reviews of relevant literature and data to obtain estimates of parameters relating to sexual behavior, drug use, injections and transfusions, the epidemiology of AIDS, and country demography

1.5. Field studies and representative surveys to supplement desk reviews of these phenomena

2. Second objective: To provide information and tools linked to demographic projections to countries to use in developing national strategies and assessing the effects of prevention and control efforts

Possible mechanisms

2.1. Development of user-friendly microcomputer planning packages, in the Bank or by other institutions with some funding support

2.2. Development of training exercises and courses

2.3. Participation of modellers in national planning exercises or technical assistance missions

3. Third objective: To develop policy recommendations relating to population programs and how they should respond to problems relating to AIDS

Possible mechanisms

3.1. Synthesis of findings from the best available epidemiological-demographic models

3.2. Review and assessment of how population programs are responding

3.3. Workshops involving family planning policy makers and professionals

4. Fourth objective: To link the modelling effort to a system for estimating economic costs

Possible mechanism: This will be accomplished mainly by a Bank economist, M. Over.

5. Issues

5.1. Are these objectives reasonable? Are some of lower priority than others?

5.2. What support is currently available from all sources for modelling? How can further support be mobilized, especially in the short run? How should it be organized and what level should it be at?

5.3. How should support be mobilized for associated studies, necessary for providing parameters for models, on sexual behavior, drug use, injections, and other social factors in transmission?

5.4. How can work be encouraged on particular aspects of country demography that require clarification if projections are to be reliable?

5.5. What part should SPA and the Bank play in mobilizing support, organizing programs of research and development, providing technical oversight, and ensuring that results are translated into usable form for health planners?

RAB16Jun87

VARIOUS SUBSTANTIVE ISSUES TO RAISE WITH SPA/WHO **ATTACHMENT 5**
(Proposed agenda of questions for discussion with J. Mann, 26 Jun 87)

Epidemiological-demographic models

1. Is this an accurate summary of SPA/WHO's interest in epidemiological-demographic modelling:

1.1. SPA/WHO is fundamentally interested in such work and thinks it will be useful.

1.2. However, SPA/WHO will not do any such work itself.

1.3. Nor will it directly support such work, for the reason that it believes other funders (USAID, ODA, any others?) are providing or will soon provide adequate support.

1.4. SPA/WHO will, however, support meetings, at its own initiative or jointly with other agencies, to evaluate epidemiological-demographic models, assess and interpret their results, and plan their utilization.

1.5. Anything else to add?

2. Epidemiological-demographic modelling of course requires much data about different aspects of HIV infection.

2.1. Does SPA/WHO have any intentions of creating an appropriate worldwide data bank?

2.2. If not, would it encourage creation of a data bank by other agencies?

2.3. Would it support such efforts by contributing its own data?

2.4. Would it consider financial support for such efforts, or would it leave this to others?

2.5. Some of the planned SPA/WHO activities in social research will generate data useful for epidemiological-demographic models. How will such data be disseminated? Will SPA/WHO rely on standard journal publication, or will some effort be made to provide such data more quickly to modellers?

3. One of the objectives of modelling work is to produce tools for national programs to use in resource planning.

3.1. Is it correct to say that SPA/WHO also chooses to leave the development of such tools and financial support for such work to other agencies?

3.2. Should these other agencies make arrangements themselves directly

with national programs for the use of such tools? Or does SPA/WHO want to play a mediating role?

4. Models will eventually be the main method for generating expected numbers to attach to the pandemic.

4.1. Will SPA/WHO want to retain a role in producing official numbers?

4.2. If so, how ill it interface with the modellers? Are meetings to generate and agree on such numbers contemplated?

5. Another use of models is to test alternative control strategies. What alternative strategies does SPA/WHO consider the most important to immediately evaluate?

Sexual behavior and condom use

6. Dr. Carballo has suggested that the Bank might collaborate with SPA/WHO in the area of surveys of sexual behavior, given, e.g., our current work on adolescent fertility in Africa.

6.1. Do you approve of such collaboration?

6.2. Assuming that plans for work in this area are still under development, can we expect to be involved in the planning?

6.3. Can we therefore expect an invitation to the meeting on this topic on 19-21 July 1987?

7. I suggested to Dr. Carballo that consideration be given to supplementing USAID support for the Demographic and Health Surveys (DHS) project (at Westinghouse) in order to get enhanced data on condom use. He indicated he had some correspondence from them. I have much occasion to use DHS data, will soon be on their technical committee, and have a special interest in the topic of contraceptive choice (I am editing a book and have a meeting planned for October). Could I therefore find out your likely intentions in this area.

8. It is also my understanding that Axel Mundigo (HRP) will be responsible for some work on condom use. Could I have some information about what is involved?

Other areas of social research

9. I am unclear about the purpose of the consulation on social research last month. I understand that several of the urgent topics for

research--drug use, prostitution, etc.--are already covered. What additional information or ideas was SPA/WHO searching for? Were you looking for general perspectives, innovative ideas, or something else? If you were looking for an overall perspective, it might be worth adding information about historical research, management research, medical sociology, and health economics to the list of concerns.

9.1. Could you give me some idea of the amounts you have budgeted for social research?

10. Will SPA/WHO consider unsolicited proposals relating to social research? In my opinion, some of the best research ideas are likely to be generated by individual researchers without official prodding or sponsorship.

10.1. Is SPA/WHO looking for such ideas?

10.2. Will it have the mechanisms to support such work?

11. What is SPA/WHO doing regarding providing public information and information to other agencies about its activities in social research?

11.1. Some of the areas currently being reviewed are potentially of interest to us, and it would therefore be helpful for us to find out what is already being done or being contemplated.

11.2. The results, of course, could also be useful for our project officers in the design of health projects. How will they find out about this work? Should they depend on formal publication, or will other, quicker channels be devised?

Practical issues

12. What would be an appropriate schedule for Mead Over (the Bank economist) to visit SPA/WHO? If he is expected to work with Drs. Carballo and Chin, when should they be available?

13. Given that Dr. Chin is away and Dr. Carballo tied up in a meeting Monday and Tuesday, would you object if I attended your meeting on HIV and Contraception on Monday and Tuesday, before I leave early Wednesday?

RAB26Jun87

THE WORLD BANK / INTERNATIONAL FINANCE CORPORATION **ATTACHMENT 6**

OFFICE MEMORANDUM

Date: 22 June 1987

To: Dr. Manuel Carballo, SPA/WHO

From: R. A. Bulatao, PHNPR

Extension: 61517

Subject: Comments on social research agenda

1. The background paper for the Consultation on Psychosocial Research Needs in HIV Infection and AIDS presents an expansive but poorly focused view of what social research can contribute in this area. Although your name is on the paper, I gather from the content and the quotations that it is largely (apart possibly from the sections on AIDS, which are unexceptionable) the work of sociologists, and therefore I feel free to criticize it. I hope some of the points I raise below did in fact come up at your consultation.

2. I will mention a few criticisms, without attempting to be thorough. Then I will suggest an alternative approach, together with a list of 12 possible priority topics and a discussion of the SPA/WHO role.

Criticisms

[Since Dr. Carballo showed me the paper in confidence, I leave out this portion of the memo, which in any case did not contain anything essential to the remainder.]

Alternative approach

8. What is needed urgently is not the broad list of topics provided in this paper but a short, tightly focused agenda of research that should be planned immediately. Also needed is some conception of the role SPA/WHO should take in generating this research. These are the issues I address next.

9. Priority research topics will be considered in two groups: empirical research and literature reviews. Generally, the literature reviews refer to areas where the immediate empirical needs are unclear, the potential for empirical work is unresolved, or the empirical work possible is unlikely to produce quick results. In the area of empirical research, these are the six priorities I see:

- o surveys of sexual behavior
- o surveys of condom availability, marketing, and use

- o modelling demographic consequences
- o developing estimates of economic costs
- o surveys of public opinion
- o program evaluation studies.

For literature reviews, these are my six priority topics:

- o prostitution in sub-Saharan Africa
- o innovative approaches to condom marketing.
- o intravenous drug use in developing countries
- o cultural perceptions and practices relating to injections and skin-piercing
- o patterns and effects of counselling
- o status of and experience with controlling other sexually transmitted diseases (STDs)

Each of these topics is discussed below.

Empirical research

10. Surveys of sexual behavior. Reliable, representative data on sexual behavior are virtually nonexistent. Such data are essential for at least three reasons:

- o to inform national programs about potential approaches, areas for interventions, and targeting possibilities in reducing sexual transmission of HIV

- o to provide estimates of parameters in models to predict the course of the epidemic

- o to provide a baseline for subsequent studies of the effects of educational and informational programs.

The variety of topics to cover include sexual practices, sexual experience, acquisition of partners, experience with STDs, contraceptive use, information about AIDS, reactions to AIDS, etc.

One possible strategy in this area is to begin with small area samples, such as urban samples in two or three African cities, partly to develop and test the methodology and partly to gain public acceptance for such studies. (Cf. the recent three or four studies of sexual attitudes and fertility among schoolchildren in African cities.) Subsequently, national surveys should also be planned.

11. Surveys of condom availability, marketing, and use. In principle, this topic could be considered under sexual behavior. However, much more is known about condom use and many more opportunities for studying it exist. In particular, it would be cost-effective to include detailed investigation of condom use in the worldwide Demographic and Health Surveys (DHS) program run by Westinghouse under contract with USAID. These surveys already

collect information about condoms, together with other contraceptive methods. Three extensions of these surveys should be considered:

o additional questions, or possibly an additional module, relating specifically to condom use to prevent HIV transmission (and possibly also including reference to spermicides and diaphragms)

o special subsamples including the most active or potentially most active transmitters of HIV

o ancillary studies of condom availability in local stores and of social and commercial marketing strategies.

Various agencies other than DHS, such as the Futures Group, might be worth considering with regard to the last item because of their direct involvement in condom marketing. Note that this last item is meant to provide empirical data to complement the literature review on the related topic below.

12. Modelling demographic consequences. Though this may fall under a different unit of SPA/WHO, it is essential to much of the other social science work needed in this area. As noted earlier, reactions to the epidemic cannot be fairly assessed until you have some idea of what the epidemic is likely to do. Models should provide three things:

o reconciliation of estimates of different aspects of the phenomenon (HIV seroprevalence, proportions progressing to AIDS, numbers of deaths, etc.) within a coherent framework that allows one to detect inconsistencies

o projections of numbers affected (those infected, those with AIDS, and deaths) over at least a ten-year period, with some idea of the age-sex distribution of these people

o estimates of the potential impact of particular interventions or strategies, such as cleaning the blood supply and targeting particular high-risk behaviors.

Models should also be useful in answering questions about public policy, such as whether the demographic effect of the epidemic will be such as to obviate the need for population control.

Given the number of models proposed so far, a review of alternatives through a workshop does seem an appropriate initial step. Further work will then be needed, however, in applying the most promising models to developing countries (which almost no modellers have done). After that, more work should be done to develop a package that country planners can use to make their own projections.

