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[Joint United Nations Programme on HIV/AIDS (UNAIDS)-Various Reports 1997]

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Folder Title	Joint United Nations Programme on HIV/A	OA Number	19410	Box Number
Description of Item(s)	15 full color slides, World Health Organization briefing on 1997 HIV/AIDS pandemic			

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Action
Programme
on
Essential
Drugs



Access to HIV-related drugs

**Challenges and opportunities for
improving selection, affordability,
availability**

World Health Organization
November 1997

Challenges

**Access to HIV-related drugs presents political,
social, ethical, economic, medical challenges**

- ♦ health systems must have capacity to diagnose and monitor
- ♦ proper use requires education of providers and patients
- ♦ treatment regimens are complex, side effects common
- ♦ many priority drugs are extremely costly and not available from international low-cost suppliers
- ♦ improper use leads to ineffective treatment and resistance
- ♦ treatment effectiveness depends on continuum of care and social support network
- ♦ barriers to access are social, political, ethical - not simply medical and economic



Challenges

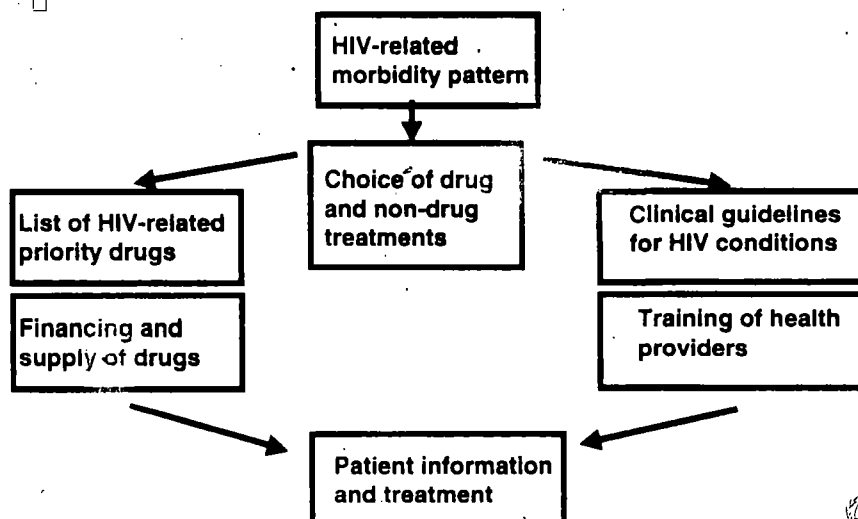
Access to HIV-related drugs depends on rational selection and use, affordability, and availability

- **Therapeutic access - rational drug use**
 - select drugs based on morbidity pattern, best options
 - educate providers and the public
- **Financial access - affordability**
 - decrease prices
 - increase financial resources
- **Physical access -- availability**
 - recognize unique features of HIV treatment
 - use effective mix of public and private systems

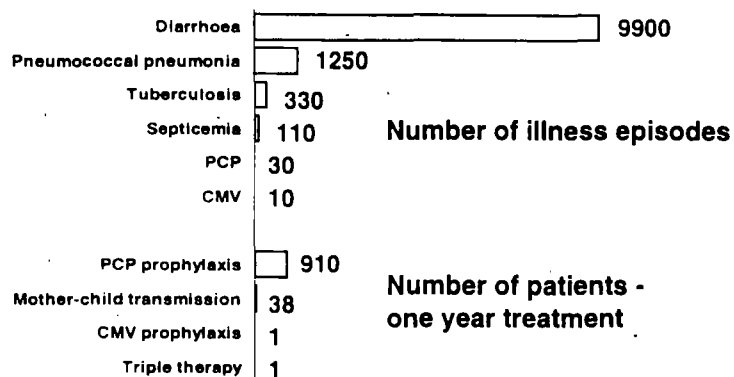


Rational use

HIV-related morbidity pattern should guide local selection, training, supply and drug use



The number of illness episodes and patients who can be treated with US\$ 10,000 varies hugely



5 -- DAP-HIV1.PPT (10.11.97)

WHO - DAP



"Affordability" varies with HIV prevalence, treatment policy, fertility, economy, health spending...and drug prices

Estimated annual ARV drug costs as percentage of total annual public drug budget

	Mat-Child Transmission	AIDS-Triple Therapy	Treatment of HIV+
Argentina	0.1	2.	5.
Colombia	0.2	7.	14.
Brazil	0.2	16.	18.
Sri Lanka	0.2	8.	15.
Philippines	0.6	16.	31.
Thailand	5.3	357.	526.
Guinea	18.0	349.	692.
Zimbabwe	35.0	616.	1221.
Cote d'Ivoire	70.6	906.	1796.

Prepared by WHO/DAP with data from: Prescott (WB), UNAIDS, WHO/DAP, WHO/RHT

6 -- DAP-HIV1.PPT (10.11.97)

WHO - DAP



Affordability

Cost reduction strategies must target source prices and mark-ups to the consumer

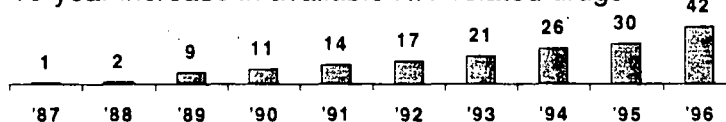
- **Source prices - producers and importers**
 - ◆ information - price and sources
 - ◆ negotiation
 - ◆ competition - therapeutic class tendering
 - ◆ price control
 - ◆ local production - as appropriate
- **Mark-ups to consumer**
 - ◆ taxes - importation, value added
 - ◆ wholesaler margins
 - ◆ dispensing margins - professional fee vs. percentage



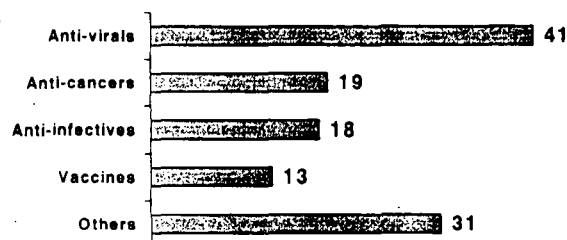
Affordability

Rapidly expanding therapeutic choices provide new options and opportunities

10-year increase in available HIV-related drugs



Over 122 HIV drugs currently under development



Financing strategies should be based on understanding current drug financing patterns

1. Public financing

- developed countries: 66% of drug costs
- developing countries: usually <20%

2. Health insurance

- Latin America 35% • Asia 10% • Africa 8%
- inclusion of drugs & HIV varies greatly

3. Out-of-pocket payment

- 50-90% of drugs bought by households
- government services more dependent on user fees



Financing strategies should be based on understanding current drug financing patterns

4. Voluntary and other local financing

- PLWH solidarity funds - especially north-south
- drug donations

5. Donor financing

- more health sector, less disease focus
- more prevention, less drug funding

6. Development loans

- increasing WB health, pharmaceutical lending
- generally an interim measure



Availability

Improving supply of HIV-related drugs requires different strategies for different sectors

■ Public sector

- ◆ information for PLWH, doctors, pharmacists, others
- ◆ national health and drug policies
- ◆ reliable quantification of needs
- ◆ new supply strategies, integration

■ Private sector, NGOs

- ◆ information for PLWH, doctors, pharmacists, others
- ◆ registration, quality assurance, control of outlets
- ◆ regulation of source prices and mark-ups
- ◆ NGO/PLWH group purchasing
- ◆ industry partnerships for quality, promotion, supply



Conclusions

Opportunities for individual groups to contribute to rational use, affordability, availability

- PLWH groups
- NGOs
- UN family
- Governments
- Private sector
- Donors and development banks



Access to Drugs for HIV/AIDS and STDs

Overview of WHO Activities

November 1997

WHO Programmes Concerned with Drugs for HIV/AIDS and STDs

(overview of programmes and examples of activities; not all programmes or activities are listed)

ASD — Office of HIV/AIDS and Sexually Transmitted Diseases

- overall coordination of WHO work in the area of HIV/AIDS and STDs and liaison with UNAIDS
- participation in regional, international meetings (Vancouver, 1996; Amsterdam, 1997; Manila 1997, Adijan 1997, with satellites/round tables on care and medicaments etc.)
- organization of ARV (antiretroviral) consultation (April, 1997), publications of proceedings and follow-up, including 9 guidance modules for decision makers at national and international level
- sexually transmitted diseases: diagnosis, treatment guidelines, drug recommendations
- participation in European Commission Working Group on Access to Drugs for HIV in Africa/Care of HIV/AIDS: participation in INSERM initiatives on ARVs in Africa: participation in AFRO inter-country meetings on ARVs and Health Systems in Africa, Harare, 1997
- Coordinating "care for PWHA's" activities in WHO

DAP — Action Programme on Essential Drugs

(see pages 2 and 3 for additional information)

- policy, technical and country work on access to drugs, rational use, and drug quality
- review report, *HIV opportunistic infections and STDs: morbidity rates and standard treatments* (1997)
- assessment and improvement of in-country access, including manual on *Indicators for rapid assessment of access to HIV/AIDS-related drugs* (joint with UNAIDS)
- working group on access to new drugs and drug development (including ARVs)
- management of ketoconazole and miconazole donation (Janssen)
- affordability and supply issues for antiretroviral drugs (presentation at April, 1997 meeting)
- participation in regional and global meetings (various UNAIDS; Amsterdam, 1997; etc.)

DMP — Drug Management and Policies

- normative guidelines for drug quality, safety, efficacy, and information
- WHO Model List of Essential Drugs (revised every 2 years since first list in 1977; 10th list will be prepared by Expert Committee in December, 1997)
- revision of treatment guidelines manual, *Drugs used in sexually transmitted diseases and HIV infection*



GTB — Global Tuberculosis Programme

- diagnosis, treatment, and drug recommendations for tuberculosis in HIV+ individuals
- publication of *TB/HIV: A clinical manual*
- integration of TB and HIV/AIDS care in primary health care
- publication of *A Deadly Partnership: Tuberculosis in the Era of HIV* with UNAIDS (1996)
- section on HIV infection and tuberculosis in *Treatment of Tuberculosis: Guidelines for National Programmes* (1997)

RHT/MSM — Reproductive Health (Technical Support) / Maternal and Newborn Health/Safe Motherhood

- development of best practice guidelines for antenatal care, delivery, postnatal and post abortion care including section on HIV/AIDS.
- Technical paper on HIV in pregnancy shortly to be published (with UNAIDS) and policy paper on HIV and pregnancy in preparation (with UNAIDS)
- integration of STD care into reproductive health services/MCH

WHO Action Programme on Essential Drugs (DAP)

WHO Mission in Essential Drugs

To contribute to reduced morbidity and the mortality from common illnesses by collaborating with countries to develop and implement national drug policies and programmes which ensure equity of access to essential drugs, rational use of drugs, and drug quality, within the context of the national health policy.

Priority Activities Related to Access to Drugs

National drug policies

- establishing NDPs as a framework for action
- emphasis on multi-sectoral participatory process
- rapid movement from policy to implementation planning (masterplan) and follow-up

Economics and drug financing

- practical approaches to drug financing:
 - public financing of drugs (rationale and quantification)
 - insurance and drugs (specific features of providing drug benefits in insurance schemes)
 - user fees (protecting equity, lessons from experiences, cautions)
 - donor and development bank financing (role and cautions)
- affordability of drugs in the private sector (price information, pricing strategies and price regulation, price competition through generic drugs)
- effect of WTO (World Trade Organization), TRIPs (new patent agreements), and related measures

Access and supply strategies

- application of modern management methods
- innovative supply strategies (autonomous CMS, direct delivery, primary distributor)
- availability of drugs in the private sector (rationalization of wholesale and retail networks)
- role of NGOs in drug supply
- access to new drugs; local production; other access issues

Rational use of drugs

- local adaptation of treatment guidelines, essential drug lists
- better prescribing through undergraduate, clinical, and in-service training
- improved pharmacy and dispensing training for drug information, patient counseling
- focus on consumer and patient education

Regulation and quality assurance capacity

- innovative approaches to putting standards into practice
- improved financing, staffing, and organization of regulatory functions
- implementation of ethical criteria for drug promotion
- promotion of drug quality management throughout the production and distribution chain

Traditional medicines

- assessment of safety and efficacy; information on proper use
- integration into national policies and programmes
- regulation and quality assurance



THE GLOBAL TB INITIATIVE

A Coordinated Attack on TB

*Developed by
reps of many agencies:
WHO, ~~EC~~ CDC, others.*

Tuberculosis is the single most important adult infectious disease as measured by death or share of global disease burden; yet, it remains terribly neglected. It is worsening, spreading, and poses a global airborne disease threat. The main cause of this epidemic remains bad TB treatment and prevention strategies, which fail to cure infectious cases and stop the spread of the infection. The HIV/AIDS epidemic is further fuelling the TB epidemic in sub-Saharan Africa and will exacerbate the TB epidemic overall, especially in Asia and the former USSR countries.

A simple, highly cost-effective TB treatment and management system - the DOTS strategy - has been proven effective in all regions of the world. The problem is that the DOTS strategy is not used widely and intensively enough and the international human and financial resources to reverse this have not been provided.

In addition, multi-drug resistant forms of tuberculosis (MDR-TB) are emerging in all parts of the world. MDR-TB poses a serious threat for the control of TB for three simple reasons: i) it is virtually incurable in developing country-settings; ii) it is casually transmissible by air; and iii) it is already widespread, poised to substantially worsen and will inevitably breakout from "hot-zones" unless much improved control efforts are rapidly put in place.

A draft of activities termed "the global TB initiative" follows with indicative costing. Expansion and refinement of the elements of this menu will be required along with agreement on responsibility and roles for implementation of different components.

*DRAFT
NOT FOR DISTRIBUTION*

GLOBAL TB INITIATIVE COMPONENTS SUMMARY

I. TB and MDR-TB Surveillance

\$ 2 million

1. Strengthening of the global TB monitoring and surveillance system - (\$ 1 million) to monitor and track trends of MDR-TB, especially in "hot-zones".
2. Maintenance and expansion of the MDR-TB surveillance system - (\$ 1 million) to monitor DOTS implementation status and its impact on global TB burden.

II. Focused Tuberculosis Control Initiatives

\$ 12 million

Expansion of Effective TB Control

Strengthen the capacity of selected countries, particularly those of economic and immigration importance to the US, to:

- i) implement the DOTS TB strategy and expand its coverage;
- ii) slow MDR-TB creation in the most critical areas of the former USSR and Eastern Europe and,
- iii) build international human resources to manage containment of the MDR-TB hot-zones through the DOTS strategy over the medium term.

Details: Expansion of Effective TB Control

- i. Immigration to US - Technical support (\$ 3 million) to rapidly expand the DOTS TB strategy in those countries which are developing MDR-TB hot-zones and which are centers of US bound immigration (Mexico, Vietnam, Philippines, and Central America).
- ii. Eastern Europe and ex-USSR - Urgent technical support for upto 19 countries to establish the DOTS strategy (\$ 2 million), coupled with an emergency fund (\$ 5 million) for purchase of quality fixed-dose-combination anti-TB drugs before longer-term drug financing can be provided by the World Bank and other development agencies.
- iii. Global TB Expertise - Develop, train and manage international experts (\$ 2 million) to provide ongoing expertise to countries on implementation of the DOTS strategy and to prepare national staff in epidemic countries to control the TB epidemic.

III. Research for MDR-TB Containment and Management

\$ 3 million

1. Prevention of Hot-Zone Seedlings - (\$ 1 million) Development, testing and expansion of programmes at the community level in Latin America, Asia and Africa to empower civil society at the local level to stop TB even when confronting the dual TB/AIDS epidemics. *looking at effects in / useful in MDR TB*
2. Field Trials for TB Diagnostics Tests - (\$ 1 million) Bring to market effective products being developed by (mainly US) companies to enable much more rapid detection of TB disease to allow earlier, more focused and cost-effective treatment, particularly where HIV is prevalent. *potential in 24 mths*
Some Field Trials leading effort - at WHO
3. TB Vaccine Animal Model Initiative - (\$ 1 million) Speed ultimate development and testing of candidate TB vaccines to more effectively treat, prevent and ultimately eradicate TB.

I. TB AND MDR-TB SURVEILLANCE

1. OVERALL TB SURVEILLANCE

Background

Worldwide surveillance of TB and monitoring of treatment results is crucial to global TB control. WHO established in 1995 a new global surveillance and monitoring project allowing the continuous assessment of TB epidemiology and effectiveness of control programmes. A system of data collection has been created, together with guidelines on production of the essential information needed for regional and global assessment. A database has been established at WHO headquarters to store the information collected and produce reports on the global situation. The first product of this new project has been published in early 1997 and a second report will be published in early 1998. The report contains the essential information on case notifications and treatment results for all countries of the world. In 1996 3.5 million cases were notified in the world. Of the 1.1 million reported infectious cases which occurred in 1995, only 56% were reported as treated successfully. Moreover, these figures are limited to only a fraction of cases truly occurring, as WHO best estimate of the total number of cases arising globally in a given year is 7.3 million. Improvement of surveillance of TB at country level worldwide would substantially strengthen both knowledge of the TB epidemic and its trends and would facilitate development of political commitment to combat it and adopt the DOTS strategy for TB control more widely and rapidly.

Aim

To accelerate high quality surveillance of the global status of tuberculosis epidemiology and control and to determine the impact of DOTS on TB epidemiology.

Specific objectives

1. To maintain an accurate system of global TB surveillance and treatment monitoring and to strengthen it in order to describe the status of TB epidemiology and the national programme performance through systematic assessment of control policy, case finding and treatment results.
2. To establish a global network of interested agencies assisting in data gathering and verification.
3. To improve surveillance systems in many high-burden countries with poor information on the TB epidemic through training and education, and to study a mechanism of coordination among various information systems, including the private sector.

4. To determine the impact of a successful implementation of DOTS on the transmission of TB.

5. To disseminate information on the status of the epidemic and its control.

Methods

1. *Data collection, management, and analysis.*

The established system of data collection and management currently in place at WHO will be maintained and improved. In particular, countries will be provided with a simple software for data management and production of electronic files containing the essential information for global monitoring at WHO. To allow rapid reporting, the Internet will be used so that data produced in countries can be provided quickly. In turn, the WHO database will be displayed in the world wide web in order to make it accessible to other interested international surveillance sites. Analysis of the data will allow the regular production of global reports.

developed already
by GEMD - Tom Fox

2. *Assessment of quality of information at country level.*

Many countries adopting the standard recording and reporting system recommended by WHO need to improve their performance. A network comprising the most reputable institutions involved in TB control, including CDC and the IUATLD, etc, will be established under the coordination of WHO to assist in data gathering and verification. A guideline on rapid verification of district data for non-TB experts will be produced. Based on it, local epidemiologists and WHO consultants will verify data collected in most countries of the world. This will allow an assessment of the quality of data produced by countries.

as a part of
completeness of
reporting system
not reporting system
ad hoc time-limited
surveys
② case reporting to
assess DOTS success

3. *Improvement of surveillance systems in countries with poor information.*

Many countries suffer from poor performance in TB surveillance and monitoring. This is due to a variety of factors, such as weak information systems, duplication of efforts, presence of a private sector which fails to report, poor diagnostic capacity, etc. Focusing initially on high-burden countries, such as the Philippines, India and Indonesia, the project will try to determine the contribution of various systems, including the private sector, in TB notifications. Special surveys will be designed and, from the lessons learned, interventions will follow.

4. *Coordination of global information on airline outbreaks.*

More and more concern has been raised in the past few years regarding transmission of TB and multi-drug resistant TB during air flights up to and within the US. WHO often receives requests of information on this issue. Coordination of information is essential to guide proper

BUDGET:

Breakdown		
Personnel		170,000
1 coordinator	140,000	
Secretarial support	30,000	
Development of software for standardization of reporting		140,000
Programming	20,000	
Testing	20,000	
Training (materials, consultants & sessions)	100,000	
Development and use of guideline on data verification		160,000
Document production	10,000	
Training (consultants)	50,000	
Data verification (sub-contracts to consultants, IUATLD and others)	100,000	
Studies to improve surveillance (contracted to IUATLD)	100,000	
Establishment of coordination center for airline outbreaks	100,000	
Studies of DOTS impact on TB epidemiology		
Data analysis (sub-contracted to academic institutions or other partners)	100,000	
TB prevalence surveys coordinations (sub-contracts to IUATLD or academic institutions)	130,000	
Dissemination of results		
Meeting and workshops	70,000	
Publication	30,000	
Total Cost:		US\$ 1 million

2. GLOBAL SURVEILLANCE OF DRUG RESISTANCE IN TUBERCULOSIS

The WHO Tuberculosis Programme and the IUATLD, alarmed by reports of spreading drug resistant tuberculosis cases, launched in 1994 a global antituberculosis drug resistance surveillance project. Tuberculosis is currently curable in the greatest majority of cases thanks to the potent effective drugs available. However, if drug resistant and multi-drug resistant strains spread beyond the areas where they have been clearly detected, tuberculosis threatens to become an incurable airborne disease.

In the majority of the countries of the world the true extent of the problem of drug resistant tuberculosis was not known in 1994. In order to respond to this serious threat to tuberculosis control, WHO, in collaboration with the IUATLD, supported sound surveys and surveillance projects, standardized and capable to produce internationally comparable results. They have established a global network of supranational reference laboratories (including 22 reputable laboratories in the five continents) and creating a Working Group on Global Drug Resistance Surveillance. As a result, nearly 50 countries were surveyed between 1994 and 1997. For 35 of them, including some of the largest burden countries, results were published in a monograph in September 1997. This publication, produced by WHO in collaboration with staff from IUATLD, CDC and other major institutions, presents reliable, quality-controlled, standard data on drug resistance worldwide. This was partly possible thanks to a grant from USAID.

The main messages emerging from these first three years of activity can be summarized as follows:

1. drug resistance is everywhere and is more serious in some places than others. There are “hot spots” in the Americas, Asia, and the former Soviet Union where multidrug resistance is truly alarming,
2. the level of resistance to single drugs is already quite high in many developing countries. As a result, the threat of progressing rapidly to multidrug resistance is very serious,
3. while many countries have effectively been surveyed, for other large burden countries, such as Mexico, Philippines, China, Russia and other former socialist countries, data are not yet available or are limited to only one region or two within the country. Thus, there is a clear need to expand surveillance to new countries and to new areas within sampled countries using the established method and network,
4. for most of the countries surveyed, data are available for the first time. Thus, it is important to monitor trends over time in order to measure the impact of sound, and unsound, TB control strategies on the onset of drug/multidrug resistance.

Aims

To study the true extent and severity of antituberculosis drug resistance in the world building on a well-established global network and working group.

Specific objectives

1. To implement additional WHO-recommended drug resistance surveillance and surveys in various countries during the next biennium, particularly in those resource-poor countries where the tuberculosis burden is often the highest and where drug resistance may be a major problem and a global threat (China, India, Mexico, Philippines, countries of the Former Soviet Union, Vietnam and Korea).
2. To monitor trends of prevalence of drug resistance over time, by repeating, at three years intervals, surveys in those priority countries recently surveyed.
3. To maintain an international network of reference laboratories for quality control.
4. To establish a training center and system for training future investigators on drug resistance surveillance.
5. To disseminate information on the prevalence of drug resistance worldwide.

Methods

1. *Establishment of projects in high priority countries.*

This activity will be based on universally accepted guidelines produced by WHO and IUATLD, in collaboration with world experts, on methods of drug resistance surveillance (latest edition May 1997). Single projects will be based on carefully reviewed protocols and linked to the network of supranational reference laboratories to ensure quality of drug susceptibility testing. Local investigators will be provided with contracts covering local personnel cost, support to laboratories for supply and equipment, local training, supervision by local teams, etc.

2. *Interlaboratory reference strain exchange.*

thus is an essential component of quality control and the only means to ensure that data obtained in various countries are comparable. A coordinating center will be distributing test strains throughout the network of 22 laboratories worldwide at regular intervals.

3. *Training of Principal Investigators and responsible persons in countries.*

A formal training centre and system will be established with the purpose of educating country investigators on the WHO methods of drug resistance surveillance. Training courses will be held once or twice a year for investigators from countries ready to start the activity.

4. *Monitoring visits by WHO staff or consultants.*

This is an essential project component to ensure that ongoing activities are standardized and regularly and uniformly proceeding. WHO staff and consultants (including CDC and the IUATLD) will visit countries where the survey or surveillance is ongoing in order to assist with the implementation and provide guidance throughout the conduct of the project.

5. *Global coordination.*

Global coordination will be ensured by a staff based at WHO responsible for monitoring the activities of the supranational laboratory network, for verifying that protocols are based on sound epidemiological and microbiological methods, for collecting, reviewing, analyzing and publishing reports periodically.

6. *Dissemination of results from the Global Drug Resistance Surveillance.*

In late 1998, members of the global WHO working group on drug resistance surveillance will meet to review the available results, the status of the project, and make decisions regarding future activities. A new summary report will be produced and widely disseminated to medical journals, health officials, and all interested agencies.

7. *Impact of drug resistance on treatment results under programme conditions.*

The only data available on the impact and significance of various types of drug resistance on results of standardized treatment are those compiled in 1986 from a variety of clinical trials. However, the response of single-drug and multi-drug resistant patients to standardized short-course chemotherapy under programme conditions has not been sufficiently studied. A small number of projects in a variety of developing country settings will analyze the outcome of treatment by type of drug resistance.

Expected Products

Reliable data on the prevalence of antituberculosis drug resistance from most countries worldwide and analysis of drug resistance level as function of treatment policies adopted by countries, to be published in a report.

Monitoring/Evaluation

The project will be monitored centrally by WHO/MTB staff and its partners (IUATLD, CDC and others), as well as through the monitoring visits of consultants, who will assess the quality of data collected from participating countries.

The project will be evaluated based on the quality of the data collected, which will be verified by a thorough evaluation of the results in view of other indicators of TB control.

12 <https://doi.org/10.1017/S0007122619000075>

1. EXPANSION OF EFFECTIVE TB CONTROL

The DOTS strategy has been proven to cure the majority of TB patients, including in resource poor settings. Successful DOTS programmes have been initiated in all large countries in all regions. The results of these field programmes are:

- (i) the DOTS strategy is achieving almost the same results in poor socio-economic settings as the best treatment in rich countries,
- (ii) emergence of drug resistant TB appears to be contained, and
- (iii) health systems and community health projects are strengthened as both health workers and the populace can see and measure results.

It is in the direct interest of those areas of the world where TB rates are low, to support expansion of the DOTS strategy in countries where TB rates are higher, to avoid the creation of MDR TB, which will ultimately spread through migration and travel.

Specific Objectives

The main goal of the project is to strengthen the capacity of selected countries to implement DOTS and expand its coverage. This section contains three proposals. Two of them are designed for countries which have high communication with the USA in Latin America, East Europe, Middle East and Asia. The third project specifically address capacity building of the human resources needed in the global expansion of the DOTS strategy.

Sub-section a: Support to TB programme in selected countries (\$ 3 million).

The selected countries could be of USAID's choice and could include Mexico, 9 countries in Central America including Dominican Republic, plus Viet Nam, the Philippines, Egypt and Pakistan. Most of these countries have high TB rates, an insufficient TB control programme and poor recognition of the TB problem. All countries have accepted the WHO strategy in principal, but have weakness in the programme implementation which could be overcome through this project. The CDC would be closely involved in each project as desired along with consultants from the IUATLD and its associated member institutions, and from qualified US academic institutions and consultants.

④
- AFrica
- HIV
- PVT, SECTOR
- HSRGAM

Sub-section b: Implementation of DOTS in Eastern Europe and Russia.

Public health services have collapsed accross much of this region. Families of TB patients' are not subsidized and most drugs and services have to be paid out of the patients' pockets. Drug supply is highly irregular. This situation has created a burden of chronic TB cases, some harboring MDR-TB and the situation is getting worse. DOTS projects have been successfully launched in parts of Russia, Kyrgyzstan and the Caucasus countries. The goal of the proposal is to create a critical mass of DOTS sites in Russia where DOTS is successfully implemented to thus substantially influence public health authorities and official policy toward TB and to provide the training/demonstration bases from which National DOTS Programmes could be rapidly scaled-up once there is the political will to do so.

Sub-section c: Development of human resources (\$ 2 million).

International and country based public health experts have too limited knowledge of the DOTS strategy. Existing TB experts in developing countries are often in late middle age, or even elderly, with limited skills in communication and management. The goal of this proposal is to select the best young available candidates and expose them to experiences in programme implementation under the close supervision of recognized experts. Special

management training courses and tools will be produced for building leadership and testing candidates in field conditions. Special care will be paid to select candidates who will continue working in the key DOTS projects. The International Union Against TB and Lung Disease (IUATLD) would be leading this project with collaboration from WHO and CDC as needed.

**** (Add section here on laboratory training - with leading role to CDC)**

Methods

The project builds on the existing strategy and plans for technical support and strengthening human resources carried out by WHO and the IUATLD. Government counterparts in most of the countries have already been involved in the initial stage of launching the implementation of the DOTS strategy. Thus the projects could start quickly and produce measurable results within two years.

Special attention will be paid to involve USAID staff or USAID collaborating NGOs and firms already working at country level. A more detailed plan for allocation of resources will have to be prepared in consultation with USAID and CDC. The IUATLD and its member associations would be closely involved depending on the countries and for all of component (c), along with CDC.

Monitoring/Evaluation

Improved country-based leadership, adaptation of the DOTS strategy to the country situation, accelerated implementation of DOTS in selected countries and increased number of experts in TB programme organization. Involvement of all sectors of government to support the DOTS project as a major development issue is a key element in ensuring project sustainability and replicability. Thus the project will focus on ensuring ownership of DOTS in the selected countries. The ultimate goal of the project is to create, replicate and expand diagnostic, curative and support services for DOTS that will ensure high cure rates in diagnosed TB cases.

Rationale: The reduction of tuberculosis in countries with low incidence rates and high migration (including the USA) requires rapid reduction of TB transmission in countries providing immigrants or visitors, through expansion of effective TB control programmes.

Countries: The project would target and benefit directly countries to be selected in discussion with USAID and could include: Mexico, Central America and Dominican Republic, Vietnam, Philippines, Egypt, and Pakistan

Strategy: The project will support a package of activities to improve national programmes, based on the WHO/MTB Framework for Effective TB Control (the DOTS strategy). Implementation roles could vary by country and would be agreed among WHO, IUATLD, CDC and other partners as appropriate.

