WHO-EM/STD/076/E

Report on the

Fourteenth intercountry meeting of national AIDS programme managers

Damascus, Syrian Arab Republic
10–13 May 2004

World Health Organization
Regional Office for the Eastern Mediterranean
Cairo
2005

© World Health Organization 2005
All rights reserved.
The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.
The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.
The World Health Organization does not warrant that the information contained in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use.
Publications of the World Health Organization can be obtained from Distribution and Sales, World Health Organization, Regional Office for the Eastern Mediterranean, PO Box 7608, Nasr City, Cairo 11371, Egypt (tel: +202 670 2535, fax: +202 670 2492; email: DSA@emro.who.int).
Requests for permission to reproduce WHO EMRO publications, in part or in whole, or to translate them – whether for sale or for noncommercial distribution – should be addressed to the Regional Adviser, Health and Biomedical Information, at the above address (fax: +202 276 5400; email HBI@emro.who.int).

Document WHO-EM/STD/076/E/10.05/128

CONTENTS

1. INTRODUCTION 1

2. REGIONAL HIV/AIDS SITUATION UPDATE 3

3. THE 3 BY 5 INITIATIVE 4
   3.1 Progress to April 2004 4
   3.2 Regional update 6

4. TECHNICAL PRESENTATIONS 7
   4.1 Antiretroviral treatment guidelines in resource limited settings: 2003 revision 7
   4.2 Drug procurement and AIDS medicines and diagnostic services 8
   4.3 Gulf Cooperation Council experience in bulk drug procurement 9
   4.4 Comprehensive care for people living with HIV/AIDS in Djibouti 9
   4.5 Morocco experience in scaling up antiretroviral treatment 10
   4.6 Integrated care and prevention: an entry point for people living with HIV/AIDS 11
   4.7 Egypt's experience in infection control and blood safety 12
   4.8 Sexually transmitted infection services as entry points for people living with HIV/AIDS in Tunisia 14
   4.9 Prevention of mother-to-child transmission 15
   4.10 Services for injecting drug users as an entry point for people living with HIV/AIDS 17
   4.11 Testing and counselling: the global perspective 17
   4.12 Testing and counselling in the Eastern Mediterranean Region: issues for discussion 19
   4.13 Regional HIV/AIDS database 20
   4.14 Human resource needs for the 3 by 5 Initiative 21

5. GROUP WORK 22
   5.1 Entry points for people living with HIV/AIDS in the Region: strengths, weaknesses, gaps and areas for improvement 22
   5.2 Regional HIV/AIDS database: pretesting and endorsement of new reporting techniques, country reporting 28
   5.3 Country capacity-building plans 28

6. PARTNERSHIP AND PARTNERS' WORK THROUGH COUNTRY THEME GROUPS 29
   6.1 Introduction by the UNAIDS intercountry team representative 29
   6.2 Panel discussion among partners 31

7. HIV/AIDS ADVOCACY 31

8. UPDATE ON THE WORLD AIDS CAMPAIGN 2004 32

9. CONCLUSIONS 34

10. RECOMMENDATIONS 34

Annexes

1. AGENDA 38
2. PROGRAMME 38
3. LIST OF PARTICIPANTS 40

1. INTRODUCTION

The fourteenth intercountry meeting of national AIDS programme managers was held in Damascus, Syrian Arab Republic, from 10 to 13 May 2004 to discuss the scaling up of antiretroviral treatment (ART), in line with the 3 by 5 Initiative, and matters of surveillance and regional reporting, and to emphasize partnerships and the roles of the different partners in United Nations Country Theme Groups on HIV/AIDS.

The meeting was organized by the WHO Regional Office for the Eastern Mediterranean (WHO/EMRO) and was attended by national AIDS programme managers and representatives from 18 countries of the Eastern Mediterranean Region, in addition to members of the HIV/AIDS and sexually transmitted diseases (STD) Regional Advisory Group (ARAG), representatives from other United Nations agencies and staff from WHO headquarters and the Regional Office.

The meeting was inaugurated by H.E. Dr Mohammed Eyad Chatty, Minister of Health, Syrian Arab Republic, and Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean. In his speech, Dr Gezairy noted that the epidemic of HIV/AIDS in the Region had not abated and was still spreading. This implied that the Region was not coping with the epidemic as it should, and that the current response was not keeping pace with the spread of the epidemic, although some progress had been made in the fight against HIV/AIDS. This could be clearly seen in the activities planned in the joint programme review and planning mission workplans, or by comparing the agenda of the current meeting with that of the same meeting a few years ago. The topics of consultants' missions, training workshops, field projects and meetings indicated a significant involvement of the countries in HIV/AIDS prevention and care. These topics included, for example, antiretroviral guidelines and therapy, voluntary testing and counselling, HIV prevention among injecting drug users, peer education and sexually transmitted infection management. As well, stigma and discrimination related to HIV/AIDS had decreased, and the media was showing a greater involvement in HIV/AIDS issues than previously known.

Concerning access to HIV/AIDS care, significant hope had appeared with the launch of the 3 by 5 Initiative by WHO in collaboration with the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Regional Office already had two countries in the focus of 3 by 5, namely Djibouti and Sudan. However, the intention was to extend 3 by 5 to support more countries in the Region. Scaling up of antiretroviral therapy had, in fact, started in the Region before the launch of the 3 by 5 Initiative. Some countries had started this process with their own national funding, notably the countries of the Gulf Cooperation Council and the Islamic Republic of Iran. Moreover, through negotiations with pharmaceutical companies, and with the support of WHO and UNAIDS, three countries had reached agreement on the price of antiretroviral drugs, namely Lebanon, Morocco and Tunisia. The World Bank had also joined in the efforts to fight HIV/AIDS by supporting projects in Djibouti and Somalia. However, much remained to be done, especially in the countries with the highest burden of HIV/AIDS, namely Dji Somalia and Sudan.

Dr Gezairy, in his speech, emphasized that efforts in prevention, which had been the main focus for several years, must be maintained. Prevention activities should cover the management of sexually transmitted infections, and effective strategies should target youth and other vulnerable groups. Special focus should be directed to the problem of injecting drug use which represented a growing problem in several countries of the Region, and which may spread to other countries. Surveillance systems were still weak and needed strengthening. This was an essential step in generating more accurate data about the epidemic, and had important implications in advocacy and in planning.

H.E. Dr Chatty, Minister of Health, Syrian Arab Republic welcomed the participants and acknowledged the efforts that had been made in the fight against HIV/AIDS in the Region. He recommended that the problem of hepatitis B and hepatitis C be tackled alongside HIV/AIDS, because, in his opinion, the socioeconomic and health impacts of the former were equally important as those of HIV/AIDS. Around 6% of the world's population had clinical hepatitis B and 3% had hepatitis C. He added that the higher resistence of the hepatitis C virus in comparison with HIV/AIDS, in addition to the lack of any effective treatment against the hepatitis C virus, added another dimension to the problem.

He noted that both the Syrian Arab Republic and United Arab Emirates had comprehensive programmes for the prevention of bloodborne pathogens. In the Syrian Arab Republic, annual health expenditure per capita equalled the cost of ensuring the safety of one unit of blood. He added that the health sector in the Syrian Arab Republic respected all of the WHO recommendations, in particular those generating from the Regional Office due to the unique aspects of the Region. He emphasized the importance of measures of prevention in the fight against HIV/AIDS particularly those related to dental practices, circumcision, tattooing, cosmetic fat redistribution among women, as well as blood-letting or *hijama*.

Dr Zuhair Hallaj, Director of Communicable Disease Control in the WHO Regional Office for the Eastern Mediterranean, presented the objectives, outcomes and programme of the meeting. Emphasis would be placed on the group work in which country participants would evaluate and measure the main achievements and the regional strategies of HIV/AIDS prevention and care, by undertaking to:

- review the progress of implementation of the Regional Strategic Plan 2002–2005;
- update countries on the progress of the 3 by 5 Initiative;
- assess the status and needs of countries in relation to the scaling up of antiretroviral treatment (entry points and capacity-building).

The expected outcomes of this process were that the participants would be updated on the HIV/AIDS epidemic and on the progress of the implementation of the Regional Strategic Plan, in addition to being updated on the achievements of the 3 by 5 Initiative both globally and regionally. The status and needs regarding entry points necessary for the scaling up of HIV/AIDS care would be identified, in addition to the status and needs of national capacity-building plans in the context of 3 by 5 and the scaling up of antiretroviral therapy. The new reporting form of the regional HIV/AIDS/STI database would be pre-tested and agreed upon, and participants orientated about examples of HIV/AIDS advocacy efforts and briefed on the

theme of the World AIDS Campaign 2004. Participants were also to be made aware of the roles of partners through their membership in the UNAIDS Theme Groups.

The Chair was shared on a rotating basis. Dr Ali Sadek was appointed as rapporteur. The meeting agenda, programme and list of participants are included as Annexes 1, 2 and 3 respectively.

2. REGIONAL HIV/AIDS SITUATION UPDATE

Dr Hany Ziady

In December 2003 the number of people living with HIV/AIDS (PLWHA) was 40 million (34–46 million); 95% of people infected with HIV/AIDS are in developing countries. The number of people living with HIV/AIDS in the Region is 700 000. Globally, the number of newly-infected people with HIV in 2003 was 5 million (4.2–5.8 million), i.e. 14 000 new infections daily, while the number of people newly-infected with HIV in the Region in 2003 was 55 000 or 151 new infections occurring daily. The number of deaths from AIDS in 2003 was 3 million (2.5–3.5 million) or 8219 deaths per day, regionally the figure for 2003 was 45 000 or 123 deaths per day.

The total number of reported AIDS cases from the beginning of the epidemic until the end of 2003 was 14 198. The number of reported cases is lower than official estimates but the number of reported cases has increased from 56 in 1986, to 1852 in 2002. Men are generally affected more by the disease than women. Women constituted 30% of all AIDS cases reported in 2003. Two thirds of reported cases are within the age group of 20–39 years. Women acquire infection at a younger age (25–29) than men (35–39). The heterosexual mode of transmission is the main mode of transmission among reported AIDS cases (79.7%). Injecting drug use is increasingly gaining significance as a mode of transmission for HIV (2.4% of reported AIDS cases in 1999 and 10% in 2003). The increase is evident in Bahrain, Islamic Republic of Iran, Libyan Arab Jamahiriya and Oman.

In addition to the Regional Strategic Plan 2002–2005 to strengthen the health sector response to HIV/AIDS and sexually transmitted infection (STI), there is also the 3 by 5 Initiative which was launched in September 2003.

Challenges for scaling up HIV/AIDS/STI response in the Region

- health systems are weak, especially in countries with a higher burden of the disease, such as Somalia, Djibouti and Sudan, or in countries with potential vulnerability, such as Yemen;
- instability in countries with a higher burden of HIV (Somalia and Sudan);
- lack of funds, especially in countries with a higher burden and those with potential risk;
- scarcity of human resources;
- wide gap in accessibility of antiretroviral therapy (ART). It is estimated that 5000 out of 100 000 people needing ART are receiving it, which represents only 5% of the actual need;

- serious problem of injecting drug users which needs special attention, especially in Bahrain, Islamic Republic of Iran and the Libyan Arab Jamahiriya;
- weak HIV/AIDS/STI surveillance systems.

