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Progress report on the implementation of the regional health sector response strategy for HIV 2011-2015

1. The regional strategy for health sector response to HIV 2011–2015 was developed through a broad consultative process with all relevant stakeholders in the Region and endorsed by Member States in the 57th session of the Regional Committee for the Eastern Mediterranean (resolution EM/RC57/R.5). The goal of the strategy is to reduce the transmission of HIV and to improve the health of people living with HIV (PLHIV). Its specific objectives focus on enhancing HIV-related information and access to HIV care, treatment and preventive services and on strengthening health systems.

2. The strategy identifies strategic priorities for countries, taking into account the epidemiological situation in the Region and the main obstacles and challenges faced by governments, civil society and their partners. This report presents progress in implementing the strategic priorities and interventions laid out in the strategy in terms of achievements, gaps and challenges.

Progress by objective

Objective 1: Generate relevant and reliable information on the HIV epidemic and the response to enable strategic decision-making

3. By the end of 2010 the estimated number of PLHIV was 560 000. Although the overall HIV prevalence in the Region remained low (0.2%), new infections reached 82 000 (including 7400 children)[1]. The rising number of new infections puts the Eastern Mediterranean Region among the top two regions in the world with the fastest growing HIV epidemics. HIV estimates remain unsatisfactory in many countries because countries have insufficient data available for inclusion in UNAIDS/WHO mathematical estimation models, and when available these data are often of limited quality and reliability. Thus estimates continue to be imprecise with wide margins of error.

4. Recently, substantial investments were made by several countries to improve their knowledge of the local dynamics of the HIV epidemic. The WHO Regional Office for the Eastern Mediterranean, in close collaboration with UNAIDS and the World Bank provided technical and financial support to strengthen the capacity of local institutions to carry out surveillance. Grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria also contribute to the strengthening of strategic information systems.

5. Significant progress has been made by more than half of countries in terms of collecting information on behaviours and HIV prevalence among high risk populations: concentrated HIV epidemics among injecting drug users have been confirmed recently through HIV prevalence and behavioural surveys in Libya (22%), Pakistan (21%), Morocco (14%), Islamic Republic of Iran (13%), Egypt (7%) and Tunisia (3%).[2] Moreover, HIV epidemics among men who have sex with men are seen increasingly, including in Pakistan (37%), Egypt (6%), Tunisia (5%) and Morocco (3%). Studies among female sex workers showed elevated HIV prevalence in Djibouti (15.4%), Afghanistan (4%), Islamic Republic of Iran (4%) and Morocco (3%).[2] In the few countries that collected data over

[1] *Global HIV/AIDS response: epidemic update and health sector progress towards universal access. Progress report 2011*. Geneva, WHO/UNAIDS/UNICEF, 2011.
[2] Regional review of HIV surveillance systems 2011, country reports.

time and in different geographical areas such as the Islamic Republic of Iran, Morocco and Pakistan the heterogeneity and diversity of the local epidemic has become evident.

6. A major gap and challenge remains the estimation of the sizes of most-at-risk populations using reliable methodologies. This knowledge gap makes it impossible for countries to estimate the coverage of prevention services for these populations and thus the impact of their programmes on the HIV epidemic.

7. About half of countries have a national monitoring and evaluation plan for the HIV response. However, few have been able to fund the plans and many countries also acknowledge deficiencies in national monitoring and evaluation systems. This makes it difficult to estimate epidemic trends and service coverage. In particular, insufficient or inadequate data on populations at higher risk limit the ability of countries to develop and deploy effective responses to HIV.

Objective 2: Increase access to HIV care and treatment services for people living with HIV

8. AIDS-related mortality has almost doubled in the past decade among both adults and children in the Region. Projections for the next five years show that, with a rapid increase in treatment coverage to 50% across the Region (i.e. coverage target of the regional strategy), 25 000 deaths could be averted by 2015.[3] In 2010, the availability, access and quality of health-sector interventions varied widely among countries. Access to antiretroviral therapy (ART) improved steadily, with nearly a 25% increase between 2009 and 2010 (from 15 473 to 19 050 PLHIV on ART)[4] (Figure 1). Nonetheless the Region continues to have, at 10%, the lowest ART coverage of all regions.

9. Importantly, five countries in the Region contribute > 80% of the estimated regional ART needs (190 900 PLHIV in need of ART): Sudan and South Sudan (together 93 000); Islamic Republic of Iran (26 000); Somalia (25 000); and Pakistan (22 000).[4] Achieving regional targets for ART coverage depends on the four countries with the highest burden scaling up their national treatment strategy, together with serious commitment to expand HIV testing and counselling, which is the most critical step to accessing treatment. A large number of people diagnosed with HIV in the Islamic Republic of Iran and Pakistan are injecting drug users and it is difficult to engage and retain them in chronic care.