13. Developing estimates of economic costs. Economic consequences could of course be built into epidemiological-demographic models. However, the cost data needed for developing countries are so lacking at present that a special effort must be made first to obtain them. Three areas might be covered:

- o direct costs of treatment and medical interventions, including testing and the diversion of personnel from other tasks
- o direct costs of information-education-communication efforts
- o indirect costs, particularly manpower losses to the society.

The former two categories of costs are essential in planning national programs, and the last one is essential in providing justification for an appropriate level of national effort. Eventually, countries will have to fund most of the effort themselves, and the issue will become how much to spend against AIDS as opposed to how much to spend on other items in the national budget. Economic costs, of which most are expected to be indirect, will be a key in this determination.

14. Surveys of public opinion. Much of the effort against AIDS is currently a media effort. Is the message getting out, and is it reaching the right groups? A few simple survey questions would help determine whether efforts are properly directed and provide the baseline in areas where media and other communication efforts have not begun. The surveys might also provide a means of altering programs to rumors and prejudices relating to AIDS as they spread in the population. These surveys should be much quicker, simpler, and cheaper than the surveys on sexual behavior or condom use, and are therefore worth keeping separate.

15. Program evaluation studies. Since programs have barely begun, it may appear premature to worry about evaluation. However, a proper focus on monitoring and evaluation at the very beginning does help ensure a properly structured and properly guided program and should eventually provide information useful for late-starting programs in assessing best practice. One possible approach here is to provide an evaluation adviser when a medium-term plan is being prepared, so that evaluation concerns will be a part of the plan.

Literature reviews

16. Prostitution in sub-Saharan Africa. Cultural interpretations of what constitutes prostitution and how it is perceived will be crucially important in attempting to reach prostitutes and reduce transmission. Much of the empirical work in this area is probably anthropological, and difficulties of generalization to national populations will certainly exist. Several reviews of what is known for different countries or subregions in Africa might be commissioned. Similar reviews for Asia, Latin America and the Caribbean, and the Middle East might also be considered, but should have lower priority.

17. Innovative approaches to condom marketing. Enough experience with condom marketing exists to warrant a review that will highlight innovative approaches for other programs to consider. This review should consider especially the experience in areas where condoms account for a substantial share of the contraceptives market (Japan, Singapore, Trinidad and Tobago)

and with the experience of social marketing programs in a variety of developing countries. The paper should be updated or replaced with subsequent reports as data become available from the condom surveys.

18. Intravenous drug use in developing countries. I know little about this topic, and in fact there may be little scientific information. Nevertheless this is a standard area of sociological research (usually considered under the heading of deviant behavior or criminology), and there may be work, or at least various perspectives and approaches, that would give some initial indication of the scope of this problem. Behavioral as well as legal aspects of the problem are relevant. Some work certainly exists for Asian countries, and possibly for Latin America and the Caribbean and for the Middle East as well. For sub-Saharan Africa, which should be the priority, much less is probably known. An international seminar on this topic primarily to collect available material is probably appropriate.

19. Cultural perceptions and practices relating to injections and skin-piercing. Again, anthropological work in this area may be valuable in providing insights and ideas for culturally sensitive program interventions. The topic is probably sufficiently delineated and the literature sufficiently small to permit a comparative view across all developing regions.

20. Patterns and effects of counselling. It is assumed that minimal counselling for HIV seropositives and AIDS patients currently takes place in most developing-country settings. The purpose of this review is to list what actually takes place there, and then to consider the experience in industrialized countries, evaluate the research on it, and make prescriptions for practice in developing countries.

21. Status of and experience with controlling other sexually transmitted diseases. Data on other STDs need to be collected, and the experience of programs that have attempted to deal with them assessed. At least one recent review dealing with infertility in sub-Saharan Africa suggests that some information potentially exists even for this region. The review should focus on the lessons to be learned in understanding, predicting, and controlling the spread of HIV.

The SPA/WHO role

22. Set as a first principle the idea that social research, since it generally is meant to feed information into national programs, should be done in country by nationals as part of and with funding through national programs. Qualify this by noting the paucity of expertise in social research in Africa; the situation is better in Asia and Latin America, but even in these areas, the best research often still requires at least initial collaboration with industrialized-country researchers. SPA/WHO would then have a variety of roles to play, including these:

- setting an overall agenda for social research needs and encouraging countries to consider areas on the agenda

o setting standards for the conduct of research and facilitating exchange of information on best practice

o directly supporting research in areas where the work is essentially cross-national and the gains not limited to a single country

o encouraging other potential funding agencies to support items on its research agenda, either for in-country or for comparative work

o publicizing research results and serving as a clearinghouse for information on research.

23. The role of national programs does not imply the need for uniformity, nor for restrictive national research plans that channel work exclusively in particular directions. It is probably most constructive to allow researchers considerably leeway at this point, given the substantial amount that remains to be learned.

24. These principles imply that SPA/WHO, either singly on jointly with other potential funders, should provide direct support for the six literature reviews noted above. The empirical work, especially the surveys, will be more costly. Here is how I think responsibility might be divided:

24.1. Surveys of sexual behavior. Funding for initial pilot studies should come directly from SPA/WHO, with country concurrence. Funding for subsequent national surveys should come mainly through national programs, with SPA/WHO technical assistance, including possible direct SPA/WHO funding for international consultants to assist national survey teams.

24.2. Surveys of condom availability, marketing, and use. Since DHS is a project of USAID, USAID should ideally be persuaded to provide a supplemental grant to cover this work. Alternatively, national programs might buy into DHS for this purpose. If national programs express an interest, SPA/WHO should assist in negotiating with DHS. The SPA/WHO role would also involve contributing to the development of appropriate modules, sampling recommendations, and similar guidelines.

24.3. Modelling demographic consequences. Various funding agencies, including USAID and ODA, are likely to support some costs for individual modellers. Because this work is critical, however, SPA/WHO should retain some flexibility to support additional work with specific features or approaches that it considers most useful for its own needs. For application of models to specific country circumstances, some funding through national programs might be possible, but the costs should be minor and should mainly involve travel of international consultants, and might most conveniently be borne centrally.

24.4. Developing estimates of economic costs. The World Bank should support initial work by its own staff. Should good proposals be received to supplement this work, SPA/WHO might still consider them or refer them for possible World Bank support.

24.5. Surveys of public opinion. These should be mainly funded through national programs. International consultants may be less necessary in this area than in others, given the existence of an infrastructure in many countries to conduct the fairly simple surveys required. Again, SPA/WHO should attempt to provide guidelines, and might in fact consider some direct contribution for an initial study of this sort in order to set standards for the work.

24.6. Program evaluation studies. As earlier noted, these should be built into national plans. A direct SPA/WHO contribution in the form of technical assistance for initial studies would be appropriate.

25. This approach implies the need for SPA/WHO to develop some competence in managing social research in this area and selecting and monitoring the activities of consultants and researchers with specific competencies. Some degree of peer review of proposals will also be desirable, and might be achieved either through a representative committee or through a panel, members of whom are requested to comment depending on their competencies.

26. A distinction has not been made here between work on social, behavioral, demographic, and economic aspects and on surveillance, forecasting, and impact assessment. The demographic and economic work listed above could fall under either heading, but should be linked to other social research because the competencies of the investigators are likely to be similar to those of other social researchers and because the demographic and economic work will both rely on and contribute to the other areas for social research.

27. These suggestions for research priorities constitute a short list, and clearly other ideas might be appended to it. The list should not remain static. As more is learned, priorities should be regularly reviewed and updated. In addition, it is desirable to attempt to provide some support for innovative ideas from individual researchers that promise to have some quick, useful impact on programs, even if they fall outside this agenda.

3867F

SUMMARY STATEMENT ON CONTRACEPTIVE METHODS AND HUMAN IMMUNODEFICIENCY VIRUS (HIV)

A consultation on contraceptive methods and HIV infection was organised by the Special Programme on Research in Human Reproduction and the Special Programme on AIDS (20-30 June 1987) in order to review currently available information on the possible interactions between contraception and HIV infection, and to identify research needs in this area. The consultation brought together 15 participants from nine countries representing epidemiology immunology, sexually transmitted disease control, reproductive physiology and gynaecology.

Given the substantial risk of perinatal transmission, HIV infected women need access to effective methods of fertility regulation. In addition, women at risk of HIV infection need safe and effective contraception. In both cases, the potential interaction between HIV infection and contraception must be considered. Three areas of potential interaction between contraceptive methods and HIV infection were reviewed: a) infectiousness of HIV infected persons, b) susceptibility to HIV infection, c) development and course of HIV related illness.

All current methods of contraception were reviewed; the following ones were reviewed in detail: a) Intrauterine devices (IUDs), b) Combined oral

contraceptives, c) Progestogen-only contraceptives (e.g., injectables, implants, progestogen-only oral contraceptives).

Irrespective of whether other contraceptive methods are used, condoms should be used whenever there is a risk of sexual transmission of HIV infection. Condoms and spermicides are to be reviewed in more detail by a separate consultation.

A number of theoretical interactions - both adverse and beneficial - between the contraceptive methods and HIV infection were considered. Conclusions were difficult to draw because of the marked paucity of basic and epidemiologic data in this area. For example, no epidemiologic data are currently available on the relationship between HIV infection and the use of either IUDs, or progestogen-only contraceptives. In addition, although one unpublished report has suggested a possible association between oral contraceptives and susceptibility to HIV infection, the data are preliminary and insufficient to support any conclusion at this time. Other preliminary reports, moreover, have suggested no association between oral contraception and susceptibility to HIV infection.

The group made the following recommendations:

- Further research is urgently needed. Areas of highest priority are:

  i) Epidemiological studies of the influence of combined oral contraceptives, DMPA, and IUDs on susceptibility of HIV

infection, infectiousness of HIV infected women, and the development and course of HIV related illness.

ii) Basic studies of the mechanisms of HIV transmission (both in humans and in animal models) and their modification by contraceptive methods.

iii) Epidemiologic studies of the influence of pregnancy on the development and course of HIV related illness.

iv) Studies of immune function in women without HIV infection who are using hormonal contraception.

The need for WHO to undertake epidemiologic studies particularly in developing countries ~~was~~ were emphasized.

o In the light of current information, no changes in existing recommendations concerning contraceptive use are warranted. ~~For~~ example, IUDs ~~are not~~ a method of choice for women who are at high risk of sexually transmitted diseases, including HIV infection. The choice of contraceptive method for an individual/couple should continue to take into account the risks and benefits of each method, and the particular circumstances and lifestyle of the individuals concerned.

THE WORLD BANK / INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

ATTACHMENT 8

Date: 19 June 1987

To: Dr. Manuel Carballo, SPA/WHO

From: R. A. Bulatao

Extension: 2706

Subject: Omissions in background paper for HIV and Contraception meeting

1. Susan Harlap's background paper on "HIV and fertility regulation" is interesting and raises important points, but does not cover social science and management issues relating to family planning and population programs. This is of concern because the background paper on psychosocial research and HIV also does not specifically address these issues.