Future priorities

- supporting the development of HIV/AIDS care services including ART accessibility;
- strengthening STI control programmes and services;
- maintaining efforts to strengthen infection control;
- strengthening HIV/AIDS/STI surveillance;
- maintaining and strengthening HIV/AIDS preventive efforts, with emphasis on high-risk groups, especially injecting drug users;
- supporting resource mobilization.

3. THE 3 BY 5 INITIATIVE

3.1 Progress to April 2004

Dr Andrew Ball

In December 2003, WHO and UNAIDS launched the global 3 by 5 Initiative which aims at treating 3 million people by the year 2005. The strategy offers clear and measurable goals, objectives and milestones to scale up treatments. The initiative is based on five pillars:

- global leadership, strong partnership and advocacy;
- urgent, sustained country support;
- simplified, standardized tools for delivering antiretroviral drugs (ARV);
- effective, reliable supply of medicines and diagnostics; and
- rapidly identifying and reapplying new knowledge and success.

In response to this, Member States at the WHO Executive Board Meeting strongly endorsed the strategy. WHO has received 52 official country requests for participation in the 3 by 5 Initiative, including requests for emergency mission assessment visits.

Twenty-three assessment missions were undertaken to some countries (Botswana, Burkina Faso and Burundi). Since March 2004, 35 staff members from WHO headquarters and Representative's Offices were deployed to 26 countries to assist in developing the Global Fund fourth round proposals with a focus on the planning and implementation of ART scale-up (21 countries); and comprehensive national HIV/AIDS treatment and care plans. Intensive work is under way to address technical assistance needs identified during assessment missions and deployments. A strengthening of capacity is needed to respond to country needs, and recruitment of the 3 by 5 Initiative by country team leaders is under way. Concrete options are being identified to help countries build the necessary capacity (such as how to adapt existing training materials and help train the trainers).

Among the achievements to date are the following: an AIDS medicine and diagnostic service team (AMDS) set up in the HIV department at WHO headquarters, strong partnership with United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank (WB) and UNAIDS Secretariat, collection of available technical and country data initiated, and lastly, existing initiatives brought under the AMDS umbrella: such as the sources and price of selected medicines and diagnostics for people living with HIV/AIDS (Médicins sans frontières [MSF], UNAIDS, UNICEF, WHO); patient status database (MSF, UNICEF, WHO); regulatory status database (UNICEF, WHO); procurement guide and procurement training programme (WB).

WHO is working with UNAIDS, WB, UNICEF, United Nations Population Fund (UNFPA) and the Centers for Disease Control and Prevention (CDC) to harmonize monitoring and evaluation measures. At the meeting of UNAIDS cosponsors 12 February 2004, the progress to date at global and country level was reviewed, and clarified the nature and the mechanisms for contribution of cosponsors of the 3 by 5 Initiative. Effective participation in the implementation of the initiative was identified, especially at country level, and mechanisms for ongoing communication were also identified, in addition to mapping commitments and the possible roles of UN partners.

The three most needed areas of technical assistance according to the majority of countries are capacity-building, tools and training (60%), medicines and diagnostics, procurement, supply chain management (56%), in addition to the monitoring and evaluation, of the patient tracking system (48%).

WHO's expected role and relevance are to undertake the role of broker with ministries of health, assume a technical leadership role, convene and coordinate partnership efforts in the implemention of 3 by 5 activities, assist, facilitate and implement previous Global Fund proposals, and lastly, to strengthen country office capacity to support ministries of health and treatment scale up.

A wide range of partners are identified: CDC, Canadian International Development Agency (CIDA), Department for International Development (DFID), Ensemble pour une Solidarité Thérapeutique (ESTHER), Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), MSF, UNICEF, USAID, WB and other UN partners. Partner coordination is seen as a key role for WHO. However, in general, there is insufficient information to date on the specific role and contribution of each partner. National mechanisms at country level include care and treatment in the ministry of health, country coordination mechanisms, 3 by 5 technical working groups, national forums, and task forces. In general, there is insufficient information about how ART programmes will be coordinated at national level.

Issues and barriers to scale up are related to overall commitment and policy issues, AIDS medicines and diagnostics, human resources and capacity-building, weak coordination at national and regional level, partnership coordination and role definition and the scaling up of programming and implementation.

Priorities for the next 3–6 months will be directed to intensive fund-raising, advocacy, coordination and joint planning with partners, responding to specific technical assistance needs identified in countries, to continue in-country capacity-building, working towards achieving the Three Ones (one agreed HIV/AIDS action framework, one national AIDS authority and one agreed country-level monitoring and evaluation system), and lastly a plan to focus on a number of countries which can quickly be identified as having the added value of the AMDS approach.

3.2 Regional update

Dr Hany Ziady

Concerning the present situation of ART in the Region, it is estimated that 5000 out of 100 000 people needing ART are receiving it, which represents only 5% of the need. ART is provided free of charge in countries of the Gulf Cooperation Council (GCC) and in Jordan, Lebanon, Morocco, Syrian Arab Republic and Tunisia, and is administered as a targeted provision to specific populations in the Islamic Republic of Iran and Libyan Arab Jamahiriya. Other progress:

- Sudan and Djibouti are in the 40 priority countries.
- The Regional Office plans to extend 3 by 5 activities to six additional countries, namely Egypt, Islamic Republic of Iran, Libyan Arab Jamahiriya, Pakistan, Somalia and Yemen.
- WHO received letters requesting to be included in 3 by 5 Initiative from six new countries (letters are pending from the Libyan Arab Jamahiriya and Pakistan).
- The Regional Office has developed a regional workplan to implement 3 by 5 in priority countries. The workplan activities will be implemented by priority as funds become available.
- The Regional Office organized the Regional Advocacy and Briefing Meeting on the 3 by 5 Initiative in Cairo, 16–18 February 2004, which was attended by representatives of seven countries.
- Successful WHO missions to Djibouti, Somalia and Sudan in March 2004. Achievements of the missions include a plan to scale up ART in Djibouti, and a commitment of partners to 3 by 5 in Somalia and the Fourth Round Global Fund proposal in Sudan.
- Global Fund proposals submitted to the fourth round by Djibouti, Somalia, Sudan and south Sudan, with support from WHO, UNAIDS and UNICEF. All proposals have ART scaling up activities, i.e. contributing to 3 by 5.
- The Regional Office established the regional 3 by 5 taskforce to advise on activities related to their areas of work.
- The Regional Office printed the 3 by 5 strategy ("Treating 3 million by 2005: Making it happen") in Arabic. An additional three documents are currently in translation or printing.
- Recruitment of one 3 by 5 country officer in Sudan is currently in process. WHO headquarters will support recruitment also of one national professional officer and support staff in Sudan.

The role of the Regional Office is:

- assisting priority countries to scale up HIV/AIDS care;
- responding to requests for technical assistance from other countries concerning the scaling up HIV/AIDS care;
- advising countries of the Region of offers of low price ARVs.

4. TECHNICAL PRESENTATIONS

4.1 Antiretroviral treatment guidelines in resource limited settings: 2003 revision
Dr Andrew Ball

The principles of the revised WHO ART guidelines are that they should be simplified and standardized for the WHO 3 by 5 Initiative to allow for the rapid scaling up of treatment, targeted at resource limited settings, and for use by national AIDS programme managers and other policy-makers.

Eligibility criteria for ART in adults and adolescents are not totally dependent on the availability of CD4 testing technology. In cases where it is not available, decisions on eligibility can be based on total lymphocyte count:

- If CD4 assay is available:
  - WHO stage IV disease, regardless of CD4
  - WHO stage III disease, (under special consideration) using CD4 <350 to assist decision-making.
  - WHO stage I or II if CD4 <200.
- If CD4 assay is not available:
  - WHO stage IV disease, regardless of total lymphocyte count.
  - WHO stage III disease, regardless of total lymphocyte count.
  - WHO stage II disease with total lymphocyte count <1200.

Considerations that inform the choice of first-line ART regimens are: potency, side-effect profile, maintenance of future options, predicted adherence, availability of fixed-dose combination tablets, coexistent medical conditions (tuberculosis, and pregnancy or risk thereof), concomitant medications, presence of resistant viral strain, cost/availability, limited infrastructure and rural delivery.

WHO recommend first- and second-line ART regimens for HIV treatment in adults/adolescents, as follows: first-line (d4t (stavudine) + 3TC (lamivudine) + NVP (nevirapine) or EFZ (efavirenz), second (TDF (tenofovar disoproxil fumarate) or ABC (abacavir) + ddl (didanosine) + protease inhibitor: LPV/r (lopinavir) or SQV/r (saquinavir)). The major side-effects of the first-line, as well as the problems with second-line ARV regimens include: multiple resistant mutations, high pill burden, limited experience, tenofovir disproxil fumarate (TDF) availability, abacavir (ABC) hypersensivity, cold chain for RTV (ritonavir), and high cost.

The recommended tiered laboratory capabilities to monitor ART were presented at the three levels of community health care, district hospital and regional referral hospital levels. Clinical and laboratory assessment of adults and adolescents on ART were also presented at baseline and evaluations were made during therapy.

Special considerations are given to pregnant women or women of childbearing age, patients with tuberculosis, and children. Fixed 2–3 dose combinations of antiretrovirals available for use in HIV-positive adults and adolescents in 2003 were presented.

4.2 Drug procurement and AIDS medicines and diagnostic services

Dr Andrew Ball

AIDS medicine and diagnostic services (AMDS) supports HIV medicines and diagnostics supply management through collaboration between the UN and technical partners. It comprises:

- AMDS secretariat, housed by the WHO;
- technical departments of WHO, UNICEF, WB and UNAIDS;
- technical and donor partners with HIV-specific procurement and supply management activities.

The objectives of AMDS are to ensure that the supply of quality commodities is never an obstacle to expanding treatment, care and support, and lastly, to use improved commodity supply to catalyse rapid expansion of treatment, to promote equity and to support prevention.

The general principles of AMDS involve using partners to the best capacity, involving all partners in planning and further expansion, as well as using all available channels (government, nongovernmental organizations, insurances), to build on existing structures and systems when possible.

Partners and levels of cooperation being sought are technical partners (John Snow International and MSF), producers of ARVs (Aid Action International companies, and companies of the International Generic ARV Manufacturers Association) and manufacturers of diagnostics, Malaria Medicines and Supplies Service and Global Drug Facility. AMDS functions can be summarized as follows:

- clearinghouse on ARVs and HIV diagnostics;
- support for planning, capacity-building and monitoring at national level;
- procurement;
- communication;
- brokerage of technical assistance;
- fund-raising.

4.3 Gulf Cooperation Council experience in bulk drug procurement
Dr Nasser Saleh Al Hozaim

In February 1976, Ministers of Health from the Gulf Cooperation Council (GCC) states established a programme by forming a scientific consultative committee that set a scientific basis for improving group purchase. A detailed programme regarding the request, importation and tenders was put forward by the general secretariat which took into consideration the local regulations. The member states were requested to secure at least 60% of their needs from all items submitted through group purchasing and at least 20% of the need from locally produced drugs. In 1999, the drug central registration system in the GCC states was agreed upon.

The nine steps of the mechanism of group purchasing are as follows; tender preparation committee, presentation of tenders, receiving the quotations, committee of envelopes opening, awardation committee, primary notification of awardation, handling objections, stabilizing quantities, and lastly, final notification of awardation for states and companies.

