

WHO-EM/STD/153/E

Report on the

**Technical consultation  
with civil society  
organizations and  
networks on ending  
the HIV treatment  
crisis in the Eastern  
Mediterranean Region**

Beirut, Lebanon  
19–20 August 2013



**World Health  
Organization**

Regional Office for the Eastern Mediterranean

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## CONTENTS

1.	INTRODUCTION.....	1
2.	OVERVIEW OF THE REGIONAL INITIATIVE TO END THE HIV TREATMENT CRISIS.....	2
3.	TECHNICAL UPDATE: CONSOLIDATED GUIDELINES ON THE USE OF ANTIRETROVIRAL DRUGS FOR TREATING AND PREVENTING HIV INFECTION: RECOMMENDATIONS FOR A PUBLIC HEALTH APPROACH .....	3
4.	SUMMARY OF FORUM DISCUSSIONS.....	4
	4.1 HIV testing and counselling and linkage to treatment and care services.....	4
	4.2 Care and treatment .....	5
	4.3 Community systems .....	6
	4.4 Reflections on civil society priorities and support needed from partners.....	9
5.	THE WAY FORWARD .....	10
	Annexes	
1.	PROGRAMME.....	12
2.	LIST OF PARTICIPANTS .....	13
3.	RANAA POSITION STATEMENT .....	16

## 1. INTRODUCTION

The Middle East and North Africa is one of two regions in the world experiencing growing HIV epidemics. Though the prevalence of HIV remains low in the general population, increasingly countries of the region are documenting epidemics that are concentrated among key populations at increased risk of HIV; namely men having sex with men, sex workers and people who inject drugs.

The growing epidemic is accompanied by low access to and coverage of all prevention, treatment and care services in the region. Despite commendable efforts to make antiretroviral therapy (ART) available in all countries of the region, ART coverage did not exceed 14% in 2011.

The WHO Regional Office for the Eastern Mediterranean launched in 2013 a regional initiative: Ending the Treatment Crisis in the Eastern Mediterranean Region. The initiative is intended to mobilize urgent remedial actions that enable accelerating HIV treatment scale up in the region; and further planning for rapid sustained scale-up.

The civil society organizations of the region have a pivotal role in advocating for and assisting their governments and other partners in ending the treatment crisis. They have firsthand experience as people living with HIV (PLHIV), members of most at risk communities or representatives of nongovernmental organizations providing HIV prevention, treatment and care services to PLHIV and key populations at increased risk of HIV.

The Regional Office, in collaboration with partner agencies – particularly UNAIDS – held a technical consultation for the civil society organizations of the region to explore their views and to deliberate their contribution to ending the treatment crisis in the region. The consultation was held in Beirut, Lebanon on 19–20 August 2013. It was attended by representatives from three regional networks, the Middle East and North Africa Harm Reduction Association (MENAHRRA), Regional Arab Network Against AIDS (RANAA) and MENA-Rosa. Also attending were representatives from three national nongovernmental organizations from the Islamic Republic of Iran, Sudan and Yemen and three United Nations system partners (UNAIDS, UNDP and UNODC), in addition to WHO staff. The meeting programme and list of participants are attached as Annexes 1 and 2, respectively.

The objectives of the consultation were to:

- present to the civil society representatives of the region the “Ending the HIV Treatment Crisis” initiative;
- explore, from the civil society point of view as key stakeholders in the HIV response, the bottlenecks facing increasing coverage of antiretroviral therapy;
- discuss the role of civil society and its contribution to “Ending the HIV Treatment Crisis” and the corresponding support required from WHO and other UN partners; and

- identify necessary tools and guidance material needed in support of civil society involvement in ending the HIV treatment crisis in the region.

Ms Joumana Hermez, Technical Officer, opened the meeting on behalf of the Director of Communicable Disease Control in the WHO Regional Office for the Eastern Mediterranean. She stressed the important role of the civil society in advocating for and delivering services that can help ending the HIV treatment crisis; particularly to those most at risk and with least access to HIV prevention, treatment and care services.

