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Contents

1. Introduction: From “3 by 5” towards universal access

Following on the 3 by 5 Initiative, which succeeded in mobilizing many stakeholders in an international effort to scale up antiretroviral therapy (ART) and intensify HIV prevention efforts, in 2005 leaders of G8 countries and other UN Member States committed to working with WHO and UNAIDS to develop and implement a package for HIV treatment, care and prevention with the aim of coming as close as possible to universal access to treatment by 2010.

In the Eastern Mediterranean Region, the 3 by 5 Initiative was considered by WHO and its Member States to be both an ethical imperative and a critical step towards achieving the goal of universal access to HIV prevention, treatment, care and support. Although the 3 by 5 target of treating with ART 3 million people living with HIV by 2005 was not achieved, the initiative created an irreversible momentum and mobilized many partners globally to expand access to treatment. It demonstrated that providing treatment is possible, even in settings with limited resources including in the Eastern Mediterranean Region. However, it also raised questions regarding the sustainability of treatment and its expansion to an increasing number of people in need. These challenges can only be resolved through renewed and increased national and international commitment and by substantially enhancing efforts to prevent new HIV infections, by targeting in particular those most at risk.

In 2006, WHO formulated a global plan for the health sector’s contribution to achieving the universal access goal, based on the provision of an essential package of health services and interventions for HIV/AIDS prevention, care, treatment and support to all those in need, while at the same time contributing to the broader strengthening of health systems. In the Eastern Mediterranean Region, the essential package was defined through the regional strategy for strengthening the health sector response to HIV/AIDS, which was adopted in 2005 by ministers of health at the Fifty-second Session of the Regional Committee for the Eastern Mediterranean.

In 2006, countries reviewed their national efforts to curb the HIV epidemic and its impact during two sub-regional consultations and identified major obstacles to achieving universal access common to all or to groups of countries. These obstacles include the persisting fear and stigma associated with HIV, overburdened health systems, inefficiency in spending increasing funds available for HIV programmes and high cost of HIV treatment, in particular second-line ART.

2. The burden of the HIV/AIDS epidemic in the Region

2.1 Morbidity and mortality due to HIV/AIDS

By the end of 2005, the estimated number people living with HIV (PLWH) in the Eastern Mediterranean Region reached 620 000 and an estimated 100 000 new HIV infections occurred in 2006[1]. Despite efforts to increase access to antiretroviral therapy in the Region, an estimated 47 000 adults and children died as a result of HIV infection. In the light of the weak surveillance systems in most countries of the Region, margins of these estimates remain wide.

By the end of 2006, countries had reported a cumulative number of 1134 AIDS cases. More than half (55.6%) of the reported AIDS cases in the Region to date are adults aged between 25 and 39 years; 8.1% are youth aged between 15 and 24 years and 1.8% are children below 5 years of age. 30% of the cumulative total reported AIDS cases are female. Sudan, Djibouti and parts of Somalia are experiencing generalized epidemics (HIV prevalence >1% in the general population). Concentrated epidemics (HIV prevalence >5%) among injecting drug users are established in the Islamic Republic of Iran, Libyan Arab Jamahiriya and Pakistan. In the remaining countries of the Region, available data suggest that the HIV/AIDS epidemic has remained at low level (<1% HIV prevalence in the general population and <5% in at-risk groups). However, the lack of reliable information on the extent to which HIV has entered the most at-risk populations prevents early detection of concentrated epidemics among such groups. Out of the total cumulative reported AIDS cases, 31.3% are of unknown modes of

[1] UNAIDS/WHO: Report on the Global HIV epidemic. UNAIDS, 2006

transmission. Out of the total AIDS cases with known mode of transmission, the main mode of HIV transmission is heterosexual (78.5%), followed by injecting drug use (9.7%), blood transfusion (5.2%) and transmission from mother to child (2.3%). Table 1 gives an overview on the HIV epidemic situation by country.

