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Contents

1. Introduction: the goal of universal access to HIV prevention, treatment care and support

In 2006, following on the 3 by 5 Initiative, world-wide governments, civil society organizations, UNAIDS co-sponsor agencies and others have expressed their commitment to working jointly towards universal access to HIV prevention, treatment care and support for those in need. WHO, as the specialized United Nations agency for health and the UNAIDS cosponsor responsible for the health sector response to HIV/AIDS, has established priorities for its technical work and support to countries on the basis of five strategic directions. Each of these represents a critical area where the health sector must invest if significant progress is to be made towards achieving universal access.

- Enabling people to know their HIV status.
- Maximizing the health sector's contribution to HIV prevention.
- Accelerating the scale-up of HIV/AIDS treatment and care.
- Strengthening and expanding health systems.
- Investing in strategic information to guide a more effective response.

In 2007, the Regional Office focused its efforts on providing guidance and building capacity in the area of strategic information, while supporting countries according to their specific needs in strengthening and expanding access to HIV care and treatment, testing and counselling and prevention of sexually transmitted infections and injecting drug use related to HIV transmission.

2. Update on the HIV/AIDS epidemic situation in the Region

By the end of 2007, the estimated number people living with HIV (PLHIV) in the Eastern Mediterranean Region reached 530 000 (420 000–700 000), and an estimated 55 000 (28 000–110 000) new HIV infections occurred in 2007[1]. Despite efforts to increase access to antiretroviral therapy in the Region, an estimated 33 000 (28 000–46 000) 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[1].

The difference in estimations between the number of PLHIV in 2006 and 2007, (620 000 versus 530 000, respectively) and in the number of new HIV infections (100 000 versus 55 000, respectively) is largely due to increased availability of reliable data to base estimations on and to improved methods of HIV estimation[1,2]. The seeming decrease, therefore, is artificial and should not be interpreted as a true decrease, as estimates from 2006 and 2007 are not comparable due to changes in the method used for estimation.

The Regional Office collects quarterly HIV and AIDS case reports from countries in the Region. By the end of 2007, countries had reported a cumulative number of 18 574 AIDS cases (not all countries submitted reports). 91% of the reported AIDS cases in the Region to date are adults; 8% are youth aged between 15 and 24 years and 2% are children below 5 years of age. 29% of the cumulative total reported AIDS cases are female.

Out of the total cumulative reported AIDS cases, 31% are with unknown mode of transmission. Out of the total AIDS cases with known mode of transmission, the main mode of HIV transmission is heterosexual (77%), followed by injecting drug use (11%), blood transfusion (5%) and transmission from mother to child (2%). Table 1 gives an overview on the HIV epidemic situation by country.

Estimated HIV prevalence among adults aged 15–49 years in the Region is 0.2 % (0.1%–0.3%) as of the end of 2007[1]. HIV prevalence varies widely between countries. Variations occur also within countries and have been confirmed in some countries through surveys using the same survey methodology in different geographical locations. For example, Morocco and Somalia have been using the methodology of unlinked anonymous sentinel HIV and syphilis sero-surveillance among antenatal care attendees, tuberculosis patients and STI patients consistently in different parts of the country for

[1] *AIDS epidemic update*. UNAIDS, 2007.

[2] *Report on the Global HIV epidemic*. UNAIDS, 2006.

more than a year. These countries are now in a position to observe differences in HIV prevalence within the country and trends over time.

Most countries in the Region report low levels of the HIV epidemic, i.e. <1% HIV prevalence in the general population and <5% in at-risk groups. These countries include Afghanistan, Egypt, Iraq, Jordan, Lebanon, Libyan Arab Jamahiriya, Morocco, Palestine, Qatar, Saudi Arabia, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen. However, limited biological surveillance of HIV infection may mask higher prevalence among specific populations and geographic areas.

Djibouti, Sudan and parts of Somalia are experiencing generalized epidemics (HIV prevalence >1% in the general population). Concentrated epidemics (HIV prevalence >5%) among injecting drug users (IDUs) are established in the Islamic Republic of Iran, Libyan Arab Jamahiriya and Pakistan. Surveillance data from Pakistan from 2006–2007 showed a prevalence of 15.8% among IDUs[3]. In the Islamic Republic of Iran, the prevalence of HIV among IDUs was found to be 18.8% in a 2007 survey[4]. Additionally, some data suggest a concentrated epidemic among IDUs in Oman and Bahrain. A 2006 survey among injecting drug users in Kabul City, Afghanistan showed a HIV prevalence of 3%, pointing to the imminent risk of a growing HIV epidemic in this population.