10. For 2010, 17 countries of the Region reported data on retention in care for people receiving antiretroviral therapy after 12 months. Data clearly show the positive impact that antiretroviral therapy can have on the lives of PLHIV. Six countries reported retention rates at 12 months above the global average of 82% for low-income and middle-income countries while a number of countries have very low rates, such as Djibouti, Sudan and Yemen. While many countries in the Region, in particular higher income countries, succeed in enrolling nearly all known PLHIV in need of treatment in ART services, it is important to note that there is also significant attrition in some countries among patients in pre-ART care.

11. While knowing one's HIV status is a pre-condition for accessing treatment, increasing access to HIV testing remains a serious challenge in countries of the Region. Nearly 60% of the HIV tests carried out between 1995 and 2008 were for migrant workers, while only 4% of tests were for the key populations at higher risk. Also, most of the HIV testing in the Region is mandatory, and if quality voluntary counselling and testing is available, it is not always readily accessible by those at highest risk.

[3] *UNAIDS Middle East and North Africa regional report on AIDS 2011*. Cairo, Joint UN Programme on HIV/AIDS, 2011.

[4] Country reports on universal access, 2011.

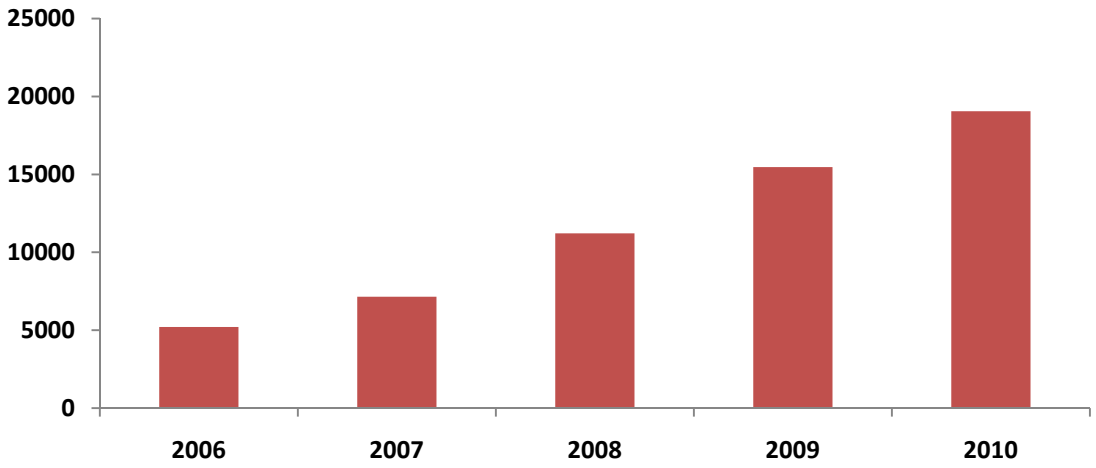

Figure 1. Number of people living with HIV on ART in the WHO Eastern Mediterranean Region,

Several countries report under-utilization of voluntary HIV testing and counselling services. The Regional Office recommends that countries review their approaches to HIV testing and counselling in terms of their adequacy and appropriateness to identify PLHIV and link them to HIV prevention, care and treatment services.

12. The routine offer of an HIV test to certain patient categories in health facilities, i.e. provider-initiated HIV testing and counselling has increasingly been adopted in the Region, although it is still at nascent stage and has low coverage. Recent experiences in Morocco, Oman and Somalia show high rates of HIV testing when pregnant women are offered the test in antenatal care clinics. Provider-initiated HIV testing and counselling in tuberculosis services in Djibouti and Sudan succeeded in 55% and 60%, respectively, of tuberculosis patients knowing their HIV status. Of the tuberculosis patients tested in Djibouti and Sudan, 10% and 4% respectively were HIV positive.

Objective 3: Increase access to HIV prevention services for people at risk of HIV infection and HIV transmission

13. In the Region, the estimated number of pregnant women living with HIV who need antiretroviral medicine for preventing mother-to-child transmission is less than 20 000. This is a relatively small number; however, without PMTCT interventions the number of children born with HIV will increase each year and add to the overall burden of disease. In 2010 the estimated coverage of PMTCT services was very low, at 4%. The number of children aged less than 15 years on antiretroviral therapy increased slightly from less than 500 in 2008 to 600 in 2009 and 780 in 2010. Very few countries in the Region implement a comprehensive package of effective interventions to prevent mother-to-child transmission of HIV. There is wide variability among countries in the Region with regard to burden of HIV disease, availability of resources and strength of the HIV and maternal and child health programmes (Table 1).