The representatives of the regional networks RANAA and MENA-Rosa solicited input from their network members around the issues discussed in the consultation prior to holding it. This input (attached as Annex 3) provided a basis for the discussion by the networks representatives during the consultation.

## **2. OVERVIEW OF THE REGIONAL INITIATIVE TO END THE HIV TREATMENT CRISIS**

*Ms Joumana Hermez, WHO/EMRO*

The HIV treatment crisis in the region manifests itself as a very low coverage with ART not exceeding 14% of the people in need of treatment. This coverage is the lowest in the world. The low coverage is the result of a cumulus of losses and missed opportunities to engage and retain PLHIV along a continuum of HIV prevention, testing, linkage to care and treatment and retention in lifelong successful treatment. The biggest gap along this continuum is in the number of PLHIV who know their HIV status. Nevertheless, even those who learn their HIV status may be lost from the system due to failure to link them to care or due to attrition from treatment. These are the reasons for the failure to significantly increase the coverage of PLHIV in the region.

The regional initiative to End the HIV Treatment Crisis has the objective of mobilizing urgent remedial action to accelerate treatment scale-up in order to end the treatment crisis in the region, with a vision to achieve universal coverage of HIV treatment by 2020 in all countries of the region. To achieve its objective, the initiative employs high level advocacy towards governments and their partners for increasing commitment and investments to end the crisis. It also seeks building and strengthening partnerships and focuses on country support to countries to optimize policies, strategies and service delivery approaches as well as to strengthen health and community systems to cope with the scale up. This is accompanied by collection and dissemination of the relevant strategic information.

Discussion by the participants highlighted several current and foreseeable challenges to engaging and retaining people living with HIV along the continuum of care. Of the current challenges the participants mentioned the frequent interruption of supply of antiretroviral medications (ARV), the un-assured quality of medications in certain countries, particularly where

they are produced locally. They also emphasized the unavailability of third-line treatment medications as well as the inadequacy of the approaches, services and capacities to the need of special population groups such as people who use drugs and children.

Civil society organization representatives at the meeting expressed concern over the foreseen lack of funding with the changing funding eligibility criteria of the Global Fund to fight AIDS, Tuberculosis and Malaria. This is heightened by the total dependence of certain countries on the Global Fund to avail treatment to those who need it, especially that ARVs are still procured at high prices in the region. In this respect, the participants suggested extensive advocacy towards donors, as well as towards governments to step up commitment and action to ensure uninterrupted supply of ARVs.

Furthermore, the participants at the meeting highlighted the gap in using treatment as prevention. This pertains to early treatment of key populations at increased risk of HIV and the use of ARVs for pre-exposure and post exposure prophylaxis.

### **3. TECHNICAL UPDATE: CONSOLIDATED GUIDELINES ON THE USE OF ANTIRETROVIRAL DRUGS FOR TREATING AND PREVENTING HIV INFECTION: RECOMMENDATIONS FOR A PUBLIC HEALTH APPROACH**

*Dr Agnes Chetty, WHO/EMRO*

They are rooted in the scientific evidence around the benefits of earlier initiation of treatment for the individuals and benefits for public health in terms of reducing transmission. The new WHO guidelines consolidate new and existing recommendations into one document; provide guidance across the continuum of care and across different populations and age groups. The consolidated guidelines are based on the guiding principles of a public health approach that promotes human rights and equity; and that uses a mix of approaches and strategies to maximize effectiveness and efficiency across the continuum of care.

In a nutshell, the guidelines focus on earlier initiation of treatment; at a cutoff of CD4 count  $\leq 500$  cells/ml for asymptomatic persons or irrespective of CD4 count for PLHIV with a serodiscordant partner, all pregnant and breastfeeding women and children under five years of age. They also emphasize the use of simpler, safer and less toxic medications with harmonized first-line treatment regimens for most population groups. The guidelines also call for better monitoring of the response to ART through routine viral load testing.

In their discussion, the participants reflected on the challenges facing the implementation of the new WHO consolidated guidelines at the country level, including of lack of certain ARVs, the poor quality of some and the price at which they are procured. Moreover, the participants highlight the inaccessibility to monitoring tests such as CD4 and/or viral load in some countries, or their prohibitive cost in other countries. Furthermore, the cost of associated diagnostic and care needs can impede access to ART.