Areas of activity, interventions and cost:

1. Developing effective leaders and advocacy to raise TB programme profile	\$ 310 000
National/intercountry training workshops	100 000
Observation of successful national programmes	60 000
Advocacy/Education materials and events	150 000
2. Improving TB programme management	\$ 520 000
Produce updated national guidelines (for each country)	60 000
Adapt available WHO training materials (to each country)	150 000
Training for trainers of the country's NTP	150 000
Building consensus on the application of the DOTS strategy	100 000
Technical Assistance to countries to prepare annual TB work plans	60 000
3. TB laboratory activities (bacteriological diagnosis and control) with US-CDC	\$ 430 000
Situation analysis	80 000
Production of national guidelines	60 000
Training and specification of equipment and facilities	140 000
Organization of the network (information, quality control)	150 000
4. Monitoring and surveillance (in collaboration with US-CDC)	\$ 480 000
Analysis of the information system	100 000
Consensus building	80 000
Adaptation of WHO materials and testing	150 000
Develop system for data analysis, monitoring and reports	150 000
5. Management of TB by the non-government sector (in collaboration with US NGO's ATS and ASTER)	\$ 200 000
Analyse procedures private practitioners, hospitals, NGOs	120 000
Studies on treatment outcome in selected areas	80 000
6. TB drug supply and quality	\$ 460 000
Analysis of drug resources and procurement, distribution	

3.	Improving of diagnostic capacity training of supervisors (national and intermediate staff)	\$ 520 000 120 000
	revision of existing guidelines on laboratory procedures	60 000
	upgrading the laboratories (microscopes, materials)	340 000
4.	Monitoring and surveillance	\$ 200 000
	analysis of the existing information systems	60 000
	adaptation of WHO recording and reporting systems	40 000
	upgrading of the national level monitoring and surveillance capacity (training, computers, software)	100 000
5.	Quality fixed dose combination Anti-tuberculosis drugs	\$ 5 000 000
6.	Staff - 4 inter-country coordinators = 88 months	\$ 700 000
Total cost :		US\$ 8 000 000

c) BUDGET: DEVELOPMENT OF HUMAN RESOURCES (US\$ 2 MILLION)

Rationale: To provide technical support to national TB programmes and ensure effective TB control, it is necessary to develop national and international experts on TB control, who can provide ongoing technical assistance. In addition global training materials must be updated and adapted to be applicable to different stages of (national and TB programme) development.

Countries: The project would target and benefit directly large burden countries, and also prepare a cadre of young experts to sustain technical and operational programme quality for all countries in the future.

Strategy: The project includes development of international experts and preparation of national staff at central and intermediate level.

Areas of activity, interventions and cost:

1. International experts on TB programme organization.

Young public health professionals would receive focussed training for a period of one years (similar to CDC EIS training). This training would include three areas - technical expertise through country visits; training skills through international training courses on TB control and management/leadership; and research skills through protocol design, operational research and analysis/interpretation of data for publication. Three to six candidates could be recruited for this package each year. Each candidate would cost approximately US\$ 100,000 per year. An alternative approach could be developed with and through the IUATLD which could manage its implementation. Upon satisfactory completion of this training, successful candidates should serve 3-5⁴ "contractships" with WHO, IUATLD or other suitable institutions or in national programmes.

2. Management and leadership skills at national and intermediate levels.

Selected nationals at managerial level (national and State) from large burden countries could benefit from this type of training. Possible partners are Management Sciences for Health, University of Boston, Harvard school of management, Indian institute of management, and other management schools. Approximately 20 candidates could be trained in 2 years. Cost for each candidate would be US\$ 10 000.

3. Laboratory Training Courses and Laboratory Management Development (to be written by CDC).

- #### 4. Tools development.

Adaptation of existing tools and preparation of new tools. Packages such as management modules at district and national levels, refugee guidelines, prison guidelines, student manual, TB handbook and laboratory materials will be tailored to suit specific country needs. They could be adapted to specific audiences and targeted to specific levels in the PHC system. Possible partners in this exercise could be Damien Foundation, Universities and other consultants (in Australia, UK, USA) and BRAC (Bangladesh).

5. Staff costs for the above: 22 months professional plus administrative support staff would amount to US\$ 300 000.

1. Development of 3-6 TB experts in 1 year	300 000
2. Training 20 candidates on management	200 000
3. Tools adaptation and development	200 000
4. Laboratory Training Component	1 000 000
5. Staff costs	300 000
Total Cost:	\$ 2 000 000

III. RESEARCH ON MDR-TB CONTAINMENT AND MANAGEMENT

1. HOT-ZONE SEEDS

DOTS THROUGH COMMUNITY BASED ORGANIZATIONS

Background

TB remains a major cause of suffering and death; in 1990 it was the leading killer of working age adults. This inspite of the availability of tools with the potential to avert much of the burden imposed by the disease. The WHO strategy (DOTS) has been shown to yield consistent documented cure rates of 85% even in adverse settings. DOTS has been adopted by an increasing number of countries over the past few years. In 1995 DOTS services delivered about 1 million documented cures. However this has to be viewed in the context of an estimated 8 million new TB cases in the same year. Only a small fraction of the global population has access to the quality TB care provided under DOTS. Even in countries which have implemented DOTS the coverage remains limited due to a number of factors.

First is the major role of the private practitioners in health care especially in Asia and Latin America. DOTS has been provided mainly by the public health services so far. Many TB patients first approach private practitioners who typically have poor treatment practices. Private practitioners prescribe haphazardly and fail to ensure regular and complete treatment. Patients receive temporary relief but no cure. Many become chronic and remain infectious for long periods which in turn helps sustain the epidemic. Incomplete treatment also breeds drug resistance. 'Sloppy' TB treatment by private practitioners is a major cause of drug resistant TB. Multi-drug resistant TB is very difficult and expensive to cure. Failure to provide DOTS to patients of private practitioners limits the overall impact of public efforts to control TB.

Secondly the public health services in many developing countries are ill equipped to expand DOTS coverage rapidly without sacrificing quality. Health infrastructures are weak and DOTS imposes stringent quality requirements. In particular, DOTS entails close and sustained contact between the patient and the provider over a period of about 6 months. This is vital to maintain high cure rates, the overriding priority in DOTS. In many parts of the developing world this imposes an additional strain on already weak public health services. The HIV/AIDS epidemic is worsening matters. It increases both, the incidence of TB and the overall burden on health services. This is already happening in Africa. The story is likely to be repeated in many parts of Asia and possibly Latin America. While a public health approach to TB control must be the main route of attack against the epidemic, these factors limit the speed at which DOTS coverage can be expanded through government channels.

To accelerate DOTS expansion, GTB has worked even more intensively with governments and also begin to explore alternative channels for DOTS delivery to compliment the efforts of the public health services. Private practitioners are a potentially valuable resource. They are numerous, often located in the neighbourhood of the patient and known to the patient. However, they are usually scattered and unorganized with low average caseloads of TB per practitioner. Community based organizations such as private voluntary organizations (PVOs), local medical associations, locally based clinics and hospitals can help organize groups of private practitioners.

Franchising of the DOTS strategy to community based organizations (CBOs) is a promising method of rapidly expanding DOTS coverage. GTB judges DOTS franchising to community based organizations to be promising because:

- DOTS as a service package is very amenable to franchising - it has standardized procedures and training, well defined outcomes, in-built quality assurance and a management information system.
- Franchising is one of the best mechanisms for rapid replication.
- GTB already has considerable experience with installing DOTS in public health services.
- In Bangladesh a CBO (BRAC) has already successfully adopted DOTS.
- CBOs are well placed to harness human resources within the community. Private practitioners are only a subset of community based human resources. Others include health volunteers, school teachers, shopkeepers etc all of whom are near to, and often known and trusted by the patient. Physical accessibility and trust greatly facilitate treatment supervision, and reduce default.

GTB envisages a DOTS franchise to be a TB unit catering to a population of 100,000-500,000 using tried and tested DOTS methods and registers. The franchise would be equipped with microscopy services, medical back-up, reporting and recording systems and uninterrupted drug supply. Essentially it would be a replica of the district based TB unit in National TB programmes. CBOs will serve as DOTS franchises. These could be groups of private providers formed with a commercial motive and/or private voluntary organizations. PVOs are likely to be more important in the African context. The franchising package would include, along with basic DOTS training, protocols for:

- linkages with public health services,
- referral systems for complications,
- financing arrangements and incentive schemes,
- quality assurance

DOTS franchising is currently being piloted in three sites in India. GTB hopes to use this experience to optimize the DOTS franchising package and rapidly expand access to quality TB care by franchising DOTS to CBOs around the world. GTB has the networking capability and international credibility to achieve such accelerated franchising.

Specific Objectives

The long term objective is to expand access to quality TB care by extending DOTS to community based organizations (private for-profit and private voluntary).

The project specifically aims:

- to design and test a franchising package for DOTS delivery through CBOs.
- to prepare a standardized shortened training programme for DOTS franchisees,
- to adopt the package to different settings around the world in consultation with local experts and through pilots if necessary,
- to launch DOTS franchise pilots in those parts of Asia and Latin America where the private sector plays a major role in TB care (eg., Indonesia, Philippines, Mexico, etc.),
- to identify groups and organizations which can serve as DOTS franchisers around the world.

1. Designing and testing a franchising package for DOTS delivery through CBOs.

GTB has already initiated a DOTS private/public mix pilot based on the franchising of the DOTS technology to a network of private providers in Hyderabad, India. Early results have been encouraging. Two more pilots are about to be launched. Based on the experience in these pilots over the next 2-3 years GTB intends to design a robust franchising package for DOTS delivery via CBOs.

The design of the training materials and programme will constitute an important component of the overall design work for the franchising package. This work will draw on experiences in the Indian pilots and will be done in collaboration with DOTS experts from WHO, IUATLD and KNCV among others as well as senior field staff.

2. Identifying new sites and collaborators for piloting DOTS franchising in Latin America, Africa and other parts of Asia.

Premier research institutions, medical associations and prominent voluntary organizations will be contacted over the next year for potential piloting of DOTS franchises. These will include the contacts of potential partners such as the WB, UNAIDS, USAID, UNICEF, IUATLD, etc. GTB will focus on large countries in Asia and L America where the private sector plays a big role in TB care.

3. Training and project planning workshops.

Interested parties will be asked to submit expressions of interest which will be screened by GTB. The selection process will involve information gathering and situation analysis through site visits by GTB staff and consultants. Selected groups will be invited to two or three workshops planned in a staggered fashion for early 1998. DOTS experts from GTB and partner agencies will impart training to the franchisees. This would be followed by detailed project planning for each site complete with timelines and budgets. The training workshop will be followed by brief priming visits to successful DOTS franchise pilots in India.

4. Launching and supporting the DOTS franchise pilots.

This would include providing start-up capital and DOTS expertise for problem solving. Monitoring visits by GTB (HQ and regional) staff and partners will assist in implementation and provide guidance. Long run financial sustainability would be based upon a mixture of public funding and user fees which would vary from country to country. A crucial aim of the DOTS franchise pilots would be to work out the financing arrangements which best suit the local conditions.

5. Finalizing the franchising package, guidelines for adoption in different settings and listing of potential franchisers.

A final workshop will be attended by project coordinators, representatives of successful DOTS franchise pilots and staff from GTB and partner agencies. The franchising package will be finalized. Based on experiences in various countries, the workshop will draw up guidelines for adoption of the package including the training materials to different settings.

Many of the successful franchisees will qualify as potential DOTS franchisers. Since GTB has limited staff capacity, rapid expansion of DOTS franchising will need creation of new franchisers around the globe. These 'area franchisers' will be responsible for:

- adopting the franchising package to the regional setting,
- recruiting and training new franchisees and,
- providing start-up assistance.

BUDGET:

Activity	Amount (in US \$)
Designing and testing of franchising package including training materials (underway in India)	\$100 000
Identifying new sites and local collaborators in other parts of Asia, Africa and L America (Asia - 3, Africa - 1, L America -2)	\$ 60 000
Training and project planning workshops (at least 2)	\$ 100 000
Launching and supporting DOTS franchise pilots	\$ 440 000
Workshop to finalize package and guidelines for adoption	\$ 100 000
Staff costs (1 senior professional till late 1999)	\$ 200 000
Total Cost:	\$ 1 000 000

Expected Products

1. Franchising package for DOTS delivery through CBOs based on experiences in the ongoing pilots.
2. Standardized shortened training programme for the DOTS franchisees.
3. Guidelines on adopting the DOTS franchising package to different settings around the world.
4. DOTS franchise pilots in Asia, Africa and L America.
5. List of potential franchisers around the globe.

Monitoring/Evaluation

The project will be monitored centrally by GTB. Monitoring would include submission of essential reports (quarterly case finding, sputum conversion, treatment results) as well as reports on costs, quality of microscopy etc. Periodic site visits will be made by staff from GTB and partner agencies.

The project will be evaluated on the basis of:

- treatment outcomes especially documented cure rates,
- quality of diagnosis,
- coverage of TB patients in the private sector,
- participation rates of private practitioners,
- cost per cure,
- patient costs,
- financial sustainability.

2. FIELD TRIALS FOR TB DIAGNOSTICS TESTS

There is now an opportunity to provide timely support for the development of new tools for diagnosis, treatment, and prevention of tuberculosis. Five years of support for tuberculosis research has led to specific gains that are now about to come to fruition. These gains include completion of the sequence of the *M. tuberculosis* genome, the discovery of the means for genetic manipulation in mycobacteria, new understanding of the biology, biochemistry, and microbiology of the pathogen, and an improved understanding of the immunological response to infection. Each of these developments has the potential to lead to the development of much needed new products for the diagnosis, treatment, and/or prevention of tuberculosis. Two projects are proposed. One, to support field trials for new diagnostics, is aimed at speeding the development of products that are already close to completion. Another, to expand support for the testing of candidate vaccines in animal models, will relieve a current bottleneck in the development of candidate vaccines for tuberculosis.

Background

Need for new diagnostic tools.

AFB microscopy detects those cases of pulmonary tuberculosis that are epidemiologically most important, *i.e.*, those which are most likely to transmit the infection to their close contacts. It is also highly specific, suitable for application in low income areas, relatively inexpensive, and can be accomplished under field conditions. Yet, there are problems with the AFB microscopy both as a test for tuberculosis and how it is used. These problems diminish its value and restrict the number of cases of pulmonary tuberculosis diagnosed.

The test itself requires both microscopes and reagents. Even glass slides can be expensive. There are also problems associated with how the test is used. WHO recommends the examination of at least three sputum samples, collected during two consecutive days. This requirement for multiple samples and multiple patient visits reduces the number of smear-positive cases of tuberculosis treated. Nearly seven hours of a technician's time is needed for each case diagnosed. The result is that smear-positive cases are missed and the diagnostic follow-up system is costly.

The WHO/GTB Tuberculosis Diagnostics Initiative.

Responding to the clear need for new diagnostic tools, WHO/GTB has begun work on a Tuberculosis Diagnostics Initiative. This Initiative aims to stimulate, enable, and facilitate the efforts to develop new tuberculosis diagnostics. As a result of this Initiative, we know that there are presently over thirty [30] such products under development, some stimulated by the initiative itself. WHO/GTB plans to assist the laboratory [pre clinical] evaluation of these products by the establishment and distribution of a well characterized specimen bank. Products that perform well in the laboratory still face a more significant barrier. Each new diagnostic product must demonstrate performance under field conditions before it can be considered for approval by regulatory agencies. WHO in this proposal seeks to assist the diagnostics industry in this process.

need update

Many of these products are being formulated by small companies without significant capitalization. Such companies lack both the resources and the experience to design and conduct appropriate field trials needed to demonstrate the value of their tests. Poorly

This proposal seeks to speed the development of new diagnostics for tuberculosis through the establishment of a mechanism to enable WHO/GTB to assist industry with the development, application and evaluation of well-designed field trials needed to assess new diagnostic products.

The development, evaluation, regulatory approval, and use of effective new tuberculosis diagnostics appropriate for use in low income countries.

The overall objective is to establish a mechanism that will enable WHO to rapidly respond to the needs of companies, especially small companies, involved in the evaluation of new diagnostics for tuberculosis. The objectives described are purposefully broad to allow a specific response to be crafted, depending upon specific needs. The specific activities are prioritized.

To establish an international network of field trial sites, including laboratory personnel and facilities of proven reliability: The international nature of this network is critical for there are indications that some diagnostics [especially those based upon detection of specific classes of antibodies] may not perform with equivalent effectiveness on different population groups.

To develop “standard” protocols for field trials of new tuberculosis diagnostics: Companies commonly conduct improper tests to evaluate their products. Such tests do not provide useful information yet are often expensive. Companies who wish assistance in the design and execution of useful tests will benefit from a “standard” or model protocol.

This proposal will provide support to monitor the progress of field trials. It is anticipated that at least some of the personnel needed to accomplish this task will be drawn from the “experts” described below.

Since there are a number of products under development, it is anticipated that a number of products will be approved for use. Comparison trials where two or more products are compared with AFB microscopy and culture for the detection of pulmonary tuberculosis will be supported to help identify products with superior performance characteristics.

To provide expert advice from a standing committee of approximately six [6] experts drawn from those interested in the development of appropriate new tests for tuberculosis: This proposal seeks to establish a group of experts who will be able, through the use of confidentiality agreements, to provide specific advice to [especially small] companies involved in the development of new diagnostics for tuberculosis.

6. Support field trials of individual products:

A small amount of funds for this proposal may be used to finance field trials *per se*. It is anticipated that only products with demonstrated promise or performance characteristics, and produced by companies with severely limited resources, will be so supported.

Expected Products

The number of products evaluated in field trials will be increased. It is anticipated that 4-10 new diagnostic products will be evaluated during two years and 1-2 products should prove highly useful in developing country settings.

BUDGET FOR 2 YEARS PERIOD:

Item	Cost/yr. [US\$]
Project Coordinator	\$250,000
Site visits	\$100,000
Monitoring	\$50,000
Comparison trial	\$250,000
Advisory committee	\$150,000
Trial support	\$100,000
TOTAL	\$1,000,000

3. TB VACCINE ANIMAL MODEL EVALUATION

Background

Current research directed toward the development of an improved tuberculosis vaccine is funded by the NIH, industry, and others. A large number of candidate vaccines of different types [subunit, attenuated strains of *M. tuberculosis*, DNA] are being prepared as a direct result of this support. Additional research is being directed toward the development and testing of adjuvants to improve the immune response. Each candidate vaccine, many in combination with adjuvant[s], must be evaluated first in the laboratory, next in animals, and finally in human clinical trials. NIH/NIAID has recently issued a contract to provide support for the consistent evaluation of candidate vaccines in animals including mice, guinea pigs, and rabbits. This contract enables institutional and industry researchers to test their candidate vaccines in one or more animal models, a process that requires both specialized facilities and trained personnel. These resources are not otherwise widely available.

Testing in animal models evaluates the ability of each vaccine candidate to protect against tuberculosis in the animal. These tests begin with short term [1-4 months] experiments in mice. Successful candidates are next evaluated in guinea pigs. Finally, long term [6-12 months] experiments are done using mice, guinea pigs, and/or rabbits. The aim is to allow a relatively direct and rigorous comparison of the protective efficacy of various vaccine candidates using a standardized protocol.

Today there is a bottleneck in this process. The number of candidate vaccines exceeds the capacity for appropriate evaluation in animal models. This proposal seeks to establish two facilities for the evaluation of candidate tuberculosis vaccines in animal models.

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The US CDC and the IATLD would be closely consulted and involved in this process, to ensure its sound and rapid implementation.

Aim

The development and testing of an effective vaccine to protect against tuberculosis.

Specific Objectives

1. To establish and maintain two additional sites for the evaluation of candidate tuberculosis vaccines.
2. To use these sites to relieve the current pressure caused by the rapid development of candidate vaccines coupled with the relatively limited capacity to evaluate these candidates in animals.

Methods

Animal models for tuberculosis.

Mice are the least costly to purchase and maintain. In addition, mutant strains of mice with altered immune response are available. These mutants enable researchers to define the role of the immune system in tuberculosis protection and pathogenesis. Yet mice are not readily susceptible to tuberculosis.

Guinea pigs are exquisitely susceptible to tuberculosis but they are more costly, both to purchase and to maintain. There are, however, no mutant strains of guinea pigs with altered immune systems.

Tuberculosis in rabbits closely reflects the disease in man and is the model of choice for the study of tuberculosis pathogenesis. Rabbits are costly and not widely available.

Evaluation of candidate vaccines in mice and guinea pigs.

Support is sought to provide for the tiered evaluation of different candidate vaccines first in mice, followed by guinea pigs. A detailed protocol for this tiered process has been developed by NIH-supported researchers. These researchers have already indicated their willingness to help transfer the necessary technology to enable the replication of this protocol at new and geographically diverse sites. All candidate vaccines will be evaluated, as far as possible, using an identical testing protocol to promote a direct comparison of their protective efficacy [in animals].

It is anticipated that sites chosen will already have the required containment facilities but that some additional equipment for aerosol infection models may be required.

Expected Products

A wider network of animal testing facilities will enable the more rapid and responsive testing of TB vaccine candidates.

It is anticipated that each site will evaluate approximately twenty [20] candidates/year in short-term [1-4 months] tests in mice and approximately ten [10] candidates/year in long term [6-12 months] tests in mice and guinea pigs.

Monitoring/Evaluation

The number of vaccine candidates tested will increase by 40-60 year.

BUDGET:

Item	Amount	Cost [US\$]
Principal Investigation	50%	\$45,000
Technicians (2)	100%	\$110,000
Support personnel	100%	\$120,000
Animals		\$20,000
Animal care		\$80,000
Total/site		\$375,000
Two sites requested	TOTAL	\$750,000

Report on the Global HIV/AIDS Epidemic

D E C E M B E R 1 9 9 7



UNAIDS *Global
HIV/AIDS and STD
Surveillance* **WHO**

Surveillance of HIV/AIDS and STDs is conducted as a joint effort of UNAIDS and WHO. The data in this report have been compiled by the UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance in collaboration with National AIDS Programmes.

Global summary of the HIV/AIDS epidemic, December 1997

People newly infected with HIV in 1997	Total	5.8 million
	Adults	5.2 million
	Women	2.1 million
	Children <15 years	590 000
No. of people living with HIV/AIDS	Total	30.6 million
	Adults	29.5 million
	Women	12.1 million
	Children <15 years	1.1 million
AIDS deaths in 1997	Total	2.3 million
	Adults	1.8 million
	Women	820 000
	Children <15 years	460 000
Total no. of AIDS deaths since the beginning of the epidemic	Total	11.7 million
	Adults	9.0 million
	Women	4.0 million
	Children <15 years	2.7 million
Total no. of AIDS orphans¹ since the beginning of the epidemic		8.2 million

¹ Defined as HIV-negative children who lost their mother or both parents to AIDS when they were under the age of 15.

Global estimates

□ HIV: close to 16 000 new infections a day

New estimates show that infection with the human immunodeficiency virus (HIV) which causes AIDS is far more common in the world than previously thought (see box on page 12). UNAIDS and WHO estimate that over 30 million people are living with HIV infection at the end of 1997. That is one in every 100 adults in the sexually active ages of 15 to 49 worldwide.² Included in the 30 million figure are 1.1 million children under the age of 15. The overwhelming majority of HIV-infected people – more than 90% – live in the developing world, and most of these do not know that they are infected (see page 10).

Around 16 000 new HIV infections a day in 1997

- More than 90% are in developing countries
 - 1 600 are in children under 15 years of age
 - About 14 000 are in adults, of whom:
 - over 40% are women
 - over 50% are 15–24-year-olds
-

This year's estimates also point up the continuing rapid spread of HIV. Altogether, 5.8 million people are believed to have acquired HIV infection in 1997, 590 000 of them children. Overall, that is equivalent to nearly 16 000 new infections every day of the year, including those in children infected at birth or through breastfeeding.

Assuming that currently unbroken trends in many parts of the world will continue, it is estimated that more than 40 million people will be living with HIV in the year 2000.

An estimated 2.3 million people died of AIDS in 1997. These deaths represent a fifth of the total 11.7 million AIDS deaths since the beginning of the epidemic in the late 1970s. Of the people who died of AIDS this year, 46% were women and 460 000 were children.

² In this report, adults are defined as those aged 15–49, children as those under 15. To make it easier to compare prevalence rates (proportion of people currently living with HIV/AIDS) between countries and regions, the total number of adults aged 15–49 living in a given country or region is used as the denominator.

Regional round-up

It is becoming increasingly clear that, although almost every country is touched by HIV, the virus spreads very differently in different parts of the world. There are even important differences in patterns of spread in different communities and geographic areas within the same country.

Regional HIV/AIDS statistics and features, December 1997

Region	Epidemic started	Adults & children living with HIV/AIDS	Adult prevalence rate ³	Cumulative no. of orphans ⁴	Percent of HIV-positive adults who are women	Main mode(s) of transmission ⁵ for adults living with HIV/AIDS
Sub-Saharan Africa	late '70s - early '80s	20.8 million	7.4%	7.8 million	50%	Hetero
North Africa & Middle East	late '80s	210 000	0.13%	14 200	20%	IDU, Hetero
South & South-East Asia	late '80s	6.0 million	0.6%	220 000	25%	Hetero
East Asia & Pacific	late '80s	440 000	0.05%	1 900	11%	IDU, Hetero, MSM
Latin America	late '70s - early '80s	1.3 million	0.5%	91 000	19%	MSM, IDU, Hetero
Caribbean	late '70s - early '80s	310 000	1.9%	48 000	33%	Hetero, MSM
Eastern Europe & Central Asia	early '90s	150 000	0.07%	30	25%	IDU, MSM
Western Europe	late '70s - early '80s	530 000	0.3%	8 700	20%	MSM, IDU
North America	late '70s - early '80s	860 000	0.6%	70 000	20%	MSM, IDU, Hetero
Australia & New Zealand	late '70s - early '80s	12 000	0.1%	300	5%	MSM, IDU
TOTAL		30.6 million	1.0%	8.2 million	41%	

□ Infection reaches unprecedented levels in sub-Saharan Africa

Sub-Saharan Africa is the region with the fastest-moving epidemic. The African epidemic has also been the most underestimated one up to now (see box on page 12). Now thought to have fully two-thirds of the total world number of people living with HIV, sub-Saharan Africa as a whole has reached the unprecedented level of 7.4% of all those aged 15 to 49 infected with HIV.

Unprotected sex between men and women accounted for most of the 3.4 million new HIV infections estimated among adults in sub-Saharan Africa in 1997. In addition, high fertility combined with poor access to information and services for the prevention of mother-to-child transmission resulted in some 530 000 infected children being born to mothers with HIV – around 90% of the world total.

Although heterosexual transmission accounts for most infections throughout Africa, levels of infection vary widely across the continent.

³ The proportion of adults living with HIV/AIDS in the adult population (15 to 49 years of age).

⁴ Orphans are defined as HIV-negative children who lost their mother or both parents to AIDS when they were under age 15.

⁵ MSM (men who have sex with men), IDU (injecting drug users), Hetero (heterosexual transmission).

Southern Africa continues to be the part of the continent worst affected by HIV. By early 1997, the Government of South Africa estimated that 2.4 million South Africans were living with HIV, up by more than a third over 1996. In Botswana, the proportion of the adult population living with HIV has doubled over the last five years. In 1997, 43% of pregnant women tested in the major urban centre of Francistown were HIV-positive. In Zimbabwe, infection was estimated at one in five adults in 1996. In Harare, 32% of pregnant women were already infected in 1995; in Beit Bridge, another major city, the proportion shot up from 32% in 1995 to 59% in 1996. Although levels in cities were slightly higher than in rural areas, the difference was not great. In one town near the South African border with a large population of migrant workers, 7 pregnant women in 10 tested HIV-positive in 1995.

In general, West Africa has seen its rates of infection stabilize at much lower levels than in East and Southern Africa. However, some of the most populous countries in West Africa are the exception to this rule. For example, the National AIDS Programme estimates that 2.2 million people are currently living with HIV in Nigeria, a country whose response to the epidemic needs strengthening.

East Africa was one of the first areas to suffer a massive regional epidemic, and one country in the region, Uganda, was among the first to respond with open and concerted efforts to prevent the spread of the virus. For Uganda, this seems to be paying off. 1997 data currently being analysed show that the proportion of Ugandan adults infected is continuing to drop. All three of the surveillance sites for which figures are now available show infection levels of between 5% and 9%, representing a decrease of about one-fifth compared with 1996. The fall has been particularly marked in the younger age groups, which is in line with behaviour studies showing that young people nowadays are adopting safer sexual behaviour – later sexual initiation, fewer partners, more condom use – than was common a decade ago.

❑ Infection rates in Asia are lower than Africa's, but the numbers are large

The diversity within Asia is greater even than that in Africa. Levels of infection vary enormously, and so do routes of transmission. Often there are a number of different epidemics running concurrently within a single country. New genetic typing procedures (which allow researchers to investigate how different strains of the virus are spreading through the population) show that there is often remarkably little overlap between the HIV epidemics among injecting drug users and sex workers, for instance.

The epidemic is newer in Asia than in Africa, and only a few countries in the region have developed sophisticated systems for monitoring the spread of HIV. So estimates of HIV in Asia often have to be made on the basis of less information than in other regions. Because over half of the world's population lives in the region, small differences in rates can make huge differences in the absolute numbers of people infected.

The Government of China estimated that at the end of 1996 up to 200 000 people were living with HIV/AIDS. According to some estimates, this figure may have doubled by the end of 1997. At present, there are two major epidemics under way in China. One is in injecting drug users in the mountainous southwest of the country. The other, newer epidemic is now surfacing among heterosexuals, especially along the prosperous eastern seaboard where prostitution is re-emerging as the gap grows between rich and poor. The warning signs of high-risk behaviour are

worryingly clear: sexually transmitted diseases (STDs) have shot up in recent years, and there are no suggestions that the upward trend will be broken.

In India, infection rates, at under 1% of the total adult population, are still low by the standards of many countries, although well over 10 times higher than in neighbouring China. Surveillance is patchy, but all indications are that between 3 and 5 million people in India are living with HIV. Even at the bottom of that range, India is the country with the largest number of HIV-infected people in the world.

Recent testing of pregnant women in Mumbai shows infection rates around 2.4% in 1996. In Pondicherry, the rate among pregnant women is around 4%. Among truck drivers in the southern state of Madras, HIV infection quadrupled from 1.5% in 1995 to 6.2% just one year later. In the northeastern state of Manipur, where the epidemic took off quickly among male drug injectors, some drug clinics were registering HIV rates of as high as 73% in 1996.

There is limited information about HIV infection in other parts of south Asia, but it is clear that many people are having unprotected sex with non-monogamous partners. A recent study among sex workers in Bangladesh showed that 95% had contracted genital herpes, mostly from their clients, while 60% had syphilis.

