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Progress report on the regional strategy for health sector response to HIV 2011–2015

Introduction

1. The regional strategy for health sector response to HIV 2011–2015 was developed in 2010 through a broad consultative process with relevant stakeholders in the Eastern Mediterranean Region and endorsed by Member States at the 57th session of the Regional Committee for the Eastern Mediterranean in resolution EM/RC57/R.5. The goal of the strategy is to reduce the transmission of HIV and to improve the health of people living with HIV (PLHIV).

2. The most important outcomes expected from the regional strategy are: a) improved information on local dynamics of the HIV epidemic to enable strategic decision making; b) increased coverage of people at risk of HIV infection or transmission with HIV prevention services; c) increased coverage of people living with HIV with HIV care and treatment services; and d) strengthened capacity of health systems to enhance quality, coverage and sustainability of HIV and other services.

3. The strategy identifies priorities for countries, taking into account the epidemiological situation in the Region and the main obstacles and challenges faced by governments, civil society and their partners. This report presents progress towards achieving the objectives and implementing the strategic priorities and interventions laid out in the strategy.

Progress by objective

Objective 1. Generate relevant and reliable information on the HIV epidemic and the response to enable strategic decision-making

4. By the end of 2013 the estimated number of PLHIV in the Region was 280 000, including 16 500 children aged 0–14 years. More than half of adults living with HIV were men (58%). New infections reached 37 000 (including 2700 children) and 16 000 people died of AIDS. While the percentage of general adult population living with HIV in the Region remained among the lowest globally (0.1%), there is increasing evidence that certain populations have been disproportionately affected.

5. Experience and local capacity in conducting HIV prevalence surveys among populations at higher risk of HIV has increased. Epidemiological studies have documented elevated HIV prevalence among these populations in many settings, with recent surveys reporting levels of up to 87% among people who inject drugs and 18% among prisoners in Libya, 15.4% among female sex workers in Djibouti, and 13% among men who have sex with men in Tunisia. However, HIV prevalence data on populations at higher risk are still not available for most member states of the Gulf Cooperation Council.

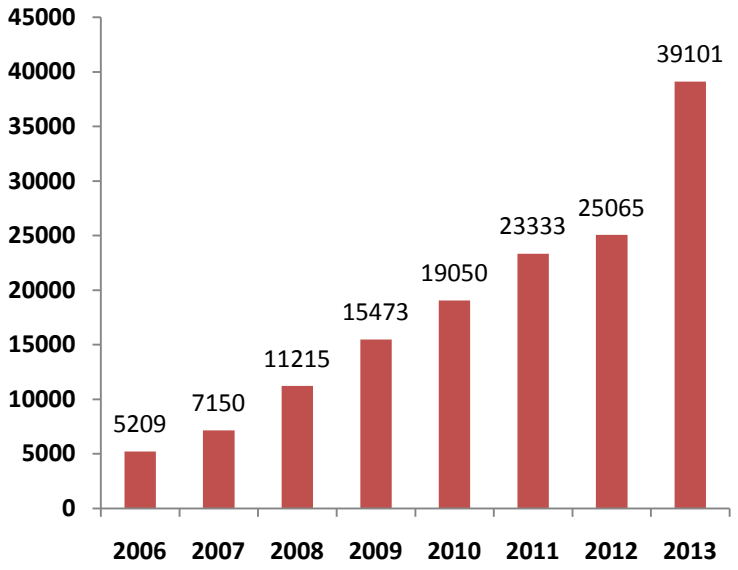
6. During 2011–2013, Djibouti, Islamic Republic of Iran, Morocco, Sudan and Tunisia and conducted studies to estimate the proportion of new HIV infections attributed to various groups at risk. These studies revealed very diverse dynamics of the HIV epidemic in the different countries: in the Islamic Republic of Iran, 56% of new infections occur among people who inject drugs and 12% among their sexual partners;

in Morocco, 24% of new infections are among female sex workers and 24% among their male clients; and in Tunisia, 84% are attributed to transmission between men who have sex with men.[1,2,3]

7. The number of countries in the Region reporting on universal access health sector indicators for HIV is steadily increasing and reached 20 in 2013. However the quality and completeness of data reported varies. There is a need to strengthen systems for collection, collation, reporting and evaluation of clinical, programmatic and community-based data.