## **4. SUMMARY OF FORUM DISCUSSIONS**

### **4.1 HIV testing and counselling and linkage to treatment and care services**

HIV testing and counselling is the first entry point to care and treatment, yet, knowing one's HIV status seems to be the biggest gap along the continuum of care. Mr Shahab Azemati introduced the barriers against access to HIV testing and counselling services. These barriers are caused not only by the limited availability of such services; but also by the limited reach to key populations at increased risk of HIV and limited offer of HIV tests in health care settings. This is accentuated by limited demand for the existing services by different population groups due to low risk perception, lack of trust in the services and their inaccessibility by certain population groups due to inappropriate service delivery approaches.

Further to the limited access to HIV testing and counselling services, there is a considerable gap in linkage of those diagnosed HIV positive to care and treatment services. The poor linkage from HIV testing and counselling to care and treatment services relates to low quality post-test counselling and poor referral and mediation systems. Furthermore, Mr Azemati pointed to inadequate HIV testing strategies that employ complicated laboratory tests which delay returning the results. In the Islamic Republic of Iran, for example, one study showed that one quarter of people who use drugs do not return for confirmatory HIV testing after the initial positive screening rapid test.

From a civil society perspective, the participants highlighted the impediment posed by stigma and discrimination, both in the society as well as in the health services. They emphasized the important role the civil society has been playing in reaching key populations through community based services, the involvement of PLHIV and the mobilization of peer support. Hotlines and nongovernmental organization-based services have been instrumental in overcoming the rigidity of health systems which pose a high threshold against access for people at increased risk of HIV. Civil society organizations have been instrumental in building trust between the service providers and the target groups.

Stressing on the broader sense of the civil society to include the private sector, unions and professional organizations, the participants identified its role in developing advocacy plans and action plans for expanded community based HIV testing and counselling. They highlighted their instrumental role in expanding outreach to key populations at increased risk of HIV and community based HIV testing and counselling; as well as in accompanying newly diagnosed PLHIV until they are successfully linked to care and treatment. However, they cautioned to the need to ensure that the system is prepared to cope with scaling up HIV testing and counselling, particularly in relation to availing ART to those newly diagnosed with HIV as a result.

The participants at the meeting recognized the weakness of nongovernmental organizations as a challenge to fulfilling their role. They called for developing the mechanisms for further



collaboration and coordination among them through the national and regional networks. They also identified a complementary role for the UN partners and regional networks to step up their advocacy efforts to ensure increased political commitment and investment and to avail special important services for key populations at increased risk of HIV, particularly opioid substitution therapy for people who use drugs, and to improve the quality of counselling, particularly post-test counselling for people diagnosed HIV positive. In addition, the UN partners and regional networks should focus on building the institutional and professional capacity of nongovernmental organizations to fulfill their role. Moreover, they requested continued update on technical developments such as self -testing.

## **4.2 Care and treatment**

Guided by inputs collected from PLHIV in Yemen prior to the meeting, Mr Hani Abdo Hasan Saeed introduced key issues related to access to and retention in care and treatment services. He signaled stigma and discrimination in health care settings as a key reason for reluctance to seek care and treatment or to maintain the engagement in those services. Furthermore, frequent stock out of ARV medications is negatively linked to the satisfaction of PLHIV from their treatment and contributes to low adherence rates and dropping out from care and treatment services. Interrupted availability of CD4 testing for long periods is also affecting the quality of care and treatment as well as patient satisfaction. Mr Saeed also pointed to the unavailability of third-line treatment medications as a key challenge to maintaining people on a lifetime successful treatment.

The participants in their discussion stressed that what keeps PLHIV engaged in care and treatment is getting their treatment with dignity. This does not, however, undervalue that good outcome of the treatment and assurance of the continuity of care and treatment as key to patient satisfaction. In contrast, bad experience at the clinic (e.g. due to bad staff attitude, long waits) as well as lack of family support, poverty, recourse to herbal treatment and lack of professional adherence support are key reasons for non-compliance with and dropping out from treatment.