Advantages of a group purchasing programme are financial saving through purchasing large quantities at lower prices (cost reduction) and the direct calling of the companies registered according to the rules and regulations set by the executive board thus ensuring high quality of the purchased items (standardization). It also ensures use of the same drugs by all member states made by the same manufacturing company (information sharing), and rapid processing of tenders and their award (enhancement of purchase operations). A continuous supply of drugs, hospital supplies and equipment are ensured all the year round through successive deliveries by minimizing routine administrative and financial procedures, and there are improvements in the application of quality assurance, control procedures and bio-equivalence. Other health sectors, such as specialized hospitals are able to secure their needs through group purchasing.

Antiretroviral drugs are not yet included in the group purchasing programme for the GCC. Member countries are considering including it in the future.

4.4 Comprehensive care for people living with HIV/AIDS in Djibouti
Dr Fatouma Mohamed Ahmed

Efforts are being made to provide a continuum of care centred around the needs of people living with HIV/AIDS (PLWHA):

- care is not only therapeutic, but also involves a social and psychological care package;
- multiple providers include health teams and nongovernmental organizations;
- three new profiles for support: accompagnateurs for each of social (nongovernmental organizations), psychological (counselling) and therapeutic (compliance) interventions;
- legislation is set to protect PLWHA's rights;
- nutritional support;
- solidarity fund for those who cannot afford the cost of drugs and tests;
- confidentiality, ethics and equity.

Activities include the training of a broad range of relevant workers, e.g. health care workers, counsellors, laboratory technicians and social assistants. There are three committees of reference, namely the eligibility committee, committee from the medical college for ART and an ethical committee as the management body of the project.

The role of the eligibility committee is to determine, according to the file constituted by the referring doctor, whether or not to place the patient under ART, to define his social group and to decide on appropriate psychological or financial support.

The role of the ethical committee is to provide legal support; this is the body of recourse for PLHWA in case of a problem. The committee is composed of lawyers, lawyers of the customary right, representatives of the Ministry of Justice, nongovernmental organizations and representatives of the Council of Drug Ordering.

4.5 Morocco experience in scaling up antiretroviral treatment

Dr Hamida Khattabi

In December 2003, there were 1316 reported cases of HIV/AIDS in Morocco, mainly through heterosexual transmission (74%). The number of PLWHA in 2003 was between 13 000 and 16 000. HIV sentinel surveillance during 2003 showed the following prevalence figures, STI patients (0.23%), antenatal care (ANC) clients (0.13%), and tuberculosis patients (0.19%), while HIV second generation surveillance in 2003 showed sex workers (2.27%) and prisoners (0.8 %).

The main activities of the national STI/AIDS control programme are improvements in STI case management (syndromic approach), targeted information, educational and communication activities (multisectorial approach) and improved HIV testing and HIV/AIDS case management.

In November 1997, a national consensus workshop was held. In May 1998, a ministerial decree on application of care and support was issued, and in July 2001, a national workshop to review the HIV/AIDS care strategy was held. In 2003, there was an elaboration of national HIV/AIDS diagnosis and care guidelines. Lastly in 2004, a national workshop for the decentralization of care and support was held, and it was recommended that five main regional centres be established, and Western blot and of CD4 testing be decentralized.

1998. The introduction of the tritherapy into one centre of excellence financed by the Ministry of Health (US$ 400 000 in 1998, US$ 500 000 in 1999 and US$ 610 000 in 2004).
2000. Morocco joining the accelerated access initiative for ARVs (reduction of 60% of price).
2002. Annulation of all governmental taxes on ARVs (reduction of 30% on price).
2003. Success of Global Fund and universal coverage of ARVs for all eligible patients (563 eligible patients covered by ART including 29 children in 2003 compared to 248 patients in 2002. Figures increased to 880 patients in 2004).
2004. Introduction of generics.

The reduction in the monthly price per patient in Moroccan dirhams (MAD) was from MAD 13 000 in 1998 to MAD 1000 in 2003.

The main challenges and future perspectives are the introduction of quality insurance tools for reliability (genotype and phenotype testing for viral resistance), reinforcement of the decentralization process at provincial level, improvements in early detection of cases, wider spread of voluntary counselling and testing (VCT) centres, encouragement of the introduction of the newest generics (ensure continuity after Global Fund support), improved care and support activities through the introduction of an educational programme for psychosocial support at the level of the five regional centres. At the end of discussions, the very wide differences in prices of ARVs were pointed out in different countries of the Region. Table 1 shows the monthly price of ART per patient in US$.

Table 1. Monthly cost of ART per patient in selected countries of the Region

Country	Price in US$
Djibouti	140
Egypt	400–450
Islamic Republic of Iran	375
Iraq	400
Jordan	400–500
Kuwait	1000–1200
Lebanon	450–600
Libyan Arab Jamahiriya	Around 152
Morocco	100
Oman	470
Pakistan	300
Palestine	Donation
Somalia	Donation
Sudan	40–43
Syrian Arab Republic	400
Tunisia	500–700
Yemen	Not available on the market

4.6 Integrated care and prevention: an entry point for people living with HIV/AIDS
Dr Andrew Ball

The key points of this presentation included:

- scaling up of ART and the subsequent scaling up of testing and counselling services;
- ensuring increased efficiency and effectiveness where symptomatic HIV/AIDS is more likely;
- ensuring ART reaches the most vulnerable groups;
- simplifying and standardizing ethical testing and counselling, and expanding the range of models.

Prevention, care and treatment are one. Treatment supports prevention because it provides motivation for people to discover their serostatus, it promotes openness and reduces stigma, fuels advocacy and PLWHA engagement, improves the morale of health workers and helps to keep families intact in a healthier and more economically stable way.

Entry points where symptomatic HIV/AIDS-related disease are more likely are tuberculosis services, acute medical services (clinic and hospital wards), outpatient clinical settings, home and community-based care facilities and STI services. While entry points where asymptomatic HIV infection are more likely are at maternal and child health (MCH) clinics and mother-to-child transmission (MTCT) prevention programmes, services for injecting drug users and services reaching out to other vulnerable groups. There is a need to scale up testing and counselling services in all of these settings, to train and support health care workers and to 'universally offer' testing and counselling for HIV/AIDS and appropriate treatment and referral, in addition to strengthening prevention interventions linked to treatment services.

Key entry points to ARV treatment for women and their families are services for the prevention of mother-to-child transmission (PMTCT) of HIV, paediatric services, and other sexual and reproductive health services and services for vulnerable groups, such as young people and sex workers. Preventing HIV among mothers and their infants is routinely offered in antenatal clinics as the standard of care, and is offered to women in integrated reproductive health services, with the right of refusal to take advantage of this service.

Key prevention elements for vulnerable populations, e.g., injecting drug users (outreach and peer education, harm reduction, drug dependence treatment, including substitution therapy and prison programmes), and for sex workers (outreach and peer education, STI screening and treatment and condoms).

Regarding public health policy responses, HIV testing and counselling must be implemented urgently on a broader and radically larger scale, making the offer of HIV testing by health workers universal in clinical management of services where HIV-infected people are more likely to present (e.g. tuberculosis, STI, injecting drug use (IDU), PMTCT and in general medical services), increased mobile and flexible models of testing and counselling are needed, as well as taking testing out of laboratory rapid testing.

HIV testing and counselling in the context of clinical care is offered whenever a patient shows signs or symptoms of HIV or AIDS, or where this will aid clinical diagnosis and management, and is offered to all patients with tuberculosis, to all patients with suggestive clinical syndromes (adults and children) and to all patients with STIs.

4.7 Egypt's experience in infection control and blood safety

Dr Nasr El Sayed

A survey conducted into health facilities through interviews with facility directors revealed the following key findings: infection control programmes are not well established (35% of hospitals have committees, and need guidance in developing policies and

procedures), there is limited technical capacity in infection control (few specialists in infection control and no surveillance system for hospital-acquired infections), and existing resources are not effectively used to promote infection control. Critical indicators of infection control are standard precautions e.g., poor understanding of standard precautions, and lack of training for health care workers in infection control, sterilization and cleaning procedures e.g. inappropriate sterilization in some facilities. Drug use in outpatient settings' survey showed high antibiotic use (every third patient), and high frequency of injections prescribed (every fifth patient). A health care worker survey revealed a lack of training in infection control, low hepatitis B vaccination coverage and high frequency of needle stick and sharp injuries (4.9 per health care worker per year).

The goals of the infection control programme are to reduce hepatitis C virus transmission and hepatitis-related chronic liver disease, to reduce transmission of infectious diseases in the health care setting and to improve quality of health care services through the promotion of infection control.

The implementation plan of the national programme for promotion of infection control has three dimensions. In the short term, the implementation of infection control activities in six governorates by the end of 2003; in the intermediate term, the implementation of infection control activities in seven governorates by the end of 2004; and in the long term, the implementation of infection control activities in the rest of Egypt by the end of 2006.

The national programme for the promotion of infection control comprises:

- development of national guidelines for infection control;
- training and capacity-building;
- supplies procurement and distribution;
- occupational safety health programme;
- supervision and monitoring at national, governorate and hospital levels;
- surveillance for nosocomial infections.

The success of the national programme resulted in significant increases in the compliance with standard precautions one year after the implementation of the programme in the 19 hospitals of the study, e.g. hand washing, protective equipment, aseptic techniques, reprocessing of instruments and waste management.

The new concept of blood safety in Egypt was highlighted. Blood banks in Egypt are either run by the Ministry of Health and Population (approximately 270 in number), the VACSERA laboratory in Cairo, universities and teaching hospitals, the military, the police, Red Crescent or are private. Strategies of blood donation adopted in Egypt are blood replacement, voluntary blood donation and blood donation campaigns. In 2000, blood donation assessment revealed the following: a major concern in the number of collected blood units, competition between different institutions to recruit donors, incentives and gifts, paid donations to private blood banks and blood donation is based on emergency and family replacement. Also, there is no continuous education for providers, no database for donors, and no national behavioural change communication strategy for blood donation. The national

blood donation strategy to promote voluntary non-remunerated donation, as well as training in basic blood bank practices for staff from all over the country and for all level of staff (nurse, physician, driver) was also discussed.

The concept of universal precautions in blood banks (UP) was introduced. A UP committee was established, and UP policy and an assessment tool were developed. Achievements can be summarized as follows: all blood units are screened for HIV, hepatitis B, hepatitis C, and syphilis, using the ELISA technique instead of rapid testing, the monitoring of screened units and the establishment of a network between central and peripheral blood banks.

4.8 Sexually transmitted infection services as entry points for people living with HIV/AIDS in Tunisia

Dr Amel Ben Said

Syndromic case management is based on principles, such as the identification of groups of symptoms and easily recognized signs, treatment of main organisms responsible for causing the syndrome, treating or improving care at the point of first encounter, promoting condom use and safer sexual behaviour. Also, advising a HIV test within the framework of a suitable VCT (entry point) because there is a very strong link between STIs and HIV, where, STIs are a cofactor for HIV transmission. Untreated STIs can increase both the acquisition and the transmission of HIV by up to tenfold. Also, in designing a HIV prevention programme, it is intended at the same time to reduce the transmission of STIs and vice versa. STIs can be a good entry point for VCT and the treatment and prevention of HIV. Lastly, STIs are a marker of unprotected sex as new cases are likely to reflect much more recent sexual activities than HIV which can be indicative of risk behaviour from as long ago as a decade earlier. So, the monitoring of STIs is a good indicator of the effectiveness of HIV prevention programmes.