Table 1. The burden of HIV/AIDS in the Eastern Mediterranean Region, 2007

Country	Estimated HIV prevalence in adult population (%)[a]	Estimated number of PLHIV[a]	Estimated number of people needing ART based on UNAIDS/WHO methodology[b]	Number of adults needing ART according to country estimation[c]	Reported number of people receiving ART[c]
Afghanistan	<0.1%[d]	< 1 000[d]	NA	NA	0
Bahrain	NA	< 1 000	NA	NA	NA
Djibouti	3.1	15 000	4 500	NA	705
Egypt	<0.1	5 300	2 200	NA	209
Iran, Islamic Republic of	0.2	66 000	19 000	8 730	829
Iraq	NA	NA	NA	NA	0
Jordan	<0.1%[d]	<1000	NA	100	53
Kuwait	NA	< 1000	NA	NA	NA
Lebanon	0.1	2 900	940	432	246
Libyan Arab Jamahiriya	NA	NA	NA	1 500	1 000
Morocco	0.1	19 000	5 300	2 230[e]	1 648[e]
Oman	0.5%[d]	3 854[d]	NA	350	260
Pakistan	0.1	85 000	20 000	7 400	550
occupied Palestinian territory	NA	NA	NA	NA	0
Qatar	NA	NA	NA	NA	NA
Saudi Arabia	NA	NA	NA	NA	NA
Somalia	0.9	44 000	6 300	5 284	211
Sudan	1.6	350 000	87 000	52 272	895
Syrian Arab Republic	NA	NA	NA	200	75
Tunisia	0.1	8 700	1 000	NA	298
United Arab Emirates	NA	NA	NA	NA	NA
Yemen Republic of	0.2%[d]	20 000[d]	NA	3150[d]	150[d]

NA: information not available
PLHIV: people living with HIV
Source:
a *Report on the global AIDS epidemic 2006*. A UNAIDS 10th Anniversary special edition. Geneva, UNAIDS, 2006
b *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Progress report 2008*. Geneva, WHO/UNAIDS/UNICEF, 2008
c Country Universal Access Reports 2007
d National AIDS programme, March–June 2008
e UNGASS reporting to UNAIDS/WHO

[3] HIV Second Generation Surveillance in Pakistan. National Report Round II. 2006–2007.
[4] WHO Universal Access Framework Questionnaire Report for Iran, 2007.

Countries in the Region have started to invest in assessments of risk behaviours and HIV prevalence among other vulnerable and most-at-risk populations, such as men who have sex with men, female sex workers, prisoners and mobile populations. Saudi Arabia, Syrian Arab Republic and Yemen initiated surveillance activities in 2007 among these identified populations. HIV prevalence of 9.3% and 6.2% has been detected among men who have sex with men in Sudan[5] and Egypt[6] respectively. In 2005–2006, a prevalence of 0.8% was detected among transvestite male sex workers in Pakistan who have been identified as a high-risk population group[7]. Among prisoners in Khartoum State, Sudan, 8.6% HIV prevalence was recently documented[8].

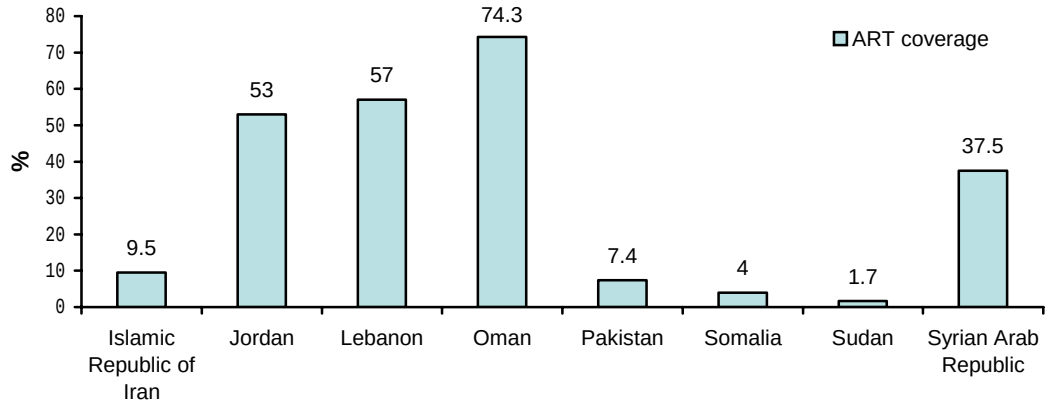
To facilitate cost-effective planning for expanding access to prevention, treatment, care and support to people in need, it is most important for each country to identify its own characteristic epidemiological patterns. This includes estimations of sizes of most-at-risk populations and mapping of risk and vulnerability factors. On the basis of this information, appropriate interventions aimed at protecting those vulnerable and most at risk will be most effective in preventing further expansion of the HIV epidemic.