As expected, tuberculosis affects HIV-infected people in the Region more than those without infection. In 2006, 9 countries reported information on HIV prevalence among tuberculosis patients to WHO. Overall HIV prevalence among the total of 1659 tuberculosis patients tested was 0.7%, ranging from 0% in the Syrian Arab Republic to 2.4% in Yemen. Morocco was a pioneer in establishing a sentinel sero-surveillance system that includes annual surveys among tuberculosis patients, with reported HIV prevalence fluctuating around 0.4% in consecutive surveys from 1995 to 2006 (range 0.12%–1.06%).

Drug-resistant tuberculosis, which has been emerging in Africa and Europe in close relation with the HIV epidemic, was found everywhere at different levels in eight countries that conducted anti-tuberculosis drug resistance surveys. The level of multidrug resistance ranged from 0.8% in Qatar to 9.1% in Jordan among new cases. No concrete data are yet available in the Region concerning extensive drug resistance (XDR), which is resistance to second-line drugs; however, a study in the Islamic Republic of Iran indicated the presence of XDR in the country.

Table 1. The burden of HIV/AIDS in the Eastern Mediterranean Region

Country	Estimated HIV prevalence in adult population (%)[a]	Estimated number of PLWH[a]	Reported AIDS cases 2006[b]	Estimated number of adults needing ART[c]	Reported number of people receiving ART[d]
Afghanistan	<0.1	<1 000	NA	<100	0
Bahrain	NA	<1 000	1[f]	<200	NA
Djibouti	3.1	15 000	NA	2 600	492
Egypt	<0.1	5 300	NA	870	NA
Iran, Islamic Republic of	0.2	66 000	176	8 100	537
Iraq	NA	NA	NA	NA	0
Jordan	NA	<1 000	25	<200	45
Kuwait	NA	<1 000	NA	<200[e]	NA
Lebanon	0.1	2 900	NA	<500	223
Libyan Arab Jamahiriya	NA	NA	NA	500[d]	217
Morocco	0.1	19 000	291	3 300	1 530
Oman	NA	NA	32	300–350[d]	247
Pakistan	0.1	85 000	5[f]	11 000	238
Palestine	NA	NA	1	100[d]	7
Qatar	NA	NA	NA	NA	NA
Saudi Arabia	NA	NA	43	550[d]	497
Somalia	0.9	44 000	NA	7 100	96
Sudan	1.6	350 000	418	56 000	986
Syrian Arab Republic	NA	NA	16	200 - 220[d]	70
Tunisia	0.1	8 700	24	346[d]	298
United Arab Emirates	NA	NA	0	NA	NA
Yemen Republic of	NA	NA	103	3 000[d]	0

NA: information not available
PLWH: people living with HIV
Source:
[a] *Report on the global AIDS epidemic 2006*. A UNAIDS 10th Anniversary special edition. Geneva, UNAIDS,2006.
[b] Regional database on HIV/AIDS, WHO Regional Office for the Eastern Mediterranean
[c] *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Progress report*. WHO, UNAIDS, UNICEF, April 2007.
[d] Estimated number of adults and children in need of ART based on regional reporting on access to ART, December 2006
[e] 20% of estimated number of PLWH (where estimated number of people in need of ART is not reported to WHO)
[f] Data of at least one quarter are missing

2.2 Risk and vulnerability factors in the Region

Injecting drug use. 9.7% of AIDS cases reported from countries of the Region between 1999 and 2006 were attributable to injecting drug use. There is major concern about an expanding epidemic of injecting drug use in the Region, affecting both sexes and characterized by decreasing age at onset of drug use. According to reports of the United Nations Office on Drugs and Crime (UNODC), the number of injecting drug users is estimated at 400 000 to 900 000 in the Region.

The possibility of considerable HIV infection rates among injecting drug users cannot be ruled out in countries where data on risk behaviour and HIV infection rates are not collected and reported. In 2006, national AIDS programmes in Egypt, Oman and Syrian Arab Republic conducted behavioural studies among injecting drug users. Preliminary results from these countries confirm behavioural data collected previously in Afghanistan, Bahrain, Egypt, Lebanon, Libyan Arab Jamahiriya, Morocco and Pakistan, which suggest that very high risk behaviour prevails among injecting drug users. Sharing injections and injection equipment, overlap between injecting drug use and selling or buying sex, unprotected sexual intercourse with multiple partners and a history of imprisonment were frequently encountered risk factors in these countries.

