9.2C Draft global health sector strategies: STIs 2016-21

Contents

In focus

In 2006, the Health Assembly adopted resolution WHA59.19 in which it endorsed the Global Strategy for the Prevention and Control of Sexually Transmitted Infections, covering the period 2006–2015 (here). The final progress report on implementation of the Global Strategy (in full here and in document A68/36(G)) was considered by the Sixty-eighth World Health Assembly in 2015, with speakers emphasizing the need for a new strategy to be developed (APSR12 and 13).

The current Global Strategy has therefore been updated and is presented to the Executive Board for its consideration (in EB138/31). The draft strategy (in full here) which is aligned with the other global health sector strategies, includes innovative solutions and interventions towards eliminating sexually transmitted infections, and is linked to the broader objectives of the 2030 Agenda for Sustainable Development. The draft strategy has been developed jointly with the draft global strategies on HIV and viral hepatitis, using a common universal health coverage framework.

Background

The final progress report on implementation of the Global Strategy 2006-2015 (here) provides useful background to the revised strategy.

PHM comment

The new draft strategy is to be welcomed. While the presentation of the strategy may be criticised the principles and strategies are comprehensive and sensible.

The Vision (p13) is poorly worded, in particular, the reference to “everybody, however marginalised, has free and easy access to STI prevention and treatment services, resulting

in people able to live long and healthy lives" which could be taken as disregarding the wider causes and consequences of marginalisation.

The metrics implied in the Vision, the Goal and the Global Targets are quite mixed. The vision is expressed in terms of the concept of 'zero STI-related complications and deaths' (which corresponds to the box on p5 summarising the burden of disease associated with STIs). The goal is expressed in terms of STI as no longer a 'major public health concern'. The Global Targets are cast in terms of incidence rates, and service coverage.

The third milestone for 2020 is listed on p14 as "70% of key populations have access to a full range of services relevant to sexually transmitted infection and HIV, including condoms". Apart from the metrics implied, this milestone appears to have been deleted from Figure 7 on p15. The list on p14 is also at odds with Figure 7 regarding the HPV vaccination target.

Drafting one strategy for a group of diseases which share a mode of transmission but have different clinical and epidemiological features is not easy, particularly when it is forced into the UHC box (services, populations and funding). Likewise the references to 'key populations' raises questions about the degree to which 'key populations' can be addressed as a generic group and to what extent are they different and require specific policies and strategies?

The decision to force all three communicable disease strategies into the UHC box tends to obscure some of the critical issues the strategy should be clarifying.

Clearly the technical content of preventive and treatment strategies needs to be considered separately from health service delivery issues including the relations between specialist programmes and generalist PHC or between programmes in the community and those in particular settings (prisons etc) or between health promotion programs and clinical programs. However, structuring the strategy within the UHC box privilege the technical 'interventions' and ignores to some extent the service and program delivery questions; most notably the lack of reference to workforce development as a key dimension of the strategy.

The delivery of prevention and treatment for STIs takes place at the conjunction of three different kinds of strategy:

- technical strategies focused on particular diseases;
- service and program delivery strategies (different kinds of service, different settings); and
- strategies to assist public health practitioners to engage with various 'key populations'.

The challenge for the policy makers and programme managers at the national and subnational levels is to ensure that the technical strategies and engagement strategies are most effectively and efficiently realised through the service delivery strategies. It is not clear that structuring these WHO strategies within the UHC box is the best way to assist those policy makers and programme managers, particularly in such a heterogeneous field as STIs.

The frequent references in all three communicable diseases strategies to including interventions in 'national benefit packages' appears to assume health insurance as the

principal service delivery framework and disregards other dimensions of health service delivery including PHC as an approach to service delivery; links between treatment services and health promotion and outreach / community engagement programs; the relation between specialist programs and PHC and other more generic services; the concept of district health systems and the overarching issue of clinical governance. The reference to a "core package" on page 23 provides no guidance at all about delivery systems.

In fact the authors of this strategy are very aware of the service delivery dimensions of this policy as is evident in the reference to a public health approach on p10, 'strengthening health systems' from p34, and 'optimise service delivery' under research.