The Regional Office worked throughout 2007 jointly with Ministries of Health, UNAIDS and its co-sponsor agencies, the Global Fund to Fight AIDS Tuberculosis and Malaria and various other international and national partners towards expanding access to HIV prevention and care services. Efforts focused on the areas of HIV treatment and care, prevention of mother-to-child transmission of HIV (PMTCT), HIV testing and counselling, interventions for injecting drug users (IDUs), control of sexually transmitted infections (STIs) and surveillance of the HIV/AIDS epidemic.

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

3.1 HIV/AIDS treatment and care

In 2007, an estimated total of 150 000 people living with HIV/AIDS were in need of antiretroviral therapy (ART) in the Region, with more than half of them living in Sudan alone. Access to HIV/AIDS treatment and care services continued to expand slowly but steadily in almost all countries. Figure 1 shows data from selected countries. Overall coverage of PLHIV in need of ART is 5%, still the lowest globally[9]. This contrasts with a high coverage (79%) of ART for known PLHIV in need of treatment reported to the Regional Office.



Source: Country universal access reports 2007

Figure 1. Antiretroviral therapy coverage in selected countries of the Region

[5] Elrashied et al, unpublished data, 2006.
[6] Ministry of Health and Population, National AIDS Programme Egypt. *HIV/AIDS Biological and Behavioural Surveillance Survey Summary Report*. Cairo, 2006.
[7] HIV Second Generation Surveillance in Pakistan. National Report Round I. 2005.
[8] Assal, unpublished data, 2006.
[9] *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Progress report 2008*. Geneva, WHO/UNAIDS/UNICEF, 2008.

The main obstacle to expanding access to HIV treatment and care in the Region is the low coverage of HIV testing and counselling for people at risk of infection. As a result, most HIV infected people are unaware of their infection and are not known to health care providers. Other factors resulting in low treatment coverage are related to limited geographical access in countries where ART services are centralized at tertiary facilities, the cost of ART to the public health system, in particular in low income countries, and importantly the lack of experience with reaching out to marginalized and stigmatized populations in most countries.

All countries in the Region except Afghanistan and Iraq are providing HIV treatment and care services at least in their capital city, and most have expanded access to peripheral hospitals. Sudan expanded HIV treatment services to 24 sites in 2007 and 1597 PLHIV in need had been initiated on ART by September 2007. However, ART monitoring data from Khartoum show that there is a high drop out rate (50%) of PLHIV on ART. The possible reasons that are currently being explored may include lack of adherence support through families due to fear of stigma and discrimination if HIV status is disclosed; inadequate adherence preparation (patients being started on treatment too quickly); obstacles to community outreach for adherence support as patients are coming to Khartoum for treatment from far; and incomplete reporting from ART services.

In Somalia, cohort analysis of ART monitoring data shows that overall, 76% of PLHIV initiated on ART were still alive and on treatment after 1 year. The experience from Sudan and Somalia demonstrates the value of careful and standardized monitoring of ART in patients. If individual patient information is aggregated and analysed it can provide valuable information to programme and service managers on strengths and weaknesses of HIV treatment and care services. In order to promote effective ART monitoring in countries of the Region, the Regional Office conducted training for programme managers and monitoring officers in 2007.

A survey on antiretroviral medicine prices carried out by the Regional Office in 2007 showed that many countries unnecessarily continue to pay high prices for these medicines. Some countries introduced generic antiretrovirals at low prices, while other countries only purchase branded antiretroviral medicines at high prices. There is considerable variation in prices of the same medicines between and within the countries. The survey findings were discussed with the AIDS Regional Advisory Group and national AIDS programme managers and it was concluded that this situation can change provided that rational and evidence-based decisions can be made. In order to make informed decisions, if countries agree to provide their procurement prices, the Regional Office can make comparative prices of antiretroviral medicines available on the EMRO website. This will enable countries to negotiate effectively with the suppliers and companies to achieve the best possible price. It was also recommended that low-income and middle-income countries use existing international initiatives and mechanisms for provision of antiretrovirals, such as the HIV/AIDS Initiative of the Clinton Foundation and UNITAID, to access antiretrovirals at negotiated low prices.