High-risk sexual behaviour. Information on the types and extent of high-risk sexual behaviour remains difficult to obtain. Very few countries conduct behavioural and biological surveillance among population groups that are presumed to be at risk of HIV through high-risk sexual behaviour. Informal sources of information such as media reports and non-health related sources such as police reports confirm the existence of high-risk behaviour attributed to prostitution and homosexual relations among men in almost every country in the Region. Globally, it is well established that sex workers and men engaging in homosexual relations are more likely to be engaged in unprotected sexual intercourse with multiple partners of unknown HIV sero-status. The risk is usually heightened where there is lack of awareness and access to condoms for those population groups.

Very few behavioural studies have been conducted on those population groups in the Region. However, some countries such as Lebanon, Morocco and Tunisia show similar determinants and risk factors. Only Morocco conducts regularly sentinel sero-surveillance among sex workers; the latest available data (2005) show an HIV prevalence of 2.2%[2]. Men engaging in homosexual relations may be an unrecognized risk population in some countries, as demonstrated in a survey in Egypt in 2006 showing a HIV sero-prevalence of 6.2%[3].

Lack of awareness and knowledge of HIV among youth. Knowledge, attitude, behaviour and practice studies conducted in different countries of the Region suggest that young people are not sufficiently aware of HIV and lack essential knowledge of modes of HIV transmission and prevention. In particular, lack of awareness and lack of access to condoms for young people who are sexually active are indicative of a significant vulnerability to HIV.

Poverty, unemployment, labour migration. Poverty and unemployment are core social determinants of health. Fourteen countries of the Region are categorized as lower–middle to lower income countries. Unemployment rates reach as high as 59% in Djibouti and 27% in Iraq and Palestine. As a result, the Region is generally marked with high mobility where higher income countries attract large numbers of migrant workers from within and outside the Region in search of work opportunities. Migrant workers are often subject to mandatory HIV testing without access to HIV prevention, treatment and care services. In some cases, they are subject to discriminatory practices such as deportation based on a positive HIV sero-status.

Women's status. The adult female literacy rate in the Region is 53%. According to the World Bank, HIV prevalence rates are lower when women have access to education and income opportunities. The regional average maternal mortality ratio of 37.9 per 10 000 live births (range 0.0–160 per 100 000

[2] Morocco National Surveillance Report, 2005. Ministry of Health, National AIDS Programme, Morocco, 2005.

[3] HIV/AIDS Biological and behavioural surveillance survey. Summary Report. Ministry of Health and Population, National AIDS Programme, Arab Republic of Egypt, 2006.

live births), and the average deliveries attended by trained personnel of 53% (range 14%–100%) are indicative of the lack of access for women to health services, thus posing a major obstacle against the provision of HIV prevention, treatment and care services for women, as well as against the implementation of appropriate interventions for the prevention of mother-to-child transmission of HIV.

Conflict and emergency situations. Several countries in the Region, including Afghanistan, Iraq, Lebanon, Palestine, Somalia and Sudan, are affected by conflict. Emergency and conflict situations put the affected populations at increased risk of HIV transmission as a result of violence and assaults, risky sexual practices of troops, inaccessibility of prevention and treatment commodities and services and destruction of facilities and infrastructure. Iraq is one example of the devastating effects of war, where antiretroviral therapy coverage has dropped from 100% coverage of known cases in need to zero.

3. Progress in strengthening health sector response to the HIV/AIDS epidemic

According to its mandate and the agreed-upon division of labour among UNAIDS co-sponsor agencies, the Regional Office focused its support to Member States on providing policy and technical guidance, capacity-building and technical assistance within the health sector.