The section on implementation and accountability from p44 is promising although there is no mention of how the various groups affected ('key populations') might be engaged in the implementation process and accountability relations. There is a reference in the Guiding Principles (p17) to "Meaningful engagement and empowerment of people living with sexually transmitted infections, key populations and affected communities" but it is not clear where this is enacted within the strategies.

The reference to benchmarking is appreciated but this needs to include rich descriptions of service and programme delivery, not just country questionnaires.

The treatment of HPV vaccination is a bit limited. There are opportunity costs associated with adding HPV to the immunisation schedule and these costs vary with the prevailing epidemiology and service delivery capacity. There are also financial risks associated with HPV immunisation arising from graduation from Gavi eligibility. The need for functioning national immunisation technical advisory groups (NITAGs) as discussed in the SAGE GVAP Assessment Report could have been underlined here.

There are repeated references to the need for further research, including various applications of operations research into service delivery.

There is also a need for new diagnostics, vaccines and antibiotics. The strategy does not include any assessment of the global pipelines for this research and the current investment effort. This may be something that the R&D Observatory could answer. It may be time to delink research into the prevention and control of STIs from its dependence on the profit incentives associated with monopoly pricing. (See PHM commentary on Item 10.3 on CEWG here.)

Notes of discussion at EB138

Three draft strategies (HIV, 2016–2021 (EB138/29); Viral hepatitis, 2016–2021 (EB138/30); and Sexually transmitted infections, 2016–2021 (EB138/31)) considered conjointly commencing Ninth Meeting (pm of Day 4)

Docs: EB138/29, EB138/30, EB138/31

CHAIR: will take statements to address them together, please specify about what you talking .

BRAZIL : has the honour hosted in april the original meeting on viral hepatitis. the strategy addressed three major public issues

new drugs not accessible for all. including high price hepatitis drugs. as regards to STIs committed to tackle the issue including transmission syphilis of mother to child

regarding HIV regarding increase of access of drugs , tracking require treatment of prevention

challenge we still need to face , evidence , commitment to tackle these 3 major health problem and support WHO in the draft

JAPAN: Specific HIV strategies. Move from a siloed approach to integration of national health strategies will ensure sustainability. Clear and ambitious targets. Challenging for resource rich countries like ours. One fits all approach does not work - each country has a different epidemiology. Hope WHO can offer maximum support in collaboration with other UN agencies such as UNAIDS. We are hopeful that due consultation is given at each level. We need innovation and R&D for new drugs, we welcome the pillar of R&D in all of these strategies. We need the already agreed wording in the strategies so we can focus on core issues, beating HIV, STIs, hepatitis. Secretariat should consider adding TRIPS flexibility.

UK: Mother to child transmission of HIV, HIV response needs to be strengthened. Welcome ambitious call to treat everyone with HIV with anti retroviral drugs. As WHO guidelines advise, priority should be given to those with CD counts under 350. Rapid expansion should not compromise quality or contribute to inequalities. Scale up equitably. Provide pre exposure prophylaxis and viral load testing. Need to understand the global burden of hepatitis. We need to support countries and plan and prioritize resources in a strategic manner. UK is interested in how will be proceeding.

ERITREA: Taking floor on behalf of 47 countries in the African region. 36.9 mill people have it, new treatment and care is required. Care and treatment should continue to expand. Cornerstone of our response. End AIDS epidemic as a public health threat by the end of 2030. Appreciate that the draft strategy, hope that the price of antiretroviral treatments can be affordable. Need to push for subregional production of diagnostics and treatments for HIV. Draft global strategy should be focused on short term strategies, while proposing long-term strategies. African regime acknowledges the investment made to control the epidemic.