STIs can be made entry points for PLWHA through a comprehensive public health package integrated into primary health care facilities and including multiple services offering entry points to PLWHA as reproductive health services, including prevention of mother-to-child transmission and STI care and tuberculosis services.

Public health care for STIs embraces the following components:

- comprehensive case management (diagnosis, treatment, risk reduction counselling, referral partner card);
- promotion of appropriate care-seeking behaviour (such as recognition of signs and symptoms of STIs, seeking health care from competent services, avoiding self medication, avoiding casual unprotected sex, involving sexual partners in STI care);
- competent services for vulnerable groups (young people, sex workers, etc.);
- VCT for HIV undertaken by well-trained health workers in respect of privacy and ethics;

- guaranteed ART availability for people who test HIV positive (depending on the country particularities). STI control could be an entry point for PLWHA, as it is an opportunity for identifying people who could benefit from treatment when a link is established with the likelihood of infection with HIV. Clinical services offering STI care are an important access point for people at high risk of HIV, not only for diagnosis and treatment but also for information and education. VCT here is a cornerstone for early access to prevention, as well as to care and support services;
- effective STI case management as an entry point to VCT;
- guaranteed availability of ARVs at an affordable price is a key entry point to VCT because when people are given hope for treatment, they are encouraged to seek their serostatus;
- effective promotion of the 3 by 5 Initiative is the key entry point to comprehensive public health prevention and care of HIV as people are more likely to seek prevention and advice when they receive comprehensive services, including treatment.

It is also recognized that there are several important challenges to address, such as how to:

- reach men who seek care mostly in the private sector (How can the private sector be included in the whole health care package?);
- make reproductive health services accessible to young people (reproductive health services are seen as services for married women and this is true in most countries in the Region);
- make HIV testing available, accessible and voluntary;
- promote voluntary testing and counselling and care for HIV and take into account gender sensitivities;
- disseminate information about sites which offer STI services.

In Tunisia, a syndromic approach to STI case management has been implemented since 1999. Doctors and midwives working in primary health care facilities have benefited from training and treatment is ensured free of charge. HIV testing is available in all laboratories but is not anonymous and accessibility is not ensured. ARV drugs are available and free of charge for all people infected with HIV according to clinical and biological criteria (based on CD4 and viral load). Data on STI patients tested for HIV are not available but in recent biological surveys to validate syndromic algorithms, there has been no diagnosis of HIV cases among the 675 STI patients who have benefited from laboratory diagnosis.

4.9 Prevention of mother-to-child transmission

Dr Jacques Mokhbat

Major risk factors of mother to child transmission (MTCT) are:

- advanced disease (low CD4, high plasma viral load, AIDS diagnosis/advanced HIV disease, high viral load genital secretions);
- obstetrical factors (vaginal delivery, ruptutre of membrane > 4 hrs);
- infant factors (prematurity <37 weeks);

- breastfeeding (maternal advanced disease, longer duration of exposure);
- use of ART.

Factors associated with MTCT are numerous, such as viral characteristics, premature rupture of membranes >4 hours, mode of delivery, prematurity, HLA-mediated immune response, maternal health and breastfeeding.

Efforts in the PMTCT aim at reducing this form of transmission to 2% through antiretrovirals, elective caesarean section at week 38 and the complete avoidance of breastfeeding. The current elements of perinatal prevention depend on provision of ARV (during pregnancy, labour/delivery and postpartum to newborn), full maternal health during pregnancy (undetectable viral load, opportunistic infections prophylaxis and management of secondary conditions), optimize delivery (elective caesarean section HIV–RNA >1000 copies/ml), minimize short and long toxicity to both mother and child.

Efforts aimed at reducing this transmission should include:

- ensuring that at least 80% of pregnant women accessing antenatal care have information, counselling and other HIV prevention services;
- increasing the availability and access of effective ARV prophylaxis to reduce MTCT of HIV;
- ensuring access to treatment including ART for HIV-infected women and the provision of follow-up care and a continuum of care to themselves, their partners and children;
- providing breast milk substitutes where appropriate.

PMTCT is enhanced with (longer duration of therapy during pregnancy, combination therapy and prophylaxis), breastfeeding often mitigates the results of PMTCT interventions (those aimed at reducing the risk of breastfeeding transmission are under way), risks and benefits of widespead highly active antiretroviral therapy (HAART) for PMTCT have not been studied.

Considerations in choosing ART regimens for PMTCT:

- availability of VCT services;
- proportion of HIV-infected women aware of their serostatus;
- proportion of women seeking antenatal care;
- timing of first antenatal visit;
- frequency of antenatal visits;
- quality of antenatal care;
- proportion of births occurring in health care facilities;
- access to early postnatal care;
- acceptability and ease of dosage schedules;
- efficacy and safety of different ART regimens including their potential to compromise future treatment options; and
- access to and cost of drugs.

4.10 Services for injecting drug users as an entry point for people living with HIV/AIDS

Dr Ali Ahmed Ba Omar

The operational strategy of services for injecting drug users in Oman includes:

- Preventing drug abuse through the prevention of the initiation of drug taking among youths (by promoting skills development, helping youths to lead a healthy drug free life and through HIV/AIDS/STI prevention activities). Targeting high-risk groups, in particular injecting drug users, through outreach activities and peer education. Promoting general awareness campaigns, and ensuring policy development (National Committee for Prevention and Control of Psychoactive Substances), and policy action (reduction of the stigma and discrimination of injecting drug users and PLWHA).

- Treatment, rehabilitation and care, including provision of coordinated care for drug users with HIV infection (HIV/AIDS educational and communication activities, VCT, access to clean syringes and condoms, treatment of STIs and opportunistic infections and access to ART. Drug abuse treatment and harm reduction, voluntary treatment of injecting drug users, methadone maintenance treatment, physical therapy, and aftercare visits, counselling, family intervention and lastly the establishment of a referral network between the different types of services).

- Outreach activities are the preliminary stage through the delivery of clean syringes and condoms, health education and counselling, the promotion of treatment and rehabilitation, encouragement of VCT and Narcotics Anonymous and Alcoholics Anonymous groups, and the application for association. Peer education can be initiated for HIV/AIDS prevention (in schools, and for scouts and women).

The challenges faced in Oman, as drugs become cheaper and easier to find are that there are no nongovernmental organizations to deal with the drug problem, there are increasing numbers of tourists and an increase in the number of unemployed youths.

4.11 Testing and counselling: the global perspective

Dr Andrew Ball

Key questions for the scale up of testing and counselling include the following:

- What is the present level of preparedness for the scaling up of testing and counselling in clinical settings?
- What strengthening is required in the following areas:
  - community preparation;
  - laboratory services;
  - training;
  - facilities;
  - procurement; and
  - policy and legislation.
- What ethical and human rights challenges need to be addressed?

- How can communications on testing and counselling scale up be clarified?
- What are the priority recommendations for the strengthening and scaling up of testing and counselling in the next 6–12 months?

A catastrophic lack of awareness of the status of HIV/AIDS occurred in Botswana. In 2001, HIV prevalence in adults was at 38.8% out of a population of 1.7 million. There were 330 000 living with HIV. In 2002, the total number of those who visited VCT centres was 30 000, of whom 3624 were enroled in ART programmes, and 309 (1.8% of those eligible) were enroled in the PMTCT programme in 2001 (up to 3% in 2003).

Up to 6 million people with HIV/AIDS currently need antiretroviral treatment (ART). Without treatment, more than 3 million people will die from AIDS this year and every year for the foreseeable future. Currently only 400 000 access these life-saving drugs in resource limited settings, and the majority of those with access to treatment live in Brazil.

Responses in public health policy

- HIV VCT must be urgently implemented on a broader and radically larger scale to meet an increasing global demand for access to care and prevention services.
- A change in emphasis is required from "opting in" to "opting out", in which the offer of HIV testing by health workers is made routine in clinical management services where HIV-infected people are more likely to present themselves at clinics for tuberculosis, STIs, at injecting drug user services, PMTCT programmes, and in general medical services.
- An increase in VCT sites and mobile outreach services.

The guiding principles of VCT are that testing must be voluntary and informed consent must be obtained from the patient. Post-test support services are essential and the confidentiality of the patient must be protected. Capacity strengthening covers testing including production capacity and clear data on production forecasting and strengthening of production efforts to meet treatment targets; quality assurance of counselling and supervision needs, referral laboratories, referral and reference laboratory networks, and the mentoring and support from northern laboratory networks; patient tracking requiring patient tracking systems which are urgently required; and patient monitoring as CD4 capacity is currently insufficient.

WHO initiatives for the scaling up of testing and counselling include:

- global mapping of testing and counselling services, laboratory support, training organizations, testing and counselling policies;
- global working group on testing and counselling;
- evidence-gathering: case studies from multiple settings, data from operational research;
- testing and counselling indicators developed;
- testing and counselling web-accessible toolkit ;
- rapid test implementation guidance;
- development of core competencies and curricula for testing and for counselling.

The following conclusions were drawn:

- urgent need to scale up coverage of rapid HIV testing and counselling globally;
- urgent need to strengthen rapid test availability and quality assurance and monitoring mechanisms;
- requirement to experiment with delivery models of ethical testing and counselling in a variety of clinical and diagnostic settings;
- requirement to locate expanded testing and counselling in a context without stigmatization and promoting advocacy;
- requirement to decentralize access to testing and counselling and use the experience and capacity of non-formal diagnostic and treatment support;
- requirement to gather more data and to use what is learnt more accurately;
- prevention and care are indivisible.

4.12 Testing and counselling in the Eastern Mediterranean Region: issues for discussion

Ms Joumana Hermez

The reasons for scale up of testing and counselling in the Region:

- discrepancy between reported numbers and estimated numbers of PLWHA, which does not allow for an adequate assessment of the situation;
- sexual transmission is the main mode of transmission;
- reported high-risk behaviour and hard-to-reach risk groups in all countries;
- stigma and discrimination against PLWHA is high;
- low rate of testing and knowledge of HIV status;
- social and psychological support to PLWHA is not equally accessible to all patients in the various countries;
- low access to ART (<5%).

The current status of testing and counselling in the Region:

- 10 countries have VCT centres;
- some countries have conducted training in VCT, but have not established VCT yet;
- some countries have hotline services to improve access to VCT centres;
- VCT availability has not ensured national coverage in any of the countries in the Region;
- VCT centres are a good entry point for PLWHA:
  - nine countries have consistently reported the results of VCT since 1999;
  - seroprevalence among VCT users is higher than in the general population, e.g., Sudan (20%), Tunisia (10%) HIV+ of those tested through VCT in 2000, Islamic Republic of Iran (5%) HIV+ of those tested through VCT in 2001.

Barriers to the scaling up of testing and counselling are stigma and discrimination, gender inequalities, concerns about confidentiality, lack of perceived risk, lack of perceived benefit, and the lack of treatment and support services.

Challenges and issues for consideration are:

- the need to develop national policies on VCT ensuring principles are met, location and settings to integrate services, methods and guidelines, links to treatment, support and prevention services, services for specific groups, selection, training and support of counsellors, monitoring and evaluation of services;
- country preparedness (priority level of VCT, national policy, infrastructure, available services, training courses and training opportunities, and monitoring and evaluation tools);
- risk perception (awareness-raising, mainly among vulnerable groups, including involvement of peers and of PLWHA);
- benefit perception (advocacy and awareness-raising about the benefits of knowing one's HIV status, services for PLWHA, involvement of PLWHA);
- the need to develop favourable environments (political commitment, awareness level, geographic and economic accessibility, quality of services, use of monitoring and evaluation data and outcome studies in planning, stigma reduction, laws and regulations, referral services and referral mechanisms, and ensuring access to ART).