3.1 Strategic planning, monitoring and evaluation

The regional strategic plan for strengthening health sector response to HIV/AIDS and sexually transmitted infections for the period 2006–2010 was endorsed by the Regional Committee in September 2005. It guides the Regional Office and Member States on systematic approaches for the health sector to contribute to the achievement of universal access to HIV prevention, treatment and care.

In 2006, the Regional Office supported national AIDS programme managers in the development of indicators for monitoring progress towards universal access and strengthened the capacity of national programmes in planning and establishing effective monitoring systems. This support will be continued in 2007. Afghanistan, Oman and Yemen were supported in the development of their national strategic plans.

3.2 Expanding access to HIV/AIDS treatment and care

An estimated total of 75 000 people living with HIV/AIDS in need of ART are living in the Eastern Mediterranean Region. Of these, more than two thirds live in Sudan alone. In 2006, access to HIV/AIDS treatment and care services expanded steadily in almost all countries except in Afghanistan, Yemen and Iraq, where ART services were not available. However, the shortfall in access to life-saving ART is still considerable: as of December 2006 fewer than 5% of the estimated number of PLWH in need were receiving ART. This contrasts with a high coverage (79%) of ART for known PLWH in need of treatment reported to the Regional Office by 15 countries. This discrepancy may be explained by three main factors that prevent PLWH in need from accessing ART: 1) obstacles related to the centralization of ART services at tertiary facilities; 2) the high cost of ART to the public health system; and 3) persisting high levels of stigma and discrimination in the Region that seriously impede the uptake of counselling and HIV testing services and health care seeking of people living with HIV.

For fear about disclosure of HIV status and subsequent stigmatization and discrimination, PLWH and their families prefer private rather than public sector services for HIV testing and treatment. However, private facilities rarely provide counselling follow-up. Consequently important opportunities are lost to use the episode of HIV testing for prevention counselling for people who test negative, or as a pathway to ongoing treatment, care and support for newly-diagnosed PLWH and for couple counselling and partner notification.

3.3 HIV testing and counselling

The vast majority of HIV infected people still do not know their HIV status.

Making voluntary and confidential counselling and testing (VCT) services available has proven to encourage people to determine their HIV status and to take the appropriate measures to prevent the transmission of HIV. Despite this evidence, VCT services, where they exist in the Region, are still extremely limited in coverage and are under-utilized. More importantly, VCT services are failing to target high risk groups.

During 2006, in order to guide countries on the practical implementation of HIV testing and counselling programmes and services in the epidemic, social and cultural context of the Region, the Regional Office initiated the development of a regional guide on HIV testing and counselling. Support to national AIDS programmes in expanding coverage of voluntary testing and counselling services through development of national guidelines and training of counsellors focused on Somalia, Sudan and Yemen.

Recently, provider-initiated testing and counselling (PITC) has been discussed globally as an additional effective measure to promote the concept of 'knowing one's HIV status'. PITC means that health care providers offer HIV testing as part of routine laboratory investigations to selected patient groups (in low-level epidemics) or to all patients (in generalized epidemics). Patients reserve the right to decline the test ("opt-out" approach) as well as the rights to confidentiality, appropriate counselling and referral. In those countries of the Region that lack a legislative and regulatory framework that protects the rights and safety of those being tested, its establishment would be a prerequisite to expanding HIV testing opportunities through PITC.

Due to significant improvements in HIV testing technology in recent years, including the development of highly specific and sensitive HIV rapid tests, there are opportunities for countries in the Region to improve the cost-effectiveness of HIV testing strategies and algorithms. In this respect, the Regional Office organized a regional workshop in order to brief national AIDS programme managers on these new developments and to provide an opportunity to discuss comparative advantages and disadvantages of different HIV testing strategies and algorithms depending on the purpose of HIV testing (diagnostic or surveillance).

