Report on the
Consultation on HIV testing and counselling policies and practices in the Eastern Mediterranean Region

Alexandria, Egypt
19–20 November 2008
Report on the

Consultation on HIV testing and counselling policies and practices in the Eastern Mediterranean Region

Alexandria, Egypt
19–20 November 2008
# CONTENTS

1. INTRODUCTION.............................................................................................................1

2. TECHNICAL PRESENTATIONS......................................................................................1
   2.1 Background..............................................................................................................1
   2.2 WHO and UNAIDS policy recommendations on HIV testing and counselling ..........2

3. RESULTS OF THE REVIEWS OF TESTING AND COUNSELLING POLICIES AND PRACTICES IN THE REGION .................................................................3
   3.1 Review of HIV testing policies in the Region................................................................3
   3.2 Review of HIV testing practices in the Region ..........................................................4
   3.3 Testing data in the Region, what does it reveal? .........................................................5
   3.4 Challenges in scaling up testing and counselling .......................................................7
   3.5 Introduction to WHO tools for operational research on HIV testing and counselling ..8

4. GROUP WORK 1: REVIEW OF CURRENT PRACTICES IN THE REGION AND THEIR ETHICAL AND PUBLIC HEALTH SOUNDNESS ..............................................9
   4.1 Mandatory testing ..................................................................................................9
   4.2 Provider- and client-initiated testing and counselling ..............................................10
   4.3 Testing for surveillance ...........................................................................................11
   4.4 Testing for blood transfusion safety ........................................................................11

5. GROUP WORK 2: PRACTICAL STEPS TO SCALE UP TESTING AND COUNSELLING IN THE REGION .....................................................................................12
   5.1 Case study 1: Scaling up HIV testing and counselling among IDUs .........................12
   5.2 Case study 2: Scaling up HIV testing and counselling among tuberculosis patients ..................................................................................................................12
   5.3 Case study 4: Scaling up HIV testing and counselling among STI clients ...............13
   5.4 Case study 5: Scaling up HIV testing and counselling in health care settings ..........13
   5.5 Further recommendations for blood safety .............................................................13

6. CONCLUSIONS............................................................................................................14

7. RECOMMENDATIONS...............................................................................................14

Annexes

1. PROGRAMME ..........................................................................................................17
2. LIST OF PARTICIPANTS ............................................................................................19
1. INTRODUCTION

The WHO Regional Office for the Eastern Mediterranean (EMRO) organized a consultative meeting to consider the current situation of HIV testing and counselling policies and practice in the Eastern Mediterranean Region. The meeting was held in Alexandria, Egypt, from 19 to 20 November and formed part of the Eighteenth intercountry meeting of national AIDS programme managers. The meeting was attended by national AIDS programme managers or their representatives from all countries in the Region, members of the HIV/AIDS and STD Regional Advisory Group (ARAG), and representatives from international organizations, staff from WHO headquarters, and HIV officers from WHO country offices. The objectives of the meeting were to:

- review and discuss the results of the regional assessment of current testing and counselling policies and practices in the Region;
- discuss means to scale-up access to HIV testing and counselling services in the Region, including the introduction of provider-initiated HIV testing and counselling (PITC);
- reach consensus over recommended testing and counselling policies and practices in the Region.

The opening remarks of Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, were read by Dr J. Mahjour, Director of the Division of Communicable Diseases, WHO Regional Office for the Eastern Mediterranean. Dr Gezairy emphasized the importance of expanding access to HIV testing and counselling in the Region as a pivotal intervention needed to enable access to HIV treatment and care and positive prevention services. He said that the Region ranked lowest in the world in terms of access to antiretroviral therapy which was mainly affected by the low access to HIV testing and counselling, particularly for at-risk populations and the low coverage of voluntary HIV testing and counselling, and yet widespread, mandatory testing in the Region, despite WHO recommendations discouraging the latter due to ethical and public health concerns. Mandatory testing was often wrongly perceived as an effective public health measure to prevent the spread of HIV. However, when looking at the public health effects of mandatory testing closely, it was observed that too often it diverted attention and public health investment from those who were marginalized and most at risk of HIV infection to lower risk population groups, such as pre-marital couples and employment seekers, because the latter were more likely to come in touch with the government system. Dr Gezairy stressed the importance of applying a human rights-based approach to ensure increased uptake of both client- and provider-initiated HIV testing and counselling in the Region.

