Summary report on the

Twenty-first intercountry meeting of national AIDS programme managers

WHO-EM/STD/159/E

Casablanca, Morocco
11–13 September 2013

World Health Organization
Regional Office for the Eastern Mediterranean

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1. Introduction

Over the past decade the WHO Eastern Mediterranean Region experienced the fastest rate of increase of new HIV infections among all WHO regions. While new infections are increasing, the majority of people living with HIV (PLHIV) do not access HIV testing and, thus do not know about their infection.

All countries in the Region have increased the number of PLHIV who receive lifesaving antiretroviral therapy (ART). However, the Region as a whole continues to lag behind other regions with regard to expanding ART coverage.

Deeply concerned by this situation, Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean, launched an initiative to end the HIV treatment crisis in early 2013 with a letter to all Ministers of Health asking for their commitment to take urgent action to accelerate access for PLHIV to HIV testing, care and treatment.

The WHO Regional Office for the Eastern Mediterranean convened the 21st intercountry meeting of national AIDS programme managers in Casablanca from 11 to 13 September 2014. Participants, namely directors of communicable disease departments from selected countries, national AIDS programme managers, regional HIV experts, people living with HIV, representatives of civil society organizations and UN partner agencies attended this meeting. The main objectives of the meeting were to discuss the causes for slow progress in accelerating HIV treatment in the Region and identify approaches to overcome the treatment crisis.

In his welcome remarks, delivered by Dr Yves Souteyrand, WHO Representative in Morocco, the Regional Director highlighted one of

the greatest challenges to increasing the number of PLHIV who benefit from lifesaving ART in the Region: the fact that the vast majority of people living with HIV do not know that they are infected. Dr Alwan emphasized the role of HIV testing, the crucial first step in linking people living with HIV (PLHIV) to a continuum of HIV care and treatment. Structural, operational, logistical and social barriers – including inappropriate service delivery models, stigma and discrimination – continue to hinder access to HIV testing and treatment, in particular for populations at higher risk of HIV. Dr Alwan urged participants to take all necessary measures to facilitate access to HIV testing, in particular for populations at higher risk of HIV and to take the opportunity of the meeting to discuss optimal approaches to increasing demand for and delivery of HIV testing and treatment services in order to reach significantly more people in need.

To reach the objectives of the meeting, four main inter-related subjects were presented and discussed: 1) the regional initiative on ending the HIV treatment crisis; 2) progress of the elimination of mother-to-child transmission of HIV in the Region; 3) WHO regional training modules for stigma reduction in health care settings; and 4) approaches to HIV testing and counselling in countries of the Region.

Presentations introduced the main subjects as well as country experiences. Discussions took place in the plenary and in groups resulting in recommendations for national AIDS programmes and WHO. One day was dedicated to field visits to intervention sites in Casablanca. Participants had the opportunity to get deeper insight in how diverse service providers can achieve high quality of services for diverse populations and how they complement and link with each other.

2. Conclusions

National AIDS programme managers, regional experts, PLHIV, nongovernmental organziation networks and regional partner organizations were updated on the status of the health sector response in the Region. They had the opportunity to discuss the implementation of the regional initiative to end the HIV treatment crisis at country level. Participants learnt by sharing experiences with the implementation of the regional eMTCT framework and by discussing country-specific and common challenges to engage and retain PLHIV in a continuum of HIV testing, care, treatment and support services. The WHO HIV basic knowledge and stigma reduction training modules were welcomed by participants.

The field exposure of national AIDS programme managers to HIV prevention, treatment and care intervention sites in Casablanca contributed significantly to the success of the meeting. National AIDS programme managers benefited from the Moroccan experience with innovative approaches to reach key populations at higher risk with HIV testing and counselling services, with involving civil society and with successful patient monitoring. The support of the Government of Morocco and its civil society partners in this respect was highly appreciated by participants.

During discussions, participants raised and discussed issues and challenges in terms of accelerating HIV treatment in the Region. They agreed that the main bottleneck for increasing treatment coverage in the Region is the low access to and utilization of HIV testing and counselling HIV testing and counselling services. According to country reports to WHO, the majority of persons tested for HIV in the Region are immigrants (55%), while only 2% of people tested belong

to key populations. A national HIV testing and counselling policy document is only available for 6 countries while only 5 countries have national guidelines on implementing provider-initiated testing and counselling.

Approaches to HIV testing and counselling are very limited, with a heavy reliance on voluntary counselling and testing centres (VCT). VCT services are often under-utilized and their access is often difficult for marginalized and stigmatized populations at higher risk of HIV. Mobile HIV testing and counselling services have been established to facilitate reach to communities at higher risk have been established, however so far with limited reach. Only a few countries offer HIV testing routinely to tuberculosis patients and pregnant women in antenatal care using an opt-out approach. HIV testing for patients with sexually transmitted infections (STI) is particularly challenging. Civil society organizations are often not permitted to perform HIV testing in community settings.