Rates of HIV infection remain low in several southeast Asian nations. In Indonesia, Malaysia, the Philippines and Singapore, for instance, infection rates are well under 1%. However, other countries in the region show much higher levels of HIV spread. The reasons for these differences are not entirely clear. Nor is there any assurance that currently low rates will remain low, given the widespread occurrence of risk behaviour including commercial sex and, in some places, drug injecting.

Thailand, which has experienced what is probably the best-documented epidemic in the developing world, is continuing to produce evidence of a fall in new infections, especially among sex workers and their clients. These are the groups who have accounted for the majority of the some 750 000 persons currently infected, representing 2.3% of the adult population. The decrease in new infections is the outcome of concurrent and sustained prevention efforts aimed at increasing condom use among heterosexuals, boosting respect for women, discouraging men from visiting sex workers, and offering young women better educational and other prospects to discourage their entry into commercial sex. HIV rates among Thailand's injecting drug users have stabilized at a relatively high level (around 40%), and a survey among men who have sex with other men in northern Thailand reported low AIDS awareness and condom use.

Elsewhere in southeast Asia the picture is mixed. It is bleakest in Cambodia, where 1 in 20 pregnant women, 1 in 16 soldiers and policemen and 1 in 2 sex workers tested positive in sentinel HIV surveillance. While condom use has grown very rapidly (condom sales have risen from virtually nothing to around a million units a month in the space of under three years) commercial sex remains very common: in a recent survey three-quarters of respondents in the military and the police force and two-fifths of male students said they had visited a sex worker in the last year. Viet Nam and Myanmar are also seeing a rapid spread of HIV. In Myanmar, HIV infection among sex workers rose from 4% in 1992 to over 20% in 1996, while two-thirds of injecting drug users are infected. Among pregnant women in the general population, an estimated 2% are infected.

Overall, about 6.4 million people are currently believed to be living with HIV in Asia and the Pacific – just over 1 in 5 of the world's total. By the end of the year 2000, just three years from now, that proportion is expected to rise to 1 in 4. Around 92 000 children now live with HIV in Asia.

□ Latin America and the Caribbean: neglected groups and a window of opportunity

In Latin America the picture is heterogeneous. For the most part, HIV is concentrated in neglected populations living on the social and economic margins of society. The epidemic has taken its greatest toll on men who have sex with men and injecting drug users. Systematic data collection is difficult in these groups and information is rather scarce as of today. Nevertheless, studies on Mexican men who have sex with men show that, on average, as many as 30% of them may be living with HIV. Rates in drug users vary from 5% to 11% in Mexico to close to 50% in Argentina and Brazil. In some places there is clear evidence of increasing spread among poorer and less educated parts of the population. For example, in Brazil most of the early AIDS cases were in individuals with secondary or university education; today 60% of cases are in people with primary schooling or less.

Rising rates in women show that heterosexual transmission is becoming more prominent. In Brazil, the male/female ratio of AIDS cases has dropped from 16:1 in 1986 to 3:1. Although HIV rates in pregnant women are still comparably low in general, they have reached levels of 1% in Honduras and more than 3% in Porto Alegre, Brazil. Rates are substantially higher in the Caribbean. Haiti found over 8% of pregnant women carrying the virus already in 1993; the same prevalence was reported from one surveillance site in the Dominican Republic in 1996.

For the most part, however, this region of the world still has an important window of opportunity: it is not too late to stop HIV from spreading to the population at large. This will require a much greater focus on meeting the special prevention needs of marginalized and impoverished populations.

As limited as the region's epidemic has been thus far, AIDS has already had a major impact. In Mexico, AIDS was the third leading cause of death in men between 25 and 34 years of age in 1995 with increasing trends. In the state of São Paulo, Brazil, AIDS became the leading cause of death in 20 to 34-year-old women in 1992. In Latin America and the Caribbean as a whole, AIDS has already overtaken traffic accidents as a cause of death. However, a recent drop in AIDS mortality – similar to that seen in Western Europe and North America (see below) – has been recorded in São Paulo and is attributed to the increasing use of antiretroviral therapy.

□ Drug use drives HIV in Eastern Europe

Drug injection is behind the dramatic surge in HIV infection in several Eastern European nations, accounting for the majority of the 100 000 new infections estimated to have occurred in 1997. In Ukraine, where around 70% of infections have been in drug users over the last three years, some 25 000 cases of HIV infection have been reported so far, half of them in 1997. It is possible that a similar pattern will be seen elsewhere in the region. Russian officials estimate there are about 350 000 regular drug users in the country, many of them sharing injecting equipment.

The potential for sexual spread also exists. In Russia, Belarus and Moldova, new cases of syphilis rocketed from very low levels in the late 1980s to well above 2 per 1000 population by 1996, with continuously increasing trends. An untreated sexually transmitted disease not only makes HIV (when present) spread much more easily from one partner to the other but is important as a marker of potential HIV spread because it has the same transmission route – unprotected sex (intercourse without a condom).

□ AIDS is falling in the industrialized world

The growing gap between the developed and the developing world concerns not only the scale of HIV spread but mortality from AIDS. In North America, Western Europe, Australia and New Zealand, newly-available antiretroviral drugs are reducing the speed at which HIV-infected people develop AIDS.

In Western Europe evidence suggests that new AIDS cases will drop by around 30% in 1997 compared with 1995, before antiretroviral treatment became available. The fall is greatest in countries in which infection has been concentrated in homosexual men, in whom HIV rates began dropping 5-10 years earlier. This shows that the decline in AIDS cases is often the combined result of better prevention and better treatment. Only in Portugal and Greece, where unsafe drug injecting is the main mode of transmission, are new AIDS cases still showing substantial rises compared with a year ago.

In the United States, newly-published figures indicate that the first-ever annual decrease in new AIDS cases – 6% – occurred in 1996, and an even bigger decrease is expected in 1997. Again, the largest fall – a drop of 11% – was in homosexual men, the very group which sought and benefited from the most open exchange of information about the risks of unprotected sex in the early years of the epidemic. In some disadvantaged sections of society, however, AIDS continues to rise. Among African-Americans, new AIDS cases rose by 19% among heterosexual men and 12% among heterosexual women in the USA in 1996. In the Hispanic community, there were 13% more cases among men and 5% more among women than a year earlier. This is partly because these communities may find it hard to access the expensive new drugs that could stave off the onset of AIDS. It is partly, too, because prevention efforts in minority communities, where transmission is often through heterosexual intercourse and drug injecting, have been less successful than in the predominantly well-educated and well-organized white gay community.

It is estimated that 30 000 Western Europeans were newly infected with HIV in 1997. Antiretroviral treatment given to women during pregnancy and the availability of safe alternatives to breastfeeding kept mother-to-child infection low – it is estimated that fewer than 500 children under the age of 15 were infected with HIV in 1997. North America estimated it had around 44 000 new HIV infections in 1997. As in Western Europe, transmission from mother to child was low, with fewer than 500 new cases.

AIDS wipes out gains in life expectancy and child survival

AIDS is systematically cutting down life expectancy in the countries where the disease is most common. The gains achieved over the last few decades in much of the developing world will in some places be cancelled out by HIV. Life expectancy in Botswana rose from under 43 years in 1955 to 61 years in 1990. Now, with between 25% and 30% of the adult population infected

with HIV, life expectancy is expected to drop back to levels last seen in the late 1960s. By the end of the decade, Zimbabwe will see 10 years wiped off the life expectancy of a child born in 1990. In Uganda, one study in a rural area measured the lifespan of the population as a whole and compared it with that of the people who were not HIV-infected. It concluded that where some 8% of the population was HIV-positive, the presence of AIDS in the community cut overall life expectancy by 16 years.

In many countries AIDS is the leading cause of death in adults. In the United States, after combination therapy to slow down the progression of HIV disease was introduced in 1996, AIDS dropped into second place among leading causes of death in people aged 25-44 for the first time since 1992. Accidental injury took over in first place. In rural Uganda, AIDS accounted for 41% of adult deaths in one study. For men between 25 and 44, and for women between 20 and 44, AIDS caused 7 out of every 10 deaths. In trading centres which are home to large numbers of younger adults, a third of whom are HIV-infected, nearly 9 out of 10 adult deaths are HIV-related. In Namibia, HIV causes nearly twice as many deaths across all ages as malaria, the next most common killer.

The high mortality due to HIV/AIDS also has major impacts on families. It is estimated that since the beginning of the epidemic more than 8 million children have lost their mothers to AIDS when they were less than 15 years old – and many of these also lost their fathers. It is estimated that this figure will almost double by the year 2000.

The worst is still to come. Since the beginning of the epidemic, it is estimated that 11.7 million people around the world have died of AIDS and HIV-related causes. That is just a third of the number currently infected. Indeed, half as many people were infected this year alone as have died in the whole epidemic to date. Because the vast majority of people living with HIV are in the developing world, access to antiretrovirals is often difficult or impossible. And these drugs do not constitute a cure: they are not effective in everyone, and at this point it is impossible to say how long their effects will last. Thus, many if not most of the 30 million people currently infected may well die in the relatively near future, perhaps within the next decade.

Developing nations have made great strides in increasing infant and child survival in recent decades. These gains, too, are threatened by HIV. Already, a quarter more babies under 12 months old in Zimbabwe and Zambia are dying than would be the case if there were no HIV. By 2010, Zimbabwe's infant mortality rate is expected to rise by 138% because of AIDS, and its under-five mortality rate by 109%. In Côte d'Ivoire, child mortality will rise by over two-thirds.

Young people at risk

In some parts of the world, the proportion of the total adult population living with HIV/AIDS has stabilized or begun to fall. While this is good news, it can hide an unpleasant truth: new infections in the younger age groups can continue unabated or even go on rising as the overall proportion of people living with HIV/AIDS falls.

□ High infection rates and risk behaviour among some young people

In most parts of the world, the majority of new infections are in young people between the ages of 15 and 24, sometimes younger. In one study in Zambia, over 12% of the 15 and 16-year-olds seen at antenatal clinics were already infected with HIV.

Girls appear to be especially vulnerable to infection, but Uganda has recently shown encouraging evidence that in some city sites infection rates have halved among teenage girls since 1990. Even there, however, the rates remain unacceptably high, with up to 1 pregnant teenager in 10 testing HIV-positive. That rate is six times higher than in boys of the same age.

In South Africa, the proportion of pregnant 15-19-year-olds infected with HIV rose to 13% in 1996 from around half that level just two years earlier. In Botswana the infection rate stood at 28% for the same group in 1997. In Maharashtra state in India, where the epidemic is in its early years, some 3.5% of pregnant teenagers tested HIV-positive in a recent study.

What is abundantly clear is that some young people all over the world engage in risky sexual behaviour. In Mongolia, there has been a recent jump in sexually transmitted diseases in children under 15, indicating that they are exposed to unprotected intercourse. One study shows that since 1994, STDs in those under 15 have shot up more than ten-fold. In Namibia, 37% of 12-18-year-olds reported that they had had sex, nearly half of them with more than one partner. Most said that they believed their own partners had had other partners, too. In Tanzania, 12% of teenage males and 37% of 20-24-year-olds reported that they had multiple sex partners in the last year. In Mali, 2 out of 5 sexually active boys in their teens said they last had sex with a prostitute or casual partner. In the United States, some studies indicate that genital herpes has jumped more than four-fold among white teenagers since the 1970s, with close to 1 in 20 now infected. Among white Americans in their 20s, the rate is 1 in 7.

Sometimes, young people know of the risks of unprotected sex but feel AIDS could not possibly happen to them. In Malawi, most young men and women know how HIV is transmitted and how it can be prevented. When asked, however, many said they felt invulnerable to the virus. Some 90% of teenage boys said they were at no risk or at minimal risk of infection, even though nearly half of them reported at least one casual sex partner over the last year, and condom use was low.

Even in countries such as Thailand – which has been among the most successful in encouraging young people to adopt safer sexual behaviour and has been rewarded by seeing a marked fall in both HIV infection and other STDs – there are groups of young people that fall through the net, such as those living on the street.

□ More education translates into lower risk

In many countries, young people are denied access to education about HIV including safe behaviour skills, or are unable to buy condoms or attend STD clinics. This is usually because older adults believe such education and services will actually encourage young people to increase their sexual activity.

In fact, the reverse is true according to a newly-published UNAIDS review of data from four continents. Good-quality sex education helps delay first intercourse and leads to lower levels of teenage pregnancy and STDs. In the years after Switzerland launched an active and very open

campaign aimed at informing young people about healthy sexual behaviour, the proportion of 17-year-old girls and boys who never had sex – a proportion that had been dropping for many years – began to show a marked rise. The same trend toward postponement of first sexual intercourse is now being observed in the USA and in Uganda.

Educational efforts are also resulting in greater condom use among those who have become sexually active. Thailand and Uganda have already been mentioned. In Tanzania, 16% of sexually active teenage women had used a condom in 1996. While this may seem woefully low, it is certainly a vast improvement on the 5% recorded in 1990. The proportion of teenage boys who had ever used a condom rose from 14% to 38% in the same period. In Zambia, too, condom use has risen from very low levels in the 1980s. In 1996 about one-third of sexually active teenage girls nationwide reported having used a condom – a level previously reported only from the capital Lusaka, where condom use has always been highest. In Switzerland, levels of casual sex among young people have remained more or less constant since the late 1980s, but consistent use of condoms with those partners has risen four-fold – a more impressive increase than seen in older people.

Over 27 million do not know they are infected

UNAIDS estimates that of the some 30 million people currently living with HIV, the vast majority have no idea they are infected. As with so many other features of the epidemic, when it comes to knowledge of HIV status there is a gaping divide between the developing and industrialized world.

In the United States, the Centers for Disease Control and Prevention (CDC) estimate that two-thirds of people living with HIV know about their infection. In Germany, the proportion of AIDS patients who knew their HIV status at least six months before an AIDS diagnosis remained steady at close to three-quarters in 1994 and 1995. Since 1995, when drugs that can delay the onset of AIDS came onto the market, the proportion has actually dropped to two-thirds. This is because people who knew their status early have already been treated and have been able to delay the onset of AIDS. People who do not know their status are more likely to go on and develop AIDS. The availability of treatment is a powerful incentive to get tested early.

In the developing world, where the epidemic is increasingly concentrated, the picture is very different. HIV testing is done mostly for purposes of surveillance, which involves very small population samples and is done “anonymously” (with no identification by name of those tested). Few people have any hope of treatment, so they feel little incentive to get tested. But even those who would want to know may not be able to find out. In many countries, there simply are no voluntary testing and counselling facilities; people have no acceptable way of learning if they are HIV-infected. An ongoing study at a rural hospital in South Africa suggests that only 2% of people who are HIV-positive know their status. The situation in urban Kenya seems to be as bad. Of 63 randomly chosen women who tested HIV-positive in one study, just one was already aware that she was infected.

The fact that current testing procedures usually require at least two visits to a test site further complicates access to testing. This can be difficult or expensive for people living in isolated areas. In rural South Africa, just 17% of the people who asked to be tested came back for the

result and the advice and support that goes with it. When an on-the-spot test was tried, nearly everyone (96%) chose to know the result.

Since the epidemic is concentrated in the developing world, a conservative estimate might suggest that 9 out of 10 infected people in the world do not know their HIV status. At current estimates, that would suggest there are over 27 million people in the world today who have no idea they are infected.

There are many reasons why HIV testing and counselling for those who want to know their infection status should become part of the broad package of interventions used for AIDS prevention, care and support. Increasingly, ways are being found to delay symptomatic HIV disease including the late stage called AIDS, and to prevent or treat the infections which afflict people whose immune systems have been damaged by the virus. Not all of these treatments are prohibitively expensive. The earlier people know they are infected, the greater the opportunity for them to access treatment – or put pressure on their communities and countries for improved access, where this is inadequate. Another benefit would flow to individuals and their families. The earlier individuals are aware of their infection, the better they can make informed and responsible decisions about childbearing, transmission to spouses or partners, and plans for their family's welfare after they fall ill or die.

Perhaps the most important benefit of self-knowledge is that it helps unmask the invisible epidemic and permits a genuine community response. The experience of the past decade shows that as long as HIV spreads silently and unnoticed, it remains at best a theoretical threat to people and does not get taken seriously. If individuals become aware of their infection early on, while they are still relatively healthy, this would give them the time and energy to support one another as well as alert their community to the epidemic, helping others avoid the disease or cope with its consequences.

However, these benefits to individuals, families and communities are realistically achievable only where people feel safe enough to find out whether they are infected. Efforts by governments and civil society to combat rejection and discrimination directed at people with HIV are vital.

Improved estimation techniques reveal epidemic is worse than previously thought

These newly-released figures reveal that there are about one-third more people living with HIV than was estimated in December 1996. There are two reasons for this increase. First, new infections are occurring at an alarming rate - some 16 000 infections a day have added 5.8 million HIV infections to the total in 1997 alone. Secondly, it now appears that previous calculations grossly underestimated the rate of transmission, particularly in sub-Saharan Africa where the bulk of infections are concentrated.

□ Why do estimates change?

Estimates are based on certain assumptions about the start of the epidemic, the rate of new infections in urban and rural areas, the time between infection and death, and the maximum level of infection in the population. Until a few years ago these data were available for only a handful of countries. It was assumed that the pattern of infection in other countries in the same region would follow that seen in countries where data was available. It seemed reasonable, then, to construct models to estimate the epidemic region by region.

This was first done for 1995. Information about levels of infection dating from 1994 or earlier was collected from as many countries as possible. From the proportion of people currently infected in various sentinel groups in each region and other available data, models were constructed to estimate the rate of growth of the epidemic and the total number of people currently infected, region by region. Extrapolations from this model were used to calculate the magnitude of the epidemic in 1996. This yielded an estimate of 3.1 million new infections over the year and brought to 22.6 million the number of people thought to be living with HIV.

By 1997, far more data were available and it became clear that there were huge differences in the way the epidemic was developing in different countries and communities within the same region. So this year, UNAIDS improved its estimation techniques. The regional models were replaced by separate models constructed for each country, which were based on better measures of levels of infection and took into account the variations in patterns of infection, in survival time, and so on. New estimates were made country by country, and then added together to yield new regional totals. The resulting estimates, given in this report, showed that global levels of infection in 1996 had been underestimated by over a third.

New infections in 1996 were in fact closer to 5.3 million than to the 3.1 million reported last year. The total number of people living with HIV in 1996 was in the range of 27 million, rather than 22.6 million as previously believed. That means that although this year's estimates are still shockingly high, there has been nothing like the doubling of new cases that might be suggested by looking at last year's published figures. Accounting for previous underestimates, there have been around 9% more new infections this year than last, and the number of people living with HIV has grown by 13%.

☐ Where did the differences appear?

To see how much of the new total was due to a rise in new infections and how much due to underestimates of previous levels, UNAIDS recalculated the totals for 1996 using the new estimation methods. The results showed that previous estimates were correct for most of the world.

The difference was found largely in sub-Saharan Africa. While the number of people living with HIV/AIDS there was originally estimated at 14 million in 1996, new information shows that the regional total at that time was probably closer to 18.6 million, as against 20.8 million in 1997. New infections in 1996 would, on the basis of current information, have been estimated at 3.8 million in Africa alone.

☐ Why was infection in Africa underestimated by so much?

At the time the regional model for sub-Saharan Africa was constructed, few countries had much reliable data and some, notably Nigeria and South Africa with their large populations, had virtually none. The country with the best surveillance system was Uganda, and that showed that infection rates were beginning to level off, with new infections dropping in younger age groups. This was taken as a model for the whole region.

Unfortunately, the epidemic in other countries has not followed the pattern seen in Uganda. In many, infection rates have continued to climb beyond the levels thought possible in 1994, when data for the regional models used for previous estimates were collected.

☐ Are the new estimates definitive?

The figures given in this report each represent a best estimate out of a range, rather than a precise number. UNAIDS and WHO believe that these new estimates are as accurate as is possible to generate with available data. But there is much that is still not known about HIV. More information about the course of infection, its impact on fertility and mortality, and the transmissibility of different strains of the virus will change some of the assumptions made in the current models. A clearer picture of current levels of infection, particularly for countries with large populations and inadequate data such as India, will improve future estimates. And the efforts governments and communities put into changing the course of the epidemic in their countries should have an impact on the rate of new infections and so on estimates and projections.

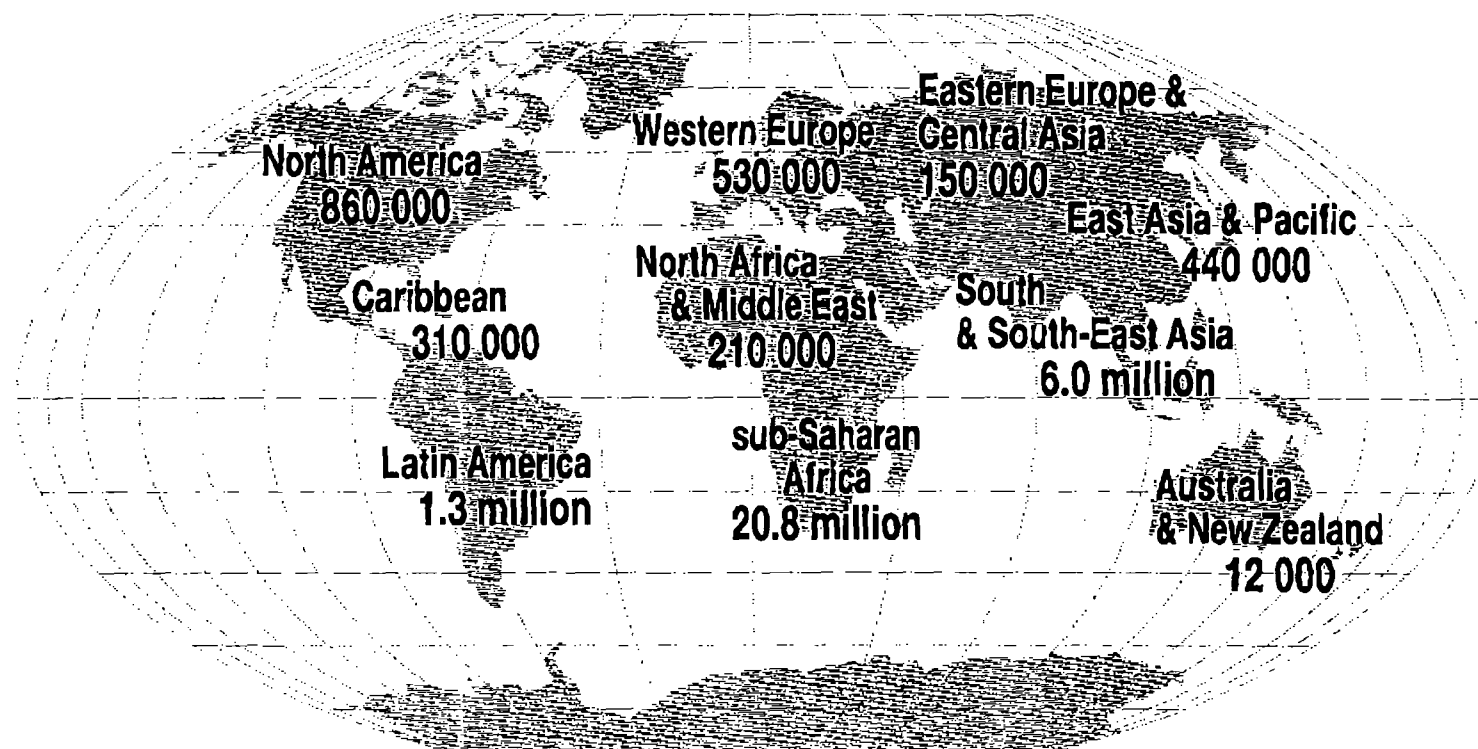
UNAIDS and WHO will continue to improve estimation methods as new information becomes available.

End-1997 global estimates

Children and adults

- People living with HIV/AIDS 30.6 million
- New HIV infections in 1997 5.8 million
- Deaths due to HIV/AIDS in 1997 2.3 million
- Cumulative number of deaths due to HIV/AIDS 11.7 million

Adults and children estimated to be living with HIV/AIDS as of end 1997



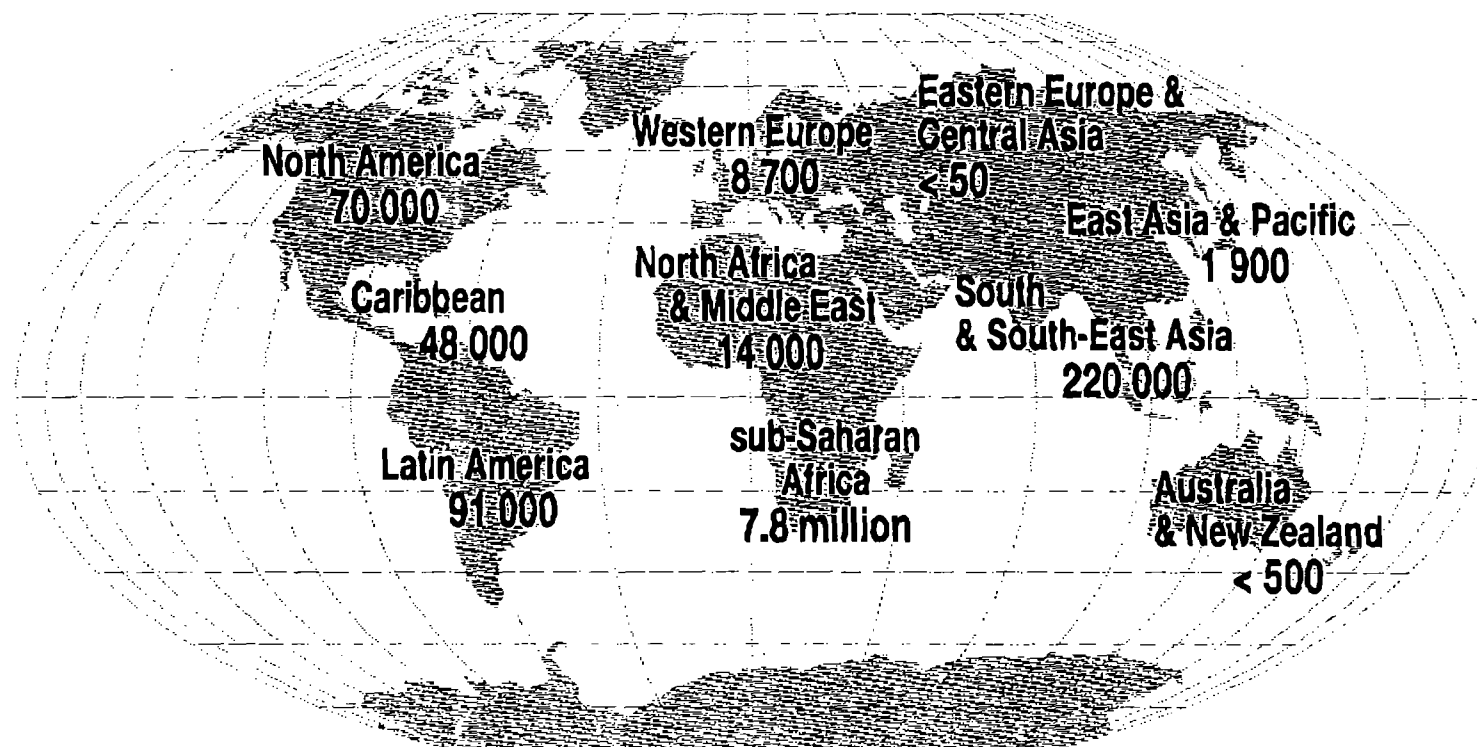
Total: 30.6 million

Estimated number of adults and children newly infected with HIV during 1997



Total: 5.8 million

Cumulative number of children estimated to have been orphaned* by AIDS at age 14 or younger



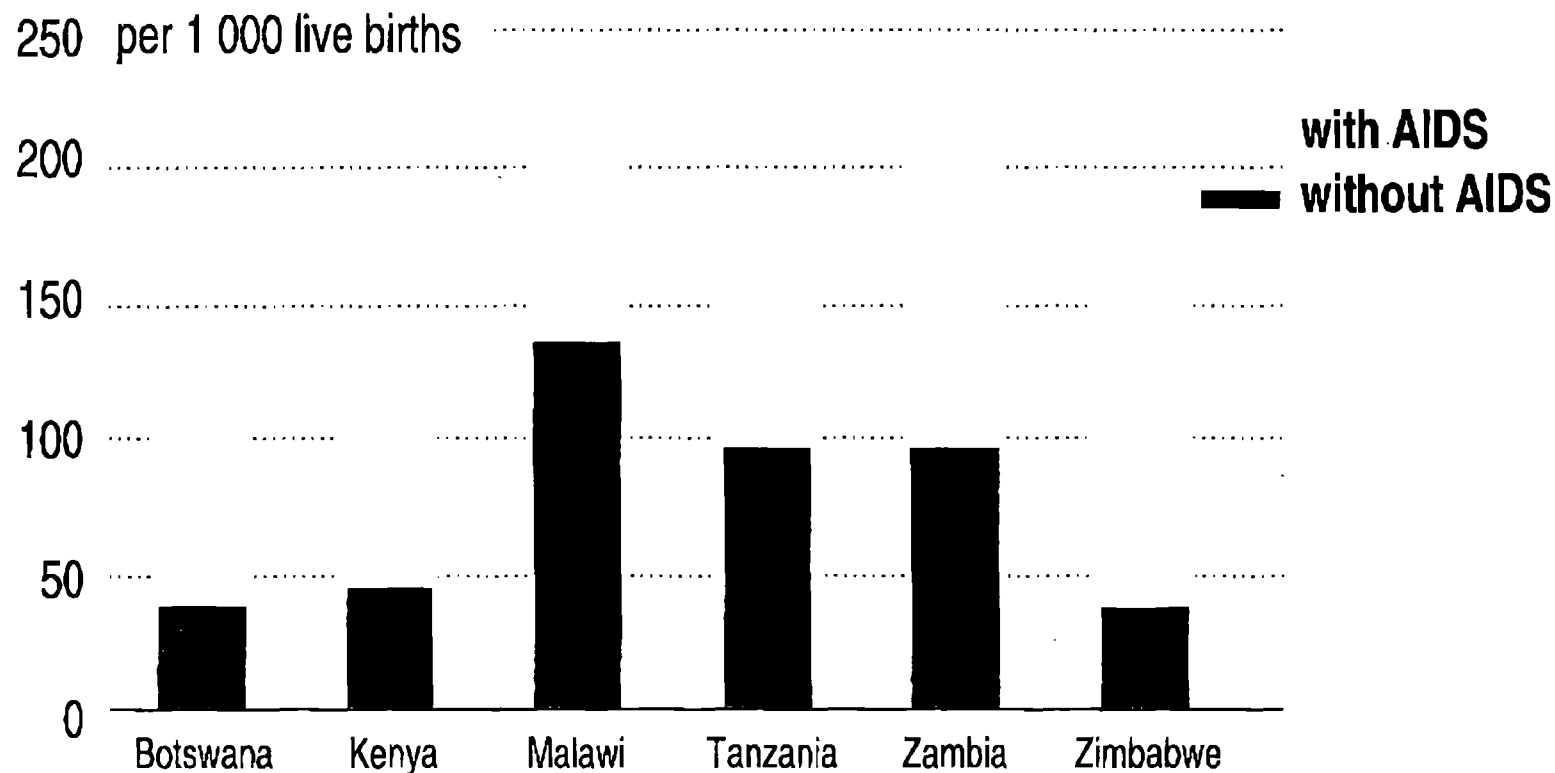
Total: 8.2 million

FSE/3 - 1 December 1997

* Orphans are defined as HIV-negative children having lost their mother or both parents due to AIDS