The Chairmanship was shared on a rotating basis. The programme and list of participants are included as Annexes 1 and 2, respectively.

2. TECHNICAL PRESENTATIONS

2.1 Background

Recommendations were developed at the 2007 national AIDS programme managers meeting to investigate obstacles towards accessing HIV testing and counselling in countries and to initiate steps for expanding access to client-initiated, as well as to provider-initiated testing and counselling
services. Programme managers requested WHO to provide guidance on strategies and policies to expand public health and sound and ethical testing and counselling. In response to the recommendation to WHO the Regional Office consulted with UNAIDS, UNICEF, the United Nations Population Fund (UNFPA) and the United Nations Development Programme (UNDP) and agreed on the following activities: 1) conducting reviews of HIV testing policies and practices in the Region; 2) holding a technical consultation meeting with programme managers, resource persons, people living with HIV (PLHIV), partner agencies for discussion and consensus-building on recommended HIV testing and counselling policies and practices; and 3) use of recommendations for advocacy (e.g. WHO Regional Committee) and planning for action at country level. In response, a review of HIV testing and counselling policies were outsourced to Dr Mehdi Karkouri, Association de Lutte Contre el Sida (ALCS), Morocco, and a review of practices, including country case studies to Family Health International, Egypt. These reviews will be presented within the meeting. The objectives of these reviews are to:

- develop an overview of HIV testing* and counselling policies and practices in the Region (testing for any purposes; with or without counselling);
- discuss the conformity of globally recommended policies and practices;
- discuss the implications of policies and practices on the beneficiaries of HIV testing/counselling services;
- identify weaknesses and strengths of the current counselling and testing policies and practices;
- recommend key strategic actions that may strengthen and facilitate increasing access to HIV testing and counselling in the Region.

Together, national AIDS programme managers, technical experts and people affected by HIV attending this consultation will be able to discuss the results of these reviews and agree on sound and ethical scale-up of HIV testing and counselling.

2.2 WHO and UNAIDS policy recommendations on HIV testing and counselling

Dr F Amolo Okero, HIV Department, WHO headquarters, Geneva

Noteworthy developments in the evolution of HIV testing and counselling have included the introduction of policy statements and guidelines by WHO and UNAIDS. The Forty-fifth World Health Assembly resolution of 1992 stated “there is no public health rationale for any measures that limit the rights of the individual, notably measures establishing mandatory screening” and the underlying principles of all HIV testing is that it should be confidential, accompanied by counselling, and conducted with informed consent (i.e. informed and voluntary; maybe informed right of refusal). Consequently, WHO and UNAIDS do not support coercive or mandatory testing of individuals on public health grounds. Exceptions for mandatory testing include all blood destined for transfusion or manufacture of blood products and all procedures involving transfer of bodily fluids or body parts (corneal grafts, artificial insemination, organ transplant). Guidelines for client- and provider-initiated HIV testing and counselling (PITC) were presented with a reminder that provider-initiated HIV testing and counselling should not be confused with mandatory or compulsory HIV testing. Provider-initiated HIV testing and counselling should include the pre-test information and informed consent, HIV test, post-test counselling for negative and positive persons and referral to other HIV services as needed. Persons should not be tested for HIV against their will,
without their knowledge, without adequate information, without receiving their test results, and without linkage to necessary services. There are now many approaches to HIV testing and counselling directed to individuals, couples, group counselling, and conducted in settings as varied as health facilities, mobile clinics and special testing events. WHO seeks to support countries, in not only helping more people to know their HIV status, but also to ensure the quality of counselling, the testing and referrals to subsequent prevention, treatment and care services. Monitoring the health sector has a number of different components, including measuring the quality of HIV testing and counselling and needs to be incorporated in country planning. WHO is collaborating with partners to develop the following new guidance on HIV testing, including UNODC/WHO/UNAIDS position statement on HIV testing and counselling in prisons and other closed settings and guidance on counselling children and the parents/caregivers on HIV status and disclosure.