Morocco provides a good example for using an evidence-based strategic approach to achieving more affordable prices for antiretroviral medicines. Since the introduction of antiretroviral medicines in 1998, Morocco has introduced measures to reduce their cost, including price negotiations with suppliers, exemption of ARVs for duties and taxes, introducing generic combinations and seeking collaboration with the Clinton HIV/AIDS Initiative. These measures resulted in a reduction of the average price for first-line regimens from US$ 1300 per person per month in 1998 to US$ 48 in 2007. Still, in 2007, Morocco has been paying high prices for some antiretroviral medicines in comparison to other middle-income countries. In 2007, the Ministry of Health reviewed the list of individual and fixed dose combinations being used in the country and selected a smaller number of cost-effective products in order to avoid having to procure in small quantities while ensuring optimal treatment outcomes. As a result, the price for first-line treatment dropped further to US$ 28 per person per month.

Monitoring of HIV drug resistance in the Region is gaining importance as ART is becoming more widely available. WHO has developed the Global Strategy for HIV Drug Resistance prevention, surveillance and monitoring, which was presented to national programme managers and experts in a

regional workshop in 2007. Recognizing the importance of preventing HIV drug resistance, the workshop recommended that each country should develop national plans for HIV drug resistance monitoring and surveillance. As well, all countries offering antiretroviral therapy should initiate collection and analysis of early warning indicators from all or some of the antiretroviral therapy units. However, countries with high incidence rates of HIV such as Djibouti and Sudan as well as those having concentrated HIV epidemics should assess their eligibility for HIV drug resistance surveillance. Countries also agreed to publish an annual national HIV drug resistance report by end of 2008.

3.2 HIV testing and counselling

Making confidential and voluntary 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. General population data on individuals who have undergone HIV testing and counselling is lacking for the Region. VCT services, where they exist in the Region, are still extremely limited in coverage. As part of efforts towards achieving universal access, most countries have set targets for expanding access to HIV testing and counselling access in terms of the number of HIV testing and counselling facilities to be operational, and some progress has been made in setting up additional HIV testing and counselling services. Reportedly, at the end of 2007 Sudan had exceeded its targets by 50% in the north and achieved 4% in the south. The Islamic Republic of Iran, Lebanon, Oman and United Arab Emirates had achieved 100% and Yemen 50% of the targets set[10].

The use of VCT services among populations most at risk is often limited by the unavailability of services adapted to the specific needs of those groups. Few countries have data on access of most-at-risk populations to HIV testing and counselling. In 2007, surveillance among IDUs in the Islamic Republic of Iran showed that 23% had accessed HIV counselling and testing services, while in Oman 1% of IDUs that were accessed through existing programmes had undergone counselling and testing.

Provider-initiated testing and counselling (PITC) in health care settings was discussed at the annual national AIDS programme managers meeting in 2007 as an option to increase access to HIV testing and counselling, in particular for selected population groups that are at elevated risk of HIV infection, including tuberculosis patients and patients with sexually transmitted infections. Moreover, introduction of PITC for pregnant women attending antenatal or obstetric care would facilitate efforts towards prevention of mother-to-child transmission. The discussions underlined that PITC should not be seen as a doorway to mandatory testing and that patients need to reserve the right to accept or decline the test (“opt-in” or “opt-out” approach) as well as the rights to confidentiality, appropriate counselling and referral in a non-discriminatory manner.

3.3 Prevention of mother-to-child transmission

The overall access to prevention of mother-to-child transmission (PMTCT) services and overall proportion of HIV infected pregnant women receiving antiretroviral prophylaxis or treatment to decrease the risk of mother-to-child transmission of HIV in the Region remain very low. The 2007 estimations for antiretroviral prophylaxis coverage of HIV pregnant women are expected to be less than 2%[9].

Only one third of the countries in the Region have functioning national PMTCT programmes. In 2007, WHO and UNICEF provided technical support to a number of countries including Yemen, Pakistan, and Somalia. Yemen has developed a plan for the implementation of PMTCT and selected the first sites. The development of National PMTCT guidelines has been initiated. In Pakistan two training courses on PMTCT were carried out in 2007 following the development of the national PMTCT training curriculum, and PMTCT services are functional in five hospitals. Somalia has reported 8 antenatal care facilities providing HIV testing and counselling as well as antiretroviral medicines for PMTCT. The uptake of HIV testing and the high drop-out of HIV infected pregnant women once included in the programme are major challenges for both countries.