2. As the major purveyors of condoms in many developing countries, public and private family planning programs are involved, willy-nilly, in controlling HIV transmission. The concerns of family planning professionals need to be directly addressed in order to create a sound basis for cooperation with them.

3. I hope you are planning a separate meeting, or some similar mechanism, to deal with these concerns and to generate the research and policy advice needed in this area. I list below some of the concerns that I see. Others may have important questions to add.

Some issues relating to family planning

4. What is the use-effectiveness of condoms in preventing HIV transmission? In developing countries, use-effectiveness against pregnancy is generally believed to be about 60 percent, but in industrialized countries, it is assumed to be 90 percent or more. Is this also true for HIV transmission? Can failures be ascribed to irregular and improper use? What cofactors are there for condom effectiveness? Is STD infection relevant?

5. What is the use-effectiveness of spermicides in preventing HIV transmission? To what extent do they enhance the protective effect of condoms? Under what circumstances should they be jointly recommended with condoms? Similarly, what is the use-effectiveness of the diaphragm?

6. Family planning programs have over the last few decades gradually overcome the stigma of association with sexual promiscuity. If they begin promoting condoms against AIDS, could the stigma return? How could such a negative consequence be avoided?

7. A related issue is targeting. The target audience for family planning programs is the mass of the adult population in reproductive ages sexually active mainly within marriage. For reducing HIV transmission, however, a special focus on groups like prostitutes and the sexually promiscuous is desirable. How can family planning programs develop such a focus? Should they try to do so, or should other channels be relied on, and if so, what connection should they have with family planning programs?

8. Will the use of more effective methods decline as condoms are promoted? It is hard enough to get some people to use one contraceptive, let alone two. How can a decline in effective methods be avoided? Not only individual choices are involved but also program focus, staff attention and training, and resources. One aspect of this is worth separate listing.

9. How will funding for increasing condom supply be arranged? Is funding expected to come directly from private sales? How will subsidized social marketing programs be affected--will additional subsidies be required? For public programs, will the increased supply of condoms be at the expense of other methods?

10. What organizational arrangements are possible between family planning and AIDS programs? What models are worth looking into?

11. Data on contraceptive choice across time in some family planning programs show permanent drops in the method share of orals in the past after damaging publicity regarding health concerns. Disruptions of this sort are worth avoiding if they are unjustified. What response is appropriate, at this point, to Plummer's findings with Nairobi prostitutes? Will further research currently underway be adequate to address concerns in this area?

The background paper does touch on the last point, and the concern with guidelines for family planning workers is appropriate and helpful. It does not, however, address the other concerns. One additional concern is the significance of abortion, the extent to which it may be relied on as a backup, whether programs should have anything to do with it, and whether they can provide adequate services, including to HIV seropositive women, without it.

FORM NO. 75
(6–83)

THE WORLD BANK/IFC

ROUTING SLIP	DATE:

NAME	ROOM NO.
Mely	

	APPROPRIATE DISPOSITION		NOTE AND RETURN
	APPROVAL		NOTE AND SEND ON
	CLEARANCE		PER OUR CONVERSATION
	COMMENT		PER YOUR REQUEST
	FOR ACTION		PREPARE REPLY
	INFORMATION		RECOMMENDATION
	INITIAL		SIGNATURE
	NOTE AND FILE		**URGENT**

REMARKS: P/s create file on WHO/Bank HIDS Cooperation.

FROM:	ROOM NO.:	EXTENSION:

Rwanda
Burundi
Nigeria

The World Bank/International Finance Corporation

OFFICE MEMORANDUM

DATE: June 4, 1987

TO: Nancy Birdsall, Chief, PHNPR; Dean Jamison, Chief, EDTDR

FROM: Mead Over, PHNPR MO

EXTENSION: 61606

SUBJECT: Cooperation between The Bank and WHO on Analysis of Economic Impact of AIDS

1. At the request of Nancy Birdsall and Dean Jamison, this memorandum records my understanding of the agreement reached between the Bank, represented by Nancy Birdsall and John North, and the World Health Organization, represented by Jonathan Mann, regarding the Bank's participation in a joint Bank-WHO effort to develop a program to address the spread of AIDS in the developing countries.

2. The Bank will provide for one year beginning July 1, 1987, a health economist, myself, to develop and apply a methodology for evaluating and comparing the cost-effectiveness of alternative AIDS prevention and control programs. The specific products of the work program will be:

a. Issues Paper. Will define the issues to be addressed and the methods to be used in analyzing the cost-effectiveness of alternative AIDS prevention and control programs.

Preliminary Draft: September 30, 1987
Bank and WHO comments: October 15, 1987
Final Draft: October 30, 1987

b. Technical Assistance Missions. Back-to-office reports on each of several missions to countries which have requested assistance of WHO and/or the Bank in analyzing and preparing for the impact of AIDS.

Missions to occur over the five month period from November 1, 1987 through April 1, 1988.

c. Macroeconomic Policy Paper on Sub-Saharan Africa. Brief paper adding results of first mission to analysis of issues in the issues paper and concluding with preliminary estimates of the costs of AIDS to African countries. To contribute to the

macroeconomic policy paper on Sub-Saharan Africa by Stanley Please.

Preliminary Draft: December 15, 1987

d. Cost-Effectiveness Model. Paper presenting a (possibly computer-based) model for estimating the cost-effectiveness of alternative AIDS prevention and control programs which can be applied in any developing country.

Preliminary Draft: May 15, 1987
Bank and WHO Comments
Final Draft: June 30, 1987

e. Analytical Paper. An analytical paper will be written to assess the economic impact of AIDS on the developing countries, especially in Africa, and to examine the feasibility, desirability and modality of an ongoing Bank role in assisting developing countries to respond to the threat of AIDS. This paper will incorporate the findings of activities b, c and d above.

Preliminary Draft: June 15, 1988
Bank and WHO Comments
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3. To accomplish these tasks, the travel schedule will include:

a. two to four joint Bank-WHO missions, each lasting two to four weeks;

b. two to four months on mission to Geneva collaborating with WHO, beginning with three weeks in the summer of 1987 to write the issues paper.

4. Bank Inputs. It is understood that the Bank economist will have no other assigned duties during this year. He will collaborate with a designated Bank demographer, and will employ approximately 4 staff-weeks of a consultant epidemiologist's time in the development of the cost-effectiveness model. During FY88 he will have the assistance of a Research Assistant who is familiar with computer modelling and is a competent programmer in Basic and/or C on the IBM micro-computer. The Bank will cover all costs of the economists travel to Geneva and on mission to affected countries. The World Health Organization will provide office space in Geneva, will provide input to the formulation of the terms of reference for each joint mission and will make available relevant data on the epidemiology and costs of AIDS.

The World Bank/International Finance Corporation

OFFICE MEMORANDUM

DATE: June 5, 1987

TO: Dean Jamison, Chief, EDTDR

FROM: Mead Over, PHNPR MO

EXTENSION: 61606

SUBJECT: Meeting with Jonathan Mann, Director of WHO Special Programme on AIDS at Washington Hilton, June 5, 1987

1. Jonathan Mann is extremely interested in meeting with you and eventually with Ann Hamilton. He could do so Saturday evening, June 6, 1987, but would much prefer to stop by the Bank at 3:30 PM on the afternoon of Tuesday, June 16, when he will again be in the United States to attend the Tuesday morning sessions of the NCIH conference. The latter date seemed preferable to me as well, partly because I thought that you might want to introduce him to Ann Hamilton also.

2. In our meeting he reiterated two concerns he had expressed to Nancy:

   a. He wants an economist to spend enough time with his team in Geneva to be able to understand and internalize their perspective on the AIDS problem. When I told him of our proposal that 50% of the time I would not be on mission would be in spent in Geneva, he was quite contented.

   b. He wants analyses and documents to bear the imprimatur (I read "clearance") of BOTH the Bank and WHO. Other than by assuring him that I would want to work closely with his team, I did not commit myself. I certainly hope that there will be no irreconcilable differences in approach, but I don't think we should give away our negotiating position up front.

3. With regard to focus and methodology, he expressed priority interest in estimating the direct costs. Such direct costs, in WHO's view, should include the upstream costs of incremental drug utilization by AIDS patients who have not yet been hospitalized or perhaps even diagnosed. He is happy to add to these direct cost estimates, the indirect costs provided that they can be estimated as well. With respect to performing cost-effectiveness analysis of alternative approaches, he said that WHO is still in the process of defining its "package", and that input would be possible, at least until that process is finished. I fear that once the package is defined, there will be less openness to alternative programs, even if more cost-effective.

4. With regard to logistics, he promised to provide secretarial support in Geneva. He said that he would much prefer that the Bank provide all the resources for the missions. The missions would be joint WHO/Bank missions in response to requests received by his program. I was surprised to learn that, to this point, requests have only been received from Kenya and Brazil, but others are expected. The understanding would be that I and any other mission members would be assisting a country team, which would, in turn, provide support, research assistance, etc..

The World Bank/International Finance Corporation

O F F I C E M E M O R A N D U M

DATE: June 9, 1987

TO: Distribution List

FROM: Mead Over, PHNPR

EXTENSION: 61606

SUBJECT: AIDS: A Brown Bag Lunch to Discuss Coordination Between the Bank and WHO Concerning Research on AIDS in Central Africa

1. Dean Jamison has asked me to organize a brown bag lunch to discuss the above topic in room N-255 from 1:00 PM to 2:30 PM on Friday, June 12. We hope you can attend.

2. Please find attached a copy of a first draft of terms of reference, which will describe my activities as the economist provided by the Bank to the WHO group charged with the analysis of the impact of AIDS.

Distribution List:

David de Ferranti, WUDOD
Jean Louis Lambouray, PHND2
Dean Jamison, EDTDR
Alain Colliou, EAPED
Anthony Measham, PHNDR
Randy Bulatao, PHNPR
Ishrat Husain, PHND2
Ramgopol Agarwala, SOA

The World Bank/International Finance Corporation

OFFICE MEMORANDUM

DATE: June 4, 1987

TO: Nancy Birdsall, Chief, PHNPR; Dean Jamison, Chief, EDTDR

FROM: Mead Over, PHNPR MO

EXTENSION: 61606

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WHO
Special Program on Aids

II Programme Goals

- to prevent HIV transmission
- to reduce morbidity and mortality associated with HIV infection

III Programme Strategies

The conceptual framework for the Programme is contained in the six strategies listed below. Annex II provides a more detailed breakdown of ongoing and foreseen activities for each of these strategies during 1987-1989 and Annex III provides information on the associated performance indicators to be used.

1. Prevention of sexual transmission

Worldwide, sexual transmission accounts for the majority of HIV infections. Sexual transmission of HIV can occur from any infected person to his or her sexual partner. Prevention of sexual transmission will require education and information leading to long-term changes in sexual behaviours.