3. RESULTS OF THE REVIEWS OF TESTING AND COUNSELLING POLICIES AND PRACTICES IN THE REGION

3.1 Review of HIV testing policies in the Region

Dr Mehdi Karkouri, WHO Temporary Adviser

The review was conducted by distributing questionnaires distributed to national AIDS programme managers, UN agency officers and other stakeholders, reviewing existing publications in the Region from a wide variety of sources and using Internet search engines (e.g. PubMed and Google) using key terms in English and French. The review of policies in the Region was conducted between December 2007 and March 2008. Accuracy of results could not always be guaranteed due to a reliance on documents found on the Internet and published literature and a low response rate to the questionnaire distributed among countries. Testing approaches in the Region have variations in the availability, accessibility and quality of HIV testing and counselling, few formal policies on testing are available and there are uneven practices regarding HIV testing, which does not always incorporate the ‘3 Cs’. Mandatory screening of various groups is conducted and there is limited access to HIV testing and counselling services for key populations at higher risk. With regard to different testing approaches, voluntary testing and counselling and client-initiated testing and counselling have low access and uptake and few national policies. Provider-initiated HIV testing and counselling was noted to be rarely undertaken in the Region and where it does exist it is provided for injecting drug users (IDUs), tuberculosis and sexually transmitted infections (STI) patients and women using antenatal care services. It was noted that a prerequisite supportive environment was not always provided for provider-initiated HIV testing and counselling. Confusion is reported between provider-initiated HIV testing and counselling and mandatory testing, including uncertainties about whether the right to refuse testing is granted or not. Monitoring and evaluation for provider-initiated HIV testing and counselling is generally lacking or under development. Diagnostic HIV testing occurs and there are national policies on clinical indications for HIV testing available in some countries resembling WHO guidelines. However, it was noted that the ‘3 Cs’ are required for diagnostic HIV testing.

With regard to mandatory testing, this is widespread in the Region, often legislatively. There is considerable variability in groups subjected to mandatory testing, including universal screening of people in certain institutions (prisons, military, hospitals) or undergoing certain evaluations
Migrant workers are the group most widely tested across the Region. Findings of the review indicate that sex workers, men who have sex with men (MSM), IDUs and prisoners are often mandatorily tested in various settings; for example, sex workers upon arrest or organized compulsory HIV testing, MSM upon arrest, IDUs in treatment centres, in prisons or upon arrest, and prisoners upon arrival at detention facilities. Other groups subjected to mandatory HIV testing in the Region include migrant workers, pregnant women (in some cases), STI-diagnosed patients, tuberculosis clinics, pre-operative and other medical screenings, individuals before employment or marriage, military recruits and health care workers.

HIV testing algorithms used in the Region are diverse and there are few written guidelines on those used. ELISA HIV-antibody testing is widely available, while rapid tests are available for use in nine countries only. A Western Blot confirmatory test is often required for confirmation and often confirmatory testing is centralized. Screening blood, tissue and organ products for HIV is mandatory by law across the Region. Screening may be done anonymously (blood or tissues found to be infected destroyed with no notification to the donor) or namely (HIV infected donor is notified). Little or no counselling is provided with blood and transplant screening.

Disclosure of HIV status can occur without consent under specific circumstances (partner notification, provision of health care, court trials) in the Region. In addition, disclosure of HIV may be required for entry to countries. Of thirteen countries of the world refusing categorically entry of PLHIV, eight of these are in the Region.