UNAIDS Global
HIV/AIDS and STD
Surveillance **WHO**

Estimated impact of AIDS on under-5 child mortality rates – *Selected African countries, 2010*



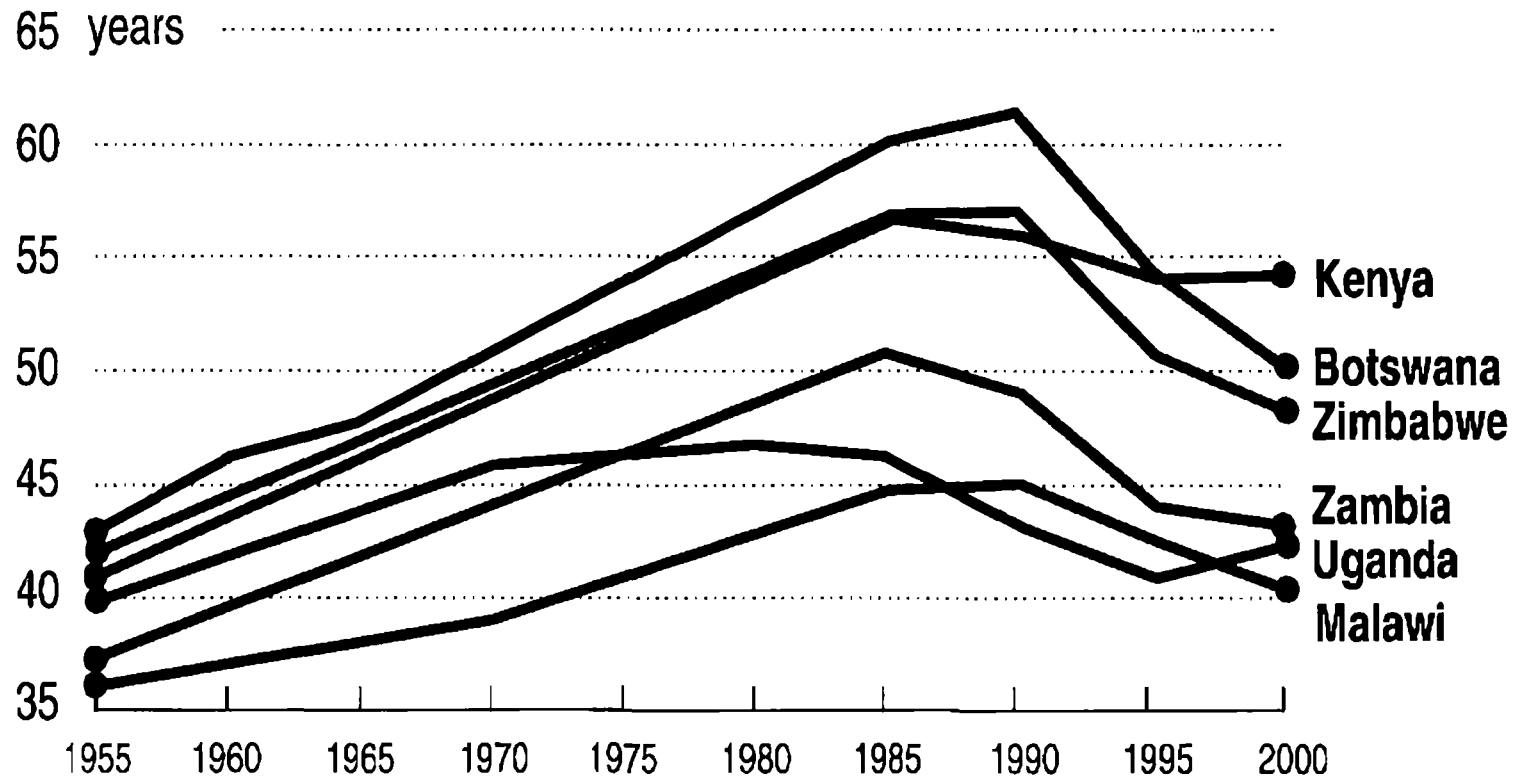
Source: US Bureau of the Census

FSE/6 – 1 December 1997

UNAIDS Global
HIV AIDS and STD
Surveillance **WHO**

Projected life expectancy at birth

Selected sub-Saharan countries



Source: World Population Prospects: The 1996 revision, *United Nations Population Division*, 1996

FSE/4 – 1 December 1997

UNAIDS Global
HIV AIDS and STD
Surveillance **WHO**

For Robert Pear:

•”Numbers like those you are citing are so overwhelming they numb the mind, but an experience I had in Nairobi, Kenya underscores the very human side of this devastating and expanding pandemic. I visited an orphanage and met a nun who four months earlier came upon a newborn baby buried up to his neck in the dirt. The nun gently rescued the infant and brought him to the orphanage. Later, the nun learned that the baby’s mother, dying of untreated AIDS, saw no other way to alleviate the baby’s suffering because soon there would be no one to care for the child. But as she began burying her son, she realized she could not complete the task. That desperate, dying mother and millions of parents like her in Africa and much of the developing world have little or no hope. The promise of any AIDS care at all--much less the new treatments which are extending life for so many in the U.S.--is far beyond the reach of these families. Even as we examine the important new information from UNAIDS, we must remain conscious of the fact that children with AIDS, children orphaned by AIDS are much more than cold statistics; they are lives worthy of saving. So, technologically advanced nations with access to effective drugs need to find ways to help and the Clinton Administration is currently working on ways to do just that, including the President’s HIV vaccine initiative.”



JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS)

(UNICEF, UNDP, UNFPA, UNESCO, WHO, World Bank)

Central Exchange: 791.36.66

Direct: 791.4762

With the compliments of

Sally G. Cowal
Director, External Relations

Mr Eric Goosby

Acting Director

Office of National AIDS Policy

Executive Office of the President

750 17th Street, N.W., Suite 600

Washington, D.C. 20816

Etats-Unis d'Amérique

address: 20 av. Appia, CH-1211 Geneva 27, Switzerland - Tel: +41.22.791.4762 - Fax: +41.22.791.4188



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13 August 1997

Joint United Nations Programme on HIV/AIDS

Report of the Fourth Meeting of the Programme Coordinating Board of UNAIDS

Geneva, 7-9 April 1997

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Agenda item 1 - Opening

1. The fourth meeting of the UNAIDS Programme Coordinating Board (PCB) took place at WHO headquarters in Geneva from 7 to 9 April 1997. The participants are listed in Annex 1.
2. The outgoing Chairperson, Ms Sally Shelton, welcomed the participants and called for nominations for her successor. Dr Dlamini Zuma (South Africa) was elected as Chairperson and took the Chair. Mr Hans Moerkkerk (Netherlands) was elected as Vice-Chairperson. In response to a proposal by one delegation, the PCB decided to amend Article 21 of its *Modus Operandi* to indicate that the Board should also elect a Rapporteur, taking into account fair geographical distribution. Mr Wu Guogao (China) was elected as Rapporteur.
3. In her retiring address, Ms Shelton reminded participants of the critical importance of UNAIDS both as a unified effort in reducing the impact of the epidemic and as a potential model for cooperation in other areas of the United Nations (UN) system. While considerable progress had been made in the short period of the Programme's existence, many challenges remained owing to the continued spread of the epidemic, and sustained commitment and efforts were required by all those engaged in the response. It was essential to involve non-governmental organizations (NGOs) and people living with HIV/AIDS as major players, and to ensure attention to developing and industrialized countries alike. The PCB must fulfil its responsibility to see that the Programme's work progressed with the urgency that the epidemic demanded and to ensure success.
4. The PCB approved the following nominations submitted by the NGO community for representatives of NGOs/people living with HIV/AIDS to participate in the work of the PCB: Ms Marina Mahathir, Malaysian AIDS Council (Malaysia) as the representative for Asia/Pacific; Dr Mabel Bianco, Fundación para Estudio e Investigación de la Mujer (Argentina) as the alternate representative for Latin America/Caribbean; Ms Cheryl Brown, International Community of Women Living with HIV/AIDS (Canada) as the representative for North America; and Mr Jairo Pedraza, Global Network of People Living with HIV/AIDS (United States of America) as the alternate representative for North America.
5. Dr Nafis Sadik (Executive Director of UNFPA and Chairperson of the Committee of Cosponsoring Organizations, CCO) addressed the Board on behalf of the Cosponsors, noting that the World Bank would shortly take on the task of chairing the CCO. She welcomed the significant progress made in establishing UNAIDS and in implementing activities. On the recommendation of the CCO, the UN Secretary-General had reappointed Dr Peter Piot as Executive Director of UNAIDS for a further term of four years.
6. Collaboration between UNAIDS and the Cosponsors had been strengthened and a number of inter-agency working groups had been set up in specific programme areas. In addition, the Programme was participating in new initiatives by the UN Secretary-General to improve country-level coordination of UN activities. In February 1997, the CCO had endorsed the UNAIDS Proposed Programme Budget and Workplan for 1998-1999, stressing the need for clear lines of responsibility and the setting of priorities. It looked forward to the development of a more integrated workplan for UNAIDS and the Cosponsors. The 1996-1997 UNAIDS Coordinated

Appeal had not been as successful as hoped, and guidance was sought from the PCB as to how the Appeal process might be improved.

7. The CCO attached great importance to UNAIDS' activities at country level and to the successful functioning of the UN Theme Groups on HIV/AIDS. The Cosponsors were taking steps to secure administrative support for the latter. Coordinating and mobilizing increased support for national AIDS programmes was the key activity of the Theme Groups, while technical and policy guidance should stem from UNAIDS. Noting that the range of Cosponsors taking responsibility for chairing the Theme Groups was broadening, the CCO encouraged the appointment of the most competent and appropriate representative in each country rather than automatic rotation.

8. She concluded by observing that all efforts to combat HIV/AIDS must be based on respect for the rights and dignity of all people. UNAIDS and the Cosponsors had a collective responsibility to take into consideration the rights of individuals to control their own reproductive and sexual health and to protect themselves from irresponsible behaviour by their partners; the need to promote responsible behaviour in infected individuals; the conflict between the right to confidentiality for infected persons and the right for those at risk to protect themselves; and the need for adequate information to enable people to make free and informed choices regarding infant feeding. Furthermore, countries needed appropriate guidance on those issues.

9. Mr Luis Gautier (Coordinator, Red de Acción Comunitaria en VIH/SIDA, Chile and the NGO representative for Latin America/Caribbean on the PCB), addressed the meeting on behalf of the representatives of NGOs/people living with HIV/AIDS. He expressed disappointment that current responses were failing to keep pace with the rapidly expanding epidemic; indeed, the gaps were widening. In many countries, denial and violation of human rights persisted, and care and treatment remained unavailable or inaccessible to the majority. Furthermore, the slow progress in developing the functions of Theme Groups from provision of information exchange to implementation of strategic plans of action and the lack of participation of NGOs and people living with HIV/AIDS were causes for continued concern. UNAIDS should seek ways of increasing the involvement of NGOs and people living with HIV/AIDS in Theme Groups, perhaps by designating a UNAIDS staff member to take responsibility for those efforts. The realities of lack of resources, the crisis in public health systems, the high cost of medicines and inadequate dissemination of information on new treatments should not be allowed to frustrate attempts to move forward with the introduction of sound initiatives to improve access to treatment and medication, including new therapies, based on pilot projects involving individuals, NGOs and countries. UNAIDS must make a difference.

10. The provisional agenda (document UNAIDS/PCB(4)/97.1) was adopted (see Annex 2).

Agenda item 2 - Consideration of the report of the third meeting

11. The PCB adopted the report of its third meeting (document UNAIDS/PCB(3)/96.10).

Agenda item 3 - Report of the Executive Director

12. In presenting his report of the Programme's activities during its first full year of operation (document UNAIDS/PCB(4)/97.2), Dr Peter Piot (Executive Director, UNAIDS) provided a brief overview of the current status of the HIV/AIDS epidemic which, despite recent breakthroughs in the area of treatment and the decrease in mortality in some countries, was far from over. The spread of HIV/AIDS was implacable, with more than 3 million new cases of HIV infection and 1.5 million HIV/AIDS-associated deaths in 1996, and increasing consequences for social and human development. The PCB expressed concern at the growing impact of the epidemic and at the continued inequalities in provision of basic health care and access to treatment, especially the newer antiretroviral combination therapy.

13. The PCB commended UNAIDS on its achievements in the short period of its existence and welcomed the progress made in setting up basic administrative and managerial systems, developing activities, and strengthening collaboration with the Cosponsors and other partners. However, further efforts were needed to make the cosponsored approach more effective, particularly at country level. UNAIDS must aim for the establishment of well functioning Theme Groups anchored solidly in the UN resident coordinator system, with a streamlined UNAIDS continuing as a major global source of advocacy, information, policy guidance and technical advice.

14. Collaboration between the Programme and the Cosponsors needed further strengthening both in the context of UN reform and in order to ensure improved support to countries through the Theme Groups, to define more clearly the roles and responsibilities of the various partners at global, regional and national level, and to develop a more integrated workplan. New partnerships in the public, voluntary and private sectors must be forged and strengthened and NGO involvement should continue to be enhanced at both national and international level. Regional initiatives should be encouraged and attention should be paid to arrangements for small countries and countries with little or no UN presence. Priorities for action and allocation of resources must be set. There was also a call for UNAIDS to respond to the Oslo consensus which urged multilateral agencies to report data on their performance with regard to the 20/20 Initiative and to become involved in UN discussions in that area.

15. UNAIDS must maintain a clear vision of its mandate; it was not foreseen as a funding agency. However, the decline in financial support to countries during the transition phase continued to have a negative impact on national HIV/AIDS activities. Long-term, predictable and sustainable funding mechanisms at all levels were clearly essential.

16. In response to queries regarding the prevention and control of other sexually transmitted diseases (STDs), the PCB was informed that UNAIDS was collaborating closely with WHO, which had a comparative advantage in that field and was developing activities through a number of

its headquarters programmes and through teams based at its Regional Offices in the areas of epidemiological research, diagnosis, prevention, treatment, integrated service provision and access to services.

17. The Board's attention was drawn to the involvement of UN system organizations other than the Cosponsors, including FAO, ILO, UNDCP and UNHCR, in various UNAIDS activities, and to their participation in Theme Groups in countries where their competence was relevant.

18. There was a call for UNAIDS and the Cosponsors to take steps to raise the international profile of UNAIDS, particularly in donor countries, making greater use of public relations and media opportunities. The Board was informed that consultations were underway to increase the role of the UN Secretary-General in that regard. Furthermore, as part of the UN reform process, it was hoped to raise awareness of all UN activities at country level.

Agenda items 4 and 5 - Functioning of UNAIDS at country level including case studies; Criteria for prioritization of UNAIDS support

19. Dr Rob Moodie (Director, Department of Country Support, UNAIDS), introducing the report on UNAIDS at country level (documents UNAIDS/PCB(4)/97.3 and UNAIDS/PCB(4)/97.3 Add. 1), said that during 1996 the number of UN Theme Groups on HIV/AIDS had risen from 36 to 126, covering 150 countries and that 37 Country Programme Advisers and 24 UNAIDS Focal Points were now in place to support Theme Group efforts. Rotation of chairpersons had commenced and distribution of that responsibility among the Cosponsors was therefore broadening. While core financial support to national AIDS programmes was not envisaged in the UNAIDS Proposed Programme Budget and Workplan for 1998-1999, programme development funds would continue to be made available for catalytic activities supported by Theme Groups, and resource mobilization efforts by Theme Groups would develop. It should be noted that the Theme Groups did not constitute entities that could themselves receive funding. A summary of a review of Theme Group functioning in four countries (Botswana, Dominican Republic, Laos and Viet Nam) was annexed to the report. A wider study of UNAIDS in over 90 countries was also being conducted and a preliminary report covering 74 countries was available.

20. During 1996 UNAIDS had developed a framework to guide and assess the development of Theme Group activities and had used it to monitor progress. After becoming operational, Theme Groups would move, although not necessarily in strict sequence, from providing information exchange to developing collaborative activities and then coordinated and joint planning for the national response, and finally to joint programming and implementation of activities. For each phase, a core set of indicative activities had been established. Of the 74 Theme Groups assessed so far, 27% had completed all activities in phase "Theme Group operational". Smaller proportions had satisfied the requirements of the other phases, although many were meeting some of the core elements of those phases.

21. The PCB noted that many of the obstacles encountered in setting up the Theme Groups were being tackled, and that evidence from a number of countries indicated that Theme Groups could operate effectively in support of national activities, given the required commitment from all

partners, and the necessary financial and technical support. However, it expressed concern that progress in translating planned Theme Group activities, including resource mobilization, into concrete actions remained slow. The Board looked forward to the full report on the assessment of UNAIDS at country level. It was suggested that the inclusion of a tabulated summary of progress on UNAIDS activities in countries in future reports to the PCB would facilitate the discussion, and that country visits by PCB members might provide an opportunity to review Theme Group operation at first hand.

22. Noting the country support priorities for 1997 set out in the report, the PCB reiterated the need for further efforts to improve collaboration between UNAIDS and the Cosponsors and to clarify the roles and responsibilities of Theme Groups and all the partners involved, in particular, in respect of administrative and funding mechanisms. The roles of Country Programme Advisers and Focal Points also required greater definition; where possible, experienced national staff with local knowledge should be selected. In that context, the Board was informed that mechanisms for monitoring and evaluating the performance of Country Programme Advisers were being developed. In addition, steps were being taken to encourage the incorporation of appropriate information on HIV/AIDS issues in existing training courses for UN and Cosponsor staff at global and, where available, regional level.

23. There was a plea for greater attention to be given to the situation of areas such as the Caribbean and the South Pacific that consisted of widely scattered small island countries, where current Theme Group mechanisms were not entirely appropriate. Countries showing signs of an impending expansion in the HIV/AIDS epidemic also required special consideration. The Theme Group approach must be adaptable to local situations and sufficiently flexible to respond to changing needs, and countries must be consulted at every stage.

24. Greater efforts were needed to involve governments in Theme Groups; without high-level political commitment, national efforts would falter. UNAIDS must also seek to improve partnerships between governments and NGOs in order to ensure the design and acceptance of appropriate national policies and to reduce fear of discrimination and stigmatization.

25. The PCB expressed the hope that the existing regional and inter-country entities of Cosponsors and other similar mechanisms could become more involved in the Programme's work at regional level. Noting the development of small UNAIDS inter-country teams to support Cosponsors' regional technical teams and offices with the aim of strengthening regional information exchange, technical resources and advisory services, and harmonizing regional and sub-regional initiatives, the Board requested that a report on progress in that regard be prepared for consideration at its next regular annual session.

26. The Board was informed that UNAIDS was developing draft materials and global and regional networks of specialists to assist in providing support for national strategic planning, and that a review of district-level programmes was being conducted. The Programme was also continuing to provide assistance to countries, either directly or through the Cosponsors, in the areas of advocacy, dissemination of best practice materials and information on the epidemic, and strengthening of technical cooperation. The PCB suggested that UNAIDS should also encourage the introduction of best practice materials into national programmes. Furthermore, since

UNAIDS' advocacy would only succeed if it was based on sound scientific evidence, the Programme should support efforts to improve surveillance at all levels to ensure the provision of accurate data on the epidemic and on prevention and control activities.

27. The PCB reviewed the proposed criteria for prioritization relating to the allocation of UNAIDS funds to countries, which were set out in the report. The criteria had been developed on the basis of the opportunities available in countries as well as their needs, and allowed countries to be classified in three categories for allocation. The Board expressed support in principle for the proposals, which were consistent with the Programme's strategic objectives, but considered that further refinement was needed before any decision could be taken. There were calls for efforts to achieve a better balance between needs-based and opportunity-based criteria, and for transparency in applying the criteria. The prioritization exercise should be linked to country support priorities and it was suggested that evaluation of countries' previous use of allocated resources might be taken into consideration. There was general support for approval of the detailed criteria prior to any categorization of countries. Some doubt was expressed as to the large number of countries proposed in category 1 (countries with the greatest opportunity as well as the greatest need for assistance); for true prioritization, a smaller number might be more appropriate. It was agreed that more detailed proposals should be prepared for consideration by the Board at its next regular annual session.

Agenda item 6 - UNAIDS performance monitoring and evaluation plan

28. Dr Stefano Bertozzi (Coordinator, Department of Policy, Strategy and Research, UNAIDS), introducing the progress report on the UNAIDS performance monitoring and evaluation plan (document UNAIDS/PCB(4)/97.5), outlined the action taken since the June 1996 meeting of the PCB, which included the establishment of a UNAIDS task force to provide oversight and guidance, consultations and workshops with a variety of partners, and the activities of the PCB Working Group on Indicators and Evaluation. A conceptual framework for performance monitoring and evaluation at four levels – outputs (goods and services delivered by the UNAIDS Secretariat), intermediate outcome (changes in the nature of the UN system response), outcomes (changes in the characteristics of national responses) and impact (changes in the epidemic itself and long-term responses to it) – had been elaborated.

29. In reply to queries regarding the accountability of UNAIDS at the four levels of the conceptual framework, the Board was informed that the extent to which UNAIDS exerted direct influence over and was accountable for the results being achieved was greatest at the output level. While it had less influence at the other levels, it was, of course, accountable in respect of activities where UNAIDS resources were involved.

30. The PCB, recognizing the need for sound monitoring and evaluation as an integral part of UNAIDS activities, expressed appreciation for the work undertaken in developing the performance monitoring and evaluation plan. It took note of the report of the PCB Working Group on Indicators and Evaluation (document UNAIDS/PCB(4)/97.5 Add. 1), presented by its Chairperson, Dr Duff Gillespie (United States of America), and agreed that a complete draft plan, along the lines proposed, should be submitted for consideration at its next regular annual session.

Given the complexity of the Programme's collaborative approach, the plan should be clearly defined, with due regard for quality. UNAIDS should work closely with the Cosponsors in monitoring and evaluating UN system responses to HIV/AIDS at all levels, taking into account existing monitoring and evaluation procedures in order to avoid duplication. It should also support efforts to encourage the incorporation of harmonized monitoring and evaluation procedures in national HIV/AIDS activities.

31. The performance monitoring and evaluation plan should be linked to the UNAIDS Proposed Programme Budget and Workplan for 1998-1999, which should be revised to include a section providing consolidated information on the funding of monitoring and evaluation activities throughout the Programme and to indicate monitoring and evaluation activities under each programme component where possible. The proposed monitoring and evaluation activities should be realistic in terms of the financial and human resources needed for implementation, and it was important to maintain an appropriate balance between those activities and the other activities of the Programme. The plan should also be flexible, allowing for adjustments on the basis of experience gained.

32. To provide staffing for the monitoring and evaluation function, the PCB endorsed the proposed reassignment of an existing professional post and the creation of two posts, one professional and one general service, additional to the 1997-1997 approved staffing level in Geneva. UNAIDS should also examine other possibilities, including secondment from the Cosponsors and others, and the services of the UN Joint Inspection Unit.

33. The Board was informed that monitoring and evaluation activities were proceeding pending the development of the plan, and that a number of priorities for implementation had been set, including: compilation and analysis of HIV/AIDS surveillance data in collaboration with WHO; development of an Expanded Response Effort Assessment for national HIV/AIDS responses; monitoring of UN responses to HIV/AIDS at country level (through Theme Group assessment, a study of the financing of national programmes and user satisfaction surveys); and development of a UNAIDS management information system to monitor the execution of the 1998-1999 Programme Budget and Workplan. It was hoped to have a report on the Expanded Response Effort Assessment for a specific set of countries by mid-1998.

33. The Board endorsed the recommendation of the PCB Working Group on Indicators and Evaluation that the Working Group should cease to function and that a technical advisory group should be established with broad-based participation, including representation from donors, NGOs, users and those responsible for programme implementation as well as technical experts, to provide technical support for monitoring and evaluation activities and to assess implementation of the performance monitoring and evaluation plan. The terms of reference might also include the development of guidelines for the harmonization of national monitoring and evaluation procedures. The reports of the new group, which would be advisory in nature, should be submitted for consideration by the PCB.

Agenda item 7 - Financial and budgetary update for 1996-1997: interim report

34. The PCB took note of the report on the financial situation of the Programme as at 31 March 1997 (documents UNAIDS/PCB/(4)/97.6 and Addendum), presented by Ms Janet Lim (Programme Administrator, UNAIDS), and welcomed the structure of the document which showed a clear separation of overhead costs, programme delivery costs and the cost of posts, as recommended at its previous meeting.

35. Concern was expressed at the potential 40% shortfall for the biennium, and donors to the Programme were urged to confirm their 1997 contributions as soon as possible so that core activities for the remainder of the year would not be affected. Donors should also make every effort to ensure prompt payment in future years. It was also essential to secure adequate funding for the core budget for the whole biennium and PCB members should meet their responsibilities in that respect. In reply to queries about the low level of contributions by the Cosponsors to the core budget, it was pointed out that the Cosponsors also funded HIV/AIDS activities, many at country level, from their own regular budgets and it was therefore important to look at the whole picture. The Board was informed that in addition to the contributions listed in Annex II, contributions in kind, such as the generous provision of premises by the Government of Côte d'Ivoire for a UNAIDS inter-country team in Abidjan, had also been received. Efforts were being made to find ways of reflecting such contributions in future reports.

36. Expressing appreciation for the work done to attract donations from non-traditional sources, including the private sector, the PCB encouraged further efforts in that regard, since a small number of donors was still contributing a high proportion of the funds raised. The UNAIDS Secretariat was requested to prepare a complete financial and budgetary update, including information on future resource mobilization prospects, for consideration by the PCB at its next annual regular session. In light of the multiplicity of possible funding mechanisms, the Board suggested that the PCB Working Group on Resource Mobilization be requested to consider the development of guidelines for channelling support to and through UNAIDS in order to provide a sound basis for long-term, predictable and sustained funding (see also paragraph 58 of this report).

37. The PCB welcomed the establishment of a Working Capital Fund, to be known as the Operating Reserve Fund, as a mechanism for dealing with short-term cash-flow difficulties. It noted that the reserve had been constituted with an initial amount of US\$ 20 million, while the monies currently available, which included funds carried over from WHO/GPA to date and carryover funds from 1995, totalled US\$ 38 million. The PCB Working Group on Resource Mobilization was requested to consider the basis for establishing an appropriate level for the Operating Reserve Fund and to submit proposals in that regard, together with recommendations on the rules and procedures for the Fund, for consideration by the PCB at its next regular annual session.

39. A report (document UNAIDS/PCB(4)/INF.DOC) was made available to the Board which contained information provided by the Cosponsors on HIV/AIDS-related activities to be funded from their core budgets. It was suggested that provision of such information in relation to each programme component of the UNAIDS 1998-1999 Proposed Programme Budget and Workplan would facilitate the Board's discussion in future.

Agenda item 8 - UNAIDS Proposed Programme Budget and Workplan for 1998-1999

40. Dr Peter Piot (Executive Director, UNAIDS) presented the UNAIDS Proposed Programme Budget and Workplan for 1998-1999, which had been developed together with the Cosponsors to ensure a more integrated approach and which was structured around 21 programme components grouped in five main areas: activities at country level; advocacy and public information; activities related to substantive aspects of the HIV/AIDS epidemic; development of inter-country technical networks; and supportive activities relating to administration, management, governance, coordination and resource mobilization.

41. The PCB expressed appreciation for the efforts made in preparing a well structured and transparent document, which provided a clear breakdown of the various costs and which was referred to as an example of "best practice" within the UN system. The Board approved the proposed budget of US\$ 120 million, which it was pleased to note was at the same level as that for the previous biennium. It also endorsed the proposed allocations to the various programme components.

4238. Although significant progress had been made in moving towards an integrated workplan, further efforts were needed to clarify the responsibilities of UNAIDS, the Cosponsors and other partners in order to ensure complementarity of activities, and to coordinate the various categories of funding. There was room in future programme budgets for further prioritization of the activities presented, and the level of narrative detail provided should reflect the priority accorded to each programme component.

4339. The Board welcomed the development of objectives and sub-objectives for each programme component but recommended that in future the distinction between them be clear and that they were used in a consistent manner for all programme components.

404. The PCB recommended that, when developing its detailed management workplans, the Secretariat should ensure that the programme components were clearly linked to the four strategic objectives of the UNAIDS Strategic Plan and that due emphasis was given to the four cross-cutting themes: human rights, gender, young people, and the greater involvement of people living with HIV/AIDS. In setting priorities, greater attention should be given to activities aimed at developing: strategies for improving access to care, in particular, access to essential drugs for the treatment of opportunistic infections and to antiretroviral therapy; effective monitoring of the dynamics of the HIV/AIDS epidemic and its impact on socio-economic development; HIV/AIDS prevention technologies – including vaginal microbicides, measures to ensure safe supplies of blood and blood products, enhancement of national capacities for participation in vaccine trials, and approaches for reducing HIV transmission through injecting drug use; guidance on human rights, legal and ethical issues; and strategies for the effective use of programme development funds, emphasizing their catalytic nature. In addition, efforts should be made to incorporate performance monitoring and evaluation procedures at all levels.

41. For their part, Member States should ensure that the priorities in respect of HIV/AIDS-related activities set by the governing bodies of the Cosponsors were consistent.

Agenda item 9 - Coordinated Appeal for 1998-1999

42. The PCB took note of the progress report on the UNAIDS Coordinated Appeal for Supplemental Funded Activities (document UNAIDS/PCB(4)/97.7), which was introduced by Ms Sally Cowal (Director, Department of External Relations, UNAIDS), and endorsed the development of the 1998-1999 Coordinated Appeal within a US\$ 20 million ceiling at global level, with a planned launch in June 1997.