Discussions with civil society participants depicted additional challenges facing access to and retention in care and treatment in the region. Persistent stigma and discrimination in the society and in health services are important deterrents from seeking care and treatment by PLHIV. However, there are further service related barriers such as the cost of baseline and follow-up laboratory tests, the lack of or interrupted availability of CD4 count testing or in some cases the out-of-pocket cost of the test.

Moreover, the participants noted that some service providers refuse to give services to PLHIV who are identified as members of key population groups at increased risk of HIV. They also underscored difficulty of PLHIV to re-engage in care and treatment after dropping out, where they are labeled as incompliant with treatment and the health care providers become reluctant to restart them on treatment. Factors related to the patients that cause dropping out from

treatment relate to a fatalistic acceptance of death from HIV as a “punishment for their sins”, weak treatment counselling doing little help to remedy this exasperation. Furthermore, given the political and security situation in the region, the participants singled out the difficulties faced by the displaced and the refugees to access and to maintain engagement with the HIV care and treatment services.

The participants noted the challenges facing their active involvement. Those pertain to the low status of nongovernmental organizations and PLHIV vis-à-vis decision making related to HIV treatment. PLHIV are in some countries threatened that they would be cut from care and treatment if they complain publicly about the way they are treated or about the quality of their treatment. Moreover, the monopoly of care and treatment services by the medical institutions leaves little room for action by the nongovernmental organizations and PLHIV groups in that respect. On the other hand, the participants acknowledged the limited capacity of the civil society organizations in that respect.

Civil society organization representatives at the meeting found their role in improving access to and coverage of care and treatment services particularly important in advocacy. Advocating for treatment as prevention is particularly important for convincing their government of the need to rapidly scale up care and treatment. Nevertheless, they also found their role in providing adherence support services and home visits to ensure continued engagement in care and treatment; in addition to conducting treatment literacy among PLHIV and mediating the navigation of PLHIV between the community and health services. The participants suggested that, in collaboration with national AIDS control programmes, they would organize regular meetings between PLHIV and health care providers to ensure sharing the issues and concerns and to find commonly accepted remedies.

On their side, UN partners and regional networks should support the actions of the civil society organizations through advocating at the regional level for commitment to scale up treatment and care services and ensuring uninterrupted supply of medications. These partners are also requested to build the capacities of civil society organizations to address the violations of the rights of PLHIV in relation to treatment, to conduct treatment literacy activities and to play the role of community mediators.

### **4.3 Community systems**

Mr Elie Aaraj introduced the topic of community systems. Community systems, as opposed to individual community organizations, develop as a result of the interaction among those community organizations and between them and the conventional health system. The strength of the community systems is derived from the ability of the community organizations to fulfill their role along the continuum of prevention, HIV testing and counselling, care and treatment in terms of: a) an accommodating infrastructure; b) strategic planning; c) implementation of activities and service delivery; d) monitoring and evaluation; and e) financial

management. With this introduction, Mr Aaraj solicited inputs from the participants to identify the weaknesses of the community systems in the region, as well as the opportunities that can be capitalized on for further strengthening.

According to the participants, the extent of contribution of the civil society organizations to the planning, implementation, monitoring and evaluation of the HIV response varies within and between countries and between community organizations. Weak contribution is driven by the weak representation of the civil society organizations on national decision making forums and the weak status of the nongovernmental organizations in the decision making processes. nongovernmental organizations lack the autonomy in many countries to mobilize, receive and spend funds without the approval of their governments. This is accentuated by the weak capacity of nongovernmental organizations in general; lack of human resources and lack of sustained funding. This is impeding the development of HIV programmes and keeping all HIV activities at the level of ad-hoc projects without necessarily sustainable effects.

Due to the cultural and social taboos around HIV and key populations at increased risk of HIV, stigma and discrimination and the above mentioned general weaknesses in the civil society organizations PLHIV groups rarely take the initiative to defend or advocate for their rights or to engage in service delivery.