2. Prevention of transmission through blood

Prevention of transmission through blood transfusion

In many parts of the industrialized world, all blood for transfusion is now screened for HIV antibodies. In these areas, two challenges remain:
(a) monitoring for newly detected human retroviruses; and (b) developing increasingly sensitive and specific tests for HIV in blood.

However, throughout most of the developing world, blood for transfusion is not screened for HIV antibodies. The technology to prevent HIV infection through blood transfusion exists, but it must be applied wherever in the world it is needed. In areas where HIV infections are epidemic, screening of blood is an urgent priority.

Prevention of transmission through blood products

Techniques to ensure safety of blood products have been developed. However, monitoring the safety of these products remains important, along with development of methods to further increase safety.

Prevention of transmission through injections and skin-piercing instruments

HIV transmission through these routes is important in three distinct settings:
(a) intravenous drug abuse; (b) injections and use of other instruments in medical practice; (c) injections and use of other instruments outside medical practice.

HIV has demonstrated potential to create explosive epidemics among communities of intravenous drug users. Intravenous drug users are not only epidemiologically important in themselves, but also may provide a "bridge" for HIV sexual transmission to the general population.

While HIV can be readily inactivated using specific chemicals or heat, tremendous efforts will be required to ensure the sterility of equipment for all injections or other uses of skin-piercing instruments in medical practice.

Outside the established medical practice system, injections and other skin-piercing practices appear to be frequent. The safety of injections and other practices performed outside the medical system must also be assured.

Prevention of transmission through organ and semen donation

Transmission through organ or semen donation can be prevented with existing HIV screening and detection technology.

3. Prevention of perinatal transmission

Perinatal transmission follows infection of women of childbearing age, usually through heterosexual spread. Pregnancy may accelerate the progression to AIDS in women already infected with HIV. In addition, approximately half of the infants born to HIV-infected women will be infected before, during, or shortly after birth.

4. Prevention of transmission from HIV-infected persons through use of therapeutic agents

Drugs may be discovered that can eliminate HIV or at least reduce the amount of HIV in the body. If such drugs were discovered and developed, the contagiousness of HIV-infected persons could be reduced or eliminated.

5. Prevention of HIV transmission through the development and delivery of vaccines

A vaccine capable of protecting against HIV infection would be the ideal prevention technology.

6. Reduction of impact of HIV infection on individuals, groups and societies

The psychological, family, economic, cultural, social and political impacts of HIV are enormous. Persons already HIV infected, with or currently free of clinical illness, must be assisted, along with their sexual partners, households, and others in their environment. The morbidity and mortality from HIV infection must be reduced.

Fig. 1 **Organizational Chart of the WHO Special Programme on AIDS**

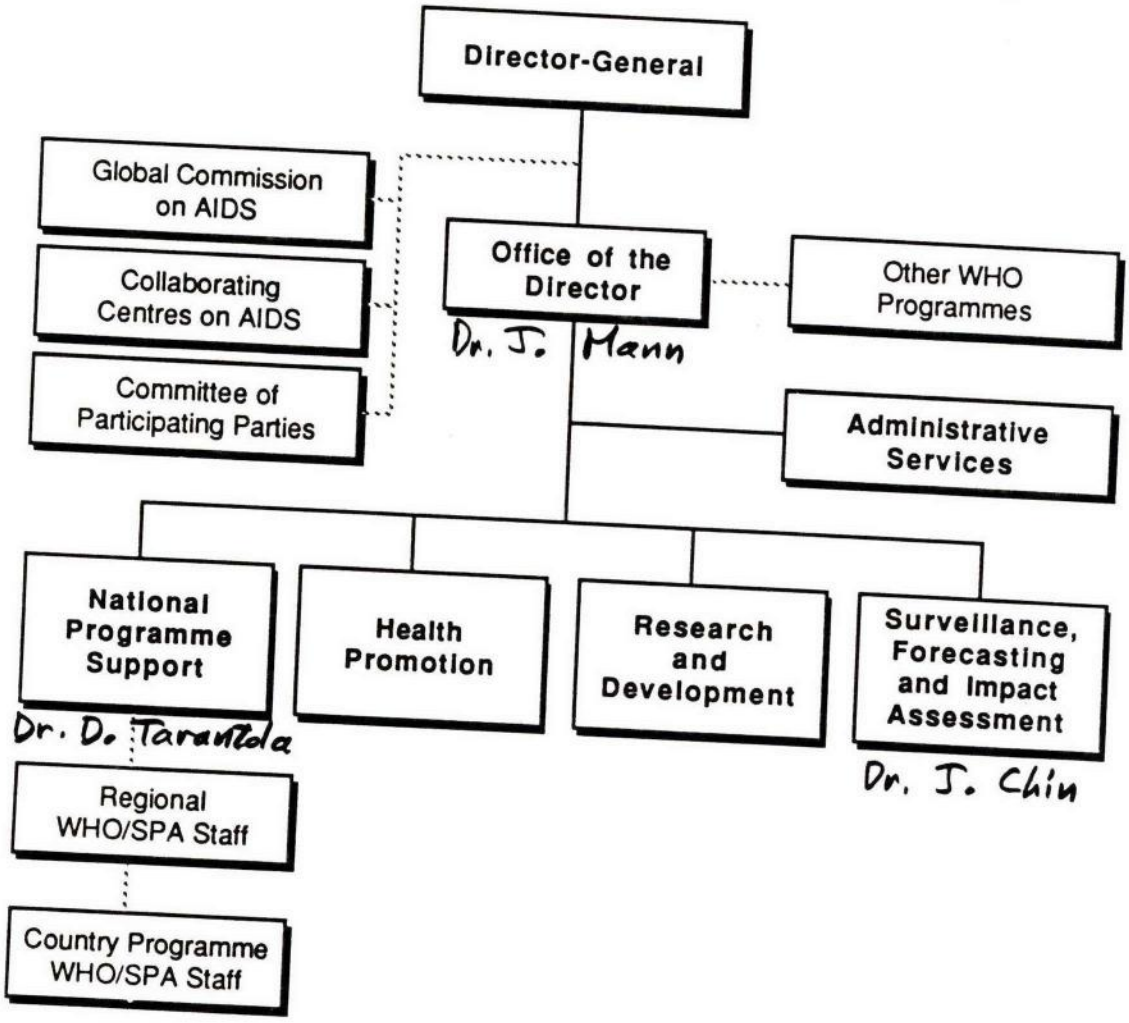
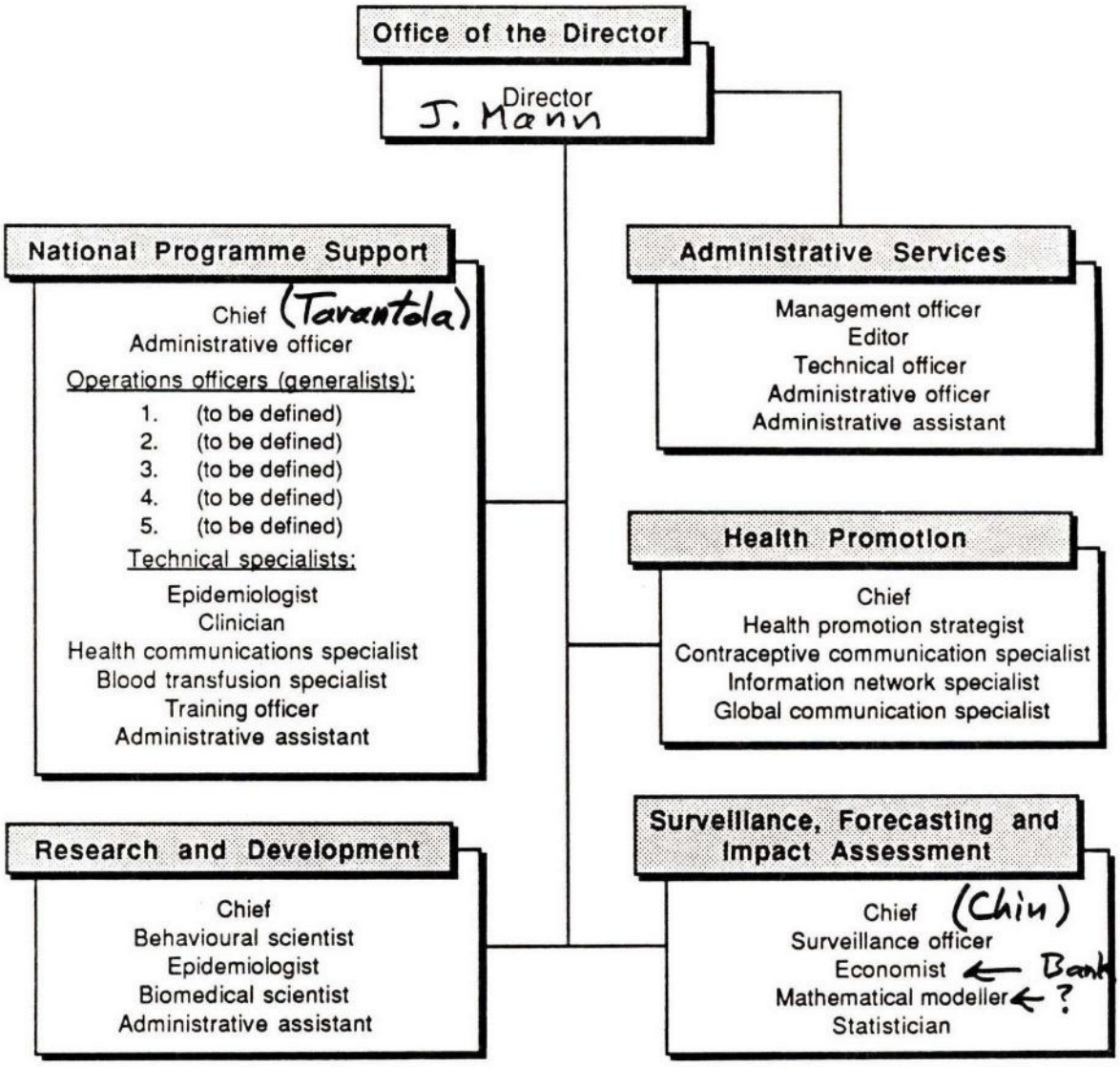


Fig. 2 **Provisional Staffing Requirements for Optimal Programme Support at Headquarters**



Secretarial staff for the Programme will be recruited on the basis of a 2:3 ratio.

Focus and Functions of Organizational Components

1. National programme support

Focus: To provide technical assistance and financial support to Member States in the planning, design, implementation, strengthening, monitoring and evaluation of all components of national AIDS programmes.

Functions:

(1) Develop generic guidelines, for national and local adaptation, on the prevention and control of HIV infection.

(2) Develop generic guidelines for, and assist in the development of, national AIDS programme plans.