43. Appreciation was expressed for the candid assessment of the difficulties encountered during the Coordinated Appeal for the biennium 1996-1997, as a result of which only US\$ 4.8 million of the requested US\$ 18 million had been raised (US\$ 1.8 million from three donor agencies and US\$ 3 million from the UNAIDS core budget). The Board noted that there was still time for donations to be received for the current biennium and welcomed the announcement that an additional Member State had pledged a contribution.

44. The Cosponsors and the UNAIDS Secretariat should build on the experience of the 1996-1997 Coordinated Appeal, the first of its kind, in proceeding with the development of the second. The Coordinated Appeal was an important and innovative mechanism for coordinating funding with the aim of increasing responses to the HIV/AIDS epidemic. It was also a valuable forum in which the Cosponsors and the UNAIDS Secretariat could continue to work together to harmonize and integrate HIV/AIDS-related activities. However, further efforts were needed to refine and prioritize the criteria for the selection of proposals for the next Appeal, which should include, on a trial basis, activities at country level. The work of inter-agency reference/working groups would be valuable in the selection process. Proposals should preferably focus on activities rather than request funding for core costs and staff salaries. They should also be linked to the programme component objectives of the UNAIDS Workplan, and responsibilities for implementation should be clearly defined. There was a call for the World Bank, whose funding situation and functions differed somewhat from those of the other Cosponsors, to be discouraged from itself submitting proposals.

49. The Board endorsed the proposed changes in the Coordinated Appeal process for 1998-1999 and urged that detailed documentation be prepared to explain the Appeal more clearly in order to encourage donors, who were faced with their own resource constraints and requirements and had to make difficult choices about where to place their contributions. The Secretariat was requested to prepare and distribute quarterly updates on contributions to the Coordinated Appeal and the activities being funded, and to report on overall progress at the next PCB meeting.

Agenda item 10 - Mode of operations of the PCB

50. Recognizing the need for an appropriate balance between formal and informal mechanisms in the UNAIDS governance structure, the PCB endorsed the proposals contained in the report on the mode of operations of the PCB (document UNAIDS/PCB(4)/97.8).

51. The introduction of *ad hoc* thematic and informal information meetings would provide an opportunity for in-depth debate on substantive HIV/AIDS issues which was not often possible at the formal regular annual session of the PCB. However, such meetings should not be restricted to

the exchange of information; they should have objectives and produce results that would enhance the work of the Programme.

52. The Board noted that, for 1997, one *ad hoc* thematic meeting of the PCB and four informal information meetings around the themes of UNAIDS at country level, budget and financial issues (including the results of resource mobilization efforts), trends and statistics of the epidemic and new case studies of best practice, and performance monitoring and evaluation had been proposed. While the number of such meetings should remain flexible, it was essential that the cost and human resources needed for their preparation should not become onerous. Furthermore, every effort should be made to ensure a broad participation in informal meetings, with particular attention to the involvement of NGOs.

53. The Board recommended that steps be taken, in consultation with PCB members, to find ways of improving the format and conduct of PCB meetings, including consideration of alternative venues. The introduction of panel discussions at *ad hoc* thematic meetings was suggested. Further informal briefing sessions, such as the one on the development of the UNAIDS Best Practice Collection held during the current PCB meeting, would also be useful.

54. The Secretariat was requested to circulate information about forthcoming meetings widely and well in advance to facilitate participation and allow sufficient time for the preparation of presentations. The calendar of meetings should be drawn up with due regard for other important HIV/AIDS-related meetings.

55. Concern was expressed at the lack of participation of PCB members in the process of selecting candidates for the offices of Chairperson and Vice-Chairperson of the Board. It was therefore suggested that the current Chairperson and Vice-Chairperson should consider the matter further and prepare proposals for consideration by the PCB at its next regular annual session.

Agenda item 11 - Next PCB meeting

56. After some discussion of the needs of the Programme and the time required by the Secretariat to complete various tasks, the Board decided that its next meeting should be an *ad hoc* thematic meeting to be held during the last quarter of 1997, most likely in November. The agenda should focus on a limited number of substantive issues to be determined by the Secretariat in consultation with the elected officers of the PCB.

Agenda item 12 - Other business

PCB Working Group on Resource Mobilization

57. The PCB endorsed the recommendations of the PCB Working Group on Resource Mobilization (document UNAIDS/PCB(4)/97.9), presented by the Working Group's Chairperson, Mr Erik Hammar skjöld (Sweden). The strengthening of resource mobilization along the lines proposed by the Working Group was essential to provide the predictable, long-term funding necessary for the continuity of HIV/AIDS-related activities. While priority should be given to

non-earmarked contributions to the core budget, it was important to maintain some flexibility, given the requirements of some donors in that regard.

58. It was agreed that further consideration should be given to the terms of reference of the PCB Working Group on Resource Mobilization in relation to the Board's earlier proposal regarding the development of guidelines on funding mechanisms (see paragraph 37 of this report).

Inter-Agency Advisory Group on AIDS (IAAG)

59. Mr Jacques du Guerny (FAO, Chairperson of the Inter-Agency Advisory Group on AIDS) briefed the PCB on the ongoing reform of the IAAG which was aimed at enhancing its contribution to UNAIDS and the UN system as a whole. The Group's terms of reference had been significantly streamlined to simplify formal procedures and reduce the number of meetings, and modified to update objectives in line with the changes from WHO/GPA to UNAIDS. In future, the Group would continue to advise on, monitor and promote the review of HIV/AIDS issues in relation to UN personnel. It would, furthermore, also advise on issues of a cross-sectoral nature which required coordinated action, with special emphasis on interrelationships with development. For example, a forthcoming meeting would consider HIV/AIDS issues in relation to migration, with broad participation of UN and relevant international organizations. The proposed changes should ensure a more focused approach on the advisory functions and would reduce the costs of the Group.

Communication and public information

60. The PCB welcomed the opportunity provided during the session to view a UNAIDS video on 1996 highlights and a TV spot from South Africa produced by Population Services International (PSI) on condom promotion and use.

Agenda item 13 - Adoption of decisions, recommendations and conclusions

61. The decisions, recommendations and conclusions of the fourth meeting of the PCB, which were discussed and adopted prior to the close of the meeting on 9 April 1997, are set out in Annex 3.

Annex 1

List of Participants

Member States

Algeria

Dr Yamina Chakkar, Director, National Programme for AIDS & STD, Ministry of Health and Population, El-Madania, Alger

Monsieur Mahiddine Messaoui, Ministre Conseiller, Mission permanente de la République algérienne démocratique et populaire auprès de l'office des Nations Unies à Genève

Barbados

Dr Carol Jacobs, Chairperson, National Advisory Committee on AIDS, Christ Church

Bulgaria

Dr Radka Argirova, Chief, Central AIDS Lab., Ministry of Health, Sofia

Canada

Mr Ross L. Noble, Senior Programme Manager, Multilateral Technical Cooperation, Canadian International Development Agency, Hull, Quebec

Dr Don Sutherland, Director, Bureau of HIV/AIDS and STD, Laboratory Centre for Disease Control, Health Protection Branch, Health Canada, Ottawa, Ontario

Ms Jean Perlin, Counsellor, Permanent Mission of Canada to the Office of the United Nations and other International Organizations at Geneva

China

Professor Li Shichuo, Director General, Department of International Cooperation, Ministry of Health, Beijing

Dr Shen Jie, Director, Division of AIDS and STD Control, Department of Diseases Control, Ministry of Health, Beijing

Mr Wu Guogao, Director, Division of International Organizations, Department of International Cooperation, Ministry of Health, Beijing

Mrs Yueming Mao, Counsellor, Permanent Mission of the People's Republic of China to the United Nations Office and other International Organizations in Switzerland, Geneva, Switzerland

Congo

Dr Pierre M'Pele, Director PNLS, Counsellor to the President of the Republic of the Congo, Brazzaville

Côte d'Ivoire

Dr Issa Malick Coulibaly, Coordinateur, Directeur exécutif du Programme National de Lutte contre le SIDA, Ministère de la Santé et des Affaires sociales, Abidjan

Mr Hyacinthe Marcel Kouassi, Counsellor, Permanent Mission of the Republic of Côte d'Ivoire to the Office of the United Nations and International Organizations at Geneva, Switzerland

France

Professeur Jean-François Girard, Directeur général de la Santé, Direction générale de la Santé, Ministère du Travail et des Affaires Sociales, Paris

Mr François Poinot, United Nations and International Organizations Division, Ministry of Foreign Affairs, Paris

Mr Bruno Clerc, First Secretary, Permanent Mission of France to the United Nations Office in Geneva, Switzerland

Dr Jean-Marie Bruno, Sous-Directeur de la Santé et du Développement social, Ministère de la Coopération, Paris

Dr Pierre Soccoja, International Relations - AIDS Division, Office of the Director General of Health, Ministry of Employment and Social Affairs, Paris

India

Mr P.S. Bhatnagar, Additional Secretary and Project Director, National AIDS Control Organization, Ministry of Health & Family Welfare, New Delhi

Mr Rajeev Shahare, First Secretary, Permanent Mission of India to the Office of the United Nations and other International Organizations at Geneva

Japan

Dr Masaharu Ito, Councillor for Science and Technology, Minister's Secretariat, Ministry of Health and Welfare, Tokyo

Mr Yoshiki Mine, Minister, Permanent Mission of Japan to the United Nations Office and other International Organizations in Geneva, Switzerland

Mr Susumu Kaneko, Director, International Affairs Division, Minister's Secretariat, Ministry of Health and Welfare, Tokyo

Dr Yasuhiro Suzuki, Deputy Director, International Affairs Division, Minister's Secretariat, Ministry of Health and Welfare, Tokyo

Mr Toshiyasu Ikenaga, First Secretary, Permanent Mission of Japan to the United Nations Office and other International Organizations in Geneva, Switzerland

Mexico

Mrs Patricia Uribe-Zuñiga, Coordinador General, Consejo Nacional de Prevención y Control del SIDA (CONASIDA), Secretaria de Salud, Mexico D.F.

Ms Lourdes Sosa-Marquez, Third Secretary, Permanent Mission of Mexico to the Office of the United Nations and other International Organizations at Geneva

Netherlands

Ms R. Weiffenbach-Steeghs, Senior Adviser, UN Aid Section, Multilateral Development Cooperation and Special Programmes Department, Ministry of Foreign Affairs, The Hague

Dr J.H. Moerkerk, AIDS Coordinator, Ministry of Foreign Affairs, DSI/SB, The Hague

Mr W. van Reenen, First Secretary, Permanent Mission of the Kingdom of the Netherlands to the Office of the United Nations and to other International Organizations at Geneva, Switzerland

Norway

Ms Marianne Loe, Adviser, Department of Multilateral Development Cooperation, Ministry of Foreign Affairs, Oslo

Mr Eiler Fleischer, Executive Officer, Department of Multilateral Development Cooperation Ministry of Foreign Affairs, Oslo

Ms Jo Kittelsen, Adviser to NORAD and the Ministry of Foreign Affairs on AIDS, Norwegian Board of Health, Directorate of Health, Oslo

Mr Tor Christian Hildan, Minister Counsellor, Permanent Mission of Norway to the United Nations Office and to other International Organizations at Geneva, Switzerland

Dr Ottar C. Christiansen, Adviser, Ministry of Health and Social Affairs, Oslo

Pakistan

Dr S. Mohsin Ali Syed, Executive Director, National Institute of Health, c/o Ministry of Health, Government of Pakistan, Islamabad

Paraguay

Dr Nicolas Aguayo, Director, National AIDS Control Programme, Ministry of Public Health and Social Welfare, Asuncion

Ms Casati Leticia , Second Secretary, Permanent Mission of Paraguay to the Office of the United Nations and other International Organizations at Geneva, Switzerland

Russian Federation

Dr A.T. Golioussov, Chief Specialist, Department of State Sanitary & Epidemiological Surveillance, Ministry of Health of the Russian Federation, Moscow

Dr A. Pavlov, Counsellor, Permanent Mission of the Russian Federation to the Office of the United Nations and other International Organizations at Geneva, Switzerland

South Africa

Dr N.C. Dlamini Zuma, Minister of Health, Department of Health, Pretoria

Dr Desmond Keith Johns, Counsellor Health Affairs, Permanent Mission of South Africa to the United Nations Office in Geneva and other International Organizations in Switzerland

Sweden

Mr Erik Hammar skjöld, Deputy Head of Division, Global Cooperation Division, Ministry for Foreign Affairs, Stockholm

Ms Eva Areskoug, First Secretary, Global Cooperation Division, Ministry for Foreign Affairs Stockholm

Mr Staffan Uddeholt, Advisr, Health Division, Swedish International Development Agency (SIDA), Stockholm

Mrs Kristina Gardell, Programme Officer, Health Division, Swedish International Development Agency (SIDA), Stockholm

Mr Anders Pedersen , Counsellor, Permanent Mission of Sweden to the office of the United Nations and other Organizations at Geneva

Thailand

Dr Damrong Boonyoen, Director-General, Department of Communicable Disease Control, Ministry of Public Health, Nonthaburi

Uganda

Mr Omwony Ojwok, Director General, Uganda AIDS Commission Secretariat, Kampala

Dr David Kihumuro Apuuli, Director General, Health Services/AIDS, Communicable Disease Control, Ministry of Health, Entebbe

Ms Joyce Banya, First Secretary, Permanent Mission of the Republic of Uganda to the Office of the United Nations, & other International Organizations at Geneva

United Kingdom of Great Britain and Northern Ireland

Dr Hilary Homans, Specialist in HIV/AIDS and Reproductive Health Programmes, Health and Population Division, Overseas Development Administration, London

Mr Philip Mason, Head, Reproductive Health, Overseas Development Administration, London

Mr Tim Simmons, First Secretary, Permanent Mission of the United Kingdom to the United Nations Office and other International Organizations at Geneva, Switzerland

Miss Helen Frary, Third Secretary, Permanent Mission of the United Kingdom to the United Nations Office and other International Organizations at Geneva, Switzerland

United States of America

Ambassador Sally Shelton (Chairperson), Assistant Administrator, Bureau for Global Programs, U.S. Agency for International Development, Washington, D.C.

Mr Eric Goosby, Acting Director, Office of National AIDS Policy, Executive Office of the President, Washington, D.C.

Dr Duff Gillespie, Deputy Assistant Administrator & Director, Global Centre for Population, Health & Nutrition, U.S. Agency for International Development, Washington D.C.

Dr Kenneth Bernard, International Health Attaché, United States Mission to the United Nations Office and other International Organizations at Geneva

Dr Paul R. De Lay, Chief, HIV-AIDS Division, Center for Population, Health and Nutrition Bureau for Global Programs, Field Support and Research, U.S. Agency for International Development, State Department, Washington D.C.

Dr Helene Gayle, Director, National Center for HIV, STD and TB Prevention, Centers for Disease Control and Prevention, U.S. Public Health Services, Department of Health and Human Services, Washington, D.C.

Cosponsors

United Nations Children's Fund (UNICEF)

Dr Denis Broun, Chief, Health Section, UNICEF, New York

Ms Theresa McCann, Assistant Programme Officer, UNICEF, New York

United Nations Development Programme (UNDP)

Mr Anders Wijkman, Assistant Administrator and Director, UNDP - BPPS, New York

Ms Mina Mauerstein-Bail, Senior Programme Coordinator, HIV and Development Programme, Bureau for Policy and Programme Support, UNDP, New York

Mr Desmond Cohen, Director, HIV and Development Programme, Bureau for Policy and Programme Support, UNDP, New York

United Nations Population Fund (UNFPA)

Dr Nafis Sadik, Executive Director, UNFPA, New York

Dr Nicholas Dodd, Chief, Reproductive Health Branch, Technical & Evaluation Division, UNFPA, New York

United Nations Educational, Scientific and Cultural Organization (UNESCO)

Ms Marie-Paule Roudil, Avocat, UNESCO, Paris

World Health Organization

Dr F. Varet, Assistant Director-General, WHO

Dr D. Blake, Director, Office of HIV/AIDS and Sexually Transmitted Diseases, WHO

The World Bank

Dr Debrework Zewdie, Senior PHN Specialist and HIV/AIDS Coordinator, Population, Health and Nutrition Department, The World Bank, Washington D.C.

NGO Representatives

Dr Mazuwa Banda, General Secretary, Churches Medical Association of Zambia, Lusaka, Zambia

Ms Marina Mahathir, President, Malaysian AIDS Council, Kuala Lumpur, Malaysia

Mr Bill O'Loughlin, HIDNA, c/o ACFOA, Coordinator, Deakin, Australia

Dr Arnaud Marty-Lavauzelle, Président, AIDES Fédération Nationale, Paris, France

Dr Erlinda N. Senturias, Executive Secretary, CMC-Churches' Action for Health, World Council of Churches, Geneva

Mr Luis Gauthier, Coordinator, Chilean NGO AIDS Network, Santiago, Chile

Ms Cherryl Brown, Vancouver, B.C., Canada

Mr Jairo Pedraza, New York, USA

OBSERVERS

Member States

Australia

Ms Ann Kern, Consultant to the Department of Human Services & Health, c/o Permanent Mission of Australia to the United Nations Office at Geneva

Mr Eric Van Der Wal, First Secretary, Permanent Mission of Australia to the United Nations Office at Geneva

Austria

Dr Jean-Paul Klein, Second Secretary, Federal Ministry of Health and Consumer Protection, Département SIDA et maladies infectueuse, Vienna

Belgium

Dr J. Laruelle, Conseiller en Santé publique, Administration Générale de la Coopération au Développement, Bruxelles

Mr Koen Vervaeke, First Secretary, Permanent Mission of Belgium to the United Nations Office and the Specialized Agencies at Geneva

Colombia

Dra. Maria Francisca Arias-Johner, Minister Counsellor, Permanent Mission of Colombia to the United Nations Office and the Specialized Agencies at Geneva

Croatia

Mr Amir Hanusic, Secretary, Croatian Info-AIDS Union and member of the Ministry of Health Commission on AIDS c/o Permanent Mission of the Republic of Croatia to the United Nations Office and other International Organizations at Geneva

Dr Ira Gjenero-Margan, Head, AIDS Register Epidemiologist, Institute of Public Health, Zagreb

Denmark

Mr Ole Torpegaard Hansen, Counsellor, Permanent Mission of Denmark to the United Nations Office and other International Organizations at Geneva

Ms Anne-Marie Steninge, Head of Section, Ministry of Foreign Affairs, Copenhagen

Finland

Dr Merja Saarinen, Senior Medical Officer, Ministry of Social Affairs and Health, Helsinki

Mrs Hanna Rinkineva-Heikkila, Counsellor, Permanent Mission of Finland to the United Nations Office and the Specialized Agencies at Geneva

Germany

Dr Astrid Potz, Deputy Head of Division for International Relations in Health, Federal Ministry for Health, Bonn

Dr Ulrich Vogel, GTZ, Eschborn

Greece

Dr M. Violaki-Paraskeva, Honorary Director General of Health, Ministry of Health, Welfare and Social Security and Coordinator, International Relations Secretariat, Athens

Dr Helene Anémouli, Department of PH Division, Ministry of Health, Welfare and Social Security, Athens

Israel

Mr Gary Koren, Counsellor, Permanent Mission of Israel to the Office of the United Nations and other International Organizations at Geneva

Mrs Tally Rimon, Adviser, Permanent Representative of Israel to the Office of the United Nations and other International Organizations at Geneva

Italy

Dr Vincenzo Racalbuto, DGCS Focal Point HIV/AIDS M.A.E., Italian Ministry of Foreign Affairs, Direction General for Cooperation, Rome

Hashemite Kingdom of Jordan

Mr Karim Masri, Second Secretary, Permanent Mission of the Royal Hashemite Kingdom of Jordan to the United Nations Office and other Specialized Agencies at Geneva

Luxembourg

Dr Robert Hemmer, Président du Comité National de Surveillance du SIDA, Luxembourg

Malaysia

Mr Hishammuddin Hussein, Parliamentary Secretary, Ministry of International Trade and Industry Jalan Duta, Kuala Lumpur, Malaysia

Mr Salleh Rostam, First Secretary, Permanent Mission of Malaysia to the United Nations Office and other International Organizations at Geneva

Mr Zainal Abidin Raja Nushirwan, Second Secretary, Permanent Mission of Malaysia to the United Nations Office and other International Organizations at Geneva

Malta

Ms Sina Bugeja, Senior Health Promotion Officer, Health Promotion Department, Ministry of Health, Valletta

Mauritius

Mrs Usha Dwarka-Canabady, Minister-Counsellor, Permanent Mission of the Republic of Mauritius to the United Nations Office and other International Organizations at Geneva

Sultanat of Oman

Mr Abdennour Seddiki, Permanent Mission of the Sultanat of Oman to the United Nations Office and other International Organizations at Geneva

Peru

Mrs Romy Tincopa, Second Secretary, Permanent Mission of Peru to the United Nations Office and other International Organizations at Geneva

Philippines

Ms Monina Estrella G. Callangan, Third Secretary, Permanent Mission, Geneva

Portugal

Mrs Isabel M. Marquez Ribeiro Da Silva, First Secretary, Permanent Mission of Portugal to the Office of the United Nations & other Internat. Organiz. at Geneva

Saint Siège

Dr Guido Castelli Gattinara, Ospedali Bambino Jesu, Rome

Mlle Anne-Marie Colandrea, Mission permanente d'observation du Saint-Siège auprès de l'Office des Nations Unies et des autres organisations internationales à Genève

Slovak Republic

Dr Fedor Rosocha, Second Secretary, Permanent Mission of the Slovak Republic to the United Nations Office and to other International Organizations at Geneva

Dr Eva Máderová, Head of Department of Epidemiology, Ministry of Health, Bratislava

Dr Emil Tomasík, National Reference Centre for Prevention of HIV/AIDS, Institute of Preventive and Clinical Medicine, Bratislava

Spain

H.E. Mr D. Raimundo Pérez-Hernández y Torra, Ambassador and Permanent Representative of Spain to the United Nations Office and other International Organizations at Geneva

Dr Francisco Parras, Secretary, National AIDS Control Plan, Ministry of Health and Consumer Affairs, Madrid

Mr D. Ricardo Martinez Vázquez, Counsellor, Permanent Mission of Spain to the United Nations Office and other International Organizations at Geneva

Switzerland

Monsieur Mark Ita, Chef de Section adjoint, Section SIDA, Office fédéral de la santé publique, Département fédéral de l'intérieur, Berne

Dr Raphael Baltès, Consultant, Bartenheim, France

Madame Dominique Petter, Premier Secrétaire, Mission permanente de la Suisse près les organisations internationales à Genève

Trinidad & Tobago

Miss Mary Ann Richards, Deputy Permanent Representative of Trinidad and Tobago to the Office of the United Nations and Specialized Agencies at Geneva

Zambia

Miss Annie Kazhingu, Second Secretary, Permanent Mission of Zambia to the Office of the United Nations Office and other International Organizations at Geneva

Intergovernmental Organizations

European Commission

Dr L. Fransen, Health, Family Planning and Aids Unit, European Commission, Directorate-General for Development, Brussels, Belgium

United Nations Organizations/Agencies

United Nations Office in New York

Mr Christopher F. Hackett, Chief, Inter-agency Affairs Section, Department for Policy Coordination and Sustainable Development, United Nations, New York

Dr Ingrid Laux, Medical Director, United Nations Medical Service, United Nations, N.Y.

United Nations International Drug Control Programme (UNDCP)

Ms Cindy Fazy, UNDCP, Vienna International Centre, Vienna

Coordinating Committee for International Staff Unions

Mr Nick Fucile, CCISUA Focal Point on HIV/AIDS, United Nations, New York

Federation of International Civil Servants' Associations (FICSA)

Mr Mark Hamilton, Vice-Chair, FICSA Standing Committee on Occupational Health and Safety (UNDP/UNFPA/UNOPS), UNDP, New York

UNHCR

Dr Mohamed W. Dualeh, Senior Public Health Officer, Office of the High Commissioner for Refugees, Geneva

FAO

Mr Jacques du Guerny, Chief, Population Programme Service, FAO, Rome

Nongovernmental Organizations

Ms Maria de Bruyn, AIDS Coordination Bureau, Royal Tropical Institute, Amsterdam

M. Modibo Kanoute, Président, Association d'aide aux malades du sida et aux orphelins en Afrique, Paris

Mr Paul Di Donato, Executive Director, Funders Concerned About AIDS, New York

INTERNATIONAL AIDS SOCIETY (IAS), represented by: Dr Mark A. Wainberg
Director, McGill AIDS Center, Canada

Mr Jeff O'Malley, Executive Director, International HIV/AIDS Alliance, London

Dr Getachew Gizaw, Senior Officer for Communicable Diseases-HIV/AIDS
International Federation of Red Cross, and Red Crescent Societies, Geneva

Ms Jackie Coleman, The National Minority AIDS Council, Washington DC

Mr Damien Rwegera, Organisation Pan-Africaine De Lutte Contre Le SIDA (OPALS), Paris

Mrs Lucile Astel, Organisation Pan-Africaine De Lutte Contre Le SIDA (OPALS), Paris

Mr Richard A. Frank, President, PSI, Washington DC, USA

Ms Garance Upham, President, Sidalerte Internationale, Lyon, France

Dr Mamoudou Diallo, Network Coordinator, Sidalerte Internationale, Lyon

Ms Susan Lucas, Coordinator, UK NGO AIDS Consortium, London

Rev. Sibylle Schar, AIDS Pfarramt, Zurich, Switzerland, (representing: CMC-Churches'
Action for Health, World Council of Churches, Geneva

Rev. Peter Lack, AIDS Pfarramt, Basel, Switzerland

Annex 2 Agenda

	<u>Reference documents</u>
1. Opening	
1.1 Opening of the meeting	
1.2 Election of officers	
1.3 Report by the Chairperson of the Committee of Cosponsoring Organizations	
1.4 Report by the NGO representative	
1.5 Adoption of provisional agenda	UNAIDS/PCB(4)/97.1
2. Consideration of the report of the third meeting	UNAIDS/PCB(3)/96.10
3. Report of the Executive Director	UNAIDS/PCB(4)/97.2
4. Functioning of UNAIDS at country level including case studies	UNAIDS/PCB(4)/97.3
5. Criteria for prioritization of UNAIDS support	UNAIDS/PCB(4)/97.4
6. UNAIDS Performance Monitoring and Evaluation Plan	UNAIDS/PCB(4)/97.5
7. Financial and budgetary update: interim report	UNAIDS/PCB(4)/97.6
8. UNAIDS Proposed Programme Budget and Workplan for 1998-1999	UNAIDS/PBW/98-99
9. UNAIDS Coordinated Appeal for 1998-1999	UNAIDS/PCB(4)/97.7
10. Mode of Operations of the PCB UNAIDS/PCB(4)/97.8	
11. Next PCB meeting	
12. Other business	
13. Adoption of Decisions, recommendations and conclusions	

Annex 3

Decisions, Recommendations and Conclusions

Agenda item 2 - Consideration of the report of the third meeting

1. The PCB adopted the report of its third meeting (Document UNAIDS/PCB(3)/96.10), held on 10-11 June 1996.

Agenda item 3 - Report of the Executive Director and general debate

2. The PCB expressed very strong appreciation for the Programme's many achievements within the short period of its existence and commended the Executive Director and his staff.
3. The PCB expressed its continuing concern about the growing impact of the HIV/AIDS epidemic, the dangers of a growing sense of complacency following the preliminary success of experimental treatment modalities, and the need for increased resources to address the epidemic.
4. The PCB recognized the value to UNAIDS's work of partnerships with the public sector, NGOs and people living with HIV/AIDS, and the business community, and encouraged the Programme to continue its partnership building efforts.
5. The PCB welcomed the Report of the Executive Director (Document UNAIDS/PCB(4)/97.2), appreciating its structure and comprehensive nature, and encouraged that future reports include further emphasis on options and suggestions for addressing issues and challenges.
6. The PCB encouraged the continued active involvement of UNAIDS in the UN reform initiative of the Secretary-General (Executive Committee of the Development Cooperation Group). UNAIDS was encouraged to further refine its methods of work, noting that the UNAIDS concept may be an example for cooperation in other areas of the UN system.
7. The PCB encouraged UN Member States, in particular the PCB members, to strengthen their commitment and fully assume their responsibilities for the success of UNAIDS. The PCB emphasized the responsibility of Member States to ensure coherent action within the Cosponsors, working through their individual governing bodies and ECOSOC. Through these channels, Cosponsors should be encouraged to be more supportive to the UNAIDS's effort, including to its approved budget programme components, bearing in mind the role of UNAIDS and the comparative strengths of the Cosponsoring Organizations; to increase their HIV/AIDS mainstreaming activities; to provide increased funding for HIV/AIDS activities at country level; and to provide necessary administrative support for the functioning of UN Theme Groups at country level.
8. The PCB encouraged UNAIDS to adopt reporting systems allowing for monitoring of its performance with regard to the 20/20 Initiative in accordance with the Oslo consensus, and

participate in discussions on this issue taking place in the relevant ACC mechanisms on coordinated follow-up to international UN conferences.

9. The PCB encouraged the Secretariat to examine and strengthen the information chain at global and regional level between the Secretariat and its Cosponsors, and within the Cosponsors, from the HIV/AIDS Focal Points to relevant global and regional structures.

10. Noting with concern the increasing disparity among and within countries in their access to appropriate drugs and therapies for HIV-related illness, the PCB encouraged UNAIDS to strengthen its advocacy, partnership mobilization, and best practice development in support to improved access to treatment, including antiretroviral therapy, in those countries where the greatest burden of HIV-related illness is borne.

Agenda item 4 - Functioning of UNAIDS at country level including case studies

Agenda item 5 - Criteria for prioritization of UNAIDS support

(Documents UNAIDS/PCB(4)/97.3 and its Addendum 1)

11. The PCB recommended continuing emphasis on further clarification of roles and responsibilities of the Cosponsors and UNAIDS in countries. In particular, the PCB also recommended that consistent guidelines be communicated by the respective headquarters of Cosponsors, bilateral agencies and UNAIDS to their country staff. These guidelines should clarify the role, functions, and expected outputs of the UN Theme Groups, with a view to facilitating joint planning and integrated programme implementation among the UN Theme Group members.

12. The PCB endorsed the purpose of programme development funds as being for activities which are catalytic, strategic, and suitable for replication. The PCB further suggested reconsideration of the nomenclature of the programme development funds to ensure clarity on the purpose of activities to be supported through these funds.