Moreover, little is known on the linkage of people diagnosed with HIV to care and treatment services. VCT services often operate as referral sites for people with signs and symptoms suggestive of HIV, due to the late diagnosis of PLHIV in the Region. The monitoring and evaluation system for HIV testing and counselling is (with exceptions) largely inadequate. In order to move forward to scale up HIV testing and counselling in the Region, countries need to undertake energetic measures, starting by setting HIV testing targets for various subpopulations such as tuberculosis patients, antenatal care attendees, STI patients and key populations at higher risk. Countries need to increase efforts for creating demand for HIV testing and building trust between the services and key populations. Linkages between field outreach targeting key populations and HIV testing services must be

strengthened, along with monitoring and evaluation of HIV testing and counselling services including the monitoring of linkages between outreach, testing and care services.

Participants highlighted further constraints and challenges to accelerating testing and treatment including: a) difficulties with estimating the sizes of target populations, in particular of key populations at higher risk; b) lack of adherence of health care providers to HIV programme policies and lack of ownership by local teams; and c) lack of community involvement in national HIV response. Persistent stigma and discrimination in health care settings has clearly been identified as a key barrier to the delivery and utilization of services.

3. Recommendations

Participants agreed that the contribution of each country is crucial to the achievement of the regional and global targets. In this respect the participants made a number of recommendations to Member States and to WHO.

To Member States

1. Carry out an analysis of the HIV test–treat–retain cascade (led by ministries of health/national AIDS programmes s and involving all relevant stakeholders) using the HIV test–treat–retain cascade analysis guide and tools developed by WHO.
2. Based on the findings of the HIV test–treat–retain cascade analysis, develop HIV treatment acceleration plans to achieve treatment targets.

3. Set targets for: a) the number of PLHIV receiving ART; b) retention (e.g. ≥ 85% after 12 months); c) HIV testing and for adherence/viral load suppression (e.g. ≥ 85% viral load suppression after 12 months).
4. Revise national guidelines on antiretroviral use to align them with recommendations of 2013 WHO antiretroviral guidelines as appropriate to the country's context.
5. Increase the number of PLHIV who know their HIV status and link them to care and treatment.
   5.1 Choose a combination of HIV testing and counseling service delivery approaches according to epidemic context to achieve maximum diagnosis of HIV positives.
   5.2 Create demand for HIV testing by: a) revising the communication strategies with a view to demystify and de-stigmatize HIV in the minds of policy-makers, populations and service providers; b) expanding provider initiated HIV testing in clinical settings using an opt-out approach (tuberculosis, STI, antenatal care, hepatitis B/C patients and others such as inpatients); and c) expanding HIV testing in community settings through partnerships with civil society organizations and the involvement of community health workers.
   5.3 Develop guidelines and protocols for HIV testing and counselling in community settings and involve/build the capacity of civil society organizations for service provision along these guidelines. Make use of rapid tests to enable same-day results.
   5.4 Develop approaches to ensure linkage to care, treatment and psychosocial support following HIV testing (e.g. decentralization of care and treatment services,peer

accompaniment, integration of ART maintenance in community settings where feasible).

6. Review retention along the PMTCT cascade and strengthen linkages between maternal, paediatric, HIV testing and ART services to achieve retention (e.g. ≥ 80% in PMTCT and ≥ 80% linkage of eligible women to ART).
7. Make use of WHO training modules on basic HIV knowledge and stigma reduction for health workers to prevent stigma and discrimination in health care settings.
8. Integrate elements of the modules in curricula of schools for nurses, midwives, medical schools, maternal and child health training, etc.
9. Carry out in-service training of health workers prioritizing those whose services are required for health care for PLHIV (gynaecologists, midwives, dermatologists, surgeons, dentists, tuberculosis care providers, providers of mental health services, harm reduction and drug dependence treatment, prison health services etc.).
10. Involve PLHIV as resource persons in the training of health care workers.
11. Monitor the effectiveness of the training in terms of reducing stigmatizing and discriminatory practices.

To WHO

12. Provide support to national AIDS programmes to carry out HIV test–treat–retain cascade analysis and to develop testing and treatment acceleration plans.
13. Provide guidance on the use of rapid testing (including in community settings).

14. Support Member States in the antiretroviral guideline adaptation and roll-out.
15. Continue to facilitate exchange of experience between countries in the Region.
16. Share the training modules on basic HIV knowledge and stigma reduction in health care settings with all national AIDS programmes and partner agencies and with Arab Medical Board.

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