3.2 Review of HIV testing practices in the Region

Dr Jenny Petrak, FHI and WHO Temporary Adviser

Numbers of reported HIV cases are increasing in the Region but access to testing remains low. There is limited epidemiological surveillance; however, unprotected sexual contact, IDUs and associated overlap are the main modes of transmission. Less is known of other vulnerable groups, including MSM. There is wide variability in HIV testing and counselling practice in the Region ranging from voluntary to mandatory testing. Generally, there is a lack of published information on HIV testing and counselling policy and practice making it difficult to generalize findings. The objectives of the consultation are as outlined above; a literature review of HIV testing and counselling policy and practice across 22 countries in the Region was conducted which includes voluntary (both client- and provider-initiated), diagnostic, mandatory, blood screening and other HIV testing approaches. These findings were augmented with case studies from Egypt, Oman, Pakistan and Sudan.

Findings reported included the harmful effects of mandatory testing on migrant workers, including deportation from countries after HIV-positive results. HIV test results were not always provided or clients did not understand their meaning as no consent, confidentiality or counselling was involved. Often no risk-reduction information was provided, resulting in HIV transmission to families after deportation. Persons are usually deported with no medical follow-up arranged in their own country resulting in illness, late presentation and death. The negative effects of mandatory HIV testing of IDUs (on entry to prison or drug treatment programmes) was also reported, including that this provides a deterrent for entering drug treatment programmes and a deterrent for accessing ART and maintaining adherence where mandatory detoxification is required prior to commencing ART. It
was noted that there is a lack of comprehensive harm reduction services in the Region, and in particular, the availability of opium substitution treatment. In addition, there are excellent examples of nongovernmental organizations working with IDUs in the Region but some are hampered in their efforts by limitations (e.g. community-provided needle exchange) imposed by legal restrictions.

A number of other key findings include low access to voluntary (client-initiated or voluntary testing and counselling) HIV testing and counselling across the Region, the need for development of optimum models of HIV testing and counselling (e.g. location, populations, approach, benefits and constraints) given particular country contexts, the need for models of provider-initiated HIV testing and counselling to be reviewed and articulated to ensure they involve the ‘3 Cs’, and the need for national HIV testing protocols to be updated as currently they may require multiple confirmatory HIV tests at national laboratories requiring a long time to diagnose. Further findings included the lack of integrated services to ensure linkages between HIV testing sites and treatment and care, the hidden costs involved, as not all HIV treatment and care is free in the Region (e.g. costs associated with a range of associated medical tests and interventions other than antiretroviral therapy and CD4), the need to strengthen PLHIV networks, the need for comprehensive harm–reduction services, including opium substitution treatment (only available in the Islamic Republic of Iran and Morocco), the need for targeted programmes for at-risk populations, such as MSM and sex workers, the widespread practice of mandatory HIV testing and associated negative public health impact, and variable practice across the Region in screening for blood donors (e.g. donors contacted with HIV-positive results with no pre-test counselling involved). Finally, further findings revealed that there are many private hospitals involved in HIV testing but that they rarely report results or make their practice accountable to national programmes, and HIV testing for surveillance and monitoring and evaluation generally requires strengthening. In conclusion, it was noted that much progress has been made to scale up HIV testing and counselling, particularly in the last few years despite the challenging context, however significant barriers continue to exist which inhibit access to HIV testing and counselling and policy and practice requires updating to conform to international guidance. There is a need to reach consensus on HIV testing and counselling policy and practice, scale-up and to share approaches which are ethical, sustainable, accessible and of best quality.

### 3.3 Testing data in the Region, what does it reveal?

*Joumana Hermez, WHO/EMRO*

Cumulatively, 77% of AIDS cases are by heterosexual transmission in the Region. Currently, estimates suggest that there are 530 000 PLHIV in the Region, constituting 0.3% of the adult population. With a rough theoretical calculation according to the prevalence (530 000 x 100/0.3), we find that massive scale up of HIV testing is needed in order to detect those cases if universal access targets were to be reached (e.g. 176 666 667 HIV tests!). To put this into perspective, the number of tests conducted since 1995 is 55 415 512. It is important to note that the number of tests needed could be much lower if HIV testing in the groups where HIV is most likely to occur, i.e. most-at-risk populations or in the settings where PLHIV, who are unaware of their HIV status, are most likely to seek care, e.g. tuberculosis. In terms of who is being tested, excluding necessary screening of donated blood, migrant and foreign workers account for the greatest number of HIV tests being conducted in the Region (59.3%). Most-at-risk populations represent only 4% of the total number of tests conducted in the Region for the purpose of HIV case identification. Another
8% are conducted in health care settings where PLHIV are most likely to be identified, or where prevention of mother-to-child transmission (PMTCT) can be effectively implemented. However, with regard to who is testing HIV positive, although most-at-risk populations are the population groups least tested, they have yielded the largest proportion of PLHIV.