CONGO: our statement is complementary to what said by AFRO. Vaccination against of Hepatitis C is to implement. For HIV, 0 children born have to born with it by 2020 and it is possible. STI may be more complicated but maybe the vaccine could be accessible for HPV, the control of the other STI may be easier. Use of condom and intensify it. Access to curative therapy of Hepatitis C

RUSSIA: on the overall strategy: aim is sustainable development for health. We must add the following points: each country has to set its own goal depending on the context. SDG's:

we should add promoting healthy lifestyles, family values and negative effects of bad habits. HIV: collection of data is key. the strategy on HIV needs to be reviewed. Like mortality, sometimes it's to ambiguous in the text. we will support the text in WHA69 provided our comments are integrated.

SAUDI ARABIA: Agreement with three global strategies and would like to share some observations from our experiences w these new drugs, drugs available but prices are very high. Forced us to set up a methodology to have a supply of these medications, prevented us to provide treatments for all patients. Undertook discussion with companies who produce this medication, weren't able to get the price reduced. Would like the WHO to set up price pressure groups so that we can provide adequate medication to all patients who have viral hepatitis, particularly hepatitis C. We know that the treatment against HIV AIDS is very expensive as well, we know that this treatment as well can be used to fight Hepatitis C and B and consequently we can prevent many deaths.

CANADA: Comments address all 3 strategies.Comprehensive straTEGIES ON STI and Hepatitis and HIV. 2030 agenda of Canada is aligned with the document. Many improvements on these topics. Pleased to see the improvement. Urge to embrace strategies in order to strengthen overall response. Pleased to note that the references are connected with AMR, priority for Canada, crucial components. Supports Brasil, recommendation of the adoption of the WHA 69 about this topic. Strategy developement: we are together achieving the main goals for the 2030. Time is come for action.

CHINA: Chinese delegation thanks secretariat for the report. Appreciate a great deal of all 3 strategies. Support all 3 strategies. AIDS is a major disease posing a grave threat to human health and socioeconomic development. 2016 Draft strategy is of significance in guiding member states to enhance their work. China stands ready to play a proactive role in reaching the goal of ending the AIDS epidemic by 2030. In formulating the China AIDS action plan, a 5 - year plan, China expects to reach 90 targets. 3 suggestions: 1) Secretariat needs to further clarify definitions for new infections + how data in the draft strategy was collected, 2) Considering there is a disparity amongst MS in their level of development, should allow flexibility to adjust the indicators, 3) Wish that the WHO plays a coordination role in the resources allocation in hepatitis. Integrate Hep B vaccine into national vaccination plan, very good surveillance based on direct reporting and monitoring and an integrated intervention that has used nucleic acid testing and the full immunization coverage to stop mother to child transmission. WHO should provide more financial and technical support, to help reduce prices of medications and carry out applied research on intervention measures.

SOUTH KOREA: support global health strategy for HIV/AIDs. to be a part of child immunisation programme is the HPV vaccination and the government of Korea pledges its support. We expect progress by strengthening health programmes. Every mother is tested with HB and every child also tested for hepatitis B at the cost of the government. Considering the inclusion of HB testing in national health programme. Look forward to WHO continuous leadership in the management and control of viral hepatitis.

USA: Welcome first health strategies for HB. Male partners also need HIV prevention testing and services. Greater use of cost studies and using program data to prioritize funding decisions related to the treatment cascade. On hepatitis, we welcome the health sector

strategy. Reducing transmission, access to affordable diagnostic care and treatment. Suggested edits to the strategy will be submitted to the relevant technical group. On sexually transmitted infections, global strategy - WHO should provide up to date guidance regarding the guidelines, including AMR and gonorrhea. Integrate reporting of STI data into maternal and child health programs.

THAILAND: Support ARV measures but however advocates for the distribution of Condoms and social protection measures. We focus on Viral hepatitis C whose measures are not very expensive. Calls for the support of low cost vaccines. Highlights the inconsistency of the 2030 document on page 7.

DOMINICAN REPUBLIC: Thanks secretariat for report. DR has made a lot of advances against these diseases, we had a generalized epidemic to one that is now more concentrated and defined. changed strategy regarding vulnerable population, drug users and sex workers. Country is paying for all viral and retroviral drugs, looking at a mechanism for buying these drugs. 20% of the patients with HIV AIDS also have TB. Coordinating stopping mother and child transmission. Efforts include drugs with Hep A. Vaccination against Hep B has been in our programme for 2 decades now, we have been able to cut down considerably the incidence of Hep B. Looking at the possibility of assuming the costs of the vaccine against HPV.