Objective 2. Increase access to HIV care and treatment services for people living with HIV

8. There has been progress in the Region: the number of people living with HIV (PLHIV) receiving life-saving antiretroviral therapy (ART) increased between 2011 and 2013 faster than in previous years and reached 39 101 by the end of 2013 (Fig. 1, Table 1). All countries in the Region have reported an increase in the number of PLHIV on ART yearly since 2006. In particular, Morocco and Tunisia have made great strides to improve access and by the end of 2012 achieved ART coverage of 49% and 56%, respectively. The Islamic Republic of Iran has also enrolled approximately 1000 new PLHIV on treatment each year for the past 3 years. [4,5]



Sources: Towards universal access: scaling up priority interventions in the health sector: progress reports. Geneva: World Health Organization; 2007–2011. Global AIDS response progress reporting, country reports 2012–2013.

Fig 1. Number of people receiving antiretroviral therapy in the Region, 2006–2013

[1] Mumtaz GR, Kouyoumjian SP, Hilmi N, Zidouh A, El Rhilani H, Alami K, Bennani A et al. The distribution of new HIV infections by mode of exposure in Morocco. Sex Transm Infect. 2013;89 Suppl 3:iii49–56.

[2] Nasirian M, Doroudi F, Gooya MM, Sedaghat A, Haghdoost A. Modeling of human immunodeficiency virus modes of transmission in Iran. J Res Health Sci. 2012;12(2):81–7.

[3] HIV surveillance in the WHO Eastern Mediterranean Region: regional update 2012. Cairo: WHO Regional Office for the Eastern Mediterranean; 2013.

[4] Global AIDS response progress reporting, 2012 country reports

[5] Global AIDS Response Progress Reporting, 2013 country reports

Table 1. Number of PLHIV on treatment (ART), number of mothers accessing treatment for prevention of mother-to-child transmission (PMTCT) and percentage of pregnant women tested for HIV, by country, 2011 and 2013

Country	PLHIV on ART		Pregnant women on treatment for PMTCT		Percentage of pregnant women tested for HIV	
	2011	2013	2011	2013	2011	2013
Afghanistan	111	211	7[a]	5	NA	0
Bahrain	NA	NA	0	0	NA	NA
Djibouti	1328	1743	47	22	60	NA
Egypt	760	1171	7	9	NA	9
Iran, Islamic Republic of	2752	4470	74	132	NA	0.5
Iraq	5	NA	0	NA	NA	NA
Jordan	108[a]	111	1[a]	0	NA	NA
Kuwait	186	238	6	0	NA	NA
Lebanon	425	665	0	7	NA	NA
Libya	NA	2662	0	54	NA	NA
Morocco	4047	6464	124	182	NA	12
Oman	661	821	23	26	99.4	99.5
Pakistan	2491	4391	57	126	NA	NA
Palestine	NA	NA	0	NA	NA	NA
Qatar	88	NA	1	0	NA	NA
Saudi Arabia	1850	2597	0	41	NA	NA
Somalia	1139	1627	79[a]	56	6.2	51.8
South Sudan[b]	3442	6899	918	1056	82	19.6
Sudan	2500	3308	76	74	2.6	7.3
Syrian Arab Republic	130	NA	0	NA	NA	NA
Tunisia	483	546	9	12	0.3	0.2
United Arab Emirates	202	276	4	4	100	100
Yemen	625	901	17	13	0. 6	0.4
Total	23333	39101	1450	1819		

NA: Data not available
Sources:
Data obtained from Global Aids Response Progress Reporting Online Tool (GARPR). Data for 2013 unvalidated and as reported by countries.
[a] UNAIDS GARPR data accessed through AIDSinfo database 20.5.2014 (aidsinoonline.org)
[b] South Sudan was a Member State of the Eastern Mediterranean Region until June 2013

9. The progress, however, has not been on a scale required to substantially influence ART coverage for the Region, which at 15% at the end of 2012 remains far from the regional target of 50% by 2015 and even further from the universal access target of 80%. Furthermore, the increase in the number of PLHIV receiving treatment in the Region can mask important disparity in access. For example, the number of children on HIV treatment has increased only slightly in the past 5 years (regional paediatric ART

coverage 6% at the end of 2012) and key populations at increased risk of HIV, such as people who inject drugs, continue to face multiple barriers to access HIV treatment in the majority of countries.

10. In 2013, the WHO launched new HIV treatment guidelines which recommend expanded ART eligibility and the use of improved ART regimens.[6] The majority of the countries in the Region have updated their national guidelines in line with new WHO recommendations. The number of new HIV infections in the Region is increasing rapidly. Additionally, expanded ART eligibility means that more PLHIV are now eligible for ART. These rapidly changing numbers create a challenge for reaching treatment coverage targets.