14. At the United Nations General Assembly high-level meeting on AIDS in June 2011, the Secretary-General launched the global plan towards the elimination of new HIV infections among children by 2015

Table 1. Variability of disease burden, maternal and child health and prevention of mother-to-child transmission programme coverage in countries

Country	Antenatal care coverage[a]	% of births attended by skilled personnel[a]	Estimated no. of pregnant women living with HIV needing ARV to prevent MTCT (2010)[b]	No. (and estimated coverage) of pregnant women who were tested and received their test result 2010[b]	No of HIV-positive pregnant women[b]	No. of HIV infected women who received ARV to reduce MTCT of HIV 2010[b]	Estimated % of HIV+ pregnant women in need of ARV who received ARV for PMTCT[b]	No. of HIV infected children aged 0–14 years currently on ART 2010[b]
Afghanistan	36	24	<100–<500	...	1	1	...	1
Bahrain	100	98	...	...	...	...	...	
Djibouti	79	56	<1000	5148 (20%)	103	38	6%	11
Egypt	74	92	<100–<1000	...	7	7	4%	32
Iran, Islamic Republic of	98	97	<500–<1000	...	...	58	7%	55
Iraq	51	86	...	...	...	...	...	...
Jordan	99	99	...	...	3	3	...	2
Kuwait	100	100	...	...	...	...	...	2
Lebanon	...	...	<100	...	...	...	...	4
Libya	93	100	...	...	...	...	...	...
Morocco	80	74	<500–<1000	3052 (1%)	124	...	26%	168
Occupied Palestinian territory	100	100	...	...	...	...	...	...
Oman	99	99	<100	67110 (>95%)	27	...	78%	9
Pakistan	61	87	<1000–<4200	3300 (<1%)	23	23	1%	...
Qatar	100	100	...	...	...	...	...	2
Saudi Arabia	97	97	...	...	...	29	...	83
Somalia	26	33	2600–6000	5995 (1%)	35	33	<1%	33
Sudan	70	49	12000	20729	110	110	2%	245
South Sudan	...	...	...	31718	533	527	...	75
Syria	88	96	...	...	...	...	...	...
Tunisia	96	95	<100–<1000	...	...	7	7%	20
United Arab Emirates	100	100	...	20207	1	1	...	...
Yemen	45	36	...	6328 (1%)	21	17	...	38

[a] Source: *Demographic, social and health indicators for countries of the Eastern Mediterranean*. Cairo, WHO Regional Office for the Eastern Mediterranean, 2011.

[b] Source: *Global HIV/AIDS response: epidemic update and health sector progress towards universal access. Progress report 2011*. Geneva, WHO/UNAIDS/UNICEF, 2011

... Information not available

ARV Antiretroviral medicines

(P)MCTC (Prevention of) mother-to-child transmission

and keeping their mothers alive. National AIDS programme managers at their regional meeting in 2011 requested WHO, UNICEF and partner agencies to develop a regional framework for the elimination of mother-to-child transmission in 2011. It is critical that policy-makers, programme managers, experts and affected people participate in the development of the framework and that it is endorsed by ministers of health in 2012. Based on the agreed framework, national plans for

prevention of mother-to-child transmission should be revised to align with elimination goals to ensure nationwide coverage, improved quality, access and utilization of services.

15. The epidemiology of HIV in the Region clearly and strongly supports focusing on prevention among the key populations at higher risk, specifically people who inject drugs, men who have sex with men and sex workers. The key populations at higher risk vary by country. There is still very limited experience and capacity in developing the most efficient and appropriate strategies and service delivery models for these population groups.

16. Currently, 13 countries in the Region include references to people who inject drugs in their plans, 14 countries reference men who have sex with men, 14 reference sex workers and 15 reference prisoners. Moreover, some countries have gradually expanded prevention interventions for these populations including Afghanistan, Djibouti, Egypt, Islamic Republic of Iran, Lebanon, Morocco, Pakistan, Sudan and Tunisia. Except for harm reduction programmes for injecting drugs users in the Islamic Republic of Iran and Pakistan and prevention services for sex workers in Morocco, the scale of interventions remains low.

Objective 4: Contribute to health systems strengthening

17. In the countries of the Region, HIV programmes interact with health systems in many different ways. Several components of HIV programmes pose challenges to health systems, particularly in low-income and middle-income countries with less mature health systems. The most challenging aspects of HIV programmes are the chronic nature of the disease, requiring life-long treatment through chronic care services, and the need to reach out to populations that tend to avoid public health services because of stigmatization, discrimination and criminalization of their sexual or drug injecting behaviours. Health systems in many countries are not yet well positioned to accommodate these specific needs of HIV programmes. Several countries benefit from Global Fund grants that include funding for strengthening of specific health system functions.

18. The Regional Office developed in consultation with national AIDS programme managers a methodology to assess interactions between HIV programmes and health systems. The methodology explores opportunities for integration, positive spillover effects for the health system resulting from investments in HIV programmes and needs for health system adaptation and strengthening in order to enhance HIV health outcomes.

Future plans

19. In view of persisting major gaps in the coverage of people in need of HIV prevention, care and treatment services, national AIDS programme managers, civil society organizations, WHO and partner agencies agreed to focus accelerated efforts on the following priority interventions during 2012–2013.

- Implementing a regional initiative for the elimination of mother-to-child transmission.
- Expanding knowledge of populations at higher risk (size estimations, mapping, behaviours, prevalence of HIV and sexually transmitted infections).
- Developing service-delivery models and systematic scale-up plans for HIV prevention and treatment reaching populations at higher risk.
- Reducing stigma among health care providers.