SWEDEN: Speaking on behalf of the Nordic + Baltic countries. Recognise the importance of STIs. welcome the global health strategies of the STIs. Encourage WHO for a specific need of each strategy well elaborated. Calls for the inclusion of preventive health care which requires comprehensive sexual education. Would stress the importance of SRHRs. Prefer as stronger language on the SRHR which is an important strategy.

ALBANIA: Welcomes report on draft strategies presented by the secretariat. Overall they have done the stakeholder consultations, some observations: some targets are quite ambitious for the 5 year period, which means that resource mobilization, focused action plans and efficiency in implementation will be needed. Alignment with SDGs is taken into account. Integration with each other and other health sector strategies has to be linked, not just for the sake of consistency but also to ensure that the health strategies are grounded to the overall health strategy framework.

NAMIBIA: Support the statement on HIV by the Eritrean group on behalf of the Afro group. Support strategies made by other countries. Pleased by progress made in africa on accessing ARV for their population (37 countries). Namibia achieved its target. Proposes adolescent friendly RHS which is important in the strategy. This would require, free testing for all with an opt out option and treating people with low CD4 count less than 500 (not 350, as we missed a lot of cases when we started with low cutoffs). it is very important to strengthen monitoring and surveillance services as this supports timely intervention and also calls for low pricing of HIV medicine.Thanks CDC and global fund for helping to finance these programs.

PHILIPPINES: Appreciate great work done by the secretariat in coming up with this strategy. We noted that HIV is declining globally but increasing in some countries, such as the Philippines. Hepatitis is a growing cause of mortality among people with HIV responsible for

1.4 million deaths. High prevalence of STIs can have a profound effect on children and adults worldwide. Fully support strategy in documents. Recognize that health system strengthening and that offering a continuum of services are effective to respond to HIV, viral hepatitis and STIs.

Comments from non-EB members

INDIA: committed to ending the AIDs epidemics. The preventive actions must be clearly mentioned in the strategy to address HB problem. On the t…

SLOVENIA: All three strategies. Growing body of evidence that linkages between alcohol use, alcohol is among the structural epidemic. New and already existing aids programs. Would like to suggest that a paragraph of addressing alcohol use in the context of prevention could be included in the strategy. Would fit in along with the prevention and management, and sexual violence. Could be included in the list of interventions that might have an impact.

SWITZERLAND: three global strategies to be adopted through decision. Integrated, not vertical approach. shared responsibility of all countries. regular follow up for in case PREP fails. Agrees with the robustness of the strategies.

GERMANY: Supports proposal by brazil. propose respective indicators in the key indicators to adequately monitor each strategy. Note with concern on WHO emphasis on prep in the overall strategy. THe use of the prep must be with caution considering its negative consequences. Propose bi-annual reporting period to elicit country responses and monitor progress.

MOROCCO: We have been speaking on the zero strategy. zero prevalence and zero stigma. Morocco is in line with the strategic goal 3, 9 and 10. our future national plans are inline with the global strategy. there is the need to mobilise funding on a sustainable basis.

AUSTRALIA: Seeks clarity for the specific proposals. not the speed and response to address the AIDS epidemic. welcome the use of UHC framework to address the situation and acknowledge is need for ensuring affordable access to health services.

GHANA: Support Eritrea. Believes in the 2030 global agenda. made progress with the strategy of targeted interventions such as PMCT. This has greatly influences reduction in prevalence which currently stands at 1.2%. raises concerns on the much needed commitment to ensuring adequate financial support for addressing the pandemic.