Currently there are good opportunities in the region to strengthen the role of civil society organizations. Stronger nongovernmental organizations and regional networks can play a crucial role in supporting and building the capacity of weaker organizations. RANAA and MENAHRA regional networks have been taking an active role in capacity building through training and providing grants for nongovernmental organizations and PLHIV groups to engage in advocacy and service delivery. Furthermore, RANAA is supporting the development of national networks of nongovernmental organizations working on HIV to enhance coordination at the country levels. A new network of PLHIV in the Region named "Positive Development" has been established recently; but is yet to start its activities and to expand its membership. MENA-Rosa network of women living with HIV is ensuring the involvement of women and advocating for their rights concerning access to HIV prevention, treatment and care services.

According to the participants, the regional networks should play a more active role in ensuring coordination between the civil society organizations. With their help, civil society organizations should develop clear strategies for communication and coordination. National civil society organizations should seek mechanisms to formalize their coordination with the national AIDS control programmes and with the joint UN teams in countries. UN partners are requested to ensure continued support to civil society to play its role in scaling up HIV treatment and care, through advocating this role and building the capacity of nongovernmental organizations to fulfil it.

*Key advocacy messages and actions for “Ending the HIV Treatment Crisis”*

The participants discussed in plenary key advocacy messages that should be employed in ending the HIV treatment crisis. Earlier this year, RANAA issued a position statement on the role of the civil society sector in continued advocacy to keep HIV high on the agenda of the stakeholders in the region and to reduce stigma and discrimination. It also calls upon governments and their development partners to take urgent action to improve the regional indicators related to the HIV response. This position statement constitutes an umbrella for promoting the role of civil society and their engagement in the HIV response.

The participants agreed that advocacy should be stepped up around the following themes and target audiences.

<b>Theme</b>	<b>Audience</b>
PLHIV have the right to access to comprehensive care and treatment including diagnostic and general health care services	Decision makers
Promoting the right to health for key populations at increased risk of HIV	Decision makers Nongovernmental organizations Religious leaders Media
Civil society organizations are central to effective scale-up of HIV care and treatment through reaching key populations at increased risk and community actions to support engagement in and adherence to care and treatment	Decision makers
Promoting the benefits of treatment to the individuals, but also the public health benefit	Decision makers PLHIV
Promoting the dignity of PLHIV in receiving the services	Decision makers Health care providers
Promoting different approaches to HIV testing and counselling, increasing the availability of services and improving their quality	Decision makers General population
The importance of adherence to ART and the risks of non-adherence	PLHIV
Developing and promoting adherence support services	PLHIV groups nongovernmental organizations health facilities
Promoting the rights of PLHIV to ART and health care, including insurance schemes	Decision makers Private sector
Promoting treatment literacy	Treating doctors and health care workers

#### 4.4 Reflections on civil society priorities and support needed from partners

Ms Rita Wahab, on behalf of MENA-Rosa and in collaboration with RANAA, contacted members of the both networks for their input to the session on civil society priorities prior to the consultation; this is in preparation for the meeting. In this session, Ms Wahab thus shared the observations, concerns and recommendations of PLHIV and of nongovernmental organizations working in the field and opened the discussion for identifying priority actions by the civil society. The following is a list of those priority actions.

- Creating demand for and delivering HIV testing and counselling services
  - Advocacy toward government to allow the use of rapid HIV testing in community based activities (within the nongovernmental organizations or in mobile outreach activities)
  - Redefining the package of services provided in outreach to include active promotion of and linkage to HIV testing and counselling services
  - Conducting HIV testing and counselling service promotion campaigns
  - Conducting HIV testing campaigns
  - Incorporating HIV testing and counselling service promotion and delivery in all their public activities
  - Training nongovernmental organizations and building their capacity in HIV testing and counselling service delivery
  - Involving PLHIV in ensuring successful linkages of those newly diagnosed HIV positive to care and treatment services
- HIV care and treatment
  - Ensuring subsidy for PLHIV to access unsubsidized diagnostic and health care services
  - Monitoring and advocating for the availability of and accessibility to CD4 count tests
  - Reaching out to expand the membership of PLHIV in support groups or for ensuring continued community-based support and follow-up
  - Conducting patient literacy activities
  - Conducting home visits to facilitate the delivery of ARVs to PLHIV in remote areas in order to reduce the need for frequent visits
  - Advocating for longer periods of take home supplies of ARVs in order to reduce the burden of transportation for long distances to collect the ARVs and that of waiting time in health care services
  - Advocating for the dignity of PLHIV in receiving the services and improving their clinic experience in relation to staff attitudes
  - Advocating in an active and timely manner for the prevention of ARV stock outs
  - Conducting an assessment to identify gaps in access to HIV care and treatment by people who use drugs.