[10] Country universal access reports to EMRO. March 2008.

The Regional Office has finalized a strategic guide for PMTCT interventions in the Region. The document is based on international best practices in PMTCT, the findings from five UNICEF-sponsored PMTCT country assessments (Djibouti, Morocco, Sudan, Tunisia and Yemen), the results of a 2006 survey of PMTCT services in the Region, observations from the PMTCT workshop held by the Regional Office in 2006, and a comprehensive literature review. It provides guidance for concerned Ministry of Health programmes (HIV/AIDS, reproductive health and maternal and child health programmes), policy-makers and service providers, on the selection, implementation and improvement of PMTCT according to the level of resources and the level of the HIV epidemic in countries. It promotes in particular the integration of PMTCT into maternal and child health services, the implementation of provider-initiated HIV testing and counselling for pregnant women attending antenatal care services, and the use whenever possible of longer antiretroviral prophylactic regimens and antiretroviral treatment for women who need it. In addition, the Regional Office is translating the WHO/CDC generic training package on PMTCT into Arabic in order to facilitate training for providers at country level.

The lack of quality data on PMTCT in the Region has been identified as an important bottleneck for the monitoring of PMTCT scaling up and the provision of adequate support to countries. In 2007 the focus of coordination among UN agencies and other partners at global, regional and country level involved in the three international monitoring processes on the national HIV response – UNGASS, Health sector response to HIV/AIDS and the Interagency Task Team (IATT) PMTCT report card questionnaire – was to ensure consistency in reported data while strengthening country capacity for data generation. WHO and UNICEF will jointly analyse PMTCT data and report to countries.

3.4 Interventions targeting populations most at risk

Interventions targeting vulnerable and most-at-risk populations are still neglected in most countries of the Region. At a meeting organized by UNAIDS and attended by a mixed audience of national AIDS programme staff, civil society organizations and UN agencies from the Region, the importance of paying urgent attention to introducing such interventions was stressed.

Recently harm reduction interventions to prevent HIV transmission among injecting drug users have been initiated by an increasing number of countries in the Region. The harm reduction programme of the Islamic Republic of Iran is a large scale comprehensive programme that is regarded globally as a good practice model programme. Morocco has adopted harm reduction as a national policy for preventing HIV transmission through injecting drug use. Lebanon has reconsidered its regulations to allow the introduction of opiate substitution therapy. Oman has reviewed its policy and programmatic factors that may enable or obstruct the introduction of harm reduction measures. Bahrain has completed a behavioural study among injecting drug users in preparation for addressing the risks and Afghanistan has adopted harm reduction as part of its drug control measures.

A joint project between WHO and the International Harm Reduction Association (IHRA), initiated in late 2006, aims at strengthening the role of civil society organizations in harm reduction in the Middle East and North Africa region. It entails the promotion of good practice in harm reduction, advocacy and capacity building. Within this framework, an interim secretariat has been assigned to initiate the Middle East and North Africa Harm Reduction network (MENAHRA); and 3 sub-regional knowledge hubs have been established in the Islamic Republic of Iran, Lebanon and Morocco. The activities of the 3 subregional hubs in the last quarter of 2007 have reached more than 1000 beneficiaries from 11 countries of the Region. Moreover, close to 350 professionals in the field of harm reduction are sharing information through the contact list and website of the MENAHRA interim network secretariat.

3.5 Strengthening surveillance

In 2007, progress towards the establishment of effective HIV surveillance systems has continued. Somalia and Sudan successfully carried out anonymous unlinked HIV and syphilis sero-surveys among pregnant women attending antenatal care, the data from which will be available by mid 2008.

An increasing number of countries are benefiting 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. Yemen is preparing for a HIV prevalence and behavioural survey (bio-behavioural survey) among female sex workers in Aden. The Islamic Republic of Iran is currently carrying out community-based bio-behavioural surveys among prisoners, non-injecting drug users and truck drivers and preparing for surveys among sex workers and injecting drug users in 2008. Saudi Arabia is carrying out a survey among a population of illegal immigrants, and Sudan has ongoing community-based surveys among men having sex with men, sex workers and truck drivers. Pakistan has established a system of regular annual surveys among female and male sex workers, injecting drug users and transsexuals since 2005. Morocco has access to sex workers and prisoners through services provided by nongovernmental organizations. These settings have been used for 2-yearly service-based HIV sero-surveys among these populations. These systems of regular surveys at fixed time intervals using consistent methodologies allow HIV programmes in Pakistan and Morocco to observe trends in sero-prevalence and behaviours over time, to adjust interventions accordingly and to draw conclusions about the impact.