4.13 Regional HIV/AIDS database

Ms Joumana Hermez

The most recent reports from May 2004 from countries of the Eastern Mediterranean Region were presented. According to the reports in 2003, the following categories of HIV/AIDS country reports exist:

- Up-to-date reporting was recorded with no problems in the system identified for the following countries: Bahrain, Egypt, Oman, Palestine, Qatar, Sudan, Syrian Arab Republic and Tunisia.
- Up-to-date accurate reporting was recorded for Lebanon and the United Arab Emirates, but reports are not submitted quarterly.
- Correct but delayed reports were noted for Jordan, Morocco, Kuwait and Yemen.
- No reporting is recorded for Afghanistan and Somalia.
- Delayed reporting is recorded from Djibouti.
- Incorrect reporting was noted from the Libyan Arab Jamahiriya, Pakistan and Saudi Arabia.
- Inconsistent reporting was recorded for the Islamic Republic of Iran.
- Special case: Iraq.

There have been no country reports for STIs from the following countries in 2004: Afghanistan, Bahrain, Djibouti, Egypt, Islamic Republic of Iran, Iraq, Morocco, Oman, Palestine, Qatar, Sudan and Tunisia. In 2003 country reports for STIs were received from Bahrain, Jordan, Palestine and Tunisia.

Problems in the regional database can arise as a result of the overlap between newly-diagnosed HIV and AIDS cases, or by including migrants who are usually not counted in the figures. Therefore, numbers of calculated HIV cases are much higher than the actual reported

numbers. Also, among problems in the regional database, reliance is mostly on AIDS cases, not HIV cases. Deaths are not recorded. Total HIV/AIDS can not be calculated, distribution of HIV cases by age, sex and/or mode of transmission is not feasible, and there is room for personal interpretation of entry items by the data entry officer. Moreover, there is room for manual entry of certain entry items resulting in spelling mistakes, i.e. items not captured in certain analysis operations, zero-displays not available, does not allow room to distinguish between sentinel and non-sentinel data.

The suggested new reporting forms are Excel sheet templates which are electronically filled in. Irrelevant cases are blocked for editing and unavailable data must be marked N/A. One sheet is added for HIV reported cases, one sheet is added for reported deaths, and one sheet is added for sentinel surveillance data. Participants would be asked to review the form during group work.

4.14 Human resource needs for the 3 by 5 Initiative
Dr Andrew Ball

Up to an additional 100 000 people need to be treated to realize the goal of treating up to 3 million people on ART. Challenges to human resources development include:

- workforce demand (eg. increasing ART clientele, adjunct service, task shift);
- workforce supply (e.g absolute shortages due to insufficient entries in health education, pre-and in-service training, incentives, stigma, and relative shortages due to structural employment barriers);
- workforce retention under known conditions (migration and brain drain, death, absenteeism and burn-out);
- workforce planning (modelling, coordination, management).

The technical and operational recommendations for the scale up of ART in resource limited settings set by WHO/UNAIDS in November 2003 were to:

- expand the supply of health workers, including community supporters;
- devolve initiation of ART to nurses and health care workers;
- mobilize the human resources required for the scaling up of ART and redistribute in the areas that have the greatest need;
- prioritize the training of health care workers for ART and related care;
- strengthen health care providers' motivation, and reduce the stigma of AIDS in the health sector, and improve working conditions;
- provide post-exposure prophylaxis and ART services to all health care providers, including community health workers;
- coordinate investment related to human resources development and training support.

The WHO strategic approach to capacity-building is to support countries with normative tools as well as direct technical assistance and capacity-building activities throughout the cycle of capacity-building of countries. This cycle comprises human resources

planning, development of technical material, training of trainers, certification and quality assurance and resource mobilization.

An important partner of WHO in capacity-building is Deutsche Gesellshaft für Technische Zusammerarbeit (GTZ). The objective of WHO/GTZ collaboration in capacity-building is to assist countries in making optimal use of the Global Fund and other large grants through providing international support to the development of local technical capacity in launching large-scale responses to HIV/AIDS.

Knowledge hubs are the regional solutions to regional technical assistance needs by supporting existing institutions and networks in building regional capacity. Local ownership with WHO provides technical assistance and seed funding and technical excellence to attract and pool additional funding. Knowledge hub functions are adaptation of tools and guidelines (including training material), direct technical assistance to training providers, subregional training of trainers and networking at subregional level. A good example is Uganda. Currently, a HIV knowledge hub in Sudan is planned for, focusing on HIV/AIDS programme management (at central and State level) with additional focus on the scale up of ART. There is also a planned partnership between the Ministry of Health, academic institutions and nongovernmental organizations under the leadership of the national AIDS programme, with participation of the national programme in Integrated Management of Adolscent and Adult Illnesses (IMAI) training of WHO and the discussion on the follow-up meeting for adaptation of IMAI guidelines in Sudan. Partnership between the knowledge hub in Uganda and Sudan is currently negotiated by the Regional Office and was initiated in June/July 2004. Assessment of the HIV knowledge hub took place in Sudan in March 2004. However, development of hub structures has been delayed, in part because of the imminent proposal implementation of approved GFATM R3 HIV. The public health approach for ART scale-up was approved by the Ministry of Health, and the recommendations include: a primary health care system based on a rural hospital, simplified diagnostic and treatment algorithms, FDC first-line treatment NVP/3TC/d4T.

5. GROUP WORK

5.1 Entry points for PLWHA in the Region: strengths, weaknesses, gaps and areas for improvement

The participants were divided into the following three groups:

Group A: Islamic Republic of Iran, Jordan, Kuwait, Oman, Pakistan, and Saudi Arabia.
Group B: Djibouti, Iraq, Palestine, Somalia, Sudan, and Yemen.
Group C: Egypt, Lebanon, Libyan Arab Jamahiriya, Morocco, Syrian Arab Republic and Tunisia.

The purpose of this group work was to identify the potential entry points available within the countries, their capacities, the population groups they capture and their coverage.

As a result, the participants would be able to identify the gaps and the needs to scale up entry points to people living with HIV/AIDS.

VCT clinics

Group A. The strengths of VCT clinics within this group of countries include: well-trained staff, confidentiality, free and comprehensive services (including free ARVs), a hotline in some countries, mainstream VCT in other government structures and good cooperation between government organizations. The weaknesses are: diagnosis written in prescriptions, limited utilization and weak referral mechanisms and linkages, a limited number of trained staff, weak referral mechanisms and weak linkages to outreach programmes with the exception of Pakistan. Gaps include the limited number of units, the fact that testing is not always conducted (dependent on the Ministry of Health), the service is not community-based, weak public–private partnership and weak nongovernmental organization capacity. The following measures could improve the level of service: an increase in the number of people providing the service, increased publicity of available services, additional training for staff, integration of prevention, care and treatment and including VCT in primary health care centres.

Group B. VCT clinics are not available in Palestine, Iraq or Yemen. The strengths of clinics in Group B include: national guidelines in both Sudan and Djibouti. In Sudan, for example, people with high-risk behaviour attend VCT centres and hotlines encourage people to utilize the service. Training is conducted in Djibouti, Sudan and Somalia. In Djibouti, counselling is linked to ART and there is a good quality service. The weaknesses in both Sudan and Djibouti include an insufficient number of sites which are generally unknown to the targeted population. In Sudan, the training is insufficient, results are often delayed and testing components neglected. There is a staff deficiency in Djibouti and no system in place in Somalia. The gaps in the service are that the community are not well orientated in using the service in either Sudan or Somalia. In Somalia, training is given once and without practice, there is no policy and the infrastructure is weak, in addition there is no home care or support. In Djibouti, there is no promotion of the service, there is no continuous training and the coverage rates are low. The suggested solutions are to simplify the guidelines in Sudan, to increase the number of sites in Djibouti and Sudan and establish a procurement and distribution plan for testing kits in Sudan, Somalia and Yemen. Advertisement and advocacy campaigns for the service exist in Djibouti, Sudan and Palestine. In Somalia, proper needs assessment is required in addition to set criteria for piloting. There is a need to establish a system in Somalia, Palestine and Yemen. VCT is in the planning process in Iraq. Training for additional staff in Djibouti, Yemen and Sudan is planned.

Group C. VCT clinics are non-existent in both the Libyan Arab Jamahiriya and Tunisia. VCT is either provided by nongovernmental organizations (except in the Syrian Arab Republic), or by government. There is free and anonymous testing, easy accessibility, mobile, national activity, policy and guidelines. Weaknesses are a lack of confidentiality and trained staff, weak career and promotion possibilities for staff, lack of sustainability of funding, lack of motivation. In addition, the service is not well targeted and breeds stigmatization. Gaps include weaknesses in referral services and the absence of rapid testing. The following

measures could improve the level of service: improve credibility/operating procedures, increase availability of care, promote social mobilization through advocacy, increase availability of services, decentralization, integration with other public/medical services, staff training, one-day test in addition to hotline services in some countries.

Injecting drug users and harm reduction services

Group A. Injecting drug users and harm reduction services have the following strengths as entry points: availability and the potential to reach the most vulnerable populations, used by people from across the country, including other nationalities, provision of comprehensive services (including needle exchange, education of families, methadone, ART in Pakistan and Islamic Republic of Iran), under the Ministry of Interior, pilot mobile clinic (in Pakistan) with methadone and needle distribution, integrated into primary health care services, and strong network of nongovernmental organizations and outreach programmes in some countries. Weaknesses are as follows: insufficient outreach in some countries, insufficient supplies (i.e. methadone), and an insufficient number of staff. Gaps include the limited number of units and limited cooperation with the police.

Group B. Injecting drug users do not pose a big problem in Iraq, Palestine, Sudan or Yemen, although there is a weakness in the absence of baseline data in these countries. The suggested solution is to establish baseline information, in addition to establishing a surveillance strategy for injecting drug users in these countries.

Group C. Rehabilitation centres are available free of charge except in Egypt and Lebanon. The weaknesses are reflected in the existing legislation, except in Tunisia and the Syrian Arab Republic. Gaps are in the absence of harm reduction components, poor coverage of outreach programmes and linkages to VCT. The suggested solutions to the deficiencies in the system are to improve partnerships and review legislation.

Tuberculosis clinics

Group A. Tuberculosis is usually the longest-running health programme, there is reciprocal testing (HIV for tuberculosis and tuberculosis for HIV), wide network, well equipped, strong coordination/integration between tuberculosis and HIV. Primary health care centres have integrated tuberculosis with first level care, and will integrate HIV, as this provides the greatest opportunity for rapid scale up. Weaknesses are the vertical nature of tuberculosis and HIV programmes, integration is new, at the lower level, integration does not mirror central level. In Sudan, Pakistan and Jordan HIV and tuberculosis programmes are not integrated and this lack of integration results in inadequate compilation of HIV and tuberculosis data. Closer networking and collaboration would improve this gap.