Certain health care settings, such as tuberculosis and STI services, are places where PLHIV who are unaware of their health status can be identified and antenatal care services, in spite of the low HIV prevalence in pregnant women, are the primary settings for PMTCT. The reviews have shown that voluntary testing and counselling services are generally under-utilized and used as referral places for people suspected to be HIV positive. Therefore, the numbers in the regional database are not accurate regarding the numbers tested through voluntary testing and counselling and not indicative regarding the proportion of HIV positive. Voluntary testing and counselling remains an important service for those who wish to know their HIV status. Migrant workers have been subject to massive mandatory testing in the Region and those detected as HIV positive may acquire the infection in the host country. Migrant workers are exposed to the risk of HIV in the host country but due to deportation they are not counted in the pool of PLHIV in the host country and are ineligible for HIV services.

Scaling up HIV testing and counselling is critical for the identification of PLHIV and for achieving the universal access targets. In order to scale up HIV testing this should be conducted in a cost-effective and public health efficient manner. This includes ensuring provider-initiated HIV testing and counselling and client-initiated testing and counselling are targeted to most-at-risk populations, antenatal care, STI and tuberculosis services. Migrant workers who are exposed to the risk of HIV in their host country should have access to HIV prevention efforts, in addition to ethical HIV testing and counselling. In addition, non-coercively offering HIV tests to pregnant women is the key for effective PMTCT. Finally, universal screening of donated blood, blood products and human organs needs to be always ensured, while observing the rights of donors.

Discussion

Countries raised specific examples of mandatory testing practice having been set aside after providing data to the government proving that it was not cost effective in identifying people who are HIV positive (e.g. in the Libyan Arab Jamahiriya associated with the previous practice of mandatory testing of enrolled students; in Afghanistan there was an initial requirement for mandatory testing for migrant workers, the national AIDS programme tested 1000 + and identified only one HIV-positive individual, and consequently, were able to persuade the government to abandon mandatory testing for migrant workers and adopt a more humanistic approach). Somalia provided examples of their successful voluntary testing and counselling programme established in 2006, where 50% of contacts are client-initiated and continue to increase and stated “strategies can work without having to go in to those that have no public health value”. Some countries emphasized, however, how difficult it is to challenge and change government policy in relation to mandatory HIV testing. National programmes will attempt to advocate among government and change attitudes, but ultimately, fighting such policy was not productive. In some countries most-at-risk populations never initiate testing as knowing their status is another burden for an already stigmatized population, and if they stopped mandatory testing then nobody would ever receive ART in their country.
The attitude of health care workers in imposing mandatory testing (e.g. particularly surgeons) was also mentioned, including confusion between what constituted ‘opt-in’ versus ‘opt-out’ HIV testing. It was also emphasized that the need was for targeted testing and counselling as it was logical that resources are put in this direction; migrant workers are isolated from the social network, young, and therefore may be a risk group in their own right. Negative aspects related to the practice of mandatory HIV testing were highlighted, including that it ignores the ‘window period’ and does not address high-risk behaviour; that many countries are in low level epidemic and consequent low rates of identification in the general public which means it is therefore not cost effective to impose, for example, pre-marital testing; mandatory testing for migrant workers, many who are desperate to work will lead to illegal activity to falsify results; and finally, if countries are identifying migrant workers who are HIV positive, as a minimum intervention, they can at least provide services. While the group thought it would be difficult to enforce a change in government policy there was a suggestion that the issue is brought forward to the Regional Committee to ensure high-level commitment and decision-making. By presenting evidence, it is possible to change mandatory HIV testing policy.