(3) Provide technical, financial and operational support to develop, strengthen and maintain:

- national AIDS committees, task forces and other planning and coordinating bodies and mechanisms;
- national epidemiological assessment and surveillance of AIDS;
- national assessment of human and technical resources currently and potentially available to the AIDS programme;
- laboratory diagnostic capabilities, including equipment, supplies, training and meeting of recurrent costs;
- education and training of health workers at all levels;
- programmes for counselling of HIV-infected persons;
- programmes for medical management and psychosocial assistance to HIV-infected persons;
- targeted communication and education interventions for risk groups and the general public;
- national systems for procurement and distribution of technologies to prevent HIV transmission;
- blood screening, collection and transfusion systems;
- evaluation of blood donor referral mechanisms and appropriate donor counselling techniques;

- systems to ensure appropriate use of injection equipment and other skin-piercing instruments, including educational strategies directed towards practitioners, high risk groups and the general public;

- monitoring, training, supervision and counselling mechanisms for reduction of perinatal HIV transmission;

- monitoring and evaluation systems for tracking progress of prevention and control activities, including analysis of recurrent costs, and information exchange systems on those activities.

2. Health promotion

Focus: To develop, promote and assist in the design, implementation, monitoring, and evaluation of health promotion interventions which utilize behavioural change strategies and communication techniques.

Functions:

(1) Establish guidelines for health promotion interventions at global, regional and national levels.

(2) Design, develop, support and coordinate targeted communication, social science and audience research.

(3) Design, field test and refine generic models of communication and education systems, strategies, methods and materials.

(4) Design, field test and refine modifications to assure consumer adoption of technologies to prevent HIV transmission, including condoms and viricidal agents.

(5) Design and implement global communication and education strategies and materials.

(6) Design and conduct in-service training for global programme staff in communication and education strategies and processes.

(7) Monitor and evaluate the effectiveness of ongoing behaviour change, communication and education activities; and revise strategies, methods and materials accordingly.

(8) Identify and coordinate experts relevant to communications strategies including experts in social sciences, social marketing, health education and advertising.

(9) Develop, coordinate and support the monitoring, evaluation, and active exchange of communication, education and research strategies, models and prototype materials.

(10) Develop generic strategies and prototype materials for counselling of HIV-infected persons and their sexual partners, families, and other relevant groups.

3. Research and development

Focus: To coordinate, promote and support biomedical, epidemiological, social, behavioural and operational research and development.

Functions:

(1) Establish, support and coordinate mechanisms that will ensure international scientific collaboration and social and ethical acceptability in the design, implementation, monitoring and analysis of:

- vaccine trials in humans;
- therapeutic agent field trials.

(2) Stimulate, support and coordinate research to:

- determine the nature, extent, risk factors and efficiency of all modes of HIV transmission;
- describe the natural history of HIV infection, especially among mothers, infants and children;
- develop and assess case definitions for AIDS and HIV-associated conditions;
- improve medical management of HIV-infected persons;
- develop and evaluate counselling strategies;
- determine co-factors for expression of HIV disease;
- evaluate the epidemiology and natural history of HIV-associated neurological disease;
- identify and evaluate other, as yet unreported health consequences of HIV infection.

(3) Assess, stimulate, coordinate and/or support the development and improvement of:

- HIV laboratory screening techniques;
- technologies, including condoms, viricidal agents, and single-use syringes, designed to prevent HIV transmission.

(4) Assess the current state-of-knowledge and support new social, behavioural and operational research relevant to:

- all risk factors and their relative importance in HIV transmission;
- sexual transmission of HIV and the development of appropriate health promotion and product strategies;

- blood collection, screening and transfusions systems;
- injection and other skin-piercing practices in medical and non-medical settings;
- health-care and behavioural practices related to perinatal HIV transmission;
- counselling strategies and programmes.

(5) Develop a WHO-coordinated bank for HIV and related retroviruses, serum, and related reagents.

(6) Develop recommendations for the production of, and standards for, vaccines and priority therapeutic agents.

(7) Develop scientific criteria and standards for heat inactivation, chemical treatment, and serological testing of blood products.

(8) Review manufacturing protocols for blood products according to WHO standards, and provide guidance to importing countries.

4. Surveillance, forecasting, and impact assessment

Focus: To promote, support and coordinate the data collection and analysis designed to describe current and future HIV infection trends, their social, economic and demographic impacts, and implications for interventions.

Functions:

(1) Maintain a global epidemiological surveillance system for HIV infection and associated morbidity and mortality.

(2) Stimulate, coordinate and support the design, implementation and analysis of surveys and other studies of the social, economic and demographic impact of HIV infection.

(3) Stimulate, coordinate and support development and use of mathematical models for prediction of spread of HIV infection, and associated social, economic and demographic impact.

(4) Incorporate model-derived information to evaluate and refine strategies for limiting spread and impact of HIV infection.

Progress Report Number 1: 4/87

Part I

Support to National AIDS Programmes

Every country in the world needs a National AIDS Prevention and Control Programme.

The Special Programme on AIDS (SPA), in close association with regional offices, has thus far provided over 75 consultant visits and US $5.6 million to support and strengthen national AIDS programmes.

Collaboration with a Member State begins promptly after preliminary discussions between the Ministry of Health, the Regional Office and SPA. The initial phases of SPA/WHO support follow a logical, yet pragmatic and flexible sequence:

WHO action course

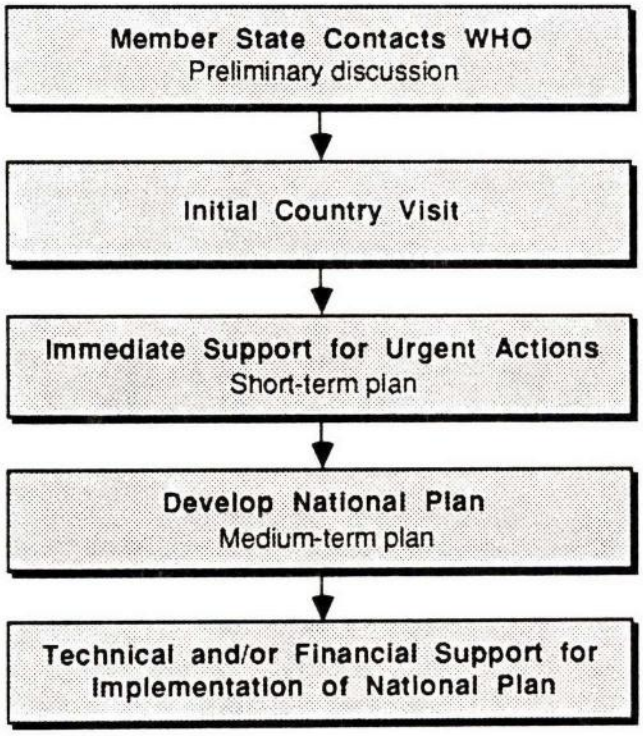


Table 1 SPA/WHO collaboration with Member States to support national AIDS programmes

(as of 15 April 1987)

■ Completed □ Under way or planned

Country	Initial visit	Immediate support	Short-term plan	Medium-term plan
Argentina	■	□		
Benin	□			
Brazil	■	■	■	□
Burundi	□			
Cameroon	■	□	■	□
Cape Verde	□			
Caribbean Islands (through CAREC*)	■	■	■	
Central African Republic	■	□	□	
Congo	■	□	■	□
Côte d'Ivoire	□			
Dominican Republic	□			
Egypt	□			
Ethiopia	■	■	■	□
Gabon	□			
Ghana	□			
Guinea	□	□		
Guinea-Bissau	□	■		
Haiti	■	■	■	
Jordan	□			
Kenya	■	■	■	■
Kuwait	■			
Liberia	■	□	■	□
Mali	□			
Mauritius	■	□	■	□
Mexico	■	■	■	
Mozambique	■	□	■	□
Niger	□			
Nigeria	■	□	■	□
Rwanda	□			
Senegal	□			
Sudan	□			
Swaziland	□			
Syrian Arab Republic	□			
Togo	□			
Uganda	■	■	■	■
United Republic of Tanzania				
Mainland	■	□	■	■
Zanzibar	□			
Venezuela	□			
Zaire	■	□	■	□
Zambia	■	■	■	■

* **Caribbean Epidemiology Centre** (Anguilla, Antigua and Barbuda, Bahamas, Barbados, Belize, Bermuda, British Virgin Islands, Cayman Islands, Dominica, Grenada, Guyana, Jamaica, Montserrat, Saint Christopher and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Turks and Caicos Islands)

Table 2 SPA/WHO Laboratory Workshops on HIV Antibody Screening, 1986-87

Region	Date	Location	Countries Represented	Number of Participants
Africa				
	17-22 Nov 1986	Kigali, Rwanda	Burundi, Cameroon, Central African Republic, Congo, Gabon, Rwanda, Zaire	16
	8-13 Dec 1986	Dar-es-Salaam, Tanzania	Ethiopia, Kenya, Tanzania, Uganda, Zambia, Zimbabwe	15
	2-7 Feb 1987	Accra, Ghana	Ghana, Liberia, Nigeria, Sierra Leone	13
	4-9 May 1987	Nairobi, Kenya	Angola, Botswana, Ethiopia, Gambia, Kenya, Mozambique, Swaziland	16
	22-27 June 1987	Lagos, Nigeria		18
	2-7 Nov 1987	Abidjan, Côte d'Ivoire	Benin, Burkina Faso, Côte d'Ivoire, Chad, Togo	12
	9-14 Nov 1987	Dakar, Senegal	Algeria, Mali, Mauritania, Niger, Senegal	12
Americas				
	3-7 Nov 1986	Rio de Janeiro, Brazil	Brazil, Cuba, Colombia, Honduras, Mexico, Panama Paraguay, Peru, Venezuela	15
South-East Asia				
	16-20 June 1986	New Delhi, India	India	20
	15-20 Dec 1986	Bangkok, Thailand	India, Indonesia, Maldives Nepal, Thailand	8
	Nov 1987	Under discussion		

(Cont.)

Progress Report Number 1 : April, 1987

Surveillance, forecasting and impact assessment

Surveillance

A weekly update of the AIDS case report to WHO is prepared and distributed. As of December 1982, only 711 AIDS cases had been reported to the World Health Organization from 16 countries. However, by 1 April 1987, 45,700 AIDS cases were reported to WHO from 104 countries representing all continents (Figs. 1 and 2). An additional 29 countries have informed WHO that they have no cases to report.

A reporting form which includes the age and sex of AIDS cases, clinical diagnosis and broad risk groups has been provided to all Member States. Reticence in reporting of cases from some areas, combined with under-recognition of AIDS and under-reporting to national health authorities, has meant that the number of reported AIDS cases represents only a fraction of the total cases to date, which are estimated to exceed 100,000. WHO considers the number of countries reporting AIDS to be more indicative of the geographical extent and more relevant to an assessment of the scope of the HIV pandemic than the number of cases reported.