13. The PCB endorsed in principle the need for criteria for prioritization of UNAIDS support at country level, including programme development funds and the deployment of country-based staff, noting its concerns on their application, and requested further refinement based on monitoring and accumulated experience. The PCB further emphasized that prioritization criteria should be as transparent as possible, and requested that these criteria be presented for further discussion at the next regular annual PCB session. The PCB urged that an appropriate balance be struck between opportunity and needs-based criteria, and that efforts should be made to identify more objective criteria, where possible. The PCB also expressed its concerns that the needs of small countries, small island countries, and countries with low HIV prevalence and those with minimal UN presence also be addressed within the prioritization criteria.

14. The PCB requested periodic summaries in tabular form of UNAIDS's activities at country level. The PCB encouraged that, where appropriate, UN Theme Group membership should expand to relevant UN system organizations beyond the six Cosponsors. UN Theme Groups should also play a more proactive role in effectively supporting national governments in their coordinating roles; strengthening in-country resource mobilization efforts; facilitating partnerships between national programmes and NGOs; actively seeking the inputs of people living

with HIV/AIDS; and strengthening efforts to mobilize specific technical expertise from regional and global sources for national programmes.

15. The PCB recommended that regional support activities of UNAIDS should be effectively linked to the existing regional technical support entities of the Cosponsoring Organizations and other regional mechanisms. This included emphasis on exchange of ideas and improved coordination among neighbouring countries. The PCB also requested that progress on the establishment and functioning of UNAIDS's Inter-Country Teams be provided to the next regular annual session of the PCB.

16. Reiterating the basic principle that UNAIDS was not established to serve as a funding agency, the PCB requested that the Secretariat prepare in advance of the next regular annual PCB session an overview analysis of the funding status of national AIDS programmes that have received transitional core financial support from UNAIDS in the current biennium. The overview analysis should provide an indication of the relative magnitude of this support; the success of national programmes in identifying alternative national and international financial resources; and the scope and scale of unmet needs. The analysis should also provide recommendations on how the international community, including the UNAIDS's Cosponsors and bilateral agencies, might more effectively address those needs.

Agenda item 6 - UNAIDS Performance Monitoring and Evaluation Plan

17. The PCB noted with appreciation the Progress Report on UNAIDS Performance Monitoring and Evaluation Plan (Document UNAIDS/PCB(4)/97.5) and the Report of the PCB Working Group on Indicators and Evaluation (Document UNAIDS/PCB(4)/97.5 Add.1). The PCB approved the Secretariat's request for two additional posts, one in the professional category and one in the general service category, and reallocation of an existing professional post, as contained in the Proposed Budget and Workplan for 1998-1999. It requested that the Secretariat present a comprehensive Performance Monitoring and Evaluation Plan to the PCB at its next regular annual session. The PCB recommended that UNAIDS work closely with the Cosponsors in monitoring and evaluating UN system responses to HIV/AIDS at all levels. It further recommended that, having completed its work, the PCB Working Group on Indicators and Evaluation cease to function and that a broad-based technical advisory group be created, including membership drawn from governmental and non-governmental organizations. The terms of reference of the technical advisory group should enable it to assist in maintaining the momentum established by the PCB Working Group, as well as providing technical support.

Agenda item 7 - Financial and budgetary update for 1996-1997: interim report

18. The PCB expressed its appreciation for the clarity of the financial report presented (Documents UNAIDS/PCB(4)/97.6 and its Addendum), noting that it had been aligned with the Board's recommendations to present separately overhead costs, programme delivery costs, and the cost of posts. It also noted that steps had been taken to establish an operating reserve, as requested by the PCB, and that further recommendations on procedures guiding its operations would be presented to the Board at the next regular annual session. The PCB noted the present size of the operating reserve at potentially US\$ 38 million, representing two-thirds of annual expenditures,

and requested the Secretariat with the PCB Working Group on Resource Mobilization to establish, as soon as possible, the basis for determining the appropriate level of the operating reserve.

19. The PCB noted that, while 60% of the total requirements to fund the approved budget of US\$ 120 million for 1996-1997 had been received as at 31 March 1997, there is urgency to ensure that the outstanding funds needed for the Programme are received as soon as possible. While appreciating the efforts that had been made to secure greater funding from non-traditional sources, including the private sector, the PCB also urged that the funding base for the Programme be further strengthened by a larger number of governments contributing a greater amount of resources, with priority to funding activities within the approved budget. The PCB requested the Secretariat to provide a financial and budgetary update, including future resource mobilization prospects, at the next regular annual session of the PCB.

Agenda item 8 - UNAIDS Proposed Programme Budget and Workplan for 1998-1999

20. The PCB expressed appreciation for the transparency in presentation, the structure and quality of the 1998-1999 Proposed Budget and Workplan, and noted the progress made in terms of moving towards a more integrated workplan among UNAIDS and the Cosponsors.

21. The PCB endorsed the proposed budget of US\$ 120 million for 1998-1999 and its allocations for programme components, re-emphasizing the importance of the four cross-cutting themes – human rights, gender, young people, and the greater involvement of people living with HIV/AIDS.

22. The PCB requested that, in implementing its workplan, the Secretariat give greater priority to strategies related to improving access to care, including access to antiretroviral therapy and to treatment for opportunistic infections, and to broadening the range of approaches for reducing HIV transmission through injecting drug use.

23. In emphasizing the importance of providing as comprehensive a picture as possible of the HIV/AIDS activities of UNAIDS and its Cosponsors, and of continuing to progress towards a more complete integrated workplan in future budget submissions, the PCB also recommended that continued attention be given to further clarifying the respective implementation responsibilities of the Secretariat, the Cosponsors and other partners; and that the narrative detail better correspond to the budget level of the respective programme components. The PCB also encouraged the Secretariat, in preparing its more detailed workplans for programme management, to undertake greater prioritization of the programme components along with their timeframes; to describe objectives, sub-objectives and outputs with greater precision and consistency; and to better link specific programme components, strategic objectives, and performance monitoring and evaluation.

Agenda item 9 - Coordinated Appeal for 1998-1999

24. The PCB noted the Progress Report on the UNAIDS Coordinated Appeal for Supplemental Funded Activities (Document UNAIDS/PCB(4)/97.7) at global and regional level, acknowledging the efforts of the Cosponsors and the Secretariat in developing this important instrument for harmonization, and appreciating the frank description within the Report of the difficulties encountered in establishing the process. The PCB encouraged the Cosponsors and the Secretariat

to proceed with the development of the 1998-1999 Coordinated Appeal, with appropriate prioritization of its components within a US\$ 20 million ceiling at global level, and its planned launch in June 1997.

25. The PCB requested that the 1998-1999 Coordinated Appeal documentation clearly indicate: (i) the division of responsibility for implementation among the Cosponsors and the Secretariat; (ii) how specific Coordinated Appeal proposals help to strengthen HIV/AIDS programming at country level; (iii) how proposals are linked to programme component objectives in the UNAIDS workplan; (iv) that proposals emphasize HIV/AIDS activities rather than Cosponsor core support; and (v) that the Coordinated Appeal include country-level activities on an experimental basis. The PCB further requested that the Secretariat distribute quarterly updates on funding status of the Coordinated Appeal, and that the PCB be briefed at its next meeting on overall progress.

Agenda item 10 - Mode of operations of the PCB

26. The PCB amended Article 21 of its Modus Operandi by adding the office of a rapporteur, taking into account fair geographical distribution.

27. The PCB recommended that the UNAIDS's governance structure strike a balance between formal and informal mechanisms. Where appropriate, country visits by PCB members should be encouraged to enable greater understanding of UN Theme Group operations.

28. The PCB endorsed the proposals included within the report on Mode of Operations of the PCB (Document UNAIDS/PCB(4)/97.8). The PCB also recommended that ad hoc and informal meetings be convened to complement the regular annual sessions of the PCB. One ad hoc thematic meeting and four informal information meetings have been proposed for 1997, although the number per year will remain flexible. The PCB requested the Secretariat to provide adequate notice of the meetings to facilitate participation and/or inputs by all members.

29. The PCB recognized the potential value in conducting its future meetings in a different manner to permit more in-depth exchange of ideas and requested the Secretariat, in conjunction with the chairperson and vice-chairperson, and in consultation with PCB members, to look at ways of implementing this for the next meeting.

30. The PCB requested that the chairperson and vice-chairperson present to the PCB a proposal for election procedures of future chairpersons and vice-chairpersons at its next regular annual session.

Agenda item 11 - Next PCB meeting

31. The PCB asked the Secretariat to organize an ad hoc thematic meeting of the PCB in the last quarter of 1997 (most likely November).

Agenda item 12 - Other business

Resource mobilization

32. The PCB endorsed the recommendations of the PCB Working Group on Resource Mobilization (Document UNAIDS/PCB(4)/97.9), emphasizing the need to give priority to non-earmarked contributions to the core budget, while taking note of the limitations within some donor agencies with regard to the earmarking of contributions and the subsequent need for some flexibility.
33. The PCB recommended that UNAIDS strengthen its activities to mobilize resources from non-traditional sources, including the private sector, in the response to HIV/AIDS.
34. The PCB recommended that emphasis be placed on strengthening capacity of national governments, NGOs and networks of people living with HIV/AIDS to mobilize resources.



JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

UNAIDS HIV DRUG ACCESS INITIATIVE

Providing Wider Access to HIV-related Drugs in Developing Countries

PILOT PHASE

BACKGROUND DOCUMENT

October 1997

BACKGROUND INFORMATION

INTRODUCTION

UNAIDS and WHO estimate that as of the end of 1996, over 22 million persons were living with HIV with more than twenty million in developing countries. Approximately 1.5 million deaths among adults in 1996 are estimated to be related to AIDS, 90% in developing countries.

The emergence of the HIV/AIDS epidemic together with an increasing number of AIDS cases, raises new challenges, these range from the need to develop effective drugs for treatment to the assurance of an equitable distribution. To ensure that these drugs reach the individual in the community, one is confronted with complex political, economic, social/cultural and technological obstacles which vary in expression from country to country. With the increasing number of patients with AIDS, there is an increasing demand by People Living with HIV/AIDS (PLHA) to have access to HIV-related drugs. For example, in Latin America where access to care is presented as a constitutional right, this created new political and ethical considerations. These considerations have to be reconciled with the technical, financial and social capacities of existing institutions both in the private and public sector. In many developing countries, patients do not have access even to basic treatment modalities for opportunistic infections. For example 80% of HIV/AIDS cases are concentrated in Sub-Saharan Africa with GDP per capita in the range \$80-\$256, making it doubly difficult to have these drugs available to PLHA. Yet economic arguments alone are not sufficient reason in a democratic state to deny access to those who need it, as these need to be reconciled with issues of social justice and equity. In such an environment new approaches of interaction at global and country level are required, if sustainable solutions are to be found on these issues.

Apart from challenges mentioned above, HIV/AIDS brings new opportunities to this agenda in form of increasing number of Non Governmental Organizations, Community Based Organizations and PLHA who are already opening up new avenues for improving access to care in general and drugs in particular. The increasing number of actors if not properly harnessed and coordinated could result in a fragmented response to the problem. UNAIDS sees its function as facilitator of this process.

BASIC PRINCIPLES

- The responsibility for care and treatment of people with HIV/AIDS rests fundamentally with the government and national public health systems of the countries in which these people live. However, any successful effort to make available HIV-related drugs requires a multipartite approach that effectively engages all parties with an active interest in improving the response to this world-wide health care threat. This is most true in the resource-constrained environments of developing countries.
- A rational HIV strategy in a country should objectively assess and prioritize the available medical and public health interventions in the context of the country's medical and public health infrastructure and needs. The availability of a treatment through public sector financing is dictated by its positive cost-effective clinical outcome which takes

into account realistic medical and public health considerations, especially with sophisticated or demanding pharmaceutical regimens. As public health constraints affect successful use of treatments, they also limit their commercial profile in the same environment.

- Suppliers of HIV-related drugs have sound policy and market-based incentives to facilitate access to their products and services by differentiating or subsidizing their prices to address the varying economic, medical, and public health characteristics of individual countries. An effective price which represents an agreed mutual value between supplier and purchaser will by definition vary according to the economic circumstances in which the product is acquired and its benefit realized.
- Selection of treatments and interventions should be based on the objective assessment of their medical, public health, and health economic merits.
- A multipartite framework which can address HIV treatment access issues on the basis of public health criteria can provide a model that may have applicability beyond HIV field

UNAIDS PRIORITIES.

- Without compromising HIV prevention priorities, the continuous spread of HIV epidemic especially in developing countries is increasing the need for proper HIV care in these countries. Access to HIV-related medicines together with an adequate social support and health care infrastructure for a rational use of these medicines, are the fundamental bases for proper HIV care.
- Access to HIV related drugs as well as STD treatments in developing countries requires a product pricing which is in accordance with the economic reality of the country. Specific mechanisms should be set up to facilitate such pricing and ensure a rational use of drugs.
- Such mechanisms should make HIV-related drugs available for purchase through public or private funds. The allocation of public funds rests with the government of the country and is based on the public health and economic context of the country.
- While implementing such mechanisms in countries where health care infrastructure is reasonably adequate, it is essential to keep strengthening the infrastructure within the country as well as in other countries to create a favourable setting for a wider access to HIV-related drugs.
- To implement mechanisms for access to HIV-related drugs without disrupting or altering existing Essential Drugs Programmes
- To provide the appropriate information and training to health workers and communities and foster the establishment and improvement of an adequate medical information system.
- To ultimately make HIV/AIDS and STD drugs available in each country.

RATIONALE FOR CHOOSING THE INITIATIVE

While the objective is to improve access to HIV-related drugs in developing countries, it should be kept in mind that each developing country is unique especially in the context of HIV/AIDS. There is a wide difference in their systems, economic capacities, HIV prevalence, cultural and geographical contexts. Therefore, the obstacles to drug access vary widely between countries and there is no single solution for all developing countries.

For example, the presence of an adequate health care infrastructure, together with a rational prescription of drugs in many South American countries makes the focus of these countries on negotiating bulk purchase prices by pooling their orders, an adequate and successful method for improving access to HIV-related drugs. In other countries, the health care infrastructure is so limited that it does not allow an adequate distribution and prescription of drugs even if these drugs were to be provided at no cost.

This Initiative creates through flexible mechanisms, a link between interested parties, private drug providers, health system, communities and patients. It will address the obstacles and weaknesses at any level: pricing, distribution, health care centres, drug dispensation etc... Without pretending to provide a unique solution to all problems, this Initiative is meant to address the needs of a large number of countries.

The pilot phase will be implemented in countries where the health care infrastructure is reasonably developed or may only require moderate strengthening to allow rapid implementation and results. These results will identify specific prerequisites for improving access to HIV-related drugs and will provide recommendations on how to strengthen the health care infrastructure to ensure these prerequisites.

DESCRIPTION OF THE INITIATIVE

The purpose of the Initiative is to create an appropriate environment for a long term collaboration between the pharmaceutical companies and health care providers in the country, where the companies can provide securely HIV/STD-related drugs in line with their affordability in the country and where health care providers can make these drugs available to the patients within optimal standards of care and with a rational prescription policy. To reach this goal, the Initiative will test and evaluate mechanisms to supply drugs at subsidized prices and to ensure an adequate health care infrastructure with an adapted distribution system.

THE HEALTH CARE INFRASTRUCTURE

AT NATIONAL LEVEL: The Advisory Board

It is of critical importance to have a well coordinated HIV-related National Drug Policy which takes into consideration drug supply mechanisms as well as health care delivery systems. Even if drugs are made available at the lowest prices, patients who are most in need would not be able to benefit from them without an adequate HIV-related National Drug Policy which will ensure targeted supply as well as a rational prescription and use of the drugs.

The HIV-related National Drug Policy will be determined by the Ministry of Health based on the recommendations of an Advisory Board established in the context of this Initiative, unless there is another existing body which could ensure the role of the Advisory Board.

Role of the Advisory Board

The Advisory Board has the responsibility of recommending HIV-related National Drug Policy as well as ensuring the functionality of the health care infrastructure. The Advisory Board is under the authority of the Minister of Health.

The functions of the Advisory Board will be:

- To determine HIV-related National drug policy which includes recommendations on technical aspects of the epidemic including currently available therapies and clinical management of HIV infection, as well as the establishment of a list of the HIV related drugs needed which is adapted to the local context..
- To estimate the needs of the relevant country for HIV-related drugs. The drugs will be supplied preferably but not exclusively through the financial mechanism proposed below which consist of a Non-Profit making Company (NPC). The procurement could be made through the NPC or from other sources, both for the public funds or privately funded purchases. The NPC will act as a normal supplier with no exclusivity rights.
- To determine and recommend to the government, policy for the public sector in relation to the rationale of prescription, usage and distribution of drugs supplied through the Non-Profit making Company, in the local context of the epidemic.

- Some opportunistic infections as well as antiretroviral therapy require sophisticated diagnosis and management facilities. Without basic facilities, including well trained health workers, the rational prescription of drugs cannot be ensured. The Advisory Board will establish the minimum requirements of health care centres to qualify them for selection as centres where the rational prescription and use of the drugs can be assured. It is anticipated that there will be minimal requirements for 2 levels of health care settings; first level and referral centres.
- To select the qualifying centres where the drugs will be made available, and to communicate the list of qualifying centres to the NPC Manager and the central distribution point.
- To set objective criteria of the profile of patients who will participate in the pilot project. Such criteria will include restrictive prescription indications to balance the clinical relevance with the availability of the drugs and resources.
- To recommend over time an action plan for improvement of the health care infrastructure where necessary in order to make the HIV/AIDS drugs more widely accessible in the country.
- To determine and recommend regulations concerning privately funded purchases and the proper usage of drugs supplied through the Non-Profit making Company.

The Advisory Board consisting of no more than 10 members, will be established and appointed by the Ministry of Health in collaboration with and will have the following members:

- Representatives of the Ministries of Health, and other relevant Ministries such as Planning and Finance in the Pilot country.
- Representative of UNAIDS through the UN Theme Group on HIV/AIDS
- The National AIDS Programme Manager as well as representatives of relevant AIDS authorities in the countries.
- Representatives of the NGOs who are involved in HIV/AIDS care.
- Clinicians and public health persons from the academic sector who are knowledgeable in HIV/AIDS epidemic and clinical management of HIV infection.
- Representatives of People Living With HIV/AIDS.
- The Manager of the Non-Profit making Company (as observer and liaison person)

AT HEALTH CARE DELIVERY LEVEL: Qualified health care centres

The health care centre will receive drugs only if it meets qualification criteria as set by the Advisory Board. Qualification criteria will include:

- Well trained doctors and other health workers
- Good clinical facilities for diagnosis and management
- Standard laboratory facilities
- Social support
- Drug dispensation facilities

Each qualifying health care centre, whether first level or referral will be given a single procurement number by the Advisory Board which authorises the centre to purchase the type of drugs according to its qualification. The products will be supplied to this procurement number from the central distribution point.

At the health care centre, drugs will be dispensed against a medical prescription issued by one of the centres qualified physician. All qualifying centres will be required to keep proper prescription and dispensing records in accordance with normal professional practise. Stock management programmes including anonymous data on patient number, prescriber's code and drug name will be provided and standardized by the pilot project.

Drugs supplied through the NPC will be made available in at least 2 levels of Health Care settings including, first level and referral settings. Basic drugs will be made available at both levels, however, more sophisticated drugs and drugs which require a more sophisticated management will be made available only at the referral level.

INFORMATION AND TRAINING STRATEGIES

Appropriate information and training strategies will be developed by the Ministry of Health and the National AIDS Programme, in accordance with the recommendations of the Advisory Board. Such strategies will target doctors and other health workers as well as patients and communities. The communities will play an active role in dissemination of relevant information.

The companies will continue to provide information and material as per their usual practice.

COMMUNITY INVOLVEMENT

The communities will play an essential role in the Initiative. Communities and NGOs which are involved in health care delivery systems will be encouraged and assisted to have their health care centres qualified by the Advisory Board.

NGOs and communities will play a crucial role in counselling and psycho-social support provided to the patients in all health care centres involved in this Initiative. NGOs and communities will be also involved in delivering targeted prevention and care messages to patients and the general population.

THE FINANCIAL MECHANISM

It is clearly acknowledged that the new HIV-related drugs, mainly antiretrovirals, are beyond the means of most developing countries where over 90% of people with HIV live. The issue of affordability in these countries is linked to the combination of high drug costs and high HIV prevalence rates in these countries. This combination widens the gap between the high financial requirements at the national level and the modest financial capacities of the country whatever the sources of funds. While considerable efforts are being developed to prevent HIV transmission and therefore reduce HIV prevalence, it is essential to address the other determinant of affordability and find mechanisms to reduce drug costs.

When drug costs are in line with the local needs and country's ability to pay, access to these drugs will be maximized. It is therefore conceivable that a patient in Uganda whose income is lower than a patient in the USA or Europe should pay less for antiretroviral therapy or other costly HIV-related medicines. The same economic concept applies at the national level since the national health expenditures in both the public and the private sectors are by far lower in developing countries than in developed countries.

On this basis, the financial mechanism proposed in this Initiative may enable pharmaceutical companies to provide HIV-related drugs to developing countries at country-specific subsidized prices. The price levels will be defined separately and independently by each company, following individual discussions with the country officials, taking into account the nature of the drugs to be purchased as well as the economic and epidemiological situation of the country. The financial mechanism proposed will have no exclusivity rights. The suppliers as well as the purchasers have the choice to order drugs through the mechanism or from other sources.

The Financial Structure

A financial structure will be established in each pilot country to ensure coordination of the anticipated financial transactions without compromising international competition and open market rules. It will also ensure appropriate and timely supply of drugs as requested by the country.

The financial structure will be a Non-Profit making Company through which any pharmaceutical company willing to participate in this Initiative will channel supplies. The Non-Profit making Company (NPC) will be registered under the laws of each country in which it is to be established. It will be a small structure with a manager and an administrative assistant/secretary. The administrative and operating costs of the NPC will be covered by the participating companies. All companies may participate in the Initiative and cosponsor the NPC.

Drugs will be purchased by the NPC only from the pharmaceutical companies who are willing to participate in this Initiative, and who contribute to the administrative cost of the NPC. These drugs will be supplied to the purchasers within the country at lower prices which are subsidized through the NPC.

The companies will continue to ensure direct responsibility and liability for their respective products.

Donors will not be requested to subscribe directly to the NPC; they will be requested by the country to support the programme by making donor funding available to the government and health care providers in the particular country.

Role of the financial structure (i.e. NPC)

- To liaise with the Advisory Board and the Ministry of Health on the likely demand of products, in accordance with the National Drug Policy.
- To negotiate orders of the products with the relevant pharmaceutical companies for the government and health care settings, in accordance with the recommendations of the Advisory Board.
- To arrange the supply of products to be ordered from the relevant pharmaceutical company.
- To arrange the provision of adequate funding for these orders through the NPC mechanism and to make the appropriate payments to the supplying companies.
- To discuss on an on-going basis the subsidies to be received from the supplying companies.
- To administer the flow of funds into and out of the NPC in accordance with the standards required by the Board of Directors and the Auditors.

Role of the auditors

The accounts of the NPC will be edited annually by a recognized international firm of auditors. The resultant annual report will be public and made available to UNAIDS, the participating companies, and the government of the country concerned.

Another confidential report which details the financial transactions by company will be produced and disclosed to the Board of Directors only. Any participating company may have access to its relevant section of the detailed report. This procedure will ensure confidentiality in accordance with competition rules of open-market economy.

THE DISTRIBUTION MECHANISM.

Products will be delivered by the pharmaceutical companies through the NPC to either a central distribution point, which could be the Government Central Medical Stores, or directly to the health care centres.

THE PILOT PHASE

The Pilot Project will be applied by country and will consist of 2 Phases, and will have a duration of 4 -5 years from start up.

PHASE I: IMPLEMENTATION OF THE PILOT PHASE.

The first phase will cover the initial projects in the Pilot Countries until the schemes are functioning correctly and efficiently. This process is expected to last 2 - 3 years.

It is of critical importance to ensure a sustainable access treatment to the patients who will participate in the pilot phase of the Initiative, during as well as after the pilot phase. Therefore, the participating companies should ensure that those patients who participate in the pilot phase will continue to have access to their usual drugs at the subsidized prices after the completion of the pilot phase. The National Authorities are also expected to assure sustainability of the programme with regard to these patients.

An evaluation of the structure of the Initiative and its mechanism will take place at the end of the first year to determine the difference between the theoretical design and the practical implementations.

The purpose of the first year evaluation is to establish the best and most practical methods for the implementation of such an Initiative in other countries.

A further evaluation at the end of year 2 will establish how well the whole scheme has functioned and has made the drugs accessible. This evaluation will provide the first concrete results with regard to the real impact of the Initiative on access to HIV-related drugs in developing countries. An action plan for the expansion phase will be established on the basis of this evaluation.

PROGRAMME FOR THE IMPLEMENTATION OF THE PILOT PHASE.

It is envisaged that the Pilot Projects will be implemented in the following programme:

A preliminary visit of UNAIDS team will be made to each Pilot Country, during which an assessment will be made of the tasks and activities which must be completed to ensure the successful establishment of the Pilot Programme.

The existing levels of the required infrastructures will also be evaluated in these preliminary visits.

The UNAIDS team will facilitate the implementation of the Pilot Phase for its full duration of 2 years.

It is envisaged that an experienced Project Manager will be recruited in the pilot country to supervise the start up of the Pilot Projects

The initial tasks of the Project Management team are as follows:

- An initial stock level of needed products will be established in each qualifying centre which will be funded by either public funds or in arrangement with the pharmaceutical companies. This initial stock will primarily be required to service the purchases which will be made by non state funded individual patients.
- Assist the Advisory Board in the selection of clinics on the basis of a proposal which describes clinical and lab facilities as well as an inventory of health workers and doctors in each clinic. Once selected, a list of doctors and their authorised signature should be available.
- Hold training workshop of health workers
- Prepare and distribute patient information chart and prescription format
- Provide with appropriate training stock management software for drug dispensation at the clinic.

SELECTION OF PATIENTS

The pilot phase may not be able to give access to HIV-related drugs to all patients who need them, due the high number of patients and insufficient health care infrastructure and financial resources. It is therefore of critical importance that the pilot phase provides access to those patients most in need.

Rigorous and objective selection criteria will be established in each pilot country through a large consensus process involving government officials, people living with HIV, clinicians, ethicists, religious groups and others. Some of the criteria will rely on clinical guidelines but other criteria will be established to ensure that those who are most in need will benefit from the Initiative. The Advisory Board will have the responsibility to implement such criteria and ensure that they are applied.

EVALUATION PROCESS

UNAIDS will be responsible of the evaluation process at the end of the first and second year as mentioned above.

The subsidy mechanism

All financial transactions of the NPC will be evaluated in terms of their efficiency and ease of application.

Distribution system

All ordering and dispensation procedures will be evaluated in terms of their efficiency and applicability. Issues such as stock management and warehousing and storage efficiencies will be assessed. The critical assessment will determine whether drugs were:

- a) provided in a timely fashion after receipt of orders
- b) dispensed correctly to the designated clinics

The Advisory Board

Applicability and relevance of the recommendation of the Advisory Board with regard to the National drugs Policy for HIV/STD will be evaluated. Subsequently, a strategy to increase the number of qualified centres will be determined.

Referral settings

The standard of care will be evaluated according to the spectrum of diseases managed within the clinic, both from the diagnosis and therapeutic standpoints.

A qualitative evaluation of the rationale of prescription with regard to the indication, dosage and duration of treatment will be carried out.

Patient compliance will also be assessed on a qualitative basis, through a study undertaken by social scientists, to determine compliance rates as well as the factors which influenced compliance. The results will be available with suggested solutions.

Selection of patients

UNAIDS will assist in the selection process of health care centres and patients. The evaluation will focus on the profile of patients selected with respect to their clinical stage as well as their social and geographic distribution.

UNAIDS RELEASE OF BEST PRACTICES GUIDELINES.

On completion of the evaluations of the Pilot Projects UNAIDS will prepare a guideline of best practices which will be made available to the Governments of those developing countries who wish to implement similar programmes.

PHASE II: WIDENING THE ACCESS

The experiences and results of Phase I will help in setting up an action plan for widening access to HIV-related drugs in the same country as well countries other than the pilot countries. The phase II will focus mainly on strengthening the infrastructure in the countries to allow more and more health centres to qualify and ensure an appropriate distribution of health centres in accordance with the geographic and epidemiologic needs. The phase II will be a progressive and ongoing phase. An evaluation at 3-4 years will be planned.

The main objective will be to optimize the number of centres qualified for treatment of HIV infection, opportunistic infections and STDs under this Initiative. Such optimisation may require an improvement of health care infrastructure.

The results of the phase I will be consolidated in a Best Practice model which will be made available to any country willing to improve access to HIV-related drugs through this Initiative.

COUNTRIES SELECTED FOR PILOT PROJECT IMPLEMENTATION.

The countries which have been selected to host Pilot Projects are:

UGANDA

COTE D'IVOIRE

VIETNAM

CHILE

CRITERIA FOR SELECTION OF PILOT COUNTRIES

In selecting the countries in which Pilot Projects will be implemented, the following criteria were considered:

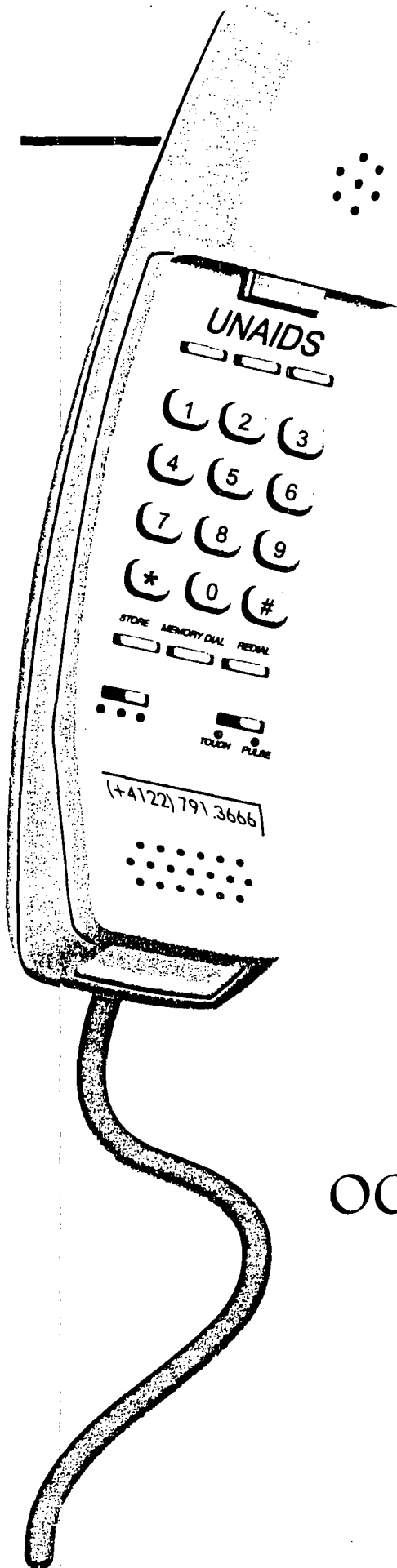
- Political and social stability.
- Political commitment to respond to the HIV/AIDS epidemic.
- Political commitment to care and support of people with HIV infection.
- Active National AIDS Programme.
- Well established Public Health platform.
- Facility to implement and evaluate the pilot phase and collect clear and unbiased results.
This requires the absence of programmes which may give confounding data.
- Geographical distribution of countries.
- High HIV prevalence or high HIV incidence.
- Existing health care infrastructure in relatively low income economy.