Within 2013, the participants foresee the inclusion of the following activities in their existing plans:

- Inclusion of HIV testing and counselling and ART for people who use drugs as topics in the upcoming MENAHRA conference in November
- Promoting HIV testing and counselling during the media awareness activities by MENA-Rosa (supported by the Ford Foundation)
- RANAA is currently developing a proposal with UNHCR regarding HIV prevention among Syrian refugees. RANAA will make sure it includes HIV testing and counselling and linkages to care and treatment.

UN partners help is needed in providing advocacy, training and information, education and communication material and, if possible, supporting the organization of annual HIV testing weeks.

## **5. THE WAY FORWARD**

It was agreed at the end of the consultation that the recommendations and priorities identified by the civil society representatives at the meeting will be taken into consideration while planning the activities of the UN partners, nongovernmental organizations and regional networks present at the consultation during the upcoming 2 years. In parallel, there will be attempts to mobilize the necessary resources to implement them

It was agreed that national AIDS programme managers in the Region would be briefed on the proceedings and recommendations of this consultation at their 21st meeting, to be held in Casablanca, Morocco on 11–13 September 2013.

Furthermore, the participants recommended the following actions.

1. National AIDS control programmes should redefine the package of services provided to key populations at increased risk of HIV to ensure that the people reached are linked to HIV testing and counselling services, to include provider-initiated treatment counselling in the relevant health care settings and to ensure that PLHIV in care and treatment have access to comprehensive services.
2. National AIDS control programmes should recognize the critical role of civil society organizations in improving access to care and treatment along the test-treat-retain continuum of care and should therefore ensure their meaningful and active participation in planning, implementation, monitoring and evaluation of HIV programmes.
3. National AIDS control programmes should ensure that PLHIV have unimpeded access to CD4 and viral load testing at least once a year.

4. UN partners should share existing information, education and communication material related to the continuum of care with the civil society organizations of the region either directly or through the regional networks and should produce new material in Arabic.
5. UN partners should support countries with their monitoring and evaluation systems to enable proper reporting and tracking of progress in scaling up access to HIV care and treatment.
6. UN partners should share best practices in scaling up ART and, in particular, in the reduction of the price of antiretroviral medicines.
7. UN partners and regional networks should undertake capacity-building of civil society organizations, including PLHIV groups, in organizational and programme management, treatment counselling and education and effective linkages between services.
8. Once finalized by WHO, the regional networks should share the report of the consultation with their networks in order to inform them and mobilize their action accordingly.
9. In the light of the prevailing security situation in the region, all partners should ensure that access to HIV prevention, care and treatment for refugees is included in their programmes.
10. All partners and civil society organizations should ensure that the advocacy messages identified during this consultation are mainstreamed in all their advocacy activities and events.

**Annex 1**

**PROGRAMME**

**Monday, 19 August 2013**

08:30 – 09:00	Registration	
09:00 – 10:00	Opening Session Welcome note Objectives of the technical consultation	<i>Ms Joumana Hermez WHO/EMRO</i>
10:00 – 11:00	Presentation on “Ending the Treatment Crisis” initiative and the test-treat-retain cascade concept	<i>Ms Joumana Hermez WHO/EMRO</i>
11:30 – 12:00	Technical update: New WHO treatment guidelines - Q&A	<i>Dr Agnes Chetty WHO/EMRO</i>
12:00 – 14:00	<b>Forum 1:</b> Civil society contribution to “Ending the Treatment Crisis” and the required support from UN – HIV testing and counseling and linkage to treatment and care services	<i>Mr Tariq Zafar WHO Temporary Advisor</i>
15:00 – 17:00	<b>Forum 2:</b> Civil society contribution to “Ending the Treatment Crisis” and the required support from UN – Care and treatment	<i>Dr Otman Mallouk WHO Temporary Advisor</i>