Predictive modelling and impact assessment

SPA is planning a series of seminars and meetings to develop and improve predictive modelling capabilities, by bringing together modellers, epidemiologists, virologists and representatives of other relevant disciplines.

The need for accurate estimates of national HIV seroprevalence has stimulated preparations for a meeting in Geneva to develop alternative strategies for collection and analysis of these data.

In order to evaluate the direct medical care costs for AIDS patients in the developing world, a collaboration with the World Bank is planned.

The demographic impact of HIV infection may be substantial. Strategies to assess and predict this impact, under development by USAID, will be evaluated for possible application in national and regional analyses.

The World Bank/International Finance Corporation

OFFICE MEMORANDUM

DATE: June 4, 1987

TO: Nancy Birdsall, Chief, PHNPR; Dean Jamison, Chief, EDTDR

FROM: Mead Over, PHNPR MO

EXTENSION: 61606

SUBJECT: Cooperation between The Bank and WHO on Analysis of Economic Impact of AIDS

1. At the request of Nancy Birdsall and Dean Jamison, this memorandum records my understanding of the agreement reached between the Bank, represented by Nancy Birdsall and John North, and the World Health Organization, represented by Jonathan Mann, regarding the Bank's participation in a joint Bank-WHO effort to develop a program to address the spread of AIDS in the developing countries.

2. The Bank will provide for one year beginning July 1, 1987, a health economist, myself, to develop and apply a methodology for evaluating and comparing the cost-effectiveness of alternative AIDS prevention and control programs. The specific products of the work program will be:

a. Issues Paper. Will define the issues to be addressed and the methods to be used in analyzing the cost-effectiveness of alternative AIDS prevention and control programs.

Preliminary Draft: September 30, 1987
Bank and WHO comments: October 15, 1987
Final Draft: October 30, 1987

b. Technical Assistance Missions. Back-to-office reports on each of several missions to countries which have requested assistance of WHO and/or the Bank in analyzing and preparing for the impact of AIDS.

Missions to occur over the five month period from November 1, 1987 through April 1, 1988.

c. Macroeconomic Policy Paper on Sub-Saharan Africa. Brief paper adding results of first mission to analysis of issues in the issues paper and concluding with preliminary estimates of the costs of AIDS to African countries. To contribute to the

macroeconomic policy paper on Sub-Saharan Africa by Stanley Please.

Preliminary Draft: December 15, 1987

d. Cost-Effectiveness Model. Paper presenting a (possibly computer-based) model for estimating the cost-effectiveness of alternative AIDS prevention and control programs which can be applied in any developing country.

Preliminary Draft: May 15, 1987
Bank and WHO Comments
Final Draft: June 30, 1987

e. Analytical Paper. An analytical paper will be written to assess the economic impact of AIDS on the developing countries, especially in Africa, and to examine the feasibility, desirability and modality of an ongoing Bank role in assisting developing countries to respond to the threat of AIDS. This paper will incorporate the findings of activities b, c and d above.

Preliminary Draft: June 15, 1988
Bank and WHO Comments
Final Draft: June 30, 1988

3. To accomplish these tasks, the travel schedule will include:

a. two to four joint Bank-WHO missions, each lasting two to four weeks;

b. two to four months on mission to Geneva collaborating with WHO, beginning with three weeks in the summer of 1987 to write the issues paper.

4. Bank Inputs. It is understood that the Bank economist will have no other assigned duties during this year. He will collaborate with a designated Bank demographer, and will employ approximately 4 staff-weeks of a consultant epidemiologist's time in the development of the cost-effectiveness model. During FY88 he will have the assistance of a Research Assistant who is familiar with computer modelling and is a competent programmer in Basic and/or C on the IBM micro-computer. The Bank will cover all costs of the economists travel to Geneva and on mission to affected countries. The World Health Organization will provide office space in Geneva, will provide input to the formulation of the terms of reference for each joint mission and will make available relevant data on the epidemiology and costs of AIDS.

FORM NO. 75
(6–83)

THE WORLD BANK/IFC

Responded 4/21 Adm.

ROUTING SLIP	DATE: 4.20.8
NAME	ROOM NO.
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	APPROPRIATE DISPOSITION		NOTE AND RETURN
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	CLEARANCE		PER OUR CONVERSATION
	COMMENT		PER YOUR REQUEST
	FOR ACTION		PREPARE REPLY
	INFORMATION		RECOMMENDATION
	INITIAL		SIGNATURE
	NOTE AND FILE		**URGENT**

REMARKS:

FROM:	ROOM NO.:	EXTENSION:

WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

A40/5

27 March 1987

FORTIETH WORLD HEALTH ASSEMBLY

Provisional agenda item 18.2

WHO SPECIAL PROGRAMME ON AIDS

Report by the Director-General

The pandemic of human immunodeficiency virus (HIV) infection, including the acquired immunodeficiency syndrome (AIDS), represents an unprecedented and urgent challenge to international public health. In May 1986, in resolution WHA39.29, the Thirty-ninth World Health Assembly requested the Director-General to explore ways of increasing WHO's cooperation with Member States in combating AIDS, to seek extrabudgetary resources for this purpose, and to report on progress to the Fortieth World Health Assembly. In January 1987, at its seventy-ninth session, the Executive Board supported the priority accorded by WHO to this global health problem, and on 1 February the Director-General established the WHO Special Programme on AIDS. This report updates the Director-General's report to the seventy-ninth session of the Board (document EB79/12) regarding HIV, AIDS and prevention and control activities undertaken by WHO.

INTRODUCTION

1. As of 26 March 1987, 45 597 AIDS cases had been reported to WHO. The current number of reported cases from many areas of the world, however, does not reflect the actual AIDS situation. A total of 130 countries reported on AIDS, of which 101 reported cases. In the following table the figures are compared with those reported to the Thirty-ninth World Health Assembly:

	26 March 1987			25 March 1986		
Continent	Cases	Countries Reporting	Countries Reporting 1 or more cases	Cases	Countries Reporting	Countries Reporting 1 or more cases
Africa	3 531	36	22	31	5	2
Americas	36 782	45	39	19 756	43	32
Asia	112	19	12	46	10	6
Europe	4 732	27	26	2 053	23	20
Oceania	440	3	2	183	2	2
	45 597	130	101	22 069	83	62

2. The name "human immunodeficiency virus" (HIV) recommended by the International Committee on Taxonomy of Viruses for the etiological agent of AIDS - previously referred to as lymphadenopathy-associated virus/human T-lymphotropic virus, type III (LAV/HTLV-III) - has been adopted by WHO.

3. Additional human retroviruses have been identified, principally in west Africa. A virus identified by French researchers as lymphadenopathy-associated virus, type 2 (LAV-2) was isolated from persons originating from west Africa and having clinical and immunological features typical of AIDS. A virus identified by United States researchers as human T-lymphotropic virus, type 4 (HTLV-4) was isolated from asymptomatic persons in west Africa. These two viruses appear quite similar to each other, are both distinctly different from HIV, and appear antigenically closer to the simian immunodeficiency virus (STLV-III) than to HIV. Seroepidemiological studies suggest that LAV-2 or HTLV-4 antibodies are present in a small percentage of healthy subjects in several west African countries.

4. The number of countries in Africa reporting on AIDS to WHO has increased substantially. National and international collaborative studies have established the basic features of AIDS and HIV epidemiology in Africa, including the knowledge that transmission occurs in the same manner as in other parts of the world (sexual, parenteral, perinatal). The primacy of bidirectional heterosexual transmission (male to female; female to male) in the epidemiology of AIDS in Africa is also accepted. Additional studies have established the importance of blood transfusions and injections with non-sterile equipment in HIV transmission. Perinatal transmission is also recognized to be important, especially in areas where 5-10% of pregnant women have been recorded as HIV seropositive. There is no epidemiological support for transmission through casual contacts (including within households), and there is considerable epidemiological evidence against the hypothesis of insect vector transmission of the disease. While the precise extent of HIV within Africa is not yet known, central, eastern and parts of southern Africa appear most affected, and western Africa appears less affected. The actual number of HIV-infected persons or AIDS cases is not known. An estimate of one million infected persons (with an extrapolated estimate of an annual incidence of at least 10 000 AIDS cases) has been advanced, but is considered a minimum by some scientific observers.

5. In the Americas (as in Europe and Australia) the basic epidemiological patterns have not changed during the past year, and cases occur mainly among young (20-49 year old) homosexual or bisexual men and intravenous drug users. However, the estimate of the proportion of cases of AIDS acquired through heterosexual contact has increased from 1 to approximately 4%. The United States Public Health Service has estimated that, by 1991, 270 000 cases of AIDS will have occurred in the USA (more than 8 times the approximate 32 000 reported cumulatively since the beginning of the epidemic); the majority are expected to occur in persons already infected with HIV. AIDS cases have been reported from 39 countries in the Americas in addition to the USA, with the largest numbers from Brazil, Canada, Haiti, Mexico, Trinidad and Tobago, and the Dominican Republic.

6. In Central and South America the epidemiological picture is dominated by the "western" pattern, involving homosexual/bisexual men and intravenous drug abusers. However, in Haiti an increasing number of cases apparently associated with heterosexual transmission have been reported; the male/female AIDS case ratio is currently about 3:1 (compared with ratios of 10:1 or greater in the USA, Europe and Australia). It is believed that the situation may be similar in other parts of the Caribbean area.

7. In Europe most countries are now considered to be facing an epidemic situation. Throughout Europe an estimated 500 000 to one million persons may be infected with HIV. The highest rates (cumulative cases of AIDS per million population) have been reported from: Switzerland (30.1), Denmark (25.6), France (22.3), and Belgium (20.9). The percentage of cases originating from Africa or the Caribbean has decreased (now about 8% of all reported cases), while that of cases associated with intravenous drug abuse is increasing rapidly (from 5% in June 1985 to 12% in October 1986). This phenomenon has been noted particularly in southern Europe. On the basis of current trends, between 25 000 and 30 000 cases of AIDS are expected to have occurred in Europe by the end of 1988.

8. Relatively few AIDS cases have been reported in Asia, and most of those confirmed have been associated with exposure to blood products or persons of western origin. However, serological evidence of HIV infection has been detected in male and female prostitutes in several countries and indigenous HIV transmission has been recorded. Seroepidemiological studies suggest that, so far, HIV has not widely penetrated the general population.

9. In Oceania the 440 cases were from Australia (407) and New Zealand (33), and were typical of the "western" epidemiological pattern.

10. Earlier estimates of the rates of progression from asymptomatic HIV infection to AIDS and other AIDS-related syndromes have been revised upwards. On the basis of current information it appears that 10% to 30% of HIV-infected persons will develop AIDS and 25% to 50% more will develop AIDS-related syndromes during a five-year period. The annual risk of progressing from asymptomatic HIV-infected to AIDS appears to increase with time (i.e. the risk during the fifth year of infection appears greater than the risk during the second year). These current data suggest that the majority of HIV-infected persons may develop AIDS during the first 10 years after HIV infection and that the remainder may have AIDS-related syndromes.