Group B. The strengths of tuberculosis clinics are that they are widespread all over the country in Iraq, Palestine, Somalia, Sudan and Yemen. There is a good reporting system in Sudan, Palestine, Iraq, and Yemen. Tuberculosis clinics are initiated as entry points for PLWHA in Somalia. All clinics are used as entry points for PLWHA in Palestine and Iraq. Djibouti has been successful in ensuring care and follow-up of tuberculosis patients, in

ensuring regional links, and in the realization of a nutritional service. Weaknesses in Yemen and Sudan are poor coordination between the two programmes and tuberculosis personnel are not trained in HIV issues. Testing is carried out only for suspected cases in Somalia. In Palestine and Iraq there is only post-test, and no pretest counselling. In Yemen, 30% of tuberculosis cases are not accessible for geographical reasons. In Djibouti, there is a staff shortage and testing and counselling are not established, and are dependent on patients' initiative. Gaps in Palestine are delays in the results of testing, and in Sudan and Yemen the clinics are not being used as entry points for PLWHA. In Somalia, there is no policy, a weak infrastructure and no home care or support. It is suggested that there be greater integration between HIV and tuberculosis programmes in Sudan, Somalia and Yemen. There needs to be increased awareness of HIV/tuberculosis coinfection in Djibouti and better training of tuberculosis personnel in counselling in both Djibouti and Sudan. The above-mentioned points are also valid for Sudan and Somalia. Palestine has already adopted rapid testing. Training for pretest counselling exists both in Palestine and Iraq and there is increased coverage through the directly observed treatment, short-course (DOTs) strategy in Yemen.

Group C. The strengths of Group C are that they are well-organized, free and integrated within primary health care but the weakness in this group is that they are not all equipped. Gaps exist in the absence of policy and guidelines for referral, except for in Morocco.

Sexually transmitted infection clinics

The strengths of these clinics as stated by participants in Group A are the wide geographic coverage, the fact that STI programmes have been recently integrated with HIV programmes, so STI cases are automatically tested for HIV, integrated into primary health care with dermatology referrals, and the syndromic approach is applied in some countries. Weaknesses are the lack of confidentiality or the perception of a lack of confidentiality, and a limited number of trained staff in both Pakistan and the Islamic Republic of Iran. The gaps include the fact that the private sector treats considerably more patients than the public sector clinics and data are not made available to the Ministry of Health, and the quality of care is poor. In addition, there is no monitoring and evaluation system. A solution would be to train private sector practitioners.

The strengths as stated by Group B are the availability of guidelines in both Sudan and Djibouti. Clinics are widespread all over the country in Sudan, Somalia and Iraq. There is one central STI clinic in Gaza where all patients can be tested. STI clinics in Djibouti and Yemen are integrated within primary health care. Djibouti has adopted a highly accessible, syndromic approach, has trained personnel, centres which are geographically accessible, and testing and counselling which are freely available. Weaknesses in Sudan and Somalia are a very poor reporting system and very poor supervision and monitoring. Testing is only conducted for suspected cases in Iraq. There is a shortage of drugs in both Sudan and Djibouti. In Yemen, there are no special STI clinics and male reproductive health is neglected. There is a general lack of trained personnel in reproductive health, primary health care and in general health clinics. The gaps in Somalia are that staff training in counselling is insufficient, there is weak coordination and men are not utilizing the services offered. There are delays in the results of testing in Palestine. Discrimination and stigma are strong in Djibouti, and in addition there is

a lack of continuous training for centre staff. The solutions include establishing a system in Somalia and facilities for testing in Iraq, establishing training in testing and counselling in Djibouti, Palestine, Somalia, Sudan and Yemen; developing a strategy for stigma reduction in Yemen, integrating testing and counselling in all centres in Djibouti, and providing provision for planning of drug procurement and supply in Djibouti and Sudan.

Group C has STI services within reproductive health services, whereas in Egypt these services are based in clinics. The weaknesses are the unavailability of these services at national level, except in Morocco and Tunisia, and the lack of counselling. The gap is in the absence of any linkage to VCT. A solution would be to link STI services to VCT, in addition to a general improvement in services.

Outreach programmes (targeting groups other than injecting drug users and prisoners)

The strengths stated by members of Group A are that existing VCT services generate peers, Pakistan has very strong outreach programmes (encompassing sex workers, MSM, truck drivers and coal miners) and a strong public–private partnership within the health sector. There is involvement of PLWHA in peer education. Weaknesses are the unavailability of services in some countries, and limited government involvement, except in the monitoring of nongovernmental organizations' performance. The gaps are a limited capacity in reaching and working with potential users of the service, legal issues related to targeting and reaching sex workers, as there are no guidelines, there is limited cooperation with both the police and judiciary. The suggested solutions include a greater involvement of nongovernmental organizations and development of support groups and peer groups, establish guidelines, exchange programmes and provision of supplies and STI services.

Group B stated that there are no outreach activities in Somalia and Djibouti, although they are widespread all over the country in Sudan, Palestine and Iraq. There are limited outreach activities in Yemen. Weaknesses are that these outreach programmes are not being utilized for HIV and counselling in Sudan, Palestine, Iraq and Yemen. Outreach programmes are not high priority in Iraq and Palestine and there is a lack of training in Palestine. Gaps are insufficient special programmes for vulnerable people in Sudan and Yemen, and denial from policy-makers regarding sex workers in Yemen. The solutions could include establishing a system in Somalia, training in STIs and counselling in Palestine, awareness-raising in Iraq, encouraging the establishment of national nongovernmental organizations in Yemen, and lastly capacity-building for nongovernmental organizations in Yemen and Sudan.

Strengths stated by Group C are as follows: these programmes are nongovernmental organization led and use peers. Weaknesses are poor coverage, the small number of nongovernmental organizations involved, and lack of adequate financing. The gaps are a lack of legislation and the absence of a supportive environment. Solutions include establishing legislation, attracting more nongovernmental organizations, and developing greater peer capacity.

Antenatal care clinics

The strengths stated by Group A include maternal and child health clinics and family planning services integrated into primary health care, automatic testing of pregnant women, and screening is not mandatory. In Oman, antenatal care in sentinel surveillance is planned. In Pakistan condoms are not provided for everybody, not even married women. There is a very strong national policy and programme, including a female health worker programme, and very strong referral system. Weaknesses are that HIV care is not integrated into family planning services in most countries. The gap in Jordan is that mother and child health is not integrated with the HIV programme. The suggested solution is to have automatic referrals for high-risk and pregnant women.

In Group B antenatal care clinics are widespread all over the country, except for in Djibouti. In Djibouti, there is a high acceptance rate for testing and counselling, a comprehensive service, and trained personnel. There are established guidelines in both Sudan and Djibouti. Weaknesses include clinics are not utilized as entry points in all countries, except for in Djibouti. Testing is only conducted for suspected cases in Iraq. Using these clinics as entry points is not priority in either Iraq or Palestine. Obstetricians and midwives are not trained in either Sudan or Somalia. Gaps include the lack of a system in Somalia. The suggested solutions are to increase the number of sites in Djibouti, raise awareness of health care workers in Sudan, Somalia, Palestine and Iraq, and train obstetricians and midwives in all countries, except in Djibouti.

Strength listed by Group C is that these clinics are well-organized and well distributed. The weaknesses are poor linkages to VCT and poor counselling. Gaps include the absence of national guidelines, except for in Egypt.

Blood banks/laboratories

In Group A strengths include universal screening (for HIV and hepatitis B and C), including behavioural pre-donation screening, private laboratories send samples to the Ministry of Health, there are private laboratories for testing purposes and the use of rapid testing, voluntary and mandatory (from family) donations. Weaknesses are a lack of monitoring in the private sector, in family donations, donating family members do not report risky behaviour, there are an insufficient number of counsellors. Gaps include blood banks in different countries attract different groups. In some countries, donations are mainly from males and there is underutilization of services by women, and thus, blood banks in these countries would not serve as entry points for women. In addition, private laboratories are not linked to the Ministry of Health.

Group B: In Sudan and Somalia the personnel working in blood banks are trained in rapid testing so they can perform the testing component. All reactive cases are confirmed in Palestine and Iraq. Weaknesses include blood banks only performing screening testing in Sudan, Somalia and Yemen. Only males are targeted in all countries, except Djibouti. There is no counselling service in either Sudan or Somalia. Units are not tested in Yemen. The organizational set up up is too poor to perform counselling in either Sudan or Somalia.

Solutions would be to plan for procurement and supply or training of laboratory personnel in Yemen.

Strengths listed by Group C are well-organized screening. The weaknesses are poor counselling, poor tracking, and poorly trained staff. The suggested solutions are capacity-building for staff and the strict application of universal standards.

Prisons

Strengths mentioned by Group A are the captive population, exhaustive post-test counselling outside prison (most countries have follow-up of HIV-positive prisoners after their release). The Islamic Republic of Iran provides comprehensive prevention and care. The weaknesses are that testing is not voluntary and there is no pre-test counselling in some countries. Regarding gaps in the service, Pakistan reported that there is no mechanism to ensure follow up of HIV-positive cases after release. The solution is to improve prevention measures.

Other entry points

Additional entry points referred to by the Palestine representative are in vitro fertilization centres, premarital and pre-employment testing. Strengths include routine testing and weakness in the absence of pretest counselling. Thalassemia and haemophilia centres were added as extra entry points by Palestine and Iraq. Strengths are in pre- and post counselling while weaknesses are that not all patients receive the service. Uniformed forces are additional entry points in Sudan. Strengths include: health facilities, good insurance coverage for personnel and their families (in some places in place of no other facilities), and serve civilians in addition to their personnel. Weaknesses are that VCT is very limited, there is a lack of trained personnel, and no clear plan for supplies management. Solutions are to increase the number of sites, to expand training in counselling and testing, to develop a procurement and distribution plan for testing kits, in addition to conducting education and advocacy campaigns.

5.2 Regional HIV/AIDS database: pretesting and endorsement of new reporting techniques, country reporting

The suggested new reporting forms were reviewed, and participants were given the freedom to make necessary modifications to the form during the group work. After the group work, one representative from each of the three groups presented the suggested new format for the reporting form. This was then followed by discussions, at the end of which the participants agreed on a final format.

5.3 Country capacity-building plans

This group work involved open discussions. At the end of the session, the chairman summarized the participants' opinions, as follows:

- a need to assess the needs of training and capacity-building in each country;
- an Arabic training module should be developed;
- the importance of the availability of consultants for training in issues, such as VCT;
- the importance of exchanging experience, as in the centre of excellence in Sudan;
- the importance of so-called "brain drain", the UN, country and personal issues, the need for more discussion;.
- the importance of the role of UN Theme Groups in helping countries and in capacity-building;
- the training of trainers is needed in order for teams to train local staff, especially those needing Arabic training;
- the identification of monitoring and evaluation as being absent or poor in the area of programme management;
- the importance of nongovernmental organization support for all programmes;
- the importance of financial support, as even the wealthier countries require technical support.

6. PARTNERSHIP AND PARTNERS' WORK THROUGH COUNTRY THEME GROUPS

6.1 Introduction by UNAIDS intercountry team representative

Mr Samir Anouti

Partnerships through Theme Groups on HIV/AIDS in the Middle East and North Africa (MENA) were presented by the intercountry team for MENA. The presentation covered the following topics: principles of partnership, partnerships in MENA, role of Theme Groups on HIV/AIDS, Theme Group support to the HIV/AIDS response in MENA and the support of the Theme Group on HIV/AIDS.

The principles of partnership that define UNAIDS include the need for a wider multisectoral response for effective prevention, care and support for HIV/AIDS, and the response to this approach. Wider partnership is necessary between UN agencies and cosponsors (between 6–10 cosponsors), government, civil society, the private sector and other agencies and partners (multi and bilaterals).

Mechanisms to establish partnerships in MENA

- Partnership Forum (the Forum was established in November 2001 and had its second meeting in December 2003) including national AIDS programmes, nongovernmental organizations, UN agencies and other partners;
- civil society networks (regional and national levels);
- interagency working groups and partnerships: drug use and HIV/AIDS, young people; etc.
- subregional initiatives: Sahara, Horn of Africa;
- unified budget and workplan (US$ 6.1 million for 2004–2005).

Principles for coordination of the national AIDS response (the "three ones")

- one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners;
- one national AIDS authority, with a broad-based multisectoral mandate;
- one agreed country-level monitoring and evaluation system.

The UN Theme Groups are the principle vehicle for carrying out the mandate of the Joint United Nations Programme on HIV/AIDS (UNAIDS). They ensure effective and coordinated strategic contribution of the UN system to the national AIDS response and priorities. The role of the Theme Group on HIV/AIDS can be summarized as follows:

- enhancing interagency action and increased dialogue with national actors;
- supporting effective national leadership of the response to HIV/AIDS by strengthening national capacities;
- enhancing joint action and support of Theme Group members in a multisectoral national response;
- advocating for greater and stronger political commitment in an expanded response to HIV/AIDS.

In the Middle East and North Africa there are 16 Theme Groups from 21 countries, of diverse composition, including UNAIDS cosponsors, other international partners, national representatives and civil society. The chairmanship assumed by different UN agencies is based on the principle of rotation.

Theme Group support to the HIV/AIDS response in MENA

- making situation assessments of vulnerable groups and HIV/AIDS;
- designing national strategic planning on HIV/AIDS;
- building partnerships: different sectors, religious leaders; etc.
- increasing the role of nongovernmental organizations, in addition to the role of PLWHA;
- mobilizing resources through development of the GFATM proposals;
- generating strategic information and best practices;
- sharing information and ensuring effective coordination.

Support of the Theme Group on HIV/AIDS: the way forward

- enhancing joint UN action in support of the country response;
- developing a UN implementation support plan which is the annual workplan of the UN theme group to support implementation of the national response on HIV/AIDS and country priorities;
- strengthening the capacities of UN agencies to programme a HIV/AIDS response within their specific mandates and increase their human and financial resources.

6.2 Panel discussion among partners

Partners' panel discussion: UNAIDS, WHO, UNICEF, WB and FHI

This panel discussion was co-chaired by Dr Hallaj, Dr Ionita, Dr Soliman and Mr Anouti. After a long discussion with participants, Dr Hallaj requested a summary of the findings to be listed as bullet points as follows:

- There is a large responsibility on the part of the national authorities to offer a comprehensive plan of action. The United Nations Theme Group should not substitute the national authorities' response, on the contrary, it should support that response;
- core technical group personnel should be available;
- a need for clarity concerning the role of work of each partner at global, regional and national levels;
- the core technical group should always be convened at the level of heads of agencies at the country level. Junior staff members or people who are not decision-makers are unacceptable in this role;
- all partners should attend the core technical group meetings;
- there should be a core for the country coordinating mechanism. The United Nations Theme Group is an established body, but the country coordinating mechanism might not continue beyond the budget of the Global Fund. The country coordinating mechanism is not intended to direct the activity, it should, rather, be the opposite.
- all agencies, particularly UNAIDS should stop subcontracting proposals unless they are a part of the national AIDS programme, or unless there is something missing from certain areas, such as in the monitoring or surveillance process. This should be raised in the United Nations Theme Group meetings with the national AIDS programme manager, who needs to be included in the plan of action.

The findings of a report into young people's sexual and reproductive health and rights were presented. The document gives guidance for policy, programme and research. The objective is to pool together all the studies related to young people's sexual and reproductive health and rights so as to analyse the information and devise a policy, programme and initiate research. The draft was reviewed in June 2004. A consensus meeting is planned for September 2004 in Beirut.

The key areas to address include: culture, employment, age of marriage, education, changing environment, religion, different key indicators, studies across nations, risk factors, fertility rates, marriage, maternal mortality rates, reproductive morbidity, substance abuse, unwanted pregnancy and abortions. Recommendations were tailored according to the country.

7. HIV/AIDS ADVOCACY

Ms Samar Ibrahim

Generally, advocacy is defined as a planned effort to inform people about an issue and instigate change. Advocacy is also winning the support of key constituencies in order to influence policies and budget allocation, and bring about social change.

The general goals of advocacy are to increase the public's knowledge and awareness of a certain health issue and to influence people's beliefs, attitudes and perceptions about the issue. It is also important that advocacy refutes myths and misconceptions, and prompts action (mobilization, prioritization, support, new legislation, attitudes, etc.), and demonstrates or illustrates the benefits of change. In the case of HIV/AIDS, advocacy is necessary because of the global crisis of HIV/AIDS with 40 million people infected with HIV worldwide. It is estimated that by 2010 more than 40 million children worldwide will be orphaned due to HIV/AIDS. By 2020, HIV is expected to be responsible for 37% of all adult deaths from communicable diseases in the developing world. At present, it is estimated that around 700 000 people are living with HIV/AIDS in our Region, although AIDS treatment is now available and has the potential to save many lives. Globally, only 400 000 out of 6 million PLWHA are actually receiving ART and in the Eastern Mediterranean Region, only 5% of PLWHA have access to ART. Advocacy can and does bring about change and for the past 2 decades, effective HIV/AIDS advocacy has raised awareness, provided education and encouraged social mobilization.

Steps for advocacy in the fight against HIV/AIDS:

- Initially, the campaign's goals and objectives, such as fighting stigma and discrimination should be planned and the target audience and intended message defined, taking into account budgetary considerations.
- The concepts (including the actual wording of the theme and slogan), the media tools, the channels and advocacy materials are then developed.
- Thirdly, the campaign, involving the production, launch and material distributions, is executed.
- Finally, there needs to an assessment of how many people the message reached. (If a campaign is aired on television, viewership rates needs to be checked. If promulgated in the printed media circulation figures need to be checked, an assessment of how much media coverage was given needs to be made, and of how much change is likely to be brought about).

A good communicative campaign can be assessed by checking if the correct message has reached the intended audience in a way that was understood and likely to bring about change. The theme of the World AIDS Campaign 2004 was "women, girls, HIV and AIDS". Through its focus on women and girls, the year-long campaign aimed to accelerate the global response to HIV and AIDS in preventing new infections, promoting equal access to treatment and mitigating the impact of AIDS.

8. UPDATE ON THE WORLD AIDS CAMPAIGN 2004

Dr Hala Abou Taleb

The Global Coalition on Women and AIDS was launched in February 2004 to raise the visibility of women and AIDS issues and to improve the evidence base, forge partnerships and collaboration, and support the massive scaling up of action. The Coalition was formed to improve the lives of women and girls. The motivation behind this coalition is the fact that

50% of new infections occur amongst girls and women, the significance of the increased impact of AIDS on women, and also to address the wider gender inequalities fuelling the epidemic. The coalition is based around the principles that women are not victims. Girls and young women are at greatest risk, which if even at low risk, they may be highly vulnerable. Also, that change is possible, HIV-positive women play a key role, and men and boys are encouraged to show new models of masculinity.

Actions can be tailored according to the relevance for each country in the form of the following:

- prevent HIV infection among girls and young women by focusing on improved reproductive health care;
- reduce violence against women (highlighting the links to HIV vulnerability);
- protect the property ownership and the inheritance rights of women and girls;
- ensure equal access for women and girls to care and treatment;
- support improved community-based care, with special focus on women and girls;
- promote access to new prevention options including microbicides and female condoms;
- support ongoing efforts towards the reality of universal education for girls.

Determinants of vulnerability of women and girls in the Region

- 36% of the population is under 15 years of age;
- 69 million women are of reproductive age;
- low levels of female education and labour force participation;
- high levels of illiteracy and school drop outs which exemplify wide gender gaps;
- weak decision-making skills;
- lack of communication skills between parents–teachers with young people in general, and girls in particular, around the issues of sex education, puberty and healthy behaviour;
- traditions and taboos are obstacles to sex education;
- gender discrimination is sometimes codified by law (family and civil);
- violence against women;
- more than 6 million refugees and displaced populations;
- increased mobility of populations;
- stigma and discrimination;
- women look after their HIV-positive family member(s);
- low-level access of women and adolescents to health care in general, and reproductive health in particular;
- economic challenges and poverty.

MENA was one of the first regions responding to this coalition by forming a regional task force to be able to produce strategic information and analysis of gender risk and vulnerability in the Region, promoting women's human rights, raising awareness and building the capacity of women's organizations.

A regional meeting on women, HIV/AIDS is planned to be held this year to sensitize participants to the issues of gender, to mobilize religious leaders and women activists, exchange experiences and outline strategic priorities and a programme for action.

9. CONCLUSIONS

At the end of the meeting, the participants agreed on the following:

- Recognition of the failure to contain the epidemic and to ensure equitable access to ART in the Region, manifested by an accelerated increase in the number of cases, increased rates among women and vulnerable populations and a growing burden of disease.
- Acknowledgement of the cost-effectiveness of ART.
- Recognition of the importance of ART in accelerating prevention, reducing stigma and as a measure for sustained development.
- Confirmation of interest in contributing to the 3 by 5 Initiative.
- Acknowledgement of the weakness of the HIV/AIDS and sexually transmitted infection surveillance systems both at country and regional levels.
- Identification of the elements of scaling up entry points for PLWHA and related capacity-building needs.
- Acknowledgement of the importance of continued advocacy to achieve prevention, rights of PLWHA and equitable access to care and treatment.

10. RECOMMENDATIONS

To Member States

1. Countries are encouraged to explore their national, as well as international resources, to ensure sustained scaling up of ART, in line with the 3 by 5 Initiative in order to achieve the long-term goal of universal access to ART.
2. Countries are encouraged to adopt and adapt WHO guidelines and the recommended ARV regimens for scaling up access to AIDS care and treatment, including ART.
3. Countries are encouraged to adopt WHO-approved rapid tests as a strategic measure for a scaled up identification of PLWHA.
4. Countries need to establish and reinforce appropriate entry points for PLWHA such as voluntary testing and counselling, sexually transmitted infections and tuberculosis clinics, outreach programmes, etc. and to identify other potential testing and counselling

facilities, and ensure gender equity and accessibility to injecting drug users and other vulnerable groups, in parallel to strengthening referral systems to treatment and care.

5. Countries are encouraged to develop national HIV/AIDS drugs and commodities procurement and supply management plans, and benefit from the AIDS Medicines and Diagnostic Services to ensure an uninterrupted supply of medicines diagnostics at the lowest cost and highest quality.

6. Countries are called upon to develop national HIV/AIDS capacity-building plans with special attention to scaled up antiretroviral therapy needs, benefit from the WHO-supported knowledge hubs, and to explore their national human and structural resources which can be used for capacity-building both at the national and regional level.

7. Countries are urged to develop or strengthen infection control programmes to be implemented in the public and private sectors, with attention to the application of universal precaution measures.

8. Countries are urged to strengthen their surveillance systems to better understand the HIV/AIDS/STI situation, its trends, and its burden for planning and estimation of needs, in addition to contributing to the regional database according to the new agreed-upon reporting forms.

9. National authorities are advised to actively participate in a core technical group and to advise the different partners on the country priorities and areas of intervention.

10. Countries are urged to work in close collaboration with civil society and Theme Group members in assessing needs, developing and implementing advocacy efforts, with special attention to the World AIDS Campaign slogans throughout the year.

To WHO and other partners

11. WHO is to assist countries in the adaptation of the ART guidelines to the local context, and to take the lead in ensuring the appropriate technical and timely support to scale up ART delivery.

12. WHO is to support the establishment of regional networks of individuals and institutions with expertise in ART and health sector response, entry points, capacity-building, etc. drug and diagnostics procurement and supply management and in surveillance, in order to ensure timely support to countries.

13. WHO is urged to convene high-level interministerial meetings in order to advocate for putting HIV/AIDS higher on national agendas.

14. WHO is to monitor the progress in the implementation of the recommendations and to present a progress report in the next national AIDS programme managers' meeting.

15. UN agencies and other partners are called upon to work together and sort out the means of supporting countries in achieving a sustainable supply of quality ARVs for the cheapest possible price, taking into consideration that the reported numbers are far less than the actual numbers of patients. These should be raised with the ministers from the countries.

16. Partners are called upon to develop their regional and national strategies according to their mandates and their comparative advantages in countries, and base their country-level activities on national priorities as defined in the national strategic plans and with full openness and transparency within the core technical group.

17. UN agencies and other partners are called upon to show high-level commitment to the core technical group and ensure high-level representation of the respective agencies in the core technical group meetings, and to learn from the positive experiences of certain countries.

18. UNAIDS is called upon to strengthen its country presence, and UN agencies to strengthen their country offices' capacity in order to ensure adequate support to countries.

Annex 1

AGENDA

1. Opening session.
2. Regional update on the HIV/AIDS situation.
3. 3 by 5 Initiative: global and regional updates.
4. Integrated care and prevention.
5. Infection control.
6. Entry points for PLWHA: STI services, PMTCT, services for injecting drug users.
7. Testing and counselling.
8. Regional HIV/AIDS database: pretesting and endorsement of new reporting techniques.
9. Capacity-building plan.
10. Partnership in HIV/AIDS response.
11. HIV/AIDS advocacy and the World AIDS Campaign 2004.
12. Recommendations.
13. Closing session.

Annex 2

PROGRAMME

Monday, 10 May 2004

09:00–09:30	Registration
09:30–11:00	Opening session Address by Dr Hussein A. Gezairy, Regional Director, EMRO Address by H.E. Dr Mohamed Eyad Chatty, Minister of Health, Syrian Arab Republic Objectives of the meeting and programme/ Dr Zuhair Hallaj, Director, Division of Communicable Disease Control, EMRO Nomination of officers
11:00–11:30	Regional HIV/AIDS situation update/ Dr Hany Ziady
11:30–12:00	The 3 by 5 Initiative/ Dr Andrew Ball
12:00–12:30	The 3 by 5 Initiative: regional update/ Dr Hany Ziady
12:30–14:30	ART guidelines in resource limited settings/ Dr Andrew Ball
14:30–15:30	Drug procurement and AMDS/ Dr Andrew Ball
15:30–16:00	GCC experience in bulk drug procurement
16:00–16:30	Morocco experience in scaling up ART
16:30–17:00	ARAG meeting

Tuesday, 11 May 2004

9:00–9:30	Integrated care and prevention: entry points for PLWHA/ Dr Andrew Ball
9:30–10:30	Integrated care and prevention: Egypt's experience in infection control and blood safety
10:30–11:00	Integrated care and prevention: STI services as entry points for PLWHA, examples from Tunisia/ Dr Amel Ben Said
11:00–11:30	Integrated care and prevention: prevention of mother-to-child transmission/ Dr Jacques Mokhbat
11:30–12:00	Integrated care and prevention: services for drug users as entry points for PLWHA/ Dr Ali Ahmed Ba Omar
12:00–12:30	Testing and counselling: the global perspective/ Dr Andrew Ball
12:30–14:00	Testing and counselling in the Region: issues for discussion
14:00–15:30	Group work I Entry points for PLWHA in the Region: strengths, weaknesses, gaps and areas for improvement
15:30–16:00	Presentation of Group work I and discussion
16:30–17:30	ARAG meeting

Wednesday, 12 May 2004

9:00–09:30	Regional HIV/AIDS database: country reporting, problems and suggestions/ Ms Joumana Hermez
09:30–11:00	Group work II Regional HIV/AIDS database: pretesting and endorsement of new reporting techniques, country reporting
11:00–11:30	Presentation of Group work II and discussion
11:30–12:00	Capacity-building plan/Dr Andrew Ball
12:00–14:30	Group work III Country capacity-building plans
14:30–15:00	Presentation of Group work III and discussion
15:00–16:00	Partnerships and partners' work through country Theme Groups: introduction by UNAIDS intercountry team leader Partners' panel discussion: UNAIDS, WHO, UNICEF, WB, FHI
16:30–18:00	ARAG meeting

Thursday, 13 May 2004

9:00–9:30	WHO collaborating centres: opportunities for cooperation
9:30–10:00	HIV/AIDS advocacy/ Mrs Samar Ibrahim
10:00–11:10	Update on the World AIDS Campaign 2004
11:00–11:30	Discussions on the regional slogan for the campaign/ Dr Hany Ziady
11:30–12:30	Conclusions and recommendations
12:30–13:00	Closing session/ Dr Z. Hallaj

Annex 3

LIST OF PARTICIPANTS

DJIBOUTI
Dr Fatouma Mohamed Ahmed
Coordinator National AIDS Programme
Ministry of Health
Djibouti

EGYPT
Dr Nasr El Sayed
Undersecretary for Preventive Affairs
Ministry of Health and Population
Cairo

Dr Ihab Ahmed A. Rahman
National AIDS Programme
Ministry of Health and Population
Cairo

ISLAMIC REPUBLIC OF IRAN
Dr Mitra Motamedi Heravi
National AIDS Programme Manager
Ministry of Health and Medical Education
Teheran

IRAQ
Dr Wadah Hamid Abood
National AIDS Programme Manager
Ministry of Health
Baghdad

JORDAN
Dr Rajai' El Azzeh
National AIDS Programme and STI manager
Ministry of Health
Amman

KUWAIT
Dr Osama Albaksami
Infectious Diseases Hospital
Ministry of Health
Kuwait

LEBANON
Dr Mostafa Mahmud El Nakib
National AIDS Programme Manager
Ministry of Public Health
Beirut

LIBYAN ARAB JAMAHIRIYA
Dr Mohamed Ahmeda Sammud
National AIDS Programme Manager
National Center for Infections Disease Control
Tripoli

MOROCCO
Dr Hamida Khattabi
Head/Directorate of Epidemiology and Disease Control
Ministry of Health
Rabat

OMAN
Dr Ali Ahmed Ba Omar
Head of HIV/AIDS/STI Section and Tuberculosis/Leprosy Programme Manager
Ministry of Health
Muscat

PAKISTAN
Dr Ali Razzaq
Provincial AIDS Programme Manager
Ministry of Health
Punjab

PALESTINE
Dr Izzat Abdel Aziz Joudah
National AIDS Programme Manager and Head of STI-HIV/AIDS Unit
Ministry of Health
Gaza

SAUDI ARABIA
Dr Nasser Saleh Al Hozayem
National AIDS Programme Manager
Ministry of Health
Riyadh

SOMALIA
Dr Abdi Awad
Director-General/Chairperson of AIDS
Technical Committee
Ministry of Health
Garowe

SUDAN
Dr Mohammed Siddig Abd Elgadir
Deputy Manager of
National AIDS Programme
Federal Ministry of Health
Khartoum

SYRIAN ARAB REPUBLIC
Dr Mahmoud Karim
Director of Environment and Communicable Diseases
Ministry of Health
Damascus

Dr Fouad Fouad
Director Public Health Care
Ministry of Heath
Aleppo

Dr Haytham Sweidan
National AIDS Programme Manager
Ministry of Health
Damascus

TUNISIA
Dr Faouzi Abid
National AIDS/STI Programme Manager
Primary Health Care Directorate
Ministry of Public Health
Tunis

YEMEN
Dr Fawzia Abdullah Gharamah
National AIDS Programme Manager
Ministry of Public Health and Population
Sana'a

MEMBERS OF ARAG

Dr Salah Al Awaidy*
Director, Surveillance and Disease Control
Ministry of Health
Muscat
OMAN

H.E. Mr Marwan Hamadeh*
International Committee on Ethics
Beirut
LEBANON

Dr Mohammad Mehdi Gouya
Director-General
Center of Disease Management
Ministry of Health and Medical Education
Teheran
ISLAMIC REPUBLIC OF IRAN

Dr Jaouad Mahjour*
Director of Epidemiology and Disease Control
Ministry of Health
Rabat
MOROCCO

---

* Unable to attend.

Dr Jacques Mokhbat
Infectious Disease Specialist
Lebanese University
Member of National AIDS Committee
Beirut
LEBANON

Dr Abdallah Sid Ahmed Osman*
Under-Secretary of Health
Federal Ministry of Health
Khartoum
SUDAN

H.E. Mr Ejaz Rahim*
Secretary Cabinet Division
Government of Pakistan
Islamabad
PAKISTAN

Dr Amel Ben Said
Deputy Director
National Institute of Childhood Protection
Tunis
TUNISIA

OTHER ORGANIZATIONS

United Nations Joint Programme on HIV/AIDS (UNAIDS)
Dr Hala Abou Taleb
Intercountry Programme Development Adviser
Cairo
EGYPT

Mr Samir Anouti
Intercountry Programme Development Adviser
Cairo
EGYPT

* Unable to attend

Family Health International (FHI)
Dr Cherif Soliman
Country Director
IMPACT Project
Cairo
EGYPT

United Nations Children's Fund (UNICEF)
Dr George Ionita
Regional Health Officer
Amman
JORDAN

WHO SECRETARIAT

Dr Hussein A. Geizary, Regional Director, EMRO
Dr Fouad H. Mujalled, WHO Representative, Syrian Arab Republic
Dr Zuhair Hallaj, Director, Communicable Disease Control, EMRO
Dr Hashim El-Mousaad, WHO Representative, Yemen
Dr Guido Sabatinelli, WHO Representative, Sudan
Dr Jihane Tawilah, WHO Representative, Djibouti
Dr Andrew Ball, Manager Country and Regional Support, Department of HIV/AIDS, WHO headquarters
Dr Hany Ziady, Medical Officer, ASD, EMRO
Ms Joumana Hermez, Technical Officer, AIDS and Sexually Transmitted Diseases
Dr Ali Ahmed Ali Sadek, Temporary Adviser, EMRO
Dr Abdallah El Gizoli, AIDS Medical Officer, WHO Somalia
Mr Hossam Younes, Technical Assistant, Help Desk Administrator, Health Information Systems, EMRO
Ms Omneya Mahmoud, Administrative Assistant, Communicable Disease Control, EMRO
Ms Samar Ibrahim, Advocacy and Communication Assistant, Communicable Disease Control, EMRO
Ms Mervat Sheta, Senior Secretary, Communicable Disease Control, EMRO
Ms Hanan Awad, Secretary, Division, Communicable Disease Control, EMRO
Ms Ragia Sharaby, Secretary, Division, Communicable Disease Control, EMRO