11. A continuous, uninterrupted supply of antiretroviral drugs (ARVs) is essential to ensure good treatment outcomes. Shortages of ARVs are rarely reported in the Region: of the 12 countries that reported data in 2013, only 2 experienced ARV stock-outs during the reporting period. Retention on ART at 12 months is improving; in 2013, 9 out of 15 countries reported 12-month retention rates above 80%. However, a few countries have unacceptably low ART retention rates. WHO is now supporting these countries to implement interventions (patient tracking registers, retention strategies) to improve ART retention rates.

12. HIV testing constitutes the entry point for PLHIV to a continuum of care and treatment. The low HIV prevalence in the general population and the concentration of the HIV epidemic in marginalized and stigmatized populations poses a major challenge in terms of reaching PLHIV who are unaware of their HIV infection with HIV testing and counselling services. Member States continue to struggle with determining the least costly, least resource-intensive strategies and service delivery approaches for increasing the number of PLHIV who know their HIV status.

13. In low prevalence settings WHO recommends focusing on creating demand for testing among populations at higher risk and to offer voluntary HIV tests routinely to patients with tuberculosis or sexually transmitted infections (STI) and to people who inject drugs and are seeking drug treatment services or needle and syringe programmes. Countries aiming at eliminating mother-to-child transmission should offer HIV testing to all pregnant women attending antenatal care. In the Region, 14 out of 22 countries have adopted policies that require a routine offer or universal HIV testing among tuberculosis patients, yet the total reported number of tuberculosis patients who received an HIV test in the Region in 2012 was only 11 863. Four countries reported HIV testing among STI patients with a total number of 19 670 patients tested.[7]

14. Few countries report on progress in terms of reaching sex workers, men who have sex with men and people who inject drugs with voluntary HIV testing services. In 2013, reported HIV testing coverage among sex workers was highest in Lebanon (64%) and Morocco (25%), while Afghanistan, Egypt, Pakistan, Sudan and Tunisia reported coverage between 1% and 13%. Similarly, between 31% and 57% of men who have sex with men reported having taken an HIV test during the previous 12 months in Egypt, Lebanon and Morocco. However, this figure remained below 20% in Afghanistan, Sudan and Tunisia. Between 20% and 25% of people who inject drugs reported having taken the test in the past 12 months in Afghanistan, Islamic Republic of Iran and Tunisia, and fewer than 10% in Egypt, Morocco and Pakistan.5

[6] Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization; 2013.

[7] WHO Regional Office for the Eastern Mediterranean HIV surveillance questionnaire survey 2013

15. Stigma associated with HIV/AIDS and discriminating attitudes and practices against these key populations prevail in communities and are still encountered in health care settings. To assist national AIDS control programmes in their efforts to reduce stigma and remove a major barrier to voluntary HIV testing, the Regional Office, in collaboration with the Ministry of Health in Morocco, developed a training course for health workers on basic HIV knowledge and stigma reduction.

16. To address the low HIV testing and treatment coverage, a regional initiative to end the HIV treatment crisis was launched in 2013 by WHO in collaboration with UNAIDS. The aim of this initiative is to catalyse HIV treatment acceleration in priority countries. The Regional Office has developed tools and guidance to help countries conduct test–treat–retain cascade analysis, followed by the development of treatment acceleration plans.[8,9]

Objective 3: Increase access to HIV prevention services for people at risk of HIV infection and HIV transmission.

Prevention of mother-to-child transmission

17. Following the launch of Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive, a regional framework for the elimination of paediatric HIV was launched in 2012. Since then, several countries have developed national plans for the elimination of mother-to-child transmission of HIV (eMTCT). Despite some progress in a few countries, at regional level PMTCT coverage remains very low: <10% at the end of 2012.

18. The main barrier lies with HIV testing of pregnant women. 12 countries of the Region report routinely offering or systematically conducting HIV tests for all pregnant women. Four countries reported risk assessment-based offer of HIV test to pregnant women. The overall coverage of HIV testing in antenatal care in the Region remains extremely low, around 1% since 2010. The United Arab Emirates and Oman reported high coverage of HIV testing among pregnant women: 100% and 99.5%, respectively. Morocco, Somalia and Sudan have demonstrated steady increase in the coverage of HIV testing among pregnant women since 2011.

19. There are also other challenges along the PMTCT care continuum for mothers and their babies; once identified as HIV infected, many pregnant women are lost to follow up and fail to benefit from the full package of eMTCT interventions. Efforts are being made to build synergies with maternal and child health programmes and other UN partners to improve the eMTCT response in the Region.

Prevention of HIV transmission targeting key populations at higher risk

20. Three out of five targets of the regional health sector strategy for HIV aim at increasing the coverage of HIV prevention for key populations at higher risk. The strategy promotes comprehensive HIV prevention packages for men who have sex with men and sex workers, opioid substitution therapy and needle and syringe programmes for people who inject drugs, each with a coverage target of at least 20%.

21. The measurement of progress towards the regional target has been challenged by the lack of reliable population size estimates in most countries of the Region. Morocco, Sudan, Tunisia and Yemen have conducted MSM population size estimations. These estimates, together with programme data, enabled

[8] Accelerating HIV treatment in the WHO Eastern Mediterranean and UNAIDS Middle East and North Africa regions. Cairo: WHO Regional Office of the Eastern Mediterranean and UNAIDS; 2013

[9] HIV test–treat–retain cascade analysis. Guide and tools. Cairo: WHO Regional Office of the Eastern Mediterranean; 2014.

determining the HIV prevention programmes coverage in 2013 in Morocco (53%), Tunisia (37%) and Yemen (29%). Similarly Morocco, Pakistan, Sudan and Tunisia reported, respectively, 42%, 14%, 6% and 28% of sex workers reached with an HIV prevention package. No other countries reported such data.5

22. After the Islamic Republic of Iran, Lebanon and Morocco introduced opioid substitution therapy for the prevention of HIV among people who inject drugs between 2011 and 2013. Afghanistan and Pakistan have pilot projects which have demonstrated the feasibility and effectiveness of opioid substitution therapy in each respective country. However, the pilot projects are at risk due to the reluctance of drug control authorities to allow the use of methadone and buprenorphine, the medicines of choice in opioid substitution therapy, for the treatment of people who inject drugs. The Islamic Republic of Iran has wide-scale coverage of opioid substitution therapy among injecting and non-injecting drug users reaching over 36% of the total population of opiate users. Coverage with such therapy is difficult to determine in Lebanon, where there is no reliable estimate of the population size of opiate users. Morocco has yet to scale up access to opioid substitution therapy, with a current coverage of 13%.

23. Due to changes in the global indicators with which regional indicators have been aligned, data that are currently collected from countries do not allow measuring the progress towards the regional target of at least 20% of people who inject drugs who have been regularly reached with needle and syringe programmes. The number of syringes distributed per injecting drug user per year can be used as a proxy indicator. Afghanistan, Egypt, Islamic Republic of Iran, Pakistan and Tunisia reported between 1.3 and 131 syringes distributed per person who injects drugs per year. Except for the Islamic Republic of Iran (131 syringes/person/year) this coverage level is considered low in all countries, according to the indicative targets for coverage levels required to achieve an impact on HIV incidence.5

Objective 4: Contribute to health systems strengthening

24. Health systems in many low-income and lower–middle income countries in the Region are not yet well positioned to accommodate the specific needs of HIV programmes. Grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria have been used to strengthen health system functions including service delivery, procurement and supply management and health information management. However, HIV programmes still tend to invest in and rely, to varying degrees, on parallel systems. The Regional Office encourages Member States to assess interactions between HIV programmes and health systems critically and to identify opportunities for integration and health systems strengthening.[10]

Future plans

25. In 2013, the Regional Committee in resolution EM/RC60/R.1 urged ministers of health to set ambitious national testing and treatment targets and to develop action plans to achieve these targets. Achieving regional and global targets for 2015 will require accelerated efforts by all countries. The commitment and success of the four countries contributing to 80% of the regional need in ART, namely Sudan, Islamic Republic of Iran, Somalia and Pakistan, will be decisive in terms of the Region's achievements as a whole.

[10] Guide for rapid assessment of interactions between HIV programmes and health systems. Cairo: WHO Regional Office for the Eastern Mediterranean; 2014.

26. Accelerated efforts should focus on:

- Reducing stigma and discrimination in health care settings
- Improving knowledge of populations at higher risk (size estimations, mapping behaviours, prevalence of HIV and sexually transmitted infections).
- Identifying the causes for low HIV testing and treatment coverage (HIV test–treat–retain cascade analysis)
- Setting ambitious HIV testing and treatment targets and developing urgent action plans to fill coverage gaps.
- Implementing strategies and service delivery approaches as recommended in the document Accelerating HIV treatment in the Eastern Mediterranean and Middle East and North Africa Region.