VENEZUELA: Regarding the 3 strategies, agree with other members who consider them as objectives that are very ambitious. Regarding HIV AIDS, this must continue being a high priority for WHO. With those objectives set forth, there is no doubt that developing countries, especially those of low income are chasing major challenges to comply with item 3.3. With regards to technical support and scientific support, this is very important. HIV AIDS is still a major threat to health in our country. In most exposed areas, our plan for 2012 - 2013, we stated very clearly our commitment with the necessary mechanisms. Consolidation of prevention plans is necessary.

PANAMA: Support the strategies for addressing HIV/AIDs, viral hepatitis which is inline with our national strategies. UNAIDs members adopted the strategy of better monitoring and cutting down MCTs. Provision of access to vulnerable populations. The support of WHO is key to addressing these strategies.

ECUADOR: Delegation thanks secretariat for support on the strategic activity in the area of health. Support what Brazil said, regarding the 2016 - 21 plan. 2015 demonstrated very positive results still have a long way to go. Gives us the possibility to further strengthen our care, prevent outbreak of new epidemics and remain very watchful. Priority remains universal health coverage - the only way to meet our SDGs of 2030. Need a change in mentality for social inclusion and to see that there is participation from all sectors of society. Need to promote a proper living and well-being. World financial crisis is hitting very hard, esp Ecuador, we need to work very hard to optimize our resources. We would like to see that our strategy for HIV AIDS must be unfolding with the activity of UN AIDS for the same dates. We will provide all of our support to arrive at this common undertaking. Organizing a parallel event within the framework of WHA, to bring forward UHC and non discrimination.

PAKISTAN: Feel that hepatitis is a major public health challenge affecting developing countries in particular. Welcome step by the WHO, Pakistan has one of the largest burdens of disease of hepatitis estimated to be 9 - 10 million.

CUBA: Review other aspects with the Global Fund. Cuba was the first country to receive the validation for the elimination of the mother to child transmission of HIV AIDS. Cuba is 1.6% below regional level and well below the 2% level set by countries. Success bears witness to the fact that UHC is the key to success in order to face up to the scourge of HIV AIDS. Cuba is committed to give rise to the generation free of HIV/AIDS. Lots of progress can be made around the world. Stand ready to work hand in hand with those people who require our experience.

Chair: Moving to second strategy on Hepatitis.

EGYPT: Viral hepatitis has always been a pressing priority in Egypt, surveillance on B and C conducted in 1996 showed that the prevalence was 4.5% and 14%. Several preventive and curative measures were taken, but in 2008 the prevalence in Hep C was still 9.8%. The biggest challenge comes from the unsafe injections and unsafe procedures. Intl community for the prevention and control of hepatitis has established 43 national centres, clinical practice guidelines, etc. for case management. Also entails injection safety, blood safety, raised public awareness and treatment and research. Finally there was a strategy and national action plan and is being acted upon between 2014 - 2018.

ERITREA: Implementation of the strategy is not without problems. Main ones: 1) High cost especially for low and middle income companies, 2) lack of comprehensive data, 3) limited coverage for protection and intervention mechanisms, 4) limited access to effective care and services, 5) barriers to equitable access of services

WHO should negotiate with Global Fund, GAVI, etc. to support people in low and middle income countries. Use public health related TRIPS flexibilities to ensure affordable access to treatment for Hep C. Proposed too many terminologies, plan focused mainly on addressing

Hep B and C but our country also needs Hep A. Need more info on strategies to deal with safe food, water and sanitation. We recommend revision of draft global strategy on viral hepatitis.

PAKISTAN ; 8-9 million are patient of hepatitis C but Hepatitis B is decreasing because of vaccine

introducing drugs for C will change this number in case the price was affordable

large number of patients was treated in the previous years.

we do propose more evidence to have hepatitis C vaccine and excess cheap diagnosis of Hepatitis B and C safely . drug resistance will emerge for a problem. The strategy is supported by pakistan

JAPAN: Hepatitis: congratulation. Medical treatment and blood transfusion were problems for blood safety. Prevention of these infections. Access to medical diagnostics and treatement: Hepatitis C is really expensive. Need flexibility, multiple factors. Access to health facilities. Let's move forward. Careful evaluation, health for all.