UNAIDS
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Joint United Nations Programme on HIV/AIDS

Telephone directory



OCTOBER - DECEMBER 1997

UNAIDS TELEPHONE DIRECTORY

GENEVA - October - December 1997

Joint United Nations Programme on HIV/AIDS
20, avenue Appia
CH-1211 Geneva 27
Tel: (41) 22 791 3666 Fax: (41) 22 791 4187

Amendments contact S. Bolvenkel-Prior, Tel: (41) 22 791 3666 Fax: (41) 22 791 4187 E-mail: bolvenkelprior@unaids.org

OFFICE OF EXECUTIVE DIRECTOR (OED)

Fax. No.: (41) 22 791 4179
 Meeting Room: M.424 Tel: 4607

	Tel. No.	Off. No.
Piot, Peter (Executive Director)	4510/4722	M.435
Mane, Purnima (Programme and Planning Coordinator)	4509/2104	M.432
Sherry, James (Senior Adviser to Executive Director)	4505/4563	M.436
Smedberg, Martina (Executive Assistant)	4774/4563	M.430
McCaul, Frances (Administrative Assistant)	4662	M.434
Marclay, Corinne (Secretary)	4722	M.431
Watters, Joanne (Secretary)	4563	M.431
Parker, Liz (Secretary)	2104	M.434

DEPARTMENT OF EXTERNAL RELATIONS (EXR)

Fax. No.: (41) 22 791 4188

	Tel. No.	Off. No.
Cowal, Sally (Director)	4716/4681	M.429
Chahil-Graf, Renu (Senior Adviser)	4714/4710	M.419
Neracher, Jean (Administrative Assistant)	4762	M.423
Rodrigues, Eva (Secretary)	4681	M.427
Winter, Anne (Manager, Communication and Public Information)	4577/4661	M.428
Cherney, Suzanne (Senior Writer)	4770	M.418
De Santis, Dominique (Information Officer)	4765/4661	M.422
Jones, Gareth (Press Officer)	3387/4661	M.420
Leon Hing, Eva (Photographic/Video Library)	4709	M.422
Mahanty, Binod (World AIDS Campaign)	4680	M.422
Verwohlt, Andrea (Biennial Report team)	4553	M.415
Schmitz, Cristina (Secretary)	4661	M.426
Liados, Jose (Manager, Donor and Corporate Relations)	4817/4506	M.425
Endo, Hiroyoshi (External Relations Officer)	4738/4506	M.417
Morganstern, Sharon (Donor and Corporate Relations)	4557	M.423
Noehrenberg, Eric (Donor and Corporate Relations)	4625	M.417
Villanueva-Edgecock, Maria	4570	M.415
Rarok, Grazyna (Secretary)	4506	M.427
Chahil-Graf, Renu (Manager, Governance & UN System)	4714/4710	M.419
Cardeza-Singh, Estela	4553	M.415
Manipoud, Elisabeth (External Relations Officer)	3902/4710	M.421
Wilson-Attobra, Lakoley (Secretary)	4710	M.426

NGO LIAISON OFFICE (from 3 November 1997)

Almedal, Calle (Senior NGO Liaison Officer)	c/o 4694	to be confirmed
Clark, Martina (NGO Liaison Officer)	4703	M.628
Ryan, Sinead (Assistant)	4694	M.628

UNAIDS Liaison Office, New York

Mailing Address:

UNAIDS
 c/o UNICEF, TA 26 C, Three United Nations Plaza
 New York, NY 10017
 Fax: (1) 212 824 6493 - E-mail: unaids@unicef.org

Visitor's Address:

UNAIDS
 633 Third Avenue, Room 26-26,
 New York, NY 10017

Wijayadasa, Somar (UNAIDS Representative)	(1) 212 824 6644
Belanger, Karen (Secretary)	(1) 212 824 6643
Visitor's office	(1) 212 824 6610

DEPARTMENT OF PROGRAMME ADMINISTRATION (PAD)

Fax. No.: (41) 22 791 4187

Meeting Room: M.536, Tel: 4692

Tel. No. Off. No.

Lim, Janet (Programme Administrator)	4664/3666	M.535
Habgood, Janet (Administrative Assistant)	4724	M.533
Angulo, Salomon (Documents Clerk)	4734	M.521
Bolvenkel-Prior, Susie (Secretary)	3666	M.533
Ryle, Theresa (Secretary)	4740	M.533

BUDGET AND FINANCE

Ray-Tabona, Simone (Planning and Budget Officer)	4767/4768	M.534
Farhat, George (Finance and Administrative Officer)	3672	M.532
Shaw, Georges (Budget and Finance Officer)	4604/4719	M.530
Buck, Helen (Budget Assistant)	4768	M.531
Samarine, Gabrielle (Finance Assistant)	4719	M.532

HUMAN RESOURCES MANAGEMENT

Fax.: (41) 22 791 4784

Giwa, Steven (Manager, Human Resources)	2734/4735	M.527
Mullally, James (Training)	4686	M.528
Partow, Jaleel (Personnel Officer)	4618/4735	M.523
Courtin, Patricia (Secretary)	4608	M.519
Horn, Annette (Secretary)	4735	M.525
Jimenez, Maria (Secretary)	4606	M.519

INFORMATION TECHNOLOGY

Bertozi, Stefano (Coordinator)	4679/4699	M.529
Hawe, Joan (Secretary)	4699	M.531
Wallace, Mark (Information Technology)	3770	M.522
Don, Pham Doan (Informatics User-Support Assistant)	4455	M.526
Bakker, Dean (Informatics User-Support)	4707	M.517
Jagoe, Louis (Informatics Support)	4605	M.524
Kromodimedjo, John (Informatics User-Support Assistant)	4737	M.526
Informatics Hotline	4800	

DEPARTMENT OF POLICY, STRATEGY & RESEARCH (PSR)

Fax. No. (41) 22 791 4165

Meeting Room: M.330, Tel: 4733

Tel. No. Off. No.

Colli-Seck, Awa Marie (Director)	3392/4759	M.325
Werasit Sittitrai (Coordinator)	4457/4656	M.326
Soper, Paula (Programme Assistant)	3272	M.322
Brenner, Corinne (Secretary)	4656	M.324
Matt, Elisabeth (Administrative Secretary)	4808	M.324
Wulf, Lesley (Secretary)	4759	M.323
Alban, Anita (Economist)	4669/3759	M.511
Benomar, Elizabeth	4451/4656	M.317
Caraël, Michel (Social Scientist)	4611/4617	M.327
Connolly, Mark (Health Promotion Adviser)	4461/4617	M.318
De Vincenzi, Isabelle (Clinical Epidemiologist)	4610/4522	M.309
Esparza, Jose (Vaccine Development Adviser)	4392/4522	M.331
Kaleeba, Noerine (Community Mobilization Adviser)	4601/4617	M.329
Kalibala, Samuel (Counselling and Social Support Adviser)	4561/4808	M.336
Kingma, Stuart (Adviser, AIDS in the Military)	4671/4523	M.335
Makinwa, Bunmi (Communications Adviser)	4552/4523	M.319
Mpendubundi, Marthe (Inter-Country Exchange PRHIV)	4720/4808	M.334
Msiska, Roland (Health Systems Adviser, Focal Point for Tools Development, PRHIV)	4756/4808	M.332
Nakari, Taina (Gender)	4356/4523	M.520
Ndowa, Francis (STDs)	4575/4808	M.509
Osmanov, Saladin (Virologist/Vaccine Specialist)	4393/3759	M.333
Patterson, David (Human Rights)	4675/4811	M.317
Pattou, Claire (Vaccines)	4515/4522	M.328
Perriens, Joseph (Clinical Research Specialist)	4456/4522	M.313
Reeler, Anne	4742/4808	M.334
Saba, Joseph (Clinical Research Specialist)	4452/4522	M.311
Schwartländer, Bernhard (Senior Epidemiologist)	4705/4678	M.633

DEPARTMENT OF POLICY, STRATEGY & RESEARCH (PSR)

(contd)

	Tel. No.	Off. No.
Thuriaux, Damien (Intern)	4567	M.517
Tungaraza, Maria (Intern)	4675	M.317
Watchirs, Helen (Human Rights Adviser)	4355/4811	M.315
Wernette, Monica (Focal Point for on-going case studies PRHIV)	4567/4808	M.328
Wilson, Andrew (Writer)	4813/4656	M.513
Adea, Cristy (Secretary)	4520	M.636
Arbogast, Veronique (Secretary)	4811	M.320
Barclay, Lisbeth (Secretary)	4617	M.321
Buencamino, Carmen (Secretary)	4678	M.636
Colicchio, Bernadette (Secretary)	3759	M.320
Forbes-Hedberg, Clare (Secretary)	4617	M.321
Gibson, Christine (Secretary)	4462	M.322
Kigundu, Margaret (Secretary)	4522	M.323
Kristoffersson, Seng Pheth (Secretary)	4523	M.321
Rousselot, Joyce (Secretary)	3759	M.320

INFORMATION CENTRE

FitzSimons, David (Information Manager)	4624	M.413
Granchamp, Marie-Laure (Desktop Publishing Assistant)	4718	M.411
Guilloux, Anne (Graphics Assistant)	4757	M.520
Laliberté, Gisele (Information Centre)	4651	M.411
Diara, Laye (Clerk, Information Centre)	4354	M.407
Firley, Andrea (Clerk, Information Centre)	4745	M.409

New York:

Baldo, Mariella (Senior School AIDS Education Adviser)

Mail address: c/o UNICEF TA-26/40

3 United Nations Plaza, New York, NY 10017, USA

Tel: (1) 212 824 6617

Fax: (1) 212 824 6481

E-mail: mbaldo@unicef.org

Street address: 633 Third Avenue

Room 40, 26th Floor

(between 40 & 41 streets)

In Geneva: 791 4811

Bangkok:

Public Sector Reform and HIV Initiative (PRHIV)

Lamboray, Jean-Louis

Coordinator, Public Sector Reform and HIV Initiative (PRHIV)

Office of the Health Care Reform Project

3d Building, 7th floor, Tiwanon Road

Nonthaburi 11000, Thailand

Tel: (66) 2 590 1864

Fax: (66) 2 590 1850

E-mail: jllamb@mozart.inet.co.th

DEPARTMENT OF COUNTRY SUPPORT (COS)

Fax. No.: (41) 22 791 4162

Meeting Room: M.633

	Tel. No.	Off. No.
Moodie, Rob (Director)	4755/4463	M.630
Ernberg, Gunilla (Coordinator, Management)	4623/4704	M.634
Bell, Samantha (Administrative Assistant)	4614	M.636
Fanals, Rachel (Secretary)	4463	M.632
Dew, Julie (Assistant, Strategic Planning & Development Funds)	4704	M.632
Adea, Cristy (Secretary)	4520	M.636

AFRICA AND MIDDLE EAST

van Dam, Johannes (Programme Development Officer, Team Leader)	4412	M.620
Buckley, Anne (Geographic Desk Officer - Africa)	4558	M.626
Han, Daw Aye (Geographic Desk Officer)	4620	M.507
Moeti, Matshidiso (Programme Development Officer)	4620	M.507
Tawilah, Jihane (Middle East)	4304	M.607
Van Roey, Jens (Programme Development Officer)	4386	M.607
Brunt, Joanne (Assistant)	4612	M.624
Gramiccia, Muriel (Secretary)	4729	M.624
Hopkins, Norrey (Secretary)	4525	M.609

ASIA AND PACIFIC

Chan Kam, Clement (Programme Development Officer, Team Leader)	4556	M.623
Bagasao, Bai (Programme Development Officer)	4654	M.629
De Knocke, Hans (Programme Development Officer)	4526	M.619
Edlund, Catharina (Geographic Desk Officer)	3646	M.627
Cordero, Agnes (Assistant)	4555	M.621
Simango, Martha (Secretary)	4670	M.621

LATIN AMERICA AND CARIBBEAN

Fax No.: (41) 22 791 4880

Loures, Luiz (Programme Development Officer, Team Leader)	4698	M.611
Ferencic, Nina (Programme Development Officer)	4812	M.609
Boyle, Raul (Geographic Desk Officer)	4655	M.615
Canaud, Anne-Françoise (Assistant)	2691	M.613
Salas-Rojas, Carla Milagros (Secretary)	4622	M.613

EUROPE

Fax No.: (41) 22 791 4880

Dehne, Karl (Programme Development Officer, Team Leader)	4736	M.617
Khodakevich, Lev (as of 1 November 1997)	c/o 4712	
Atlani, Laetitia	4391	M.513
Nyunt, Myo (Geographic Desk Officer)	4715	M.507
Perry, Christine (Secretary)	4712	M.618
Sannikova, Elena (Secretary)	4721	M.618

NGO LIAISON OFFICE (moving to External Relations by 3 November 1997)

Clark, Martina (NGO Liaison Officer)	4703	M.628
Ryan, Sinead (Assistant)	4694	M.628

SPECIALISTS

McGrath, Kevin (Theme Groups)	4691	M.625
Opuni, Marjorie (Country Profiles)	4395	M.625

UNAIDS FIELD - October - December 1997

Afghanistan (see Pakistan)

American Samoa (see Fiji)

Antigua and Barbuda (see Barbados)

Argentina (see Uruguay)

Armenia

Yessayan, Aghassi
UNAIDS Focal Point
Programme Assistant, UNDP
14 Karl Leibknecht Str.
Yervan 375 010
Tel: (374) 2 15 14 53
Fax: (374) 2 15 14 52
E-mail: unarm@arminco.com

Aruba (see Barbados)

Azerbaijan

Alekperov, Ramiz
UNAIDS Focal Point
National Programme Officer
UNFPA
3, UN 50th Anniversary Str.
370001 Baku 1
Tel: (994) 12 92 23 79 / 98 98 88
Fax: (994) 12 98 32 35
E-mail: ramiz@unfpa.baku.az

Bahamas (see Barbados)

Bangladesh

Messersmith, Dr Lisa
Country Programme Adviser
UNAIDS
c/o UNDP
GPO Box 224, Dhaka 1000
Tel: (880) 2 818 600 - 06
Fax: (880) 2 818 632-39
E-mail: lisa@citechco.net

Barbados (English and Dutch speaking Caribbean)

(covering: Antigua and Barbuda, Aruba, Bahamas, Belize, Dominica, Grenada, Guyana, Jamaica, Netherlands Antilles, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago)

Gayle, Jacob
InterCountry Programme Adviser
UNAIDS
c/o UNDP
PO Box 625C
Jemmott's Lane, St Michael
Bridgetown
Tel: (1 246) 429 2521/22 427 9871
Fax: (1 246) 437 6256 or if not available (1 246) 429 2448
E-mail: UNAIDS@caribsurf.com

Davis, Angela
UNAIDS Focal Point for the Eastern Caribbean
WHO
Dayralls & Navy Garden Roads
Christ Church
Bridgetown
Tel: (1 246) 426 3860/-65
Fax: (1246) 436 9779

Belarus (also see Ukraine)

Bezruchenko, Marina
National Country Programme Adviser
UNDP
GPO Box 103
17 Kirov Street, 6th Floor
220050 Minsk
Tel: (375) 172 27 45 27 / 27 48 76
Fax: (375) 172 26 03 40
E-mail: un_undp@bye.minsk.by

Belize (also see Barbados)

McKay, Abigail
UNAIDS Focal Point
UNDP
UNDP/UNOPS
Belize City
Tel: (501) 2 35 739
Fax: (501) 2 35 738
E-mail: czmbze@btl.net

Bolivia (see Peru)**Botswana**

Modisaotsile, Innocent
UNAIDS Focal Point
UNDP National Programme Officer
UNDP
PO Box 54
Gaborone
Tel: (267) 35 21 21
Fax: (267) 35 60 93
E-mail: fo.bwa@undp.org

Bulgaria (Romania, Turkey)

Hahn, Michael
InterCountry Programme Adviser
UNAIDS
c/o UNDP
PO Box 8
Sofia 1184
Tel (direct): (359) 2 974 3419
Tel: (359) 2 762 852/3 (secretary)
Tel UNDP: (359) 2 975 3296
Fax: (359) 2 974 3089
E-mail: mhahn@undp.online.bg

Burkina Faso (Mali, Niger)

Kourouma, Kékoura
InterCountry Programme Adviser
UNAIDS
c/o UNDP
01 BP 575
Ouagadougou 01
Tel: (226) 30 67 62/63/64
Fax: (226) 31 04 70

Cambodia

Wienrawee, Pawana
Country Programme Adviser
UNAIDS
c/o UNDP Service Centre (3rd Floor)
164 Pasteur Street (51)
PO Box 877
Bueng Keng Kang, Phnom Penh
Tel direct/Fax: (855) 23 72 11 53
Tel: (855) 23 426 872
Mobile tel. (855) 18 81 48 18
Fax: (855) 23 72 11 53
E-mail: unaidscmb@pactok.peg.apc.org or pawana@undp.forum.org.kh

Central African Republic

Samba-Maliavo, Dr Marguerite-Marie
UNAIDS Focal Point
UNDP
Boîte Postale 872
Bangui
Tel: (236) 61 19 77/4977
Fax: (236) 16 17 32

Central America (see Guatemala)

Central Asian Republics (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan)

Adamian, Rudick

InterCountry Programme Adviser

UNAIDS

United Nations Office, c/o KIMEP, Hotel 2, 4 Abai Str., Almaty 480100

Tel: (7 3272) 64 09 70/20 / 64 26 18 / 64 24 80

Fax: (7 3272) 64 26 08 or c/o UNESCO (7 3272) 64 26 61

E-mail: ra@un.alma-ata.su

Chad

Alexandre, Dr Yves-Pierre

UNAIDS Focal Point

c/o Banque Mondiale

BP 146

N'Djaména

Tel: (235) 52 65 16 / 17

Fax: (235) 52 65 18 / 14

Chile (see Uruguay)**China**

Fox, Emile

Country Programme Adviser

UNAIDS

Qijiyuan Diplomatic Compound 7-1-23

Beijing 100600

or

c/o UN Resident Coordinator

United Nations Building

2 Liangmahe Nanlu

Beijing 100600

Tel/Fax: (86) 10 6532 5467 (fax for urgent use only)

UNDP Fax: (86) 10 6532 2567

E-mail: unaids@iuol.cn.net

Sun Gang

Programme Officer

UNAIDS

Qijiyuan Diplomatic Compound 7-1-23

Beijing 100600

or

c/o UN Resident Coordinator

United Nations Building

2 Liangmahe Nanlu

Beijing 100600

Tel/Fax: (86) 10 6532 5467 (fax for urgent use only)

UNDP Fax: (86) 10 6532 2567

E-mail: sungang@iuol.cn.net

Comoros (see Madagascar)**Cook Islands (see Fiji)****Costa Rica (see Guatemala)****Côte d'Ivoire**

Lawson, Agathe

Country Programme Adviser

UNAIDS

c/o UNDP Resident Representative

01 BP 1747, Abidjan 01

Tel Direct: (225) 01 60 94 / 24 30 13

Fax: (225) 21 13 67

E-mail: onusida@africaonline.co.ci

Cuba (also see Dominican Republic)

Gudz, Ana Maria

UNAIDS Focal Point

UNDP

Calle 18 No. 110 (entre 1ra.y 3ra)

Miramar, Playa

La Habana

Tel: (537) 24 15 12 -14 / 24 15 17

Fax: (537) 24 1 5 16

Democratic Republic of the Congo

Grinling, John

Country Programme Adviser

UNAIDS

c/o UNDP

Boîte postale 7248

Kinshasa

Tel: (243) 880 0840

Fax: (1) 212 376 9466

Fax: (871) 682 380 081

E-mail: onusida_kin@kinpost.ccmil.compuserve.com

Djibouti

Watta, Mr Chehem Mohamed
UNAIDS Focal Point
UNDP HIV and Development
National Programme Officer
UNDP
Boîte postale 2001
Tel: (253) 35 33 71/72
Fax: (253) 35 05 87

Dominica (see Barbados)**Dominican Republic (Cuba, Haiti)**

McEvoy, Margaret
InterCountry Programme Adviser
UNAIDS
c/o UNDP
Avenida Anacaona 9, Mirador del Sur
Apartado 1424
Santo Domingo
Tel direct: 1 (809) 537 6319
Tel: 1 (809) 531 3403 Ext 257
Fax: 1 (809) 530 7692
E-mail: pmcevoy@pnud.org.do

Guerrero, Ernesto
UNAIDS Focal Point
UNDP
Avenida Anacaona 9, Mirador del Sur
Apartado 1424
Santo Domingo
Tel direct: 1 (809) 537 6319
Tel: 1 (809) 531 3403 Ext 257
Fax: 1 (809) 530 7692
E-mail: eguerrero@pnud.org.do

Ecuador (see Peru)

Derks, Therry
UNAIDS Focal Point
UNDP
Mariscal Foch 265
Casilla de Correo 1703-4731
Quito
Tel: (593) 2 500 543
Fax: (593) 2 500 552
E-mail: fo.ecu@undp.org

Equatorial Guinea

Abaga Nchama, Dr Luciano
UNAIDS Focal Point
WHO
Boîte Postale 330
Malabo
Tel: (240) 9 3234
Fax: (240) 9 3236

Eritrea

Brady, William
Country Programme Adviser
UNAIDS
c/o UNDP
PO Box 5366
Andinet Street, No 5
Asmara
Tel: (291) 1 18 20 18/12 48
Fax: (291) 1 18 23 75
E-mail: brady@unaids.gemel.com.er

Ethiopia

Nyamuryekung'e, Kinton
Country Programme Adviser
UNAIDS
c/o UNDP
PO Box 3069
Addis Ababa
Tel: (251) 1 51 01 52
Fax: (251) 1 51 10 21
E-mail: unaids@telecom.net.et

Fiji

(covering: American Samoa, Cook Islands, Fiji, French Polynesia, Kiribati, Marshall Islands, Nauru, New Caledonia Niue, Northern Mariana Islands, Palau, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, Wallis and Futuna Islands)

Vete, Steven
InterCountry Programme Adviser
UNAIDS
c/o UNDP
Private Mail Bag
3rd Floor, ANZ House
Victoria Parade
Suva
Tel: (679) 31 25 00
Fax: (679) 30 17 18
E-mail: unaids@undp.org.fj

French Polynesia (see Fiji)**Georgia**

Kereselidze, Tamaz Dr
Focal Point
WHO Liaison Office
Asatiani Street 7
Tbilisi 38007
Tel: (995) 32 39 84 66
Fax: 1 909 888 9698 Ext 118 / (995) 32 00 10 77
E-mail: tsk@who.ge

Ghana

Eledu, Cynthia
Country Programme Adviser
UNAIDS
c/o UNDP
PO Box M. 1423, Accra
Tel/Fax : (233) 21 23 82 56
E-mail: eledu@ighmail.com

Grenada (see Barbados)**Guatemala (Central America)**

(covering: Costa Rica, El Salvador, Honduras, Nicaragua, Panama)

Fulladolsa Forment, Angel
UNAIDS
c/o OPS/OMS
Apartado Postal 383
Guatemala
Tel: (502) 3 32 20 32 / 34 38 03
Fax: (502) 3 34 38 04
E-mail: onusida@ops.org.gt

Guinea

Bandusha, Dr
UNAIDS Focal Point
WHO
Boîte postale 817
Immeuble Pawaz (4ème étage)
Conakry
Tel: (224) 41 20 16 / 41 39 35
Fax (224) 41 50 09

Guyana (see Barbados)**Haiti (see Dominican Republic)****Honduras (see Guatemala)**

India

D'Cruz-Grote, Doris
Health Promotion and Communication Adviser
UNAIDS
C-199 Defence Colony
New Delhi 110 0024
Tel: (91) 11 464 9891-94
Fax: (91) 11 464 9895
E-mail: groted@who.ernet.in

Indonesia

Loth, George
Country Programme Adviser
UNAIDS
c/o UNDP Resident Representative
PO Box 2338, Jakarta 10001
Tel: (62) 21 314 1308 (ext. 212)
Fax: (62) 21 314 5251
E-mail: glunails@indo.net.id

Intercountry Teams

Intercountry Team, Asia-Pacific

Phongphit, Seri
Team Leader
UNAIDS Asia-Pacific Intercountry Team
UN ESCAP Building (B359), Rajadamnern Nok Ave.
Bangkok 10200
Tel: (66) 2 288 2184
Fax: (66) 2 288 1092
E-mail: phongphit.unescap@un.org

Shimizu, Midori
UNAIDS Asia-Pacific Intercountry Team
UN ESCAP Building (B359), Rajadamnern Nok Ave.
Bangkok 10200
Tel: (66) 2 288 2497-98
Fax: (66) 2 288 1092
E-mail: shimizu.unescap@un.org

France, Tim
Information Support Manager
UNAIDS Asia-Pacific Intercountry Team
UN ESCAP Building (B359), Rajadamnern Nok Ave.
Bangkok
Tel: (66) 2 288 2179
Fax: (66) 2 288 1092
E-mail: france.unescap@un.org
E-mail information service: tfranc@mozart.inet.co.th

Bennoun, Robert
UNAIDS Asia-Pacific Intercountry Team/UNICEF
UNICEF - Bangkok Area Office
PO Box 2 - 154
19 Phra Atit Road
Bangkok 10200
Tel: (66) 2 280 5931
Fax: (66) 2 280 3563
Mobile: (66) 1 831 4959
E-mail: rbennoun@unicef.org

Davis, Cornelia
Technical Adviser on Intercountry Issues
UNAIDS Asia-Pacific Intercountry Team
C-199 Defence Colony
New Delhi 110 0024
India
Tel: (91) 11 464 9891-94
Fax: (91) 11 464 9895
E-mail: davisc@who.ernet.in

Steve Kraus
Programme & External Relations Adviser
UNAIDS Asia-Pacific Intercountry Team
UN ESCAP Building (B359), Rajadamnern Nok Ave.
Bangkok
Tel: (66) 2 288 1272
Fax: (66) 2 288 1092
E-mail: kraus.unescap@un.org

Intercountry Team, Eastern and Southern Africa

Sy, Elhadj
Team Leader
Intercountry Team, Eastern and Southern Africa
UNAIDS
Metropark Building
351 Schoeman Street, PO Box 6541
Pretoria 0001
South Africa
Tel Direct: (27) 12 338 5308
Fax: (27) 12 338 5310
E-mail: assy@un.org.za

Anderson, Sandra
Care and Support Adviser
Intercountry Team, Eastern and Southern Africa
UNAIDS
Metropark Building
351 Schoeman Street, PO Box 6541
Pretoria 0001
South Africa
Tel: (27) 12 338 5305/4
Fax: (27) 12 338 5310
E-mail: sanderson@un.org.za

Intercountry Team, West and Central Africa

Grunitzky-Bekele, Meskerem
Intercountry Team Leader, West & Central Africa
UNAIDS
c/o UNDP
01 BP 1747, Abidjan 01
Côte d'Ivoire
Tel direct: (225) 32 30 38
Tel: (225) 32 16 41
Fax: (225) 32 26 19
E-mail: grubekem@africaonline.co.ci

Gershdy-Damet, Guy-Michel
Intercountry Technical Adviser, West & Central Africa
UNAIDS
c/o UNDP
01 BP 1747, Abidjan 01
Côte d'Ivoire
Tel: (225) 32 16 41
Mobile: (225) 07 80 21
Fax: (225) 32 26 19
E-mail: gershdy@africaonline.co.ci

Tawil, Oussama
Intercountry Technical Adviser, West & Central Africa
UNAIDS
c/o UNDP
01 BP 1747, Abidjan 01
Côte d'Ivoire
Tel: (225) 32 16 41
Fax: (225) 32 26 19
E-mail: oussama@africaonline.co.ci

West Africa Initiative HIV/AIDS
Sakho, Mamadou-Lamine
UNAIDS West Africa Initiative HIV/AIDS
c/o UNDP
BP 1747, Abidjan 01
Côte d'Ivoire
Tel: (225) 32 16 41
Mobile: (225) 05 38 32
Fax: (225) 32 26 19
E-mail: sakho@africaonline.co.ci

Intercountry Technical Adviser - Africa

Asamoah-Odei, Emil
Intercountry Technical Adviser
UNAIDS
c/o WHO Representative
CP 4039, 55 avenue Albert Sarraut
Dakar
Senegal
Tel: (221) 23 27 69 / 23 19 53
Fax: (221) 23 32 55

Intercountry Programme Adviser - Asia/Pacific

Fee, Nancy
Intercountry Programme Adviser (Training)
UNAIDS
AIDS/STD Unit
World Health Organization Regional Office for the Western Pacific (WPRO)
PO Box 2932
Manila 1099
Philippines
Tel: (632) 528 8001
Fax: (632) 521 1036
E-mail: nancyfee@compuserve.com

Intercountry Technical Adviser - Europe

Mikkelsen, Henning
Intercountry Technical Adviser
UNAIDS
WHO Regional Office for Europe
8 Scherfigsvej
DK-2100 Copenhagen O, Denmark
Tel: (45) 39 17 15 57
Fax: (45) 39 17 18 75
E-mail: hom@who.dk

Jamaica (see Barbados)

Kazakhstan (see Central Asian Republics)

Kenya

Tembo, George
Country Programme Adviser
UNAIDS
c/o UNDP Resident Representative
PO Box 30218, Nairobi
Tel/ Fax Direct: (254) 2 24 55 34
Tel: (254) 2 22 87 76-9 (ext. 337)
E-mail: tembo@arcc.or.ke

Kiribati (see Fiji)

Kyrgyzstan (see Central Asian Republics)

Laos

Lisle, Tony
Country Programme Adviser
UNAIDS
c/o UNDP
PO Box 345, Vientiane
Tel: (856) 21 21 33 90-95
Fax: (856) 21 21 48 19 / 21 20 29
E-mail: tony.lisle@undp.org

Latvia

Rotberga, Signe
Focal Point
UNDCP
Skolas 24
Riga LV 1167
Tel: (371) 724 2665
Fax: (371) 724 2659