11. HIV is neurotropic. The precise cellular element(s) infected are not fully understood, although mononuclear and multinuclear macrophages appear to support replication of HIV within the brain. HIV affects the neuraxis at all levels, resulting in clinical disorders involving the central and peripheral nervous systems. Approximately one-third of AIDS patients have clinical neurological findings attributable to HIV infection itself, rather than to opportunistic infections affecting the nervous system. The major clinical syndromes associated with HIV neurological infection include: subacute encephalopathy with progressive dementia, aseptic meningitis, encephalitis, and peripheral neuropathy. Given HIV's virological similarities with the lentiviruses (e.g. Visna virus), the occurrence of an epidemic of neurological disorders principally involving dementia among HIV-infected persons is considered possible during the next decade.

12. A recent clinical treatment trial among AIDS patients found that Zidovudine (Azidothymidine or AZT) prolonged life and was associated with clinical and immunological improvement. There were, however, side-effects, including bone marrow suppression. Longer-term benefits and risks are currently unknown. It may nevertheless represent the first major step towards the eventual development of safe and effective therapeutic agents. A pharmaceutical company has advised WHO that it is using WHO official statistics on AIDS as a basis for allocation between countries of available supplies of AZT after product registration. Analogues of Zidovudine (e.g. Dideoxycytidine) are under evaluation; it is hoped that they may offer increased antiviral efficacy with less toxicity. In addition, preliminary data suggest that the antiviral agent Ribavirin may prevent progression to AIDS among patients with lymphadenopathy syndrome.

13. Several prototype vaccines have reached the stage of immunogenicity and challenge testing in chimpanzees. Chimpanzees can be infected with HIV but do not demonstrate AIDS-like illnesses. Clinical studies (phase I) for several prototype vaccine preparations will start during 1987. Current scientific consensus, however, is that no vaccine will be available for widespread human use for at least five years. In addition, since no vaccine has ever been prepared against a human retrovirus, several retrovirologists have raised the possibility that the vaccines currently under development may not be protective.

WHO SPECIAL PROGRAMME ON AIDS

14. The pandemic of HIV infection poses an unprecedented and urgent challenge to international public health. In January 1987, at its seventy-ninth session, the WHO Executive Board supported the priority accorded by WHO to activities for the prevention and control of AIDS. The WHO Special Programme on AIDS was formally established by the Director-General on 1 February 1987. An unprecedented and coordinated global response is urgently required, in view of:

(a) The magnitude of the epidemic. The current magnitude of the HIV pandemic and its broad impact have been seriously underestimated. Further global spread and increase in HIV infection are certain to occur, and the evolution of the HIV pandemic cannot be accurately predicted.

(b) The outcome of HIV infection. The adverse health effect of HIV infection is of profound importance to the individual, the family and society. HIV infections threaten the health gains which had been projected in the developing world.

(c) The social impact of HIV. The personal, social and economic costs of the HIV pandemic are enormous. It threatens development through its impact on those aged 20 to 40 years and its effects on infant and maternal mortality.

(d) The challenge of prevention and control. International and national HIV control will require long-term efforts and commitment. As neither a vaccine nor therapy for large populations is likely to become available for at least several years, education is the key to preventing further spread. HIV control must be part of primary health care.

15. Available evidence suggests that we are witnessing the beginning of a major pandemic of infection with HIV (and perhaps with related retroviruses). While each feature of HIV is not in itself unprecedented, the combination of features as well as the timing appear to be without precedent. These features include:

(a) infection with HIV appears to be lifelong;

(b) infected persons may be asymptomatic for long periods yet capable of transmitting HIV;

(c) the natural history of HIV infection is not yet fully known, but the "at risk" period for progression to AIDS appears long;

(d) specific treatment (especially for infected persons not yet ill) and vaccine are not available;

(e) HIV is neurotropic and the ultimate burden of neurological pathology in the HIV-infected population is unknown;

(f) HIV is transmitted primarily sexually, from any infected person to his or her sexual partner, but also parenterally;

(g) perinatal transmission occurs, and as many as 50% of babies born to infected mothers may be affected;

(h) HIV-induced immunosuppression can interact with already existing endemic or epidemic diseases in the environment (e.g. tuberculosis);

(i) HIV-related issues have major potential impact in virtually all health areas (e.g. immunization, maternal health, child health, dental care, hospital care, infection control, sexually transmitted diseases, family planning).

The HIV situation therefore calls for extraordinary energy, creativity, and resources. The potential impact of public health interventions at this phase of the HIV pandemic is considerable. A strong emphasis on primary prevention, for individuals and for societies, is warranted.

16. The WHO Special Programme on AIDS has two major tasks:

(a) to support and strengthen national AIDS programmes throughout the world;

(b) to provide global leadership, help ensure international collaboration, and pursue global activities of general value and importance.

17. At the national level a plan of action for AIDS control and prevention is required, including the following major aspects.

(a) Creation of a national AIDS committee (or the equivalent), which is a concrete expression of national commitment to confront AIDS and HIV-associated problems. The committee should include representatives from health, social services, education and other relevant sectors.

(b) Implementation of an initial epidemiological and resource assessment. The initial assessment can be conducted within a relatively brief (four- to eight-week) period. This assessment may involve review and critical analysis of existing data on AIDS and HIV infection collected within the country, or it may require collection and analysis of new information (e.g. AIDS case-finding, seroprevalence surveys of selected populations). The resource/infrastructure assessment should determine the ability of the existing health system to support the epidemiological, laboratory, clinical and prevention components of the national AIDS programme.

(c) Based on findings of the initial epidemiological assessment, a suitable surveillance system should be established to provide timely and useful epidemiological information regarding AIDS and HIV infection to the national committee. In addition, serosurveys may be conducted among designated sectors of the population (e.g. blood donors, prostitutes, patients attending sexually transmitted disease clinics, pregnant women), and specific serological monitoring or other epidemiological studies could be considered.

(d) Laboratory support is required for epidemiological, clinical and prevention activities. On the basis of the initial assessment decisions are made regarding in-country serodiagnostic needs. Laboratory capability would be strengthened in accordance with these requirements.

(e) Education of health care personnel at all levels is important, both for management of patients and other HIV-infected persons, and for public health education.

(f) The principal goal of the national AIDS programme remains the prevention of HIV transmission to uninfected persons and groups. Prevention activities will vary according to national situations, but should in general include consideration of the following broad issues:

(1) sexual transmission: education of identified high risk groups as well as of the general population;

(2) transmission through blood transfusions: review of existing blood transfusion policies and practices; possible implementation of donor education and notification programmes, laboratory screening of donors or donated blood;

(3) transmission through intravenous drug use: education of high risk groups;

(4) transmission through non-sterile injection equipment used for medical purposes by medical or paramedical personnel (including traditional practitioners): education of health providers and of the public, additional assistance in helping to ensure use of sterile injection equipment (or other instruments that pierce the skin);

(5) perinatal transmission: education/counselling approaches; possible screening programmes among certain groups of pregnant women and women of child-bearing age.

(g) Reduction of the impact of HIV infection: the psychological, family, economic, cultural, social and political impacts of HIV infection are enormous - those who are infected, their sexual partners, members of the household and others must be assisted in dealing with the related problems.

18. The strategies, structure and projected needs of the WHO Special Programme on AIDS are detailed in document WHO/SPA/GEN/87.1, issued in March 1987. As part of the structure, the following are proposed with a view to providing additional review, support and guidance to the Programme:

(a) Global Commission on AIDS: to review and interpret global trends and developments related to HIV; to review and evaluate, from a scientific, technical and operational standpoint, the content and scope of the Programme; to advise WHO regarding short-, medium- and long-term priorities in the research and operational components of the Programme;

(b) Committee of Participating Parties: to assist the Director-General by reviewing the progress, plans and budgetary projections of the Programme; and by reviewing other aspects of the Programme, including coordination with other activities and organizations;

(c) Collaborating Centres on AIDS: to form part of an international network providing support services to the Programme.

National programme support

19. WHO has conducted missions to develop collaborative programmes with over 15 Member States. These missions include initial assessments of the AIDS situation, elaboration of action plans for immediate support, and preparatory steps for the formulation of detailed three- to five-year plans. Medium-term plans have been fully developed for three countries. Many further visits are under way or planned.

Implementation of the global programme

20. The work of the Special Programme is carried out in close collaboration with all other relevant activities of the Organization at global, regional and country levels.

21. WHO is working closely with other United Nations agencies in activities for the prevention and control of AIDS - including UNDP, UNESCO, UNFPA, UNICEF, and the World Bank.

22. Working links have also been developed between WHO and other organizations, including the African Medical Research Foundation, Commission of the European Communities, International Council of Nurses, Fondation Mérieux, League of Red Cross and Crescent Societies, Médecins du Monde, Médecins sans frontières, National Council for International Health, Nordic Red Cross Societies, Organization for Coordination and Control of Endemic Diseases in Central Africa, Terre des hommes, World Council of Churches, World Emergency Relief, World Hemophilia AIDS Center.

Exchange of information

23. Updates on AIDS are distributed every three months to regional offices and selected correspondents for further distribution to national levels. This update incorporates the most recent information on virology, immunology, epidemiology, treatment, diagnosis, and vaccine development.

24. Telex messages are sent to regional offices promptly when new information or developments occur (e.g. AZT field trial results, Ribavirin study data).

25. A weekly update of the AIDS cases reported to WHO is prepared and distributed to regional offices and selected correspondents. A reporting form which includes age and sex of AIDS cases, clinical diagnosis and broad risk groups has been provided to all Member States.

26. More than 40 articles on AIDS and related subjects have been published in the Weekly Epidemiological Record since the beginning of 1986.

27. Information regarding legislation and policies introduced by Member States to control spread of HIV is being collected and disseminated upon request. A more formal survey of national legislation in this area has been commissioned.

28. An AIDS press kit is prepared and updated frequently. This document is distributed to regional offices and to all ministries of health and permanent missions in Geneva. It serves as the basic source of information for press releases and responses to press inquiries.

29. An extensive series of press contacts (including interviews, preparation of articles, and press conferences) has been developed in order to inform the public regarding the global AIDS situation and the WHO programme. In addition, responses to press inquiries are frequently required (e.g. mosquitos and AIDS, AZT study results, precautions for international travel).

30. Meetings regarding the global AIDS situation have been held with donor agencies and scientific groups in Australia, Canada, Denmark, Finland, France, the Netherlands, Norway, Sweden, the United Kingdom, and the USA.

31. Intercountry consultations involving an extensive exchange of information have been held in the African, South-East Asia, European and Eastern Mediterranean Regions.

32. WHO co-sponsored the 1986 International Conference on AIDS in Paris, and is co-sponsor of the 1987 Conference in Washington.