3.4 Prevention of mother-to-child transmission

According to a survey carried out by the Regional Office in early 2006, comprehensive services for the prevention of mother-to-child transmission (PMTCT) are not yet available in the majority of countries. Out of 20 countries that responded to the survey questionnaire, six have reported having a national PMTCT programme. Eleven countries reported having national PMTCT guidelines. Antiretroviral prophylaxis is offered free of charge in 15 countries, though the coverage of HIV-infected women remained low. Paediatric antiretroviral medicines are available in 11 countries. HIV testing and counselling are routinely offered to pregnant women in 5 countries only.

To promote PMTCT interventions in the Region, WHO/EMRO and UNICEF/MENA joined forces in 2006. The collaboration included UNICEF-led assessment missions in Morocco, Sudan, Tunisia and Yemen, the regional survey on PMTCT implementation, a regional meeting to build consensus on appropriate strategies for PMTCT for the diverse epidemiological and socioeconomic conditions in countries of the Region and the development of a strategic guidance document for PMTCT programmes. In addition, the Regional Office is collaborating with UNICEF in supporting the establishment of PMTCT services in Djibouti and Sudan.

One major obstacle to increasing the coverage of antiretroviral prophylaxis to pregnant women before and during delivery is that cultural barriers make it difficult to identify women at risk of HIV in antenatal care settings. National AIDS programme managers have recommended introducing the routine offer of HIV testing and counselling for pregnant women in settings that serve at-risk

populations and, where affordable, for all pregnant women. However, programme managers emphasized that HIV testing cannot be imposed on women and must remain voluntary and confidential.

3.5 Interventions targeting most-at-risk populations

Albeit the reach and consistent long-term engagement with individuals and communities at risk has proven most effective and absolutely indispensable in particular in countries with low-level HIV epidemics, only a few national programmes have initiated appropriate interventions. Most of these target injecting drug users and there is considerable reluctance to address other high risk populations, namely sex workers and homosexual men. With the exception of the Islamic Republic of Iran, which has a well-known harm reduction programme, none of the countries has implemented the full spectrum of harm reduction activities among injecting drug users. Morocco has declared commitment to the harm reduction approach and has initiated action to make opiate substitution therapy available and to initiate needle and syringe programmes.

WHO, in partnership with the International Harm Reduction Association (IHRA) and with financial support from the DROSOS Foundation, is implementing a project aimed at strengthening the role of civil society organizations in harm reduction in the Middle East and North Africa. The project fosters capacity-building, support to civil society programmes for initiating and strengthening harm reduction activities and networking among harm reduction stakeholders. Three subregional knowledge hubs (training and resource centres) have been identified, in the Islamic Republic of Iran, Lebanon and Morocco. The project was launched at a regional meeting on the HIV prevention among drug users organized by the Regional Office in collaboration with UNODC, UNAIDS and Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ).

3.6 Strengthening surveillance and operational research

Progress has been made in some countries towards the establishment of effective HIV surveillance systems. Morocco succeeded in sustaining its well-functioning HIV surveillance system and Djibouti, Sudan and Somalia made significant progress towards implementing anonymous unlinked sentinel sero-surveillance.

Afghanistan, Egypt and Islamic Republic of Iran successfully carried out HIV bio-behavioural surveys among selected most-at-risk populations in 2006. The importance of such surveys is highlighted by the alarming results of the survey among homosexual men in Egypt, where HIV prevalence was 6.2%. Afghanistan, Egypt, Islamic Republic of Iran, Morocco and Pakistan have become pioneers in this field, and other countries can benefit from their experience. All these countries have benefited from better information on HIV infection rates and behavioural risks with regard to targeting prevention and care services in order to reach the populations most in need.

However, surveillance systems in the majority of countries have remained inadequate in terms of providing reliable information on the extent and trends of the HIV epidemic.

The Regional Office continued to build national capacity in planning and implementing HIV/STI surveillance. Training courses on methodologies for HIV surveillance among most-at-risk populations were held in Islamic Republic of Iran, Sudan and Yemen in collaboration with experts from the Knowledge Hub for HIV/STI Surveillance in the WHO European Region (Zagreb, Croatia). Somalia, Sudan and Yemen were supported in surveillance planning and survey protocol development. The Regional Office also supported candidates from several other countries to attend courses on surveillance at the Knowledge Hub in Croatia.

In 2006, the Regional Office held a consultation with national AIDS programme managers to build consensus on revised HIV case definitions on surveillance in line with globally adopted definitions. Meeting participants recommended that reporting of ‘advanced HIV cases’ should replace reporting of ‘AIDS cases’. The definition of advanced HIV includes, in addition to cases of AIDS, the majority of HIV cases eligible for antiretroviral therapy according to clinical and immunological criteria. In the

era of highly active antiretroviral therapy, reporting of advanced HIV has become more useful than AIDS case reporting.

Each year, the Regional Office supports operational research studies in the field of HIV/AIDS and STIs through its Small Grants Scheme for Tropical and Other Communicable Diseases. In 2006, six studies on HIV/AIDS and STI from five countries were supported covering the areas of risk and protective behaviours, HIV prevalence in special population groups, resistance to antiretroviral medicines and assessment of service delivery.

3.7 Control of other sexually transmitted infections

The Regional Office supported the establishment of a regional network of STI experts, which was launched in December 2006. The aims of the network are to: advocate for strengthening national STI responses in the Region; provide technical support to strengthen national STI responses, e.g. by establishing and maintaining a roster of STI experts who would be available as advocates and consultants to provide technical assistance; and facilitate exchange of experience and information within and beyond the Region.

The STI network secretariat is being hosted at the WHO Mediterranean Centre for Vulnerability Reduction in Tunisia until a suitable national host institution is found.

STI network members had the opportunity to familiarize themselves with methodologies of STI country situation assessment during a skills building workshop.

Under the strategic partnership programme (SPP) with UNFPA, the Regional Office conducted a regional workshop on guidelines for the management of STIs in reproductive health settings for reproductive health and STI programme experts. Following of this workshop, six countries (Afghanistan, Egypt, Pakistan, Somalia, Sudan, Tunisia) submitted successful proposals to the Regional Office for support for strengthening integrated STI prevention and care services to be funded through the SPP.

3.8 Resource mobilization

By the end of 2006, 11 low and low–middle income countries had mobilized more than US$ 130 million for HIV programmes through the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). Recognizing the importance of GFATM as a major funding source, the Regional Office and UNAIDS/MENA assisted countries in proposal development and provided training on proposal development through a regional workshop. In 2006, successful Global Fund proposals secured around US$ 31 million for financing the response in the coming two years in Djibouti, Egypt, Jordan, Morocco and Tunisia.

WHO, in collaboration with IHRA, has mobilized substantial resources (US$ 4 million) from the Swiss-based DROSOS Foundation for strengthening the role of civil society organizations in harm reduction in the Region over a period of 4 years. Additional funds for HIV programme support have been made available through the Governments of Canada, Sweden, Norway, United Kingdom and Germany, UNAIDS and the World Bank.

4. Future challenges and plans

Opportunities for expanding HIV/STI prevention and treatment interventions and for halting or reversing the HIV epidemic in the Region have increased substantially in the past few years. Funding for HIV programmes alone through GFATM and World Bank allows the majority of low income and low–middle income countries to rapidly expand access to prevention and care services. The efficient use of available resources is a major challenge, given the limited experience with HIV interventions in the Region, weak health and social service infrastructures and the still prevailing reluctance of policy-makers and decision-makers to address prevention education of youth effectively and to reach out to those population groups that are most at risk. The need to build consistent high-level political commitment and to generate the necessary sense of urgency remains in most countries of the Region.

Within the framework of the WHO universal access plan, the regional strategy on strengthening health sector response to HIV/STI and the division of labour among UNAIDS co-sponsor agencies in 2007–2008, the Regional Office will focus support on the following areas:

- Strengthening surveillance and programme monitoring
- Expansion and quality assurance of HIV prevention and care services in the health sector with special attention to HIV testing and counselling, antiretroviral therapy and prevention of mother-to-child transmission, blood safety and STI control
- Strengthening HIV prevention and care targeting those at most risk, in particular promoting harm reduction interventions for injecting drug users.