Madagascar (Comoros, Mauritius, Seychelles)

Gnaoré, Emmanuel
InterCountry Programme Adviser
UNAIDS
c/o OMS
Boîte Postale 362
Antananarivo 101
Tel: (261) 2 64669
Fax: (261) 2 64677
E-mail: onusida@bow.dts.mg

Malawi

Trenton-Mbonde, Angela
Country Programme Adviser
UNAIDS
c/o UNDP
PO Box 30135
Lilongwe 3
Tel: (265) 78 26 03
Fax: (265) 78 26 87
E-mail: atrenton-unaid@eo.wn.apc.org

Mali (see Burkina Faso)**Marshall Islands (see Fiji)****Mauritius (also see Madagascar)**

Nundoochan, Ajoy
UNAIDS Focal Point
WHO
PO Box 1194
Port Louis
Tel: (230) 201 1899
Fax: (230) 208 8305

Mexico

Romero, José
UNAIDS Focal Point
PAHO/WHO
Avenida de las Palmas 530
Lomas de Chapultepec
11000 Mexico D.F.
Tel: (52) 5 202 0395/8200/1472
Fax: (52) 5 520 8868
E-mail: jromero@mail.internet.com.mx

Moldova (see Ukraine)**Mozambique**

Tallarico, Maria
Country Programme Adviser
UNAIDS
rua Francisco Barreto 322
2nd floor
Maputo
Tel: (258) 1 49 23 40 / 49 14 09 / 49 26 33 ext. 15 (a.m.) / 43 09 70 (p.m.)
Fax: (258) 1 49 23 45
E-mail: unaid@zebra.uem.mz

Myanmar

Myint, San San
UNAIDS Focal Point
National Programme Officer
UNDP
PO Box 650
Yangon
Tel: (95) 1 54 29 10-19
Fax: (95) 1 29 27 39
E-mail: san.san.myint@undp.org

Namibia

Delaney, Mary Guinn
Country Programme Adviser
UNAIDS
c/o UNDP
Private Bag 13329, Windhoek
Tel: (264) 61 200 1190
Mobile phone: (264) 81 124 6543
Fax: (264) 61 22 90 84
E-mail: maryguinn@un.na

Nauru (see Fiji)**Nepal**

Naing, Amaya Maw
Country Programme Adviser
UNAIDS
c/o WHO
UN Common Building
PO Box 107, Pulchowk Lalitpur
Kathmandu
Tel: (977) 1 52 32 00 Ext. 309 / 52 39 93
Tel c/o Ministry of Health: (977) 1 22 66 53
Fax: (977) 1 52 39 91
E-mail: amaya.maw.naing@undp.org

Netherlands Antilles (see Barbados)**New Caledonia (see Fiji)****Nicaragua (also see Guatemala)**

Cury, Delmin
UNAIDS Focal Point
PAHO/WHO
Complejo Nacional de Salud
Camino a la Sabana
Managua
Tel: (505) 2 89 48 00 / 89 42 00
Fax: (505) 2 89 49 99

Niger (see Burkina Faso)**Nigeria**

Ofosu-Barko, Kenneth
Country Programme Adviser
UNAIDS
c/o UNDP Resident Coordinator
PO Box 2075
11 Oyinkan Abayomi Drive
Ikoyo, Lagos
Tel: (234) 1 269 2141-3 /3396
Fax: (234) 1 269 1746/3397

Niue (see Fiji)**Northern Mariana Islands (see Fiji)****Pakistan (Afghanistan)**

Zessler, Laurent F.
Country Programme Adviser
UNAIDS
c/o UNDP
PO Box 1051, Islamabad
Tel (direct): (92) 51 24 21 88
Tel: National AIDS Programme: (92) 51 24 06 51
Fax: (92) 51 27 90 80/83
E-mail: zessler@unaids.sdnpk.undp.org
5%01!.XLS21.10.97

Palau (see Fiji)

Panama (see Guatemala)

Papua New Guinea

Subrendonathan, Vaithehi
UNAIDS Focal Point
Programme Officer
UNDP
PO Box 1041
Port Moresby
Tel: (675) 321 2877
Fax: (675) 321 1224

Paraguay (see Uruguay)

Peru (Bolivia, Ecuador)

Gómez-Sagüéz, Adriana
Intercountry Programme Adviser
UNAIDS
c/o PNUD
Canaval Y Moreyra 590
Urb. Córpac, San Isidro
Apartado 4480
Lima
Tel: (51) 2 440 4758 / 221 3636/3637/3502/3503
Fax: (51) 2 440 4166
E-mail: onusida@pnudpe.org.pe

Tynjala, Tommi
UNAIDS Focal Point
UNDP
Canaval Moreyra 590, Urb. Córpac
San Isidro, Apartado. 27-0047
Lima
Tel: (51) 2 440 4758 221 1612/4446
Fax: (51) 1 440 4166
E-mail: fo.per@undp.org

Philippines

Manthey, Geoff
Country Programme Adviser
UNAIDS
United Nations Resident Coordinator System
PO Box 7285 ADC
Pasay City
Tel: (63) 2 892 0611 (local 266)
Fax: (63) 2 816 4061
E-mail: geoffmanthey@compuserve.com

Poland

Malinowska, Kasia
UNAIDS Focal Point
UNDP HIV and Development
National Programme Officer
UNDP
United Nations Centre
PO Box 1
Warsaw 12
Tel: (48) 22 25 92 45
Fax: (48) 22 25 49 58
E-mail: kasia.m-s@undp.org.pl

Romania (also see Bulgaria)

Petrescu, Eduard
National Country Programme Adviser
UNDP
18 C.A. Rosetti, 1st floor
Sector 1
PO Box 1-701
Bucharest 79362
Tel: (401) 211 5516 / 312 6639
Fax: (401) 211 3494
E-mail: uromania@igc.apc.org

Russian Federation

UNAIDS office
6 Obukh Lane
Moscow 103064
Tel: (7) 095 232 5599
Fax: (7) 095 232 3017

Saint Kitts and Nevis (see Barbados)

Saint Lucia (see Barbados)

Saint Vincent and the Grenadines (see Barbados)

Samoa (see Fiji)**Sao Tome and Principe**

Silveira, Fernando
UNAIDS Focal Point
WHO
Case postale 287
Sao Tomé
Tel: (239) 12 22211
Fax: (239) 12 21766

Seychelles (also see Madagascar)

Jones, Mrs S.
UNAIDS Focal Point
UNDP
Victoria-Mahe
Tel: (248) 22 56 40
Fax: (248) 22 48 45

Slovakia

Tomasik, Emil
UNAIDS Focal Point
Institute of Preventive and Clinical Medicine
National Reference Centre for Prevention of HIV/AIDS
Limbova 14
Bratislava 833 01
Tel: (42) 1 7 373 560 ext 158 / 547
Fax: (42) 1 7 373 906
E-mail: tomasik@upkm.sanet.sk

Solomon Islands (see Fiji)**South Africa (also see Intercountry team, Eastern and Southern Africa)**

Mikosi, Alfred
UNAIDS Focal Point
UNFPA
Metropark Building
351 Schoeman Street, PO Box 6541
Pretoria 0001
Tel: (27) 12 338 5311
Fax: (27) 12 320 4355 / 338 5310
E-mail: amikosi@un.org.za

Sri Lanka

Jayawardena, Dr H.
UNAIDS Focal Point
National Country Programme Adviser
c/o UNFPA
22 Bauddhaloka Mawatha
PO Box 1505
Colombo
Tel: (94) 1 58 08 40
Fax: (94) 1 58 06 98

Sudan

Saint-Victor, Rosalind Francis
County Programme Adviser
UNAIDS
c/o UN Resident Coordinator
UNDP
UN Compound
PO Box 913
Khartoum
Tel: (249) 11 77 31 21/23/25/28
Fax: (249) 11 78 37 64
E-mail: rosalind@undp.org

Suriname (see Barbados)

Swaziland

Mndzebele, Alfred J.
UNAIDS Focal Point
UNDP National Programme Officer
UNDP
PO Box 261
Mbabane
Tel: (268) 42301 - 4
Fax: (268) 45341
E-mail: fo.swa@undp.org

Tajikistan (see Central Asian Republics)**Tanzania**

Tennagashaw, Mulunesh
Country Programme Adviser
UNAIDS
c/o WHO
Luthuli Road
PO Box 9292
Dar-es-Salaam
Tel: (255) 51 11 30 51
Tel: (255) 11 67 41
Tel Mobile: (255) 812 781 987
Fax: (255) 51 11 31 80
E-mail: mulu.unaids@twiga.com

Thailand (also see Inter-country Teams)

Cufino, Dr Ennio
UNAIDS Focal Point
UNICEF Health/AIDS Project Officer
c/o UNICEF Area Office for Thailand, DPR Korea
and Malaysia
PO Box 2 - 154
Bangkok 10200
Tel: (66) 2 280 5931 (ext 920)
Fax: (66) 2 281 6032

Lamboray, Jean-Louis
UNAIDS Coordinator, Health Reform and HIV
Office of the Health Care Reform Project
3d Building, 7th floor, Tiwanon Road
Nonthaburi 11000, Thailand
Tel: (66) 2 590 1864
Fax: (66) 2 590 1850
E-mail: jllamb@mozart.inet.co.th

Tokelau (see Fiji)**Tonga (see Fiji)****Trinidad and Tobago (also see Barbados)**

Jardine, Tessa
UNAIDS Focal Point
UNDP
19 Keate Street
PO Box 812
Port-of-Spain
Tel: (1 809) 623 7056/57/59 /1836
Fax: (1809) 623 1658
E-mail: fo.tto@undp.org

Turkey (also see Bulgaria)

Saatcioglu, Dr Akif
UNAIDS Focal Point
Programme Officer
UNICEF
Iran Caddesi 35
06700 GOP
Ankara
Tel: (90) 312 427 8563
Fax: (90) 312 427 5740
E-mail: asaaticio@unicef.org.tr

Turkmenistan (see Central Asian Republics)**Tuvalu (see Fiji)**

Uganda

Carmichael, James
Country Programme Adviser
UNAIDS
c/o WHO
2 Berkeley Road, PO Box 6, Entebbe
Tel: (256) 42 20572
Mobile: (256) 757 33 038
Fax: (256) 41 32 14 41
E-mail: James_Carmichael_at_PO623A01@smtp.unicf.org
or
c/o UNDP
PO Box 7184
Kampala
Tel: (256) 41 32 13 95
Fax: (256) 41 32 14 41
E-mail: James_Carmichael_at_PO623A01@smtp.unicf.org

Ukraine (Belarus and Moldova)

Khodakevich, Lev
InterCountry Programme Adviser
UNAIDS
UN Office in Ukraine, 1 Klovsky Uzviz, 252021 Kiev
Tel: (380) 44 293 9323/63
Fax: (380) 44 293 2607
E-mail: khodak@un.kiev.ua

Uruguay (Argentina, Chile, Paraguay)

Weissenbacher, Mercedes
InterCountry Programme Adviser
UNAIDS
c/o WHO
Casilla de correo 1821
Av Brasil 2697 Piso 2, 11300 Montevideo
Tel: (598) 2 77 35 81/89/90
Fax: (598) 2 77 35 30
E-mail: opsuru@adinet.com.uy

Uzbekistan (see Central Asian Republics)**Vanuatu (see Fiji)****Venezuela**

Torres, Angela
National Programme Adviser
UNAIDS
c/o UNDP
Apartado 69005
Caracas 1062A
Tel: (58) 2 286 3827
Fax: (58) 2 283 7878
E-mail: ven01at%ven01.undp-ven@nylan1.undp.org

Viet Nam

Uhrig, Jamie
UNAIDS Focal Point
Project Officer
UNDP
Uy Ban Quoc Gia Phong Chong AIDS
Hanoi
Tel: (844) 846 0739
Fax: (844) 846 0740
E-mail: unaids@netnam.org.vn

Wallis and Futuna Islands (see Fiji)**Zaire (see Democratic Republic of the Congo)****Zambia**

Olowo-Freers, Bernadette
Country Programme Adviser
UNAIDS
c/o WHO
PO Box 32346, 10101 Lusaka
Tel: (260) 1 22 32 51
Fax: (260) 1 22 32 09
E-mail: freers@zamnet.zm

Zimbabwe

Maziya, Rudolph
Country Programme Adviser
UNAIDS
c/o UNDP, PO Box 4775
Harare
Tel: (263) 4 79 26 81
Fax: (263) 4 72 86 95
E-mail: rmaziya@id.co.zw

UNAIDS TELEPHONE LIST - Alphabetical - October - December 1997

E-mail

Tel. No.

Off. No. Dept.

Abago Nchama, Dr Luciano (see Equatorial Guinea)				
Adamian, Rudick (see Central Asian Republics)	ra@un.alma-ata.su			
Adea, Cristy	adeac@unaids.org	4520	M.636	COS/PSR
Alban, Anita	albana@unaids.org	4669/3759	M.511	PSR
Alekperov, Ramiz (see Azerbaijan)	ramiz@unfpa.baku.az			
Alexandre, Yves-Pierre (see Chad)				
Almedal, Calle		4694		EXR
Anderson, Sandra (see Intercountry Teams)	sanderson@un.org.za			
Angulo, Salomon	angulos@unaids.org	4734	M.521	PAD
Arbogast, Veronique	arbogastv@unaids.org	4811	M.320	PSR
Asamoah-Odei, Emil (see Intercountry Technical Adviser)				
Atlani, Laetitia	atlanil@unaids.org	4391	M.513	COS
Bagasao, Bai	bagasaob@unaids.org	4654	M.629	COS
Bakker, Dean	bakkerd@unaids.org	4707	M.517	PAD
Baldo, Mariella (see PSR New York)	mbaldo@unicef.org			PSR
Bandusha, Dr (see Guinea)				
Barclay, Lisbeth	barclayl@unaids.org	4617	M.321	PSR
Belanger, Karen (see Liaison Office, EXR)	unaids@unicef.org			
Bell, Samantha	bellshierss@unaids.org	4614	M.636	COS
Bennoun, Robert (see Intercountry Teams)	rbennoun@unicef.org			
Benomar, Elizabeth	benomare@unaids.org	4451/4656	M.317	PSR
Bertozzi, Stefano	bertozzis@unaids.org	4679/4699	M.529	PAD
Bezruchenko, Marina (see Belarus)	un_undp@bye.minsk.by			
Bolvenkel-Prior, Susie	bolvenkelpriors@unaids.org	3666	M.533	PAD
Boyle, Raul	boyler@unaids.org	4655/2691	M.615	COS
Brady, William (see Eritrea)	brady@unaids.gemel.com.er			
Brenner, Corinne	brennerc@unaids.org	4656	M.324	PSR
Brunt, Joanne	bruntj@unaids.org	4612	M.624	COS
Buck, Helen	buckh@unaids.org	4768	M.531	PAD
Buckley, Anne	buckleya@unaids.org	4558/4729	M.626	COS
Buencamino, Carmen	buencaminoc@unaids.org	4678	M.636	PSR
Canaud, Anne-Françoise	canauda@unaids.org	2691	M.613	COS
Caraël, Michel	caraelm@unaids.org	4611/4617	M.327	PSR
Cardeza-Singh, Estela		4553	M.415	EXR
Carmichael, James (see Uganda)	see Uganda			
Chahil-Graf, Renu	chahilgrat@unaids.org	4714/4710	M.419	EXR
Chan Kam, Clement	chan-kamp@unaids.org	4556/4708	M.623	COS
Cherney, Suzanne	cherneys@unaids.org	4770	M.418	EXR
Clark, Martina	clarkm@unaids.org	4703/4694	M.628	EXR
Colicchio, Bernadette	colicchiob@unaids.org	3759	M.320	PSR
Coll-Seck, Awa Marie	collsecka@unaids.org	3392/4759	M.325	PSR
Connolly, Mark	connollymr@unaids.org	4461/4617	M.318	PSR
Cordero, Agnes	corderoa@unaids.org	4555	M.621	COS
Courtin, Patricia	courtinp@unaids.org	4608	M.519	PAD
Cowal, Sally	cowals@unaids.org	4716/4681	M.429	EXR
Cufino, Ennio (see Thailand)				
Cury, Delmin (see Nicaragua)				
Davis, Angela (see Barbados)				
Davis, Cornelia (see India)	davisc@who.ernet.in			
D'Cruz-Grote, Doris (see India)	groted@who.ernet.in			
De Knocke, Hans	deknockeh@unaids.org	4526/4708	M.619	COS
De Santis, Dominique	desantisd@unaids.org	4765/4661	M.422	EXR
De Vincenzi, Isabelle	devincenzii@unaids.org	4610/4522	M.309	PSR
Dehne, Karl	dehnek@unaids.org	4736/4712	M.617	COS
Delaney, Mary Guinn (see Namibia)	maryguinn@un.na			
Derks, Therry (see Ecuador)	fo.ecu@undp.org			
Dew, Julie	dewj@unaids.org	4704	M.632	COS
Diara, Laye	dialal@unaids.org	4354	M.407	PSR
Don, Pham Doan	phamdoand@unaids.org	4455	M.526	PAD
Edlund, Catharina	edlundc@unaids.org	3646/4708	M.627	COS
Eledu, Cynthia (see Ghana)	eledu@ighmail.com			
Endo, Hiroyoshi	endoh@unaids.org	4738/4506	M.417	EXR
Ernberg, Gunilla	ernbergg@unaids.org	4623/4704	M.634	COS
Esparza, Jose	esparzaj@unaids.org	4392/4522	M.331	PSR
Fanals, Rachel	fanalsr@unaids.org	4463	M.632	COS
Farhat, George	farhatg@unaids.org	3672	M.532	PAD
Farza, Abdesselam Mohen	farzam@unaids.org	4474	M.622	COS
Fee, Nancy (see Intercountry Programme Adviser)	nancyfee@compuserve.com			
Ferencic, Nina	ferencicn@unaids.org	4812/2691	M.609	COS
Firley, Andrea	firleya@unaids.org	4745	M.409	PSR
FitzSimons, David	fitzsimonsd@unaids.org	4624	M.413	PSR
Forbes-Hedberg, Clare (Secretary)	forbeshedbergc@unaids.org	4617	M.321	PSR
Fox, Emile (see China)	unaids@iuol.cn.net			
France, Tim (see Intercountry teams)	france.unescap@un.org			
Fulladoza Forment, Angel (see Guatemala)	onusida@ops.org.gt			

Gayle, Jacob (see Barbados)	unaids@caribsurf.com			
Gershby-Damet, Guy-Michel (see Intercountry Teams)	gershy@africaonline.co.ci			
Gibson, Christine (Secretary)	gibsonc@unaids.org	4462 M.322	PSR	
Giwa, Steven	giwas@unaids.org	2734/4735 M.527	PAD	
Gnaoré, Emmanuel (see Madagascar)	onusida@bow.dts.mg			
Gómez-Sagüéz, Adriana (see Peru)	onusida@pnudpe.org.pe			
Gramiccia, Muriel	gramicciacoidanm@unaids.org	4729 M.624	COS	
Granchamp, Marie-Laure	granchampm@unaids.org	4718 M.411	PSR	
Grinling, John (see Democratic Republic of Congo)	onusida_kin@kinpost.ccmil.compuserve.com			
Grunitzky-Bekele, Meskerem (see Intercountry Teams)	grubekem@africaonline.co.ci			
Gudz, Ana Maria (see Cuba)				
Guerrero, Ernesto (see Dominican Republic)	egurrero@pnud.org.do			
Guilloux, Anne	guilloux@unaids.org	4757 M.520	PSR	
Habgood, Janet	habgoodj@unaids.org	4724 M.533	PAD	
Hahn, Michael (see Bulgaria)	mhahn@undp.online.bg			
Han, Daw Aye	hana@unaids.org	4620 M.507	COS	
Hawe, Joan	hawej@unaids.org	4699 M.531	PAD	
Hopkins, Norrey	hopkinsn@unaids.org	4525 M.609	COS	
Horn, Annette	horna@unaids.org	4735 M.525	PAD	
Jagoe, Louis	jagoel@unaids.org	4605 M.524	PAD	
Jardine, Tessa (see Trinidad and Tobago)	fo.tto@undp.org			
Jayawardena, Dr H. (see Sri Lanka)				
Jimenez, Maria	jimenezm@unaids.org	4606 M.519	PAD	
Jones, Gareth	jonesg@unaids.org	3387/4661 M.420	EXR	
Jones, S. (see Seychelles)				
Kaleeba, Noerine	kaleeban@unaids.org	4601/4617 M.329	PSR	
Kalibala, Samuel	kalibalas@unaids.org	4561/4808 M.336	PSR	
Kereselidze, Tamaz Dr (see Georgia)				
Khodakevich, Lev (see Ukraine & COS)	khodak@un.kiev.ua	4712	COS	
Kigundu, Margaret	kigundum@unaids.org	4522 M.323	PSR	
Kingma, Stuart	kingmas@unaids.org	4671/4523 M.335	PSR	
Klevens, Monina	klevensm@unaids.org	4752 M.635	COS	
Kraus, Steven (see Intercountry Teams)	kraus.unescap@un.org			
Kristoffersson, Seng Pheth	kristofferssons@unaids.org	4523 M.321	PSR	
Kromodimedjo, John	kromodimedjo@unaids.org	4737 M.526	PAD	
Kourouma, Kekoura (see Burkina Faso)				
Laliberté, Gisele	laliberteg@unaids.org	4651 M.411	PSR	
Laurent, Jacqueline	laurentj@unaids.org	2320 M.515	PSR	
Lawson, Agathe (see Côte d'Ivoire)	onusida@africaonline.co.ci			
Leon Hing, Eva	hinge@unaids.org	4709 M.422	EXR	
Lim, Janet	limj@unaids.org	4664/3666 M.535	PAD	
Lisle, Tony (see Laos)	tony.lisle@undp.org			
Llados, Jose	lladosj@unaids.org	4817/4506 M.425	EXR	
Loth, George (see Indonesia)	glunaids@indo.net.id			
Loures, Luiz	louresl@unaids.org	4698/2691 M.611	COS	
Mahanty, Binod	mahantyb@unaids.org	4680 M.422	EXR	
Makinwa, Bunmi	makinwab@unaids.org	4552/4523 M.319	PSR	
Malinowska, Kasia (see Poland)	kasia.m-s@undp.org.pl			
Mane, Purnima	manep@unaids.org	4509/2104 M.432	OED	
Manipoud, Elisabeth	manipoude@unaids.org	3902/4710 M.421	EXR	
Manthey, Geoff (see Philippines)	geoffmanthey@compuserve.com			
Marclay, Corinne	marclayc@unaids.org	4722 M.431	OED	
Matt, Elisabeth	matte@unaids.org	4808 M.324	PSR	
Maziya, Rudolph (see Zimbabwe)	rmaziya@id.co.zw			
McCaul, Frances	mccaulf@unaids.org	4662 M.434	OED	
McEvoy, Margaret (see Dominican Republic)	pmcevoy@pnud.org.do			
McGrath, Kevin	mcgrathk@unaids.org	4691 M.625	COS	
McKay, Abigail (see Belize)	czmbze@btl.net			
Messersmith, Lisa (see Bangladesh)	lisa@citechco.net			
Mikkelsen, Henning (see Intercountry Technical Adviser)	horn@who.dk			
Mikosi, Alfred (see South Africa)	amikosi@un.org.za			
Mndzebele, Alfred J. (see Swaziland)	fo.swa@undp.org			
Modisaotsile, Innocent (see Botswana)	fo.bwa@undp.org			
Moeti, Matshidiso	moetim@unaids.org	4620 M.507	COS	
Moodie, Rob	moodiea@unaids.org	4755/4463 M.630	COS	
Morganstern, Sharon	morgansterns@unaids.org	4557 M.423	EXR	
Mpendubundi, Marthe	mpendubundim@unaids.org	4720/4808 M.334	PSR	
Msiska, Roland	msiskar@unaids.org	4756/4808 M.332	PSR	
Mullally, James	mullallyj@unaids.org	4686 M.528	PAD	
Myint, San San (see Myanmar)	san.san.myint@undp.org			
Naing, Amaya Maw (see Nepal)	amaya.maw.naing@undp.org			
Nakari, Taina	nakarit@unaids.org	4356/4523 M.520	PSR	
Ndowa, Francis	ndowaf@unaids.org	4575/4808 M.509	PSR	
Neracher, Jean	neracherj@unaids.org	4762 M.423	EXR	
Noehrenberg, Eric	noehrenberge@unaids.org	4625 M.417	EXR	
Nundoochan, Ajoy (see Mauritius)				
Nyamuryekung'e, Kinton (see Ethiopia)	unaids@telecom.net.et			
Nyunt, Myo	nyuntm@unaids.org	4715 M.507	COS	

Ofosu-Barko, Kenneth (see Nigeria)				
Olowo-Freers, Bernadette (see Zambia)	freers@zamnet.zm			
Opuni, Marjorie	opunim@unids.org	4395	M.625	COS
Osmanov, Saladin	osmanovs@unids.org	4393/3759	M.333	PSR
Parker, Liz	parkere@unids.org	2104	M.434	OED
Partow, Jaleel	partowj@unids.org	4618	M.523	PAD
Patterson, David		4675/4811	M.317	PSR
Pattou, Claire	pattouc@unids.org	4515/4522	M.328	PSR
Perriens, Joseph	perriensj@unids.org	4456/4522	M.313	PSR
Perry, Christine	perryrc@unids.org	4712	M.618	COS
Petrescu, Eduard (see Romania)	uromania@igc.apc.org			
Phongphit, Seri (see Intercountry Teams)	phongphit.unescap@un.org			
Piot, Peter	piotp@unids.org	4510/4722	M.435	OED
Rarok, Grazyna	rarokg@unids.org	4506	M.427	EXR
Ray-Tabona, Simone	raytabonas@unids.org	4767/4768	M.534	PAD
Reeler, Anne	reelera@unids.org	4742/4808	M.334	PSR
Rodrigues, Eva	rodrigues@unids.org	4681	M.427	EXR
Romero, José (see Mexico)	jromero@mail.internet.com.mex			
Rotberga, Signe (see Latvia)				
Rousselot, Joyce	rousselotj@unids.org	3759	M.320	PSR
Ryan, Sinead	ryans@unids.org	4694	M.628	EXR
Ryle, Theresa	rylet@unids.org	4740	M.533	PAD
Saatcioglu, Akif (see Turkey)	asaatcio@unicef.org.tr			
Saba, Joseph	sabaj@unids.org	4452/4522	M.311	PSR
Saint-Victor, Rosalind Francis (see Sudan)	rosalind@undp.org			
Sakho, Mamadou-Lamine (see Intercountry Teams)	sakho@africaonline.co.ci			
Salas-Rojas, Carla Milagros	salasrojasc@unids.org	4622	M.613	COS
Samarine, Gabrielle	samarineg@unids.org	4719	M.532	PAD
Samba-Maliavo, Dr Marguerite-Marie (see Central African Republic)				
Sandoval, Mary Luz (see El Salvador)	els01MLS%els01.undp-els@nylan1.undp.org			
Sannikova, Elena	sannikovae@unids.org	4721	M.618	COS
Schmitz, Cristina	schmitzm@unids.org	4661	M.426	EXR
Schwartländer, Bernhard	schwartlanderb@unids.org	4705/4678	M.633	PSR
Shaw, Georges	shawg@unids.org	4604/4719	M.530	PAD
Sherry, James	sherryj@unids.org	4505/4563	M.436	OED
Shimizu, Midori (see Intercountry Teams)	shimizu.unescap@un.org			
Silveira, Fernando (see Sao Tome and Principe)				
Simango, Martha	simangom@unids.org	4670	M.621	COS
Smedberg, Martina	smedbergm@unids.org	4774/4563	M.430	OED
Soper, Paula	soperp@unids.org	3272	M.322	PSR
Subrendonathan, Vaithehi (see Papua New Guinea)				
Sun Gang (see China)	sungang@luol.cn.net			
Sy, Elhadj (see Intercountry Teams)	assy@un.org.za			
Tallarico, Maria (see Mozambique)	unids@zebra.uem.mz			
Tawil, Oussama (see Intercountry Teams)	oussama@africaonline.co.ci			
Tawilah, Jihane	tawilahj@unids.org	4304	M.635	COS
Tembo, George (see Kenya)	tembo@arcc.or.ke			
Thuriaux, Damien		4567	M.517	PSR
Tennagashaw, Mulunesh (see Tanzania)	mulu.unids@twiga.com			
Tomasik, Emil (see Slovakia)	tomasik@upkm.sanet.sk			
Torres, Angela (see Venezuela)	ven01at%ven01.undp-ven@nylan1.undp.org			
Trenton-Mbonde, Angela (see Malawi)	atrenton-unids@eo.wn.apc.org			
Tungaraza, Maria	tungarazam@unids.org	4675	M.317	PSR
Tynjala, Tommi (see Peru)	fo.per@undp.org			
Uhrig, Jamie (see Vietnam)	unids@netnam.org.vn			
van Dam, Johannes	vandamj@unids.org	4412/4612	M.620	COS
Van Roey, Jens	vanroeyj@unids.org	4386	M.607	COS
Verwohlt, Andrea	verwohlta@unids.org	4553	M.415	EXR
Vete, Steven (see Fiji)	whosp@is.com.fj			
Villanueva-Edgecock, Maria	villanuevaedgecockm@unids.org	4570	M.415	EXR
Wallace, Mark	wallacem@unids.org	3770	M.522	PAD
Watchirs, Helen	watchirsh@unids.org	4355/4811	M.315	PSR
Watta, Chehem Mohamed (see Djibouti)				
Watters, Joanne	wattersj@unids.org	4563	M.431	OED
Weissenbacher, Mercedes (see Uruguay)	opsuru@adinet.com.uy			
Werasit Sittitrai	werasits@unids.org	4457/4656	M.326	PSR
Wernette, Monica	wernettem@unids.org	4567/4808	M.328	PSR
Wienrawee, Pawana (see Cambodia)	see Cambodia			
Wijayadasa, Somar (see Liaison Office, EXR)	swijayadasa@unicef.org			EXR
Wilson, Andrew	wilsona@unids.org	4813/4656	M.513	PSR
Wilson-Attobra, Lakoley	wilsonattobrai@unids.org	4710	M.426	EXR
Winter, Anne	wintera@unids.org	4577/4661	M.428	EXR
Wulf, Lesley	wulfl@unids.org	4759	M.324	PSR
Yessayan, Aghassi (see Armenia)	unarm@arminco.com			
Zessler, Laurent (see Pakistan)	zessler@unids.sdnkp.undp.org			
UNAIDS Meeting Room		4683	M.405	