3.4 Challenges in scaling up testing and counselling

Joumana Hermez, WHO/EMRO

Scaling up testing and counselling, including using a provider-initiated approach, is viewed as a crucial step to increase access to prevention, treatment and care. In addition, it reduces mortality, morbidity and the cost of care and treatment through early detection and early enrolment in care. Of equal importance is coupling increasing awareness of HIV status with behavioural change interventions for those who are at risk. The benefits of scaling up testing and counselling are based on the assumption that those newly diagnosed with HIV will eventually have access to prevention, treatment and care after their serostatus is determined and will not suffer from negative consequences of knowing their HIV status, such as stigma and discrimination.

The success of programmes can be measured in various ways, for example, the percentage of persons who have accepted to be tested and are subsequently aware of their HIV status out of the total in need of knowing their status; the percentage of most-at-risk populations accepting testing and are subsequently aware of their HIV status out of the total most-at-risk populations populations; and the percentage of those who had a positive test result who have accessed further prevention, treatment and care services. A number of key challenges exist though for scale-up, including ‘knowing the epidemic’, attending to the legal, social and economic context, awareness raising of health care providers, awareness-raising in the community, coordination, partnership and training, models of service delivery, reaching marginalized populations, and various programmatic considerations. Detail was provided on key issues and country examples associated with each of the challenges. In summary, key areas to address for scaling up HIV testing and counselling include: ensuring capacity, infrastructure, human resources, forecasting, procurement and supply, cost and funding, and consideration of the environment. Finally, scaling up both provider-initiated testing and counselling and voluntary testing and counselling services is key for ensuring coverage of services. Challenges will need to be overcome and scaling up needs to strive for quality services in order to be effective. Sensitivity to economic, social, cultural and legal issues is a must.
3.5 Introduction to WHO tools for operational research on HIV testing and counselling

Dr C. Makhlouf-Obermeyer WHO/HQ

A number of reasons support the development of tools for operational research on HIV testing and counselling, including that there are research gaps in the evidence to support the public health approach, there are a multiplicity of approaches which can make it confusing for those who need to conduct operational research, and there is a lack of unified tools which limits comparisons across settings and learning. The operational research tools will be generic and standardized. After adaptation they should be applicable across settings, and relevant to treatment and prevention programmes and country-defined priorities. A number of contributors are developing the tools, including international consultants and the Population Council. There are currently tools available in draft form for HIV testing and counselling, disclosure, stigma, and support, adherence to ART and prevention among those who are HIV positive.

Examples of operational research questions for testing and counselling relate to clients: motivations, behaviour and experience; for example, who is tested/who is missed; age, sex, socioeconomic status, nationality; do patterns of testing correspond to “real” risks; and how does the demand for testing differ by place and change over time? Examples of other operational research questions include providers and counsellors: who they are, how they are prepared, how they cope, what happens during counselling, examining interactions between clients and providers. Other questions can be directed at services, for example, what is provided, what does counselling actually mean, how consent is obtained or not obtained, confidentiality and disclosure. Finally, the impact of how the different approaches to testing and counselling perform can be measured, including knowledge of status, risk awareness, stigma, prevention and care.

A range of research designs will be used in the generic tools for operational research. The tools document will be comprised of two parts: chapters summarizing the evidence on each of the four topics, and core instruments, including modules on each topic. The design will be simple utilizing cross-sectional, facility-based tools with questionnaires as core data collections tools. Target populations will include clients, providers, key informants and different sampling techniques. Instruments will be provided for client- and provider-initiated HIV testing and counselling. The modules will not need to be administered in full and can be selected and adapted as required. In order to use the tools, preparatory steps include defining the issues, priorities and research questions (situation analysis) and multi-stakeholder processes, and identifying resources and teams and defining tasks. Implementing steps include piloting, translating, adapting, filling-in country-specific information, sampling, recruiting, gaining ethical clearance, team selecting and training, and providing administrative and technical support throughout data collection and analysis. Finally, data analysis and dissemination will include support beyond the preliminary report, regular feedback to stakeholders, including connecting with monitoring and evaluation systems and making comparisons across settings, including the lessons learned. WHO would like to encourage countries to use the generic tools and disseminate the findings. WHO will work with regions and countries to identify funding, make tools available to the Global Fund to Fight AIDS, Tuberculosis and Malaria, conduct training in the use of the tools, and continuously revise, update, improve and expand the materials.
Discussion