The Regional Office continued to build national capacity in planning and implementing HIV/STI surveillance. It supported reviews of surveillance systems in Egypt, Lebanon and Oman resulting in recommendations on how to enforce or re-direct existing surveillance activities in order to provide more consistent and relevant information for HIV programme planning and monitoring. Surveillance experts from the Islamic Republic of Iran benefited from insight into the HIV surveillance system of Catalunia in Spain in terms of revising the Iranian HIV case reporting system. The Regional Office also supported candidates from several other countries to attend courses on surveillance at the Knowledge Hub for HIV/STI Surveillance in the WHO European Region (Zagreb, Croatia).

In 2007, the Regional Office initiated a Regional Working Group on HIV surveillance in collaboration with the UNAIDS and World Bank. The Working Group developed a joint workplan for strengthening HIV surveillance in countries of the Region covering the areas of policy and technical guidance, capacity building and support to implementation of country surveillance activities. In 2007, joint activities included the development of a technical guide on HIV surveillance in low-prevalence settings and training modules on HIV surveillance methodologies adapted to the needs and priorities of regional countries. Regional experts as well as experts from the University of California in San Francisco, Centers for Disease Control and Prevention in Atlanta and the Knowledge Hub for HIV/STI Surveillance in Zagreb are involved in the development of these documents.

3.6 Control of other sexually transmitted infections

In 2007, the World Health Assembly adopted the global strategies of reproductive health and prevention and control of sexually transmitted infections. The strategies were introduced to reproductive health and STI programme managers from Afghanistan, Djibouti, Egypt, Islamic Republic of Iran, Morocco, Palestine, Sudan, Syrian Arab Republic and Tunisia through an intercountry meeting. Participants had the opportunity to contribute to the development of a regional action plan for the implementation of the global strategies taking into consideration cultural and socioeconomic situations of countries in the Region. Based on both the global strategy and the inputs of regional experts, a STI regional strategy will be developed in 2008.

Within the framework of the WHO/UNFPA Strategic Partnership Programme, the Regional Office assisted during 2007 six countries namely Afghanistan, Egypt, Pakistan, Somalia, Sudan and Tunisia, to strengthen control of sexually transmitted infections by adaptation of WHO STI guidelines and their implementation at national level.

The Eastern Mediterranean Network of STI Control (EMNOSTIC), a registered non-profit organization initiated in 2006, expanded its membership to 26 regional STI experts. In 2007, the network facilitated exchange of information among members and interested others through a website and regular newsletters. With the support of EMNOSTIC members, reviews of existing data on STI

were carried out in Egypt, Lebanon, Pakistan, Sudan and Tunisia to get a better picture of the STI epidemiological situation and to identify information gaps.

3.7 Resource mobilization

By the end of 2007, 12 low and low–middle income countries had mobilized a total of US$ 187.5 million for HIV programmes through the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). The Regional Office and UNAIDS/MENA assisted countries in proposal development and provided training on proposal development through a regional workshop. In Somalia, Sudan and Yemen, WHO has been sub-recipient of GFATM funds amounting to a total of US$ 6.2 million over past years for the provision of technical support to HIV health sector programmes.

Additional funds for HIV programme support have been made available through the Swiss-based DROSOS Foundation (for IDU harm reduction), Governments of Canada, Sweden, Norway, United Kingdom and Germany, the European Commission (for surveillance), UNAIDS and the World Bank.

4. Future challenges and plans

Growing awareness of decision-makers of the cost of HIV in terms of morbidity and mortality and of the availability of effective prevention and care interventions, coupled with increased access to substantial financial support for HIV programmes, is showing a positive impact on progress towards the goal of universal access. The efficient use of available resources remains 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 adopt unconventional approaches to address the needs of population groups that are most at risk, often stigmatized and marginalized and therefore difficult for public health systems to reach.

Within the framework of the WHO universal access plan and the regional strategy on strengthening health sector response to HIV/STI in 2008, the Regional Office will focus support on the following areas:

- Strengthening surveillance and programme monitoring
- Promoting HIV testing and counselling through voluntary client-initiated and provider-initiated testing services
- Expanding access to and quality of HIV treatment and care and prevention of mother-to-child transmission
- Strengthening HIV prevention and care targeting those at most risk, in particular promoting harm reduction interventions for injecting drug users.