**Tuesday, 20 August 2013**

09:00 – 10:30	<b>Forum 3:</b> Civil society contribution to “Ending the Treatment Crisis” and the required support from UN – community systems	<i>Mr Elie Aaraj WHO Temporary Advisor</i>
11:00 – 13:00	Group work: Key advocacy messages and actions for “Ending the Treatment Crisis” Group work feedback Discussion	
14:00 – 16:00	<b>Forum 4:</b> Reflections on civil society priorities and support needed from partners	<i>Ms Rita Wahab WHO Temporary Advisor</i>
16:00 – 17:00	Way forward Recommendations	<i>WHO EMRO</i>
17:00	Closing session	



**Annex 2**

**LIST OF PARTICIPANTS**

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Ms Joumana Hermez, Technical Officer, HIV/AIDS/STI Unit, WHO/EMRO

### **Annex 3**

#### **RANAA POSITION STATEMENT**

RANAA is the Regional/Arab Network Against AIDS which encompasses national networks of the civil society organizations on HIV as well as associations and support groups of People Living with HIV (PLHIV) in the Middle East and North Africa (MENA).

Whereas the estimated number of people living with HIV in the MENA region reached 570 000 persons according to the report of the UNAIDS of 2012

Whereas the MENA region, a vital part of the world, had been classified as one of the top regions in the world with the fastest growing HIV epidemic, doubled AIDS related mortality rate and concentration of HIV amongst specific demographic groups, as well as lowest rate of access to ARVs

Whereas stigma and discrimination often hinder effective response to HIV, hamper the work to limit the prevalence of HIV and prevent people living with HIV from enjoying the human rights guaranteed by all religious laws and human rights systems such as the right to support, treatment and care...

In this context, we express our concern about the growing number of people living with HIV in our region while the incidence rate is going down in other regions of the world.

We note that this increase is taking place amidst: weak treatment coverage, high stigma and discrimination rate affecting people living with HIV and most vulnerable groups, including even associations operating in the field of HIV; hence threatening the future of development in this region by affecting its most precious asset which is human capacity, in particular affecting the freedom of movement and employment and the freedom to travel for people living with HIV and exposing us to a disaster that we can stave off now through exerting strenuous efforts at the local, regional and international levels.

#### **Based on the foregoing, we confirm the following positions:**

With regard to keeping HIV/AIDS as a priority within the post-2015 development agenda, RANAA will exert pressure over the governments in the MENA region to give special priority to HIV/AIDS including the adoption of a comprehensive multi-sectorial approach in fighting the epidemic covering the health, economic, social, political and legal aspects and others, and will work accordingly in its forthcoming strategy.

We, hereby, confirm the importance of maintaining the HIV and AIDS as an independent chapter in the framework of post 2015 development goals instead of limiting it to the health dimension only.

With regard to limiting stigma and discrimination, RANAA will coordinate and help develop efforts to implement effective programs for the MENA region in order to limit the stigma and discrimination, as an essential step to limit the occurrence of new cases and find a legal framework at the national level guaranteeing the rights of the people living with HIV and the most vulnerable populations to care, treatment, support and social integration, thereby fostering the governments' enforcement of the international human rights related treaties and declarations, and ensuring greater involvement of the people living with HIV in the sustainable development process.

**Based thereon, we call out to:**

- The governments in the region and legislative authorities to foresee the imminent danger threatening the future of development in the region and to play their role in facing the negative implications of the prevalence of the HIV infection through the needed legislation and services,
- The concerned international and regional bodies to consider the specificity of this region and the dire need to increase financial and scientific support to help face the growing prevalence of HIV in the region, in turn threatening and undermining all development efforts in the region and in the whole world.

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