Further group discussion highlighted the importance of including more regional experiences in the analysis of the effectiveness of HIV-testing approaches. The importance of training for health care workers, continued work to remove the ‘moral’ content to HIV which enhances stigma and discrimination, and improving the content of HIV counselling was also emphasized. The context of limited resources and funding operational research, as opposed to continuing to enhance routine monitoring and evaluation which was potentially weak in the Region, was a further issue raised. The difference between operational research and monitoring and evaluation was highlighted, including that the latter is for routine collection of data and is often limited, for example, you can not analyse stigma from monitoring and evaluation data. It was discussed that both approaches are complementary but involve different tasks. Operational research tools will encompass a wide range of tools and cover a wide range of issues, for example, barriers to access and different testing approaches. There is a low level of research from the Region and this could be increased by facilitating linkages between academic institutions and national AIDS programmes. It was suggested that a percentage of funds should be directed towards operational research for HIV testing and counselling within country budgets. The capacities within the Region to conduct operational research were also discussed. WHO operates a Small Grant Scheme from which countries are able to apply to conduct operational research projects with the provision of technical assistance from WHO.

4. GROUP WORK 1: REVIEW OF CURRENT PRACTICES IN THE REGION AND THEIR ETHICAL AND PUBLIC HEALTH SOUNDNESS

The aims of this group work session were to review current practices, including their ethical and public health soundness in the Region in relation to different testing approaches, including: 1) mandatory HIV testing; 2) provider-initiated testing and counselling (PITC); 3) client-initiated testing and counselling (client initiated testing and counselling); 4) testing for surveillance; and 5) testing for transfusion safety. Participants were divided into four groups (2 and 3 were combined) and provided with guidelines and questions to address in the session. Each group addressed a series of questions, including: 1) Who are the groups concerned by the policy? 2) What are the intended public health goals of this testing policy? 3) What are the arguments that support this policy? 4) What are the main drawbacks of this policy? 5) What are the groups’ recommendations regarding this policy?

4.1 Mandatory testing

Policies related to mandatory HIV testing in the Region were debated in this group. It was noted that a wide range of populations are affected by mandatory testing, including migrant workers, prisoners, pre-employment, pre-marital, pre-university entry, surgical patients, some clients undergoing invasive dental procedures, most-at-risk populations upon arrest, and clients of tuberculosis, STI and antenatal care services clients. It was not clear from the discussion whether there is an achievable public health goal related to this policy but it was noted that for many mandatory testing was the point of entry for HIV care and treatment for nationals. In addition, it was argued that the policy protects the community from imported HIV and that testing of migrant
workers reduces the financial burden on the host country’s public health system. However, drawbacks of this policy were also noted, including that it is a not a preventative measure and may lead to people not coming forward for HIV testing. In addition, the policy of mandatory testing takes no account of the window period in delivery of results and therefore may be providing false negative results. In general, such policy may give countries a false sense of security and enhances denial of HIV as a local problem to be addressed. Human rights issues associated with mandatory testing were also highlighted.

