Item 13.2 The global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections

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In focus

A75/10 advises:

> The Executive Board at its 150th session noted EB150/8 which conveyed the report on the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections. It also adopted EB150.R3, in which it decided that informal consultations on the draft global health sector strategies on respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030 would continue to be facilitated by the Secretariat prior to the Seventy-fifth World Health Assembly. Additional information on the development process of the strategies, including the informal consultations and the resulting final versions of the strategies in the six official languages, is available online.

The Assembly will consider EB150.R3 in which the Board recommends the Assembly adopt the global health sector strategies.

Background

Global progress report on HIV, viral hepatitis and sexually transmitted infections, 2021. World Health Organization, 2021

WHO 2021 State of Inequality: HIV, TB & malaria

Final draft global health sector strategies on respectively, HIV, viral hepatitis and sexually transmitted infections, 2022-2030 for consideration at the 75th World Health Assembly (includes notes on development of the strategies and the evolution of the text)

Report of comments from Member States during the 150th session of the Executive Board and further written feedback received from Member States as part of the intersessional process

Tracker links to previous discussions of HIV, viral hepatitis, and STIs

PHM Comment

Excellent draft document

The draft global health sector strategies document is excellent. It takes a health systems approach rather than a disease focus although recognises the disease specific needs. Aspects to be particularly appreciated include the emphasis on community engagement, the commitment to harm reduction, and the repeated references to adapting the general strategies to national circumstances.

However, there is one deep contradiction, one critical absence and a number of areas which need to be strengthened.

Integrated and people centred health services not compatible with 'universal health coverage' as endorsed by WHO, the World Bank and the Rockefeller network

The contradiction arises in the repeated references to "universal health coverage" as a basic framework for the strategies while in parallel calling upon 'integrated and people centred health services' and primary health care as basic frameworks. These are not compatible.

Notwithstanding the glossy marketing, the proposed pathways for implementation of UHC point towards a minimal safety net (the essential benefits package), publicly funded, but delivered by public, private and voluntary service agencies and paid for through commodified purchasing mechanisms. Meanwhile, what the glossy brochures don't advise is that 'beyond the package' services are to be delivered through a marketised health system financed through health insurance and delivered by an increasingly privatised fleet of service agencies. This is in essence the health system model that the World Bank has been pushing since 1993 but now with the support of WHO.

What the global health sector strategies document does not explain is how the integrated and people centred services are to be 'purchased' as part of a 'defined benefits package' from a chaotic mix of public, private and voluntary agencies.

Many of the core commitments of these strategies are not compatible with such a funding system. Consider the kinds of community engagement involved in interrupting vertical transmission, in countering stigma, in supporting harm reduction measures for people using drugs. These, and many of the other excellent principles recommended in the strategies, require stable, well organised primary health care capacity with strong support and referral links to more specialised services and who have a close relationship of solidarity with the community. The community is a co-producer, a partner and not a customer or client purchasing services.

Action 22 deals with effective and inclusive governance: “Strengthen national governance structures and costed strategic plans to guide national responses to HIV, viral hepatitis and sexually transmitted infections, with meaningful engagement of communities and promoting synergies with broader health governance structures and plans, aligned with international human rights principles and standards.” The kind of system-wide approach that this para suggests is not compatible with the safety net plus private market approach being sold under the slogan of UHC.

Action 70 deals with ‘decentralized and differentiated viral hepatitis services’. “Viral hepatitis B and C interventions have traditionally been delivered through hospital-based tertiary services and by specialists. Achieving hepatitis elimination will require adoption of a public health approach using simplified service delivery protocols including decentralization of testing and treatment to lower level health facilities, including primary care, harm reduction sites or prisons, ideally with delivery of testing and treatment at the same site to promote linkages; integration of viral hepatitis testing and treatment services into existing primary health care, HIV, harm reduction, or prison health; and delivery of care and treatment by non-specialists including primary care physicians and nurses with support from peer workers and patient navigators in some settings.” It stretches credibility to propose that this vision of a locally based person centred integrated system can be rendered as a purchasable package of ‘defined benefits’.

Social determinants of Disease

Another critical weakness in this document is the inadequate discussion of the social determinants of these diseases and the preventive actions that are required to slow down and reverse these epidemics.

The strategies document recognises (page 5) that: “HIV, viral hepatitis and sexually transmitted infections share modes of transmission and common interventions. They also are shaped in similar ways by social and structural determinants of health, such that people facing poorer socioeconomic conditions, or discrimination based upon gender or other identity markers, risk greater vulnerability to infection and worse health outcomes”. Astonishingly the passage goes on to say that, “Putting people at the centre of rights-based health system responses – by organizing services around people’s needs rather than around diseases, and by promoting integrated patient-centred approaches and linkages with primary health care services – is the key to ending these epidemics”.

Poverty, alienation, racism, stigma, and various environmental exposures have deep roots in political and economic relationships and their histories. These ‘social and structural determinants of health’ need to be addressed in a rights-based framework but redressing the oppressions, exploitations and exclusions requires much more than this. Implementing such a framework will not happen unless the institutions, ideologies and power relations are also named and reformed.

Consider, for example, the hyper-incarceration prevalent in ‘post’ colonial settler societies where the continuing dynamics of colonisation and slavery are alive and powerful. Action 20 (p32)

which deals with prisons and other settings correctly calls for equitable access to services in special settings, including prisons.

Production and innovation

A key target for these strategies is the availability of affordable, effective vaccines, diagnostics, drugs, and other health products, including protective personal equipment.

Treatment costs (especially for HIV and hepatitis C) are a major barrier to the achievement of the goals of these strategies. Likewise the supply and prices of point of care diagnostics and vaccines (for hepatitis B and HPV) are critical barriers to overcome.

Strategic Direction 2 addresses access to commodities. Action 24, from page 31, sets out an impressive range of strategies to promote access and control prices which are discussed further in the disease specific sections.

It would be a major step to implementation of the global health strategies if all of the initiatives listed in Action 24 (and later sections) were to be fully implemented, in particular, local public sector production of health care products and commodities, full use of TRIPS flexibilities, price transparency, and full use of pooled procurement (nationally or regionally). However, the Secretariat and its funders will need to be held accountable for full implementation.

Priorities for innovation are considered under Strategic Direction 5. Action 35, from page 39, sets out a range of strategies to drive innovation for health which are discussed further in the disease specific sections.

It appears that the need for innovation will be met through ‘partnerships for innovation’: “strengthening research- and development-based partnerships, including strengthening engagement with the private sector and communities”. This reliance on ‘partnerships’ is weak and completely bypasses the debate between upfront support for R&D allowing prices to be set at cost, versus market strategies based on private investment upfront with the recoupment of capital dependent on intellectual property protection, high prices and high volumes. The Covid experience (like the ARV experience before it) demonstrates that the pharma (and diagnostics) companies will exploit to the full the flexibilities available to it under this market model, notwithstanding the inequities this model creates.

The Covid experience points to the importance of building public sector R&D, and production capacity in the global South. WHO should commit to exploring new approaches to funding R&D in accordance with GSPOA recommendations as well as new approaches to expanding local public sector production capacity.

In many countries the availability of affordable penicillin as a generic drug for use against common STDs is becoming a problem, as commercial manufacturers and providers are preferring costlier alternatives. Ensuring adequate supplies of penicillin in public health facilities has thus after decades once again become a challenge.

WHO's role in implementation

Section 7.3 which outlines what the WHO Secretariat will do as part of the implementation of the strategies is dense with admirable 'WHO will …' statements. However, it is not clear how WHO will be held accountable for these and how its donors will be held to account for their funding. Given WHO's egregious dependence on donor funding there needs to be stronger mechanisms for holding the Secretariat and its donors accountable for delivering on these 'WHO will …' statements in S7.3. Annex 2 (from page 109) provides a framework for monitoring the work of the Secretariat. However, the indicators listed do not cover all of the 'WHO will …' statements in Section 7.3.

Implementation of these strategies is not just about what 'countries' decide. Rather it will depend on subnational and local policy officials, health service managers and practitioners as well as community activists. Action E (page 81) promises that "WHO will strengthen its work at country level as a technical support partner for policy development, strategic planning and implementation of national HIV, viral hepatitis and sexually transmitted infection responses with effective involvement of communities in decision-making and service delivery. WHO will also support countries to strengthen public health institutions and build health system capacity." WHO's country offices must be empowered to reach out directly to professional and community organisations to support this transformation.

A note on morality

The 1 May version of the draft global health sector strategies which is to be considered by the Assembly has been subject to intense negotiation since the 20 December version was published. It appears that the focus of these negotiations has been on the degree to which the strategies should be constrained by conservative morality. This debate has touched upon:

- whether sexuality education should be *comprehensive* or not;
- whether the health of *sex workers* should be addressed;
- whether *harm reduction* should extend to people who only want to *reduce* their drug use or should be restricted to people who want to *stop* using;
- whether harm reduction should include *safer use of drugs*;
- whether *gay men* should be explicitly mentioned or assumed to be encompassed under the term *men who have sex with men*;
- whether stigma and discrimination facing people who do not fit established gender norms should be acknowledged;
- whether the possibility of trans and gender diverse people having children and breast feeding and therefore being at risk of vertical transmission should be mentioned;
- whether there is a need to define "intimate partner violence" or perhaps delete the reference to intimacy in this term;
- the use of the concept of *intersectionality*.

The poles of opinion on these issues are well articulated in the communications of Egypt and Canada during the intersessional discussions.

PHM urges member states to be guided by human rights principles and the empirical evidence of what works.

Notes of discussion at WHA75