Preparation and distribution of guidelines

33. Guidelines[1] for the prevention and control of infection with LAV/HTLV-III (HIV), issued in May 1986, are currently under review. These guidelines cover: precautions for health care workers, providers of pre-hospital emergency care, and laboratory staff;

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[1] Document WHO/CDS/AIDS/86.1.

management of parenteral and mucous membrane exposures; considerations relevant to personal service workers, food service workers and workers sharing the same work environment; prevention of parenteral transmission through blood and blood products; and disinfection and sterilization, including commonly available disinfectants, sterilization and processing of needles and syringes. Additional guidelines - inter alia, for the prevention of sexual transmission of HIV - are being prepared.

34. A Meeting on Educational Strategies for the Prevention and Control of AIDS was convened by WHO (Geneva, 17-19 June 1986); 11 participants from five countries met for discussions focusing on the prevention of sexually acquired HIV infection. It recommended that WHO disseminate promptly current knowledge concerning AIDS, simultaneously promoting a better understanding of ways of achieving widespread and sustainable changes in sexual practices. It strongly supported WHO's role in developing educational strategies for AIDS prevention and control, including research on prevention strategies, developing links with organizations and disciplines with experience in public health communication strategies, and assisting national programmes in adapting potential communication technology and strategies to their needs.

35. Guidelines have been prepared regarding HIV infections and immunization within the framework of WHO's Expanded Programme on Immunization, emphasizing that adherence to recommended practices regarding sterilization of reusable needles and syringes will eliminate any risk of HIV transmission through immunizations. A joint WHO/UNICEF statement on immunization and AIDS was issued in February 1987.[1] In addition, guidelines have been prepared within the framework of the maternal and child health programme regarding the theoretical concern about transmission of HIV from infected mothers to children through breast-feeding. They stress the need to maintain current breast-feeding policies while awaiting results of studies to clarify the respective roles of intrauterine, peripartum and breast-feeding periods in perinatal HIV transmission.

36. A clinical manual on AIDS in Africa is being prepared for widespread distribution.

37. Messages for the general public regarding AIDS prevention are also being developed.

38. A consultation on guidelines for counselling of HIV-infected persons and AIDS patients is to be held in Geneva in April to design a series of generic guidelines in a way that will permit their adaptation to local situations, needs and traditions.

Advice on international travel

39. Three issues were addressed at a consultation on international travel and HIV (Geneva, 2-3 March 1987): whether international travellers should be screened for HIV, whether the travel of HIV-infected persons by public conveyance should be restricted, and the formulation of recommendations for international travellers on the prevention of HIV infection. It was concluded that:

(a) at best and at great cost, the screening of international travellers would only briefly retard HIV from spreading, whether regarded from the global or the national perspective. Serious logistic, epidemiological, economic, legal, political and ethical problems would be inherent in any proposal for such screening, which would have to involve both national and foreign entrants. The diversion of resources from educational programmes and measures to protect the blood supply is not justified.

(b) there is no reason to prevent HIV-infected persons from using trains, buses, airplanes, cars, or ships, since there is no risk for others of infection from sharing the same conveyance.

(c) the routes of transmission, the behaviour that puts an individual at risk, and the preventive measures are the same, regardless of whether the individual is travelling or remains in one country. Educational material should be made available to international travellers, to increase their awareness of how HIV is transmitted and how it can be prevented.

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[1] Weekly Epidemiological Record, 62: 53-54 (1987).

Test kits and reagents

40. A Meeting of Manufacturers of AIDS Test Kits was convened by WHO in Geneva on 31 January 1986. Existing technology for HIV antibody detection was reviewed, and manufacturers were requested to remain in close contact with WHO regarding new developments, especially concerning technology more adapted to conditions in developing countries.

41. Test kits produced by 13 manufacturers were evaluated by the network of WHO collaborating centres on AIDS, using a panel of reference sera.

42. A letter was sent to manufacturers of test kits in October 1986 indicating WHO's strong interest in the development and evaluation, including field testing, of HIV antibody detection methods that are fully adapted to conditions in the developing world. WHO expressed its willingness to assist in the coordination of evaluation and field testing, and two manufacturers have been working with WHO in this regard.

43. WHO reference sera from patients in Europe and the USA have been made available on request to national laboratories for evaluation of antibody tests. A global serum bank, including sera from HIV-infected persons in Africa and other regions, has been established to ensure that an adequate sample of internationally representative sera is available for the evaluation of new techniques. WHO sera panels are also being prepared.

44. A WHO-coordinated bank for HIV and related retroviruses is being established to ensure that a collection of well characterized viral strains, geographically and temporally representative of the global situation, will be available.

45. Ten workshops on screening for antibodies to HIV were held during 1986 (two in the African Region, one in the Region of the Americas, two in the South-East Asia Region, two in the European Region (for African participants), and three in the Eastern Mediterranean Region). More than ten laboratory workshops are being held in 1987.

Advice regarding blood and blood products

46. As part of the follow-up to the meeting of experts on blood and blood products (April 1986), detailed recommendations were published in the Weekly Epidemiological Record regarding, inter alia, information of the public concerning the risk of infection, donor education, and testing of blood donations for antibodies.[1]

47. At a meeting on HIV-related retroviruses (see paragraph 51, below), it was recommended that Member States take into account the epidemiology of the newly identified retroviruses (LAV-2 and HTLV-4) when establishing and reviewing country or regional blood donor screening policies.

48. A number of important issues in this area emerged during the discussions of the Programme Committee of the Executive Board in October 1986. The Committee recognized that highly complex and sensitive issues were involved for which there were no easy solutions. In developing countries the lack of technical expertise, limited financial resources and inadequate infrastructures all contributed to the major difficulties encountered in ensuring the rational and optimal use of blood. WHO should concentrate on helping its Member States to build up their transfusion policies and services on the basis of this information. This could best be achieved by mobilizing enlightened bilateral and multilateral support.

49. Discussions have been held with national health authorities, the League of Red Cross and Red Crescent Societies, national Red Cross societies, and representatives of bilateral assistance agencies regarding the need to establish blood-screening capabilities in HIV-affected areas of the developing world. The screening of blood for HIV antibodies would immediately prevent a substantial number of new HIV infections in some areas and would assist national health authorities in implementation of a proven method of HIV prevention and control.

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[1] Weekly Epidemiological Record, 61: 138-140 (1986).

Coordination of research

50. A meeting on newly identified HIV-related retroviruses was held in Geneva from 11 to 12 February 1987. The virology, immunology, serodiagnosis, epidemiology and clinical aspects of HIV-related retroviruses, isolated principally in subjects from West Africa, were discussed. It was concluded that the relationship among isolates is not clear and that further research is required. Although the epidemiology is not well defined, the HIV-related retroviruses appear to be transmitted by the same routes as HIV and therefore the same precautions are recommended to prevent infection. It was recommended that WHO should play an active role in the exchange of information and reagents. Specifically, WHO is organizing working groups, to develop criteria that will allow the comparison of HIV-related retroviruses, and to propose a system that will ensure the international exchange of human retroviral reagents, including virus isolates and sera. In collaboration with the governments of countries in West and Central Africa a meeting will be organized on the virology and epidemiology of HIV-related retroviruses and on prevention and control programmes.

51. The designation of a WHO Collaborating Centre on Simian and Related Retroviruses at the Department of Cancer Biology, Harvard School of Public Health (USA) has been proposed to help ensure close communication between WHO and the rapidly evolving field of simian retroviral research.

52. In anticipation of the need for candidate vaccines to be field tested for protective efficacy, Informal Discussions on AIDS Vaccine Efficacy Trials in Human Populations were held in Geneva from 15 to 16 December 1986. The participants agreed that it will be complex, difficult and time-consuming to test candidate AIDS vaccines. If a vaccine becomes available for general use at all it will not be before 1991 and is unlikely to be before the mid-1990s. It was recommended that WHO should establish a mechanism to ensure the open exchange of the scientific, social and ethical information necessary for advance planning and international collaboration in the clinical testing of candidate AIDS vaccines, with particular reference to phase 3 trials.

53. A meeting on the immunology of AIDS, sponsored by WHO and the International Union of Immunological Societies, was held in Geneva from 18 to 19 February 1987. The spectrum of clinical manifestations of infection with HIV and the underlying immunological abnormalities were reviewed. The spectrum of clinical manifestations may reflect different phenotypic responses to HIV infection or different stages in a progression at different rates in different individuals. The nature of the humoral and cellular immune responses against HIV is not well characterized. HIV-infected individuals develop antibodies to multiple viral proteins; however, the neutralizing activity is low in sera from both asymptomatic seropositive individuals and AIDS patients. This suggests that little protection is offered by neutralizing antibodies that develop naturally. Measure of the dimensions of HIV infection should advance with the introduction of quantitative viral culture techniques. The quantification of specific HIV antigens in the circulation is being evaluated as a marker of disease.

54. A consultation on social factors and research needs in HIV infection and AIDS will be convened in Geneva in May 1987 to determine and assign priority to current and future needs for research that is appropriate to health planning and education. Methods and approaches will be proposed for studying social epidemiological issues and a core group of biosocial scientists who can collaborate with WHO in strengthening national research capabilities will be established.

Cooperation with Member States

55. The second Meeting of Participating Parties for the Prevention and Control of AIDS was convened in Geneva on 28 June 1986. Representatives of 14 donor countries or agencies and 14 potential recipient countries met with the Director-General and staff from the regional offices and headquarters to discuss the global AIDS control strategy and its organizational and financial implications. Participants concurred that AIDS represents a unique challenge to public health, having the potential to undermine progress and prevent the attainment of health for all and the success of child survival initiatives; and stressed that it was important that bilateral and multilateral prevention and control efforts be coordinated by WHO.

56. Specific financial commitments for extrabudgetary funding of the programme have been received, totalling (as at 19 March 1987) approximately US$ 8.1 million from eight donors; in addition, commitments in principle but so far without specific allocations have been received from several additional countries. The third Meeting of Participating Parties for the Prevention and Control of AIDS will be held in Geneva from 27 to 28 April 1987.

57. Several countries have indicated their interest in providing for the secondment of experts to assist the programme.

58. A Regional Conference on AIDS in Africa was held in Brazzaville from 11 to 13 November 1986. The objectives included: a scientific review and update of the global aspects of the biology, immunopathogenesis, clinical features, laboratory aspects and epidemiology of HIV infection and AIDS; a scientific review and update of the clinical, laboratory and epidemiological features of HIV and related retroviruses in Africa; and a review of the practical experiences and activities to date in Africa. Representatives from 37 Member States of the African Region attended the conference and approved recommendations for both Member States and WHO, encouraging the latter to continue to take a strong position of leadership and advocacy for national and international programmes on the prevention and control of AIDS.

59. WHO is preparing further missions to develop collaborative programmes with Member States (see paragraph 19). Such missions pave the way for providing the effective technical and financial support required to strengthen national infrastructures as well as national AIDS prevention and control programmes. In this connection, an extensive list of potential consultants and advisers (experts in epidemiological, laboratory, clinical, and prevention aspects of HIV control) has been compiled.

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