A number of recommendations emerged from the group discussion, including broadening the focus of mandatory testing beyond solely HIV. It was noted that mandatory testing policy also related to other infectious diseases, including tuberculosis, hepatitis B and C virus. Full discussion of the implications of mandatory testing and any change in policy should include all infectious diseases. The Regional Committee meeting should be a forum to discuss and make recommendations towards amendments of countries’ mandatory testing policies. Other recommendations included that medical insurance systems for migrant workers should cover HIV and AIDS in their schemes. Another suggestion was the ‘fund basket’ should be implemented to ensure that persons with HIV were treated when tested within host countries. A recommendation which the group thought could be immediately activated was that counselling and referral channels through nongovernmental organizations in the home countries are established for persons being tested mandatorily within host countries in order to facilitate linkage to care and treatment. Finally, the group recommended that interventions, particularly through the involvement of civil society organizations (and not mandatory HIV testing) needed to be enhanced to increase efforts to reach most-at-risk populations.

4.2 Provider- and client-initiated testing and counselling

This group combined discussion and recommendations on policy related to provider-initiated HIV testing and counselling and client-initiated testing and counselling. The group agreed that provider-initiated HIV testing and counselling and client-initiated testing and counselling had clear public health goals related to increasing voluntary access to HIV testing, care and treatment. Furthermore, it was agreed that these HIV testing policies are cost effective, contribute to stigma reduction, can increase uptake of HIV testing, including early diagnosis, and provider-initiated HIV testing and counselling in particular, increases normalization of HIV testing and decentralization of services. These policies increase accessibility to a wide range of populations and can be applicable to potentially anybody although provider-initiated HIV testing and counselling is particularly applicable to persons seeking health care exhibiting signs and symptoms of HIV-related illness and also those in STI, tuberculosis and antenatal care, whereas client-initiated testing and counselling was particularly important in increasing access to prevention, treatment and care for vulnerable populations and most-at-risk populations. Difficulties associated with provider-initiated HIV testing and counselling mentioned included health care provider stigma, the need for additional capacity in health services already competing for limited resources, and concern that the quality of HIV counselling could deteriorate within busy medical services. Equally, however, drawbacks to client-initiated testing and counselling could include difficulties in monitoring the quality of counselling, in addition to lack of resources. The group agreed that policy and practice of how client-initiated testing and counselling (and PITC) should be delivered was often misinterpreted and this could be even greater as these are integrated into other services. A number of recommendations were
developed towards HIV testing policy for provider-initiated HIV testing and counselling, including the need for operational research to be incorporated in policy, that provider-initiated HIV testing and counselling must not be confused with mandatory testing and that it should be in accordance with the 3 C’s, and also that a code of ethics should be developed for health care workers to ensure that they adhere to the 3 Cs and a code of ethics of not stigmatizing clients. Other recommendations included that a multisectoral approach should be implemented for both client-initiated testing and counselling and PITC; both should be scaled up, including capacity-building and using resources where they are most likely to be utilized.

4.3 Testing for surveillance

Policy for HIV testing for surveillance was discussed within this group. The primary public health goal of testing for surveillance was agreed on as tracking the magnitude of the HIV epidemic and case detection. However, it was noted that while surveillance testing was increasing in the Region, it continues to need considerable scaling up. A number of drawbacks related to policy for testing for surveillance, including human rights issues (e.g. persons not being informed of their results), the difficulty locating most-at-risk populations, the high costs associated with surveillance testing, and that samples may be biased leading to inaccurate information about the HIV epidemic. Recommendations from this group included the importance of ensuring that policy was explicit about not confusing HIV testing for surveillance with mandatory testing, initiating sentinel surveillance, including anonymous and unlinked methods, and also initiating biobehavioural surveillance with methodological rigour.

4.4 Testing for blood transfusion safety

Policy and practice related to HIV testing of blood donors and blood safety was discussed in this group. A number of public health goals were discussed to be related to this testing policy, including the importance of ensuring blood safety and contributing to knowledge about the scope of the epidemic. Policy for blood transfusion safety and HIV testing is variable across the Region but some group members also indicated that this type of testing could also contribute to increasing awareness about HIV and can also identify HIV-positive individuals and link them to prevention, treatment, care and support. However, the group also identified that the policy for HIV testing for blood transfusion safety could also be time consuming (if it also incorporated counselling and delivery of HIV-positive results) with associated impact on limited resources. It could also lead to people not donating blood and a consequent shortage of blood supplies. The group’s recommendations included that all transