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Regional strategy for health sector response to HIV 2011–2015

The HIV epidemic continues to expand. An estimated 50 000 to 100 000 new infections have occurred each year in the Region during the past decade. Efforts to prevent further spread of the epidemic and to expand access to life-saving antiretroviral therapy have increased substantially. However, there are still major gaps in knowledge with regard to the local dynamics of the HIV epidemic and in programmes for those at increased risk. These gaps are the main reason for the continued transmission of HIV. This strategy accommodates the need for re-orientation based on better knowledge of HIV epidemiology in the Region, on lessons learnt from national HIV/AIDS programme successes and failures in the past, as well as the need to reinforce commitment and to address persisting challenges more efficiently.

A draft resolution is attached for consideration by the Regional Committee.

Contents

Executive summary

The purpose of the regional strategy for health sector response to HIV 2011-2015 is to advocate for urgent action by Member States to enhance the contribution of the health sector to achieving universal access to HIV prevention, treatment, care and support and, ultimately, to attaining the Millennium Development Goals (MDG). The strategy takes into consideration commitments made by the United Nations General Assembly in 2001 and 2006 and strategic directions for the achievement of universal access to HIV prevention, treatment, care and support developed by WHO and UNAIDS. The strategy builds on the regional strategy for strengthening health sector response to HIV/AIDS and sexually transmitted infections 2006–2010 and is complementary to the regional strategy for the prevention and control of sexually transmitted infections 2009–2015, which does not cover HIV. It accommodates the need for re-orientation based on better knowledge of HIV epidemiology in the Region, on lessons learnt from the successes and failures of national HIV/AIDS programmes in the past, as well as the need to reinforce commitment and to address persisting challenges more efficiently.

Since the early 1980s, when the first HIV infections were detected in the Region, the epidemic has continued to expand. During the past decade between 50 000 and 100 000 estimated new HIV infections have occurred each year. While overall adult HIV prevalence has remained low, at an average estimated 0.2%, evidence has accumulated that the epidemic is gaining hold in sub-groups of the population at increased risk associated with injecting drug use or risky sexual behaviour. However, in the majority of countries there are still major gaps in knowledge with regard to the local dynamics of the HIV epidemic. Efforts to prevent further spread of the epidemic and to expand access to life-saving antiretroviral therapy (ART) have increased substantially, resulting in a 70% increase in the number of people receiving ART between 2007 and 2009. A few countries, such as Islamic Republic of Iran, Morocco and Pakistan, have achieved appreciable coverage of people in need of prevention services, and low, if any, coverage of programmes for those at increased risk are the main reason for the continued transmission of HIV.

Primarily, the regional strategy promotes expansion of coverage and improvement of quality of known effective health sector interventions that are already part of the existing regional strategies. It puts increased emphasis on: strengthening existing health systems to meet the needs of HIV programmes; targeting interventions to those population groups where most transmission is likely to take place; and improving the information system related to HIV through strengthening HIV surveillance, ensuring its comprehensiveness and assuring data quality, and conducting research. In addition updated approaches to enhance access to prevention, care and treatment, such as the systematic introduction and expansion of provider-initiated HIV testing and counselling and prevention service packages for injecting drug users, sex workers and men having sex with men have been included. The most important benefits expected from the regional strategy are: a) improved information on local dynamics of the HIV epidemic to enable strategic decision making; b) increased coverage of people at risk of HIV infection or transmission with HIV prevention services; c) increased coverage of people living with HIV with HIV care and treatment services; and d) strengthened capacity of health systems to enhance quality, coverage and sustainability of HIV and other services.

1. Introduction

Since the early 1980s, when the first HIV infections were detected in the Eastern Mediterranean Region, the epidemic has continued to expand. During the past decade, between 50 000 and 100 000 estimated new HIV infections have occurred each year. While overall adult HIV prevalence has remained low, at an average estimated 0.2%, evidence has accumulated that the epidemic is gaining hold in sub-groups of the population at increased risk associated with injecting drug use or risky sexual behaviour. In 2008 an estimated 28 400 HIV-related deaths occurred, among them 4400 children below the age of 15. Efforts to prevent further spread of the epidemic and to expand access to life-saving antiretroviral therapy have increased substantially and some countries have achieved considerable coverage of people in need of treatment services. However, in the majority of countries there are still major gaps in knowledge with regard to the local dynamics of the HIV epidemic and in programmes for those at increased risk. These gaps are the main reason for the continued transmission of HIV. Moreover, HIV programmes in low-income and middle-income countries, which have benefited in recent years from considerable donor support, are confronted with the challenge of achieving quality, coverage and sustainability of interventions within often weak existing health systems.

The purpose of the regional strategy for health sector response to HIV 2011–2015 is to advocate for urgent action by Member States to enhance the contribution of the health sector to achieving universal access to HIV prevention, treatment, care and support. Ultimately, interventions promoted by the strategy will contribute to attaining Millennium Development Goals (*1*), in particular: goal 4, which seeks to reduce child mortality by 2015, through prevention of mother-to-child transmission; goal 5 which seeks to reduce maternal mortality by three-quarters by 2015, through intensified efforts to detect pregnant women in need of HIV care and treatment and provision of antiretroviral therapy; and goal 6, which calls on nations to reverse the spread of diseases, especially HIV among marginalized populations who frequently have poor access to services.

The strategy takes into consideration commitments made by the United Nations General Assembly in 2001 (*2*) and 2006 (*3*) and strategic directions for the achievement of universal access to HIV prevention, treatment, care and support developed by WHO (*4*) and UNAIDS (*5*). The strategy builds on the regional strategy for strengthening health sector response to HIV/AIDS and sexually transmitted infections 2006–2010 (*6*) and is complementary to the regional strategy for the prevention and control of sexually transmitted infections 2009–2015 (*7*), which does not cover HIV. It accommodates the need for re-orientation based on better knowledge of HIV epidemiology in the Region, on lessons learnt from the successes and failures of national AIDS programmes in the past, as well as the need to reinforce commitment and to address persisting challenges more efficiently.

2. Situation analysis

2.1 Global context

Globally, in 2008, it is estimated that 33.4 million adults and children were living with HIV and 2.7 million people were newly infected, while 2.0 million people died of HIV (*8*). In 2008, the estimated number of new HIV infections was approximately 30% lower than at the epidemic's peak 12 years earlier. There have been many successes in the HIV response in recent times, including increases in HIV treatment coverage from 7% in 2003 to 42% in 2008 and an indication of decline in HIV incidence in some regions (*8*). However, currently, globally five people become infected with HIV for every two people accessing treatment.

2.2 Regional situation

According to 2008 estimates the HIV epidemic in the Eastern Mediterranean Region continues to expand. In 2008, an estimated 60 600 people in the Region became infected with HIV, and 28 400

related deaths occurred. The total number of people living with HIV (PLHIV) in the Region at the end of 2008 was estimated to be 461 000 (UNAIDS, unpublished estimates, 2010). HIV prevalence in the general population remained low with a regional average of 0.2%, which is the second lowest globally after northern America and western and central Europe, with 0.1% each. However, there is considerable regional variation and Djibouti, parts of Somalia and southern Sudan have confirmed HIV prevalence in the general population above 1% as reflected in HIV prevalence among pregnant women attending antenatal care (Table 1). Estimations of PLHIV and new HIV infections each year during the past 5 years show major fluctuations due to a) improvement in the estimation methodology recommended by the UNAIDS monitoring and evaluation reference group, and b) improved epidemiological data from several countries, including Pakistan and Sudan. It is therefore not possible to make firm inferences from these data with regard to trends in the epidemic. A number of countries have recently collected information on HIV prevalence and risk behaviours among key populations at increased risk, namely injecting drug users, prisoners, sex workers and men having sex with men using institution-based and community-based probability sampling methodologies (Table 1).

According to a regional review of available data on the epidemic carried out by the World Bank, UNAIDS and the Regional Office, several epidemiological patterns are contributing to the spread of HIV in the Region (*9*). First, within countries, the epidemic is spreading mainly through unsafe injecting drug use, high-risk behaviour among men having sex with men, and women and men engaging in commercial sex followed by onward transmission to regular sexual partners. Epidemics among injecting drug users have been confirmed in Afghanistan, Bahrain, Islamic Republic of Iran, Libyan Arab Jamahiriya and Pakistan. Data from Egypt, Lebanon, Sudan and Tunisia suggest emerging epidemics among men having sex with men. High HIV prevalence among sex workers has so far been reported from Djibouti and Somalia.

A second pattern, which exists at varying levels in countries of the Region, is characterized by nationals who contract HIV outside their home country and then transmit HIV to their sexual partners upon return to their home country. The majority of such infections are linked to sexual and injecting exposures abroad. This transmission pattern leads to randomly distributed infections in the general population but does not usually result in significant onward transmission beyond direct sexual partner(s).

Finally, there are three countries in the African part of the Region experiencing generalized HIV epidemics, i.e. Djibouti, Sudan (southern) and Somalia (some areas). Data from sentinel sero-surveys among pregnant women in southern Sudan suggest substantial HIV transmission within the general population in some areas. However, in these three countries also, HIV transmission related to key populations at increased risk, in particular to commercial sex and possibly to sex between men, is none-the-less likely to disproportionately contribute to new HIV infections.

In conclusion, there is increasing evidence of HIV penetrating into the networks of injecting drug use and high-risk sexual behaviour, but much of these data require confirmation through repeated surveys or improvements in survey quality. However, data are sufficient to alert all countries in the Region to increase their vigilance regarding epidemic dynamics focusing on populations at high risk, their interaction with so-called bridging populations (sexual partners of high-risk populations) and potential linkages to the general population.

In terms of achieving the target 1 of Millennium Development Goal 6, i.e. halting or reversing the spread of HIV, the most recent epidemiological data shows that epidemic spread has not been contained yet in the Region and that, without effective prevention programmes, growing epidemics among high-risk populations and their sexual networks can be expected.

2.3 Current response and challenges

The regional strategy for strengthening health sector response to HIV/AIDS and sexually transmitted infections 2006–2010 emphasized three main components: 1) enhancing political commitment and mobilizing additional resources for the HIV response; 2) creating evidence of the status and trends of the HIV epidemic; and 3) expanding access to an essential package of HIV prevention, care and treatment services. The degree to which national AIDS programmes have put the recommended strategies into practice has varied depending on many factors, including political commitment at highest level, willingness and ability to address culturally and politically sensitive issues pragmatically, other national priorities (e.g. emergency and conflict situations) and availability of resources.

Epidemic surveillance

Significant progress has been made in several countries regarding the understanding of the local epidemic situation, in particular with regard to populations likely to be most at risk of HIV infection. The number of countries that carried out surveys on HIV prevalence and risk behaviours among prisoners, injecting drug users, men having sex with men and sex workers increased. Also, countries improved the quality of surveys by using, for the most part, probability-based sampling methodologies. These achievements show that even in a difficult cultural context, where these populations are highly stigmatized and discriminated against, it is possible to conduct community-based surveys if confidentiality, respect for human rights and access to services for those in need are ensured. However, the majority of countries have not yet taken the necessary steps to estimate the sizes of these populations and are therefore not able to forecast the burden of new infections among them and, accordingly, plan for effective coverage with prevention programmes. Still, many countries rely largely on passive reporting and on HIV testing of large groups of low-risk populations, which neither serves the purpose of determining where, among whom and how most transmission is taking place, nor contributes efficiently to HIV case detection.

HIV care and treatment

All countries have made efforts to increase access to life-saving antiretroviral therapy (ART). During 2008 and 2009, the number of people living with HIV on ART increased, rising between end of 2007 and end of 2009 by 70%, from approximately 7850 to approximately 13 370, and several countries doubled the number of PLHIV receiving ART (Table 2). The number of HIV-infected pregnant women reported to the Regional Office, who received ART for prevention of mother-to-child transmission increased three-fold during this period. All countries provide antiretroviral medicines free of charge to those PLHIV who are in need of ART and known to the health system. However, in spite of all efforts, the gap between the estimated need and actual regional ART coverage remains approximately 90%, the widest globally. The main obstacle to achieving higher coverage is identification of PLHIV for enrolment in care, treatment and prevention services. Dependence on donor funding for ART is a threat to the sustainability of current achievements in many lower income countries.

HIV testing and counselling

Knowing one's HIV status by obtaining an HIV test has still not become a viable option for most people at risk of HIV infection in the Region. Limited access to confidential HIV testing services, lack of risk awareness, fear of stigmatization and discrimination in families, communities, schools and workplaces, including the violation of human rights, are all factors contributing to this situation. Moreover, the common policy of mandatory testing demands huge investments in testing of low-risk populations while failing to reach high-risk populations unless they are accessible in institutions, i.e. through arrest or health care admission. Regional HIV testing data show the failure of such policies in terms of identifying substantial numbers of HIV-infected people (*10*). A policy shift in favour of attracting people at high risk to voluntary and confidential counselling and testing, with linkages to

HIV prevention, care and support, as recommended by WHO and UNAIDS, is likely to result in higher coverage of PLHIV with HIV testing, counselling, prevention and care. The health sector bears responsibility for reducing stigma related to HIV among health workers, ensuring that health workers have knowledge of HIV-related clinical signs and symptoms in order to initiate HIV diagnosis at an early stage, and promoting client-initiated and provider-initiated voluntary and confidential HIV testing and counselling services.

Prevention of mother-to-child transmission

Although all countries in the Region offer some services for the prevention of mother-to-child transmission of HIV (PMTCT), these services remain fragmented and limited in many settings. Accordingly, the estimated number and percentage of pregnant women needing antiretroviral medicines for PMTCT in the Region is, as with ART, the lowest globally. In 2008, of the estimated 18 000 pregnant women with HIV needing antiretroviral medicines for PMTCT, fewer than 500 received them, i.e. 1%. Apart from geographical availability of PMTCT services within country, there are other factors explaining the low coverage, including stigma, low community awareness, the low priority accorded to it by policy-makers in some countries with low-level HIV epidemics, lack of integration in reproductive health services (e.g. provider-initiated HIV testing and counselling in antenatal care services), low antenatal care attendance rates, weak health systems, and lack of sustained financial resources. Comprehensiveness and quality of services, retention of PLHIV on treatment, and linkages between reproductive health and HIV care and treatment services are other major bottlenecks to achievement of lower mother-to-children transmission rates.

Reaching populations at high risk

Reaching those populations that are most at risk of HIV with prevention services continues to be the most urgent and, at the same time, most challenging task for national programmes. Notable progress has been made in some countries with the promotion of harm reduction services for injecting drug users. However, even though evidence shows that injecting drug users, men who have sex with men, sex workers and prisoners are those most at risk of HIV infection, the level of efforts directed towards focused prevention programmes for these groups has remained quite low in most countries (Table 3). Moreover, intensified culture-sensitive and gender-sensitive prevention efforts are needed, in particular for the female partners of men who engage in high-risk behaviour including through individual and couple counselling.

Challenges related to health systems

Countries with the highest burden of HIV in the Region are at the same time those with the greatest challenges in their health systems. The main challenges for increasing coverage with quality HIV and other health services are lack of qualified health workers, weak financial and commodity management systems, lack of quality assurance for the public and private sector, weak laboratory infrastructure and low capacity of existing management information systems.

Political commitment and funding for HIV programmes

The majority of low-income countries have been successful in recent years in mobilizing external funding for their HIV/AIDS programmes, largely through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and/or the World Bank. While availability of substantial external funding brought increased commitment from national leadership to HIV prevention and control, this has not yet translated in all countries into allocation of increased domestic resources. There is concern that the increasing dependence on donor funding is a threat to sustainability of current achievements in many lower income countries. To move towards sustainability of HIV responses, countries need to: 1) gain efficiency by prioritizing interventions where most impact is expected (populations at increased

risk); 2) allocate domestic resources; and 3) make use of opportunities for integration into existing systems to deliver HIV prevention, care and treatment.

3. Regional strategy for health sector response to HIV 2011–2015

The regional strategy 2011–2015 aims to provide a framework to guide accelerated efforts for an efficient health sector contribution to national multisectoral HIV strategies and plans. It focuses on strategic priorities in relation to the epidemic context in the Region. It will help countries to develop or update their multisectoral HIV strategies, to integrate HIV in their broader health sector plans and to develop annual operational plans for HIV interventions and service implemented through the health sector. Ultimately it will contribute to achieving universal access to HIV prevention, treatment and care and the Millennium Development Goals, in particular goals 4, 5 and 6. The strategy will focus on the following goal and objectives.

Goal

To reduce the transmission of HIV and to improve the health of people living with HIV.

Objectives

1. Generate relevant and reliable information on the HIV epidemic and response to enable strategic decision-making
2. Increase access to HIV care and treatment services for people living with HIV
3. Increase access to HIV prevention services for people at risk of HIV infection and HIV transmission
4. Contribute to health systems strengthening

Targets

- ≥ 50% of estimated number of adults and children with advanced HIV infection receiving ART in the Region
- ≥ 90% of known PLHIV enrolled in HIV care and treatment in the Region
- ≥ 20% of the estimated number of injecting drug users regularly reached (once per month or more) by the needle syringe programme in the past year
- ≥ 20% coverage of the estimated number of opioid injectors with opioid substitution therapy
- ≥ 20% coverage of the estimated number of men having sex with men and of sex workers with an HIV prevention of sexual transmission service package (information, condoms, testing and counselling, treatment of sexually transmitted infections)

Guiding principles

The strategy is underpinned by internationally agreed frameworks of ethics and human rights, which recognize the right of all persons to the highest attainable standards of health, including sexual and reproductive and mental health and builds on existing protective religious and cultural values and practices. It promotes a public health approach, evidence-based interventions and gender sensitivity, and emphasizes broad engagement of all sectors, including both the public and private sectors and civil society, in order to expand access to effective prevention and care as widely as possible.

Components of the strategy

The strategy comprises the following five principal components, each of which entails several regional strategic priorities:

1. Strengthening health information systems for HIV and operational research;
2. Fostering political will, broad participation and increased financing for a coordinated and sustained national response to HIV;

3. Providing quality HIV prevention, care and treatment services and enhancing their utilization;
4. Strengthening the capacity of health systems for effective integration of HIV services;
5. Promoting a supportive policy and legal environment to facilitate the health sector response.

Countries are urged to adapt the strategy to their specific contexts, i.e. populations affected by HIV, health system characteristics and cultural factors. Countries are encouraged to use the five components and the strategic priorities identified for each component as the basis for planning of national health sector responses to HIV. They will find themselves at different stages of implementation of strategic priorities. Where some of the strategic priorities and interventions have already been firmly established, countries should move without delay towards mobilizing resources and building the technical and managerial capacity to implement other priority interventions.

Component 1: Strengthening health information systems for HIV and operational research

Reliable information on the distribution and trends of HIV infection and risk behaviours in the population and the coverage of prevention, care and treatment interventions is essential for rational decision-making. Epidemic surveillance and programme monitoring data should allow for dis-aggregation by sex and age and by other relevant variables in order to enable programme managers to tailor interventions according to gender and age-specific needs.

Regional strategic priorities

- Establish core elements of an HIV surveillance system: universal and confidential HIV case reporting; size estimations and behavioural and biological surveys among key populations at increased risk; analysis of information obtained from HIV testing of blood donors, antenatal care attendees and other low risk populations; HIV drug resistance monitoring and surveillance (11); surveillance among antenatal care attendees (in countries with HIV prevalence levels above 1% in the general population);
- Strengthen monitoring of programme implementation and effectiveness. Basic monitoring and evaluation of the health sector contribution to the multisectoral response should be an integral part of the overall monitoring and evaluation of the national HIV response. Monitoring of programme performance requires clearly defined gender-sensitive indicators for availability and quality of services, coverage of populations in need and impact on risk factors and health outcomes.
- Provide evidence of quality, feasibility and effectiveness of different approaches and interventions through operational research. Operational research is needed to fill the gaps in strategic information that cannot be obtained through routine surveillance and programme monitoring. In particular, information is urgently required on which interventions are most feasible and effective in the Region to overcome stigma and to reach populations at increased risk who are often marginalized, stigmatized and discriminated against.

Component 2: Fostering political will, broad participation and increased financing for a coordinated and sustained national response to HIV

Sustained and demonstrated political commitment, broad engagement of national and international partners and increased financing by national governments as well as commitments by international donors are crucial if universal access to quality HIV services is to be achieved.

Regional strategic priorities

- Build national strategic and operational plans on sound knowledge of the local epidemic situation, analysis of the current response and evidence-based public health interventions.
- Leverage broad participation of stakeholders in strategic planning and promote accountability for results by all partners.

- Use strategic plans as the basis for mobilization of domestic and international resources.
- Contribute to harmonization, alignment and synergism of efforts of national and international partners within the context of a multisectoral response.
- Take a health sector-wide approach to planning, implementation and monitoring and evaluation of the health sector response to HIV.
- Engage and support civil society.

Component 3: Providing quality HIV prevention, care and treatment services and enhancing their utilization

With the aim of achieving universal access to HIV prevention, care, treatment and support for people in need, it is the health sector's responsibility to ensure availability, quality, accessibility, affordability, acceptability and utilization of health services.

Regional strategic priorities

- Ensure blood safety and safety of medical procedures.
- Increase access to and utilization of HIV testing and counselling as an entry point to HIV prevention and care.
- Focus on expanding coverage of known effective HIV prevention interventions for populations at increased risk of HIV and their sexual partners.
- Integrate information and education on HIV prevention in services for reproductive health services, maternal and child health and sexually transmitted infection services.
- Integrate prevention of mother-to-child transmission services in reproductive and child health services.
- Develop and expand service delivery models for a continuum of care and treatment services.
- Apply standardized treatment regimens and patient monitoring.
- Intensify tuberculosis case finding, prophylaxis and treatment among PLHIV.
- Make standard operating procedures for all prevention, care and treatment interventions available to service providers.

Component 4: Strengthening the capacity of health systems for effective integration of HIV services

The progress of health programmes, including HIV, depends substantially on strengthening of health systems[1]. Addressing the weaknesses of current health systems will facilitate integration of HIV interventions with the aim of increasing coverage and sustainability of quality HIV services. National AIDS programmes and their partners should participate actively in country-led and global efforts to improve health systems in all major areas, including policy, human resources, financing, management, service delivery and information systems. Lower income countries should use opportunities to mobilize international resources (e.g. GFATM) for strengthening the health infrastructure and health work force.

[1] Health systems encompass the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health.

Regional strategic priorities:

- Strengthen the health work force.
- Strengthen health infrastructure.
- Strengthen commodity procurement and supply management.
- Strengthen quality assurance of services delivered by the public and private sector.
- Develop policies and mechanisms for involvement of non-governmental organizations in HIV service delivery.

Component 5: Promoting a supportive policy and legal environment to facilitate the health sector response

National policies should explicitly define the framework of the response. Leadership in the health sector needs to foster partnerships with non health-sector stakeholders, as well as with civil society and PLHIV to advocate supportive policies. Above all, policies should ensure respect for the human rights of PLHIV and those at increased risk of HIV transmission in general, and for their right to the highest attainable standard of health in particular.

Regional strategic priorities

- Reduce stigma among health workers and develop codes of practice that ensure that PLHIV and people belonging to stigmatized groups are treated with dignity, respect and care.
- Contribute to stigma reduction in communities.
- Ensure protection of those who test positive to HIV from discrimination.
- Make available the necessary health services for all those who need them irrespective of their HIV status, gender, ethnicity, risk behaviour or any other factor.
- Ensure voluntarism and confidentiality of HIV testing.
- Protect PLHIV and key populations at increased risk of HIV from prosecution and/or arrest while seeking health services.
- Ensure affordability of HIV prevention commodities, HIV medicines and diagnostics.

4. Conclusions

HIV continues to be a cause of significant morbidity, mortality and social exclusion. The United Nations has committed to achieving universal access to HIV prevention, care, treatment and support and to halting or reversing the HIV epidemic (MDG 6). This paper advocates for accelerated health sector responses as part of multisectoral national HIV strategies.

The regional strategy is intended as an advocacy tool for re-orientation and prioritization of health sector interventions and services to better reach those at risk of infection or living with HIV and provides guidance for all countries on evidence-based and effective interventions. The most important benefits expected from the regional strategy are: a) improved information on local dynamics of the HIV epidemic to enable strategic decision making; b) increased coverage of people at risk of HIV infection or transmission with HIV prevention services; c) increased coverage of people living with HIV with HIV care and treatment services; and d) strengthened capacity of health systems to enhance quality, coverage and sustainability of HIV and other services.

WHO will advocate for political commitment, support resource mobilization efforts, strengthen collaboration with relevant partners, promote WHO-recommended policies, provide strategic and technical guidance, and support countries upon request, in order to meet their technical and

operational needs and to strengthen the generation and exchange of knowledge and strategic information on HIV.

5. Recommendations to Member States

1. Fill gaps in knowledge of the local epidemic situation using appropriate HIV surveillance methodologies.
2. Review and revise national HIV prevention and control strategies to prioritize interventions according to the local epidemic context.
3. Develop costed operational plans for the health sector response to HIV in line with overall national strategic frameworks and allocate an adequate proportion of expenditure on health to the implementation of these plans.
4. Build capacity of both governments and civil society organizations in order to make optimal use of their potential to contribute to the health sector response in a complementary manner.
5. Promote the conduct of research to provide evidence for development of policies and approaches which enable access to services for key populations at increased risk.

Table 1. Prevalence in low and high-risk populations according to surveys or routine screening 2005–2009

Country	Antenatal care attendees	Blood donors	Tuberculosis patients	Sexually transmitted infections patients	Injecting drug users	Female sex workers	Men having sex with men	Prisoners
	HIV+ (%)	HIV+ (%)	HIV+ (%)	HIV+ (%)	HIV+ (%)	HIV+ (%)	HIV+ (%)	HIV+ (%)
Afghanistan	–	<0.1[b]	0.2[b]	–	1–18.2 (2009)[b]	0 (2009)[b]	NA	0.57-1.57 (2009)[b]
Bahrain	–	–	–	–	–	–	–	–
Djibouti	1.7 (2008)[a]	0.6 (2008)[a]	11.8 (2008)[a]	–	–	20.3 (2008)[a]	–	–
Egypt	–	0.0 (2008)[a]	0.2 (2008)[a] – <0.001 (2009)[a] (S)	0.0 (2008)[a] (S)	0.6 (2006)[a]	0.8 (2006)[a]	6.2 (2006)[a]	0.22 (2008)[a] <0.001(2009)[a] (S)
Iran, Islamic Republic of	0.0 (2008)[a] (S)	0.0 (2008)[a]	–	1.2 (2008)[a]	13.3 (2007)[a]	–	–	2.8 (2008)[a]
Iraq	0.0 (2009)[a]	0.0 (2008)[a]	0.02 (2009)[a] (S)	0.0 (2008)[a] (S)	–	–	–	0.0 (2008)[a] (S)
Jordan	–	0.0 (2008)[a]	0.0 (2009)[a] (S)	0.0 (2009)[a]	–	–	–	0.0 (2009)[a]
Kuwait	–	–	–	–	–	–	–	–
Lebanon	–	–	0.05 (2008)[a] (S)	–	0 (2007)[a]	0.0 (2007)[a]	3.6 (2007)[a]	0.16 (2007)[a]
Libyan Arab Jamahiriya	0.07–0.3 (2004)[d]	–	–	–	54.0 (2003) (S) (Tagura centre)[d]	–	–	18 (2004) (national survey)[d]
Morocco	0.2 (2008)[a]	0.02 (2008)[a]	0.4 (2009)[a]	0.3 (2009)[a]	–	2.4 (2009)[a]	–	0.4 (2009)[a]
Oman	–	0.02 (2007)[c]	5.9 (2007)[c] (S)	0.5 (2007)[c]	0.43 (2007)[c]	–	–	0.44 (2007)[c] (S)
Pakistan	–	–	3.6 (2008)[a]	–	12-30 (2008)[a]	0-0.25 (2007-8)[a]	1.8 (MSM) (2008)[a] 0–27 (*hijra* SW) (2008)[a] 0-3.1 MSW (2008)[a]	
Palestine	0.0 (2008)[a] (S))	0.0 (2008)[a] (S)	0.0 (2008)[a] (S)	–	2[b-]	–	–	–
Qatar	–	–	–	–	–	–	–	–
Saudi Arabia	0.0 (2007)[a]	0–0.67 (2007)[a]	0–0.3(2007)[a]	0-2.8 (2007)[a]	0-1.6 (2007)[a]	–	–	–
Somalia	1.7 (2007) (North-west zone)[d]	-	4.5 (2004) (3 zones)[d]	6.3 (2007) (Hergeisa)[d]	–	–	–	–

Country	Antenatal care attendees	Blood donors	Tuberculosis patients	Sexually transmitted infections patients	Injecting drug users	Female sex workers	Men having sex with men	Prisoners
	HIV+ (%)	HIV+ (%)	HIV+ (%)	HIV+ (%)	HIV+ (%)	HIV+ (%)	HIV+ (%)	HIV+ (%)
	0.9 (2007) (North-east zone)[d]			2.2 (2007) (North-east zone)[d]				
Sudan, northern	0.19 (2007)[d]	1.25 (2007)[d]	1.66 (2005)[d]	1.47 (2005)[d]	NA	–	9.3 (2005)[d]	8.6 (2006)[d]
Sudan, southern	3.4 (2007)[a]	–	13.4 (2008)[a] (S)	–	–	–	–	–
Syrian Arab Republic	na[b]	na[b]	0.02[b]	na[b]	0.30[b]	0.10[b]	0.5-10[b]	0.010[b]
Tunisia	na	0.004 (2009)[a] (S)	0.08 (2008)[a] (S)	0.0 (2008)[a] (S)	3.1 (2009)[a]	0.4 (2009)[a]	4.9 (2009)[a]	na
United Arab Emirates	0.0 (2008)[b] (S)	0.0 (2008)[b]	0.0 (2008)[b] (S)	–	–	–	–	0.0 (2008)[a] (S)
Yemen	0.2 (2007)[a]	0.02 (2008)[a] (S)	0.6 (2007)[a]	3.7 (2008)[c] (S)	–	1.3 (2008)[a] (Aden)	–	2.1 (2008)[c] (S)

Source WHO Regional Office for the Eastern Mediterranean. Regional HIV database:
(s) Data obtained from routine screening

[a] Bozicevic I. *Regional review of national HIV and STI surveillance systems*, 2009 (unpublished)

[b] Reported by National AIDS Programme managers, 19th National AIDS Programme managers' meeting, Beirut, 13–15 March 2010.

[c] Regular quarterly HIV/AIDS case reporting to the Regional Office for the Eastern Mediterranean by countries

[d] Reports/presentations on surveillance activities provided to the Regional Office for the Eastern Mediterranean by countries

NA Reported as not available

– No data reported to the Regional Office for the Eastern Mediterranean

Table 2. Availability and/or coverage of selected priority interventions in countries of the Eastern Mediterranean Region in 2008/9

Country	Number of PLWH on ART 2007	Number of PLHIV on ART 2009	Percent increase in numbers of PLWH on ART between 2007 and 2009	% health facilities experiencing ART stock out	Number of pregnant women living with HIV who received ARVs for PMTCT	% of transfusion blood screened for HIV
Afghanistan	0	19	NA	NA	0	39
Bahrain	NA	40	NA	100	NA	100
Djibouti	705	893	27	92	NA	NA
Egypt	209	359	72	0	15	100
Iran, Islamic Republic of	825	1 181	43	0	52	100
Iraq	0	6	NA	0	NA	100
Jordan	53	77	45	0	2	100
Kuwait	107	132	23	NA	3	100
Lebanon	246	362	47	100	NA	NA
Libyan Arab Jamahiriya	1 000	1 200	20	100	NA	100
Morocco	1 648	2 614	59	0	56	NA
Oman	260	412	58	0	4	100
Pakistan	550	1 296	137	0	5	87
Palestine	11	8	-27	NA	NA	NA
Qatar	NA	72	NA	NA	NA	NA
Saudi Arabia	662	865	31	0	44	100
Somalia	211	696	230	67	6	100
Sudan, northern	895	1 996	123	33	30	100
Sudan, southern	303	1 829	NA	0	NA	NA
Syrian Arab Republic	75	100	33	0	4	100
Tunisia	NA	412	NA	0	2	100
United Arab Emirates	NA	121	NA	0	NA	100
Yemen	107	268	150	0	3	NA

NA: data not available to the Regional Office

Source: Data obtained from national AIDS programmes through two surveys: Global Universal Access Monitoring 2008; and Review of implementation of the regional strategy on strengthening health sector response to HIV/AIDS in the Eastern Mediterranean Region (2006–2010), January 2010.

Table 3. Availability and/or coverage of populations at increased risk with priority interventions in countries of the Eastern Mediterranean Region in 2008/9

Country	Injecting drug users			Sex workers			Men having sex with men		
	Needle syringe programme	Opioid substitution therapy	HIV testing and counselling	Condom	Sexually transmitted infections	HIV testing and counselling	Condom	Sexually transmitted infections	HIV testing and counselling
Afghanistan									
Bahrain									
Djibouti									
Egypt									
Iran, Islamic Republic of									
Iraq									
Jordan									
Kuwait									
Lebanon									
Libyan Arab Jamahiriya									
Morocco									
Oman									
Pakistan									
Palestine									
Qatar									
Saudi Arabia									
Somalia									
Sudan, northern									
Sudan, southern									
Syrian Arab Republic									
Tunisia									
United Arab Emirates									
Yemen									

Legend

Services not available	
Low coverage (pilot projects of limited scale)	
Moderate coverage (1-2 large cities)	
Large scale coverage (≥ 3 cities)	

Source: Universal Access reporting, Global Fund applications and/or performance reports.

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