Non EB members

Morroco : thank you . we would like to put some comments setting goals. there is in case absence of data in mortality , secondly that SDGs target about fighting hepatitis , other info saying limiting hepatitis , so goals are confusing

Concern the prevalence of Hep C and B in the population and risk groups. Preparation of our plan. Tech and financial assistance from WHO to be able to back up our strategy.

GHANA: align with Eritrea. Increasing price is a matter of concern. SDGs 3.3 is also align. High number has viral hepatitis. We have programs for also prevention. We use all the strategies in the guidelines. policy frame that has the highest committements. Adequete and appropriate strategy. Strenghten advocacy to companies for affordable treatement. thank you

GREECE: we thank WHO for leadership with whole strategy, we committed to end the hepatitis in our country. Commitment in ending viral hepatitis in our country, but the economical crisis is a problem.

Austerity measures damage of health system which had great impact on health our population. We recognised the challenge on financing. Greece government recognise the potential to work with cooperation of EU partners . we want to learn from countries like Georgia and Egypt how they going in preventing this disease we will know their experience .

importantly harm reduction plan is imp for hepatitis and HIV.

there is treatment for hepatitis but greece is not able to afford. We have the political will, . we want to ensure input of public support and civil society . committed to implement national hepatitis plan by utlizing

in order to achieve its goal ministry of health want to work closely with WHO and partners

VIETNAM: estimated 600 thousand die for hepatitis. People infected are 90% infant in the first years of life. HBV is the biggest issue: we started the vaccination but speculation that the vaccines were not in a proper number. Recrimination: both dose was not possible. Urge WHO for the recommendations:

1. guidelines for hepatitis and to reduce vertical permission.
2. no price increase
3. access to therapy
4. program of monitoring

TANZANIA : align with Eritrea welcome strategy . we noted that , vulnerable affected population, marginalized group, these terminologies are not linking well when you read the Hep strategy

JAPAN: control on STI. Important global health issue we point on the problem. Adaption on comprehensive approach. Single approaches doesn't work. Education save sex and condom use.

ERITREA STIs has impact to reproductive and child health and transmission of HIV .

adverse pregnancy outcome. STI play role of infertility , anal and cervical cancer.

furthur more primary prevention played role in decreasing infection.

the draft strategy based on achievement does not reflect primary preventions of new STIs,

including Women and children not only certain population

as we understand STI affect men , women boys .we propose for more prevention in document. empowerment of all communities. we must also take care of antimicrobial resistance . we support strategy.

UNAIDS: in october 2015, adoption of the global strategy on AIDS. This strategy has a HR based approach, and incorporates realistic commitment from State to fully harness of the health sector. The aim is to ensure that no one is left behind. The new strategy is fully in line with the UNAID strategy and recommend that EB adopt of the strategy.

ICRC:

NGOS talking about Hepatitis .

- International Planned Parenthood Federation (IPPF)
- Medicines Patent Pool Foundation (MPP)
- World Hepatitis Alliance (WHA)

- MSF;
- FICR

ADH/HTM: thanks for contribution. we understand how it is public health thread. government of brazil and south africa we thank them for hosting HIV consultation.

this is first time we look into how we work together to reach target . we are committed to achieve targets by 2030. target 3.3 is very encouraging and we have tools to reach the target . we hear many comments and we recognise many issues should be considered, resistance , health access, medications. we understand this strategy have components

ADG/FWC: i will focus as Universal health coverage. On STIs focus in innovation , clearly link to strategyto look into new drugs esp after resistance of gonerea to medication.

we will work with . there are several comments from india and other countries. WHO has clear paper on Cancer prevention y use of HIV vaccine. we have lot of tool online

SECRETARIAT (?): concern about price reduction: what was possible to do about reducing prices was already been made.

SLOVAKIA: thanks the Secretariat. Welcoming the document. this document addresses this strategy. underlining the importance of the health sector in order to combat STDs. They want to include sexual and reproductive rights

remind that no definition of STI in adopted. A part of the document has to be deleted.

CHAIR : will endorse strategies in May WHA including comments. will be reflected in summary :-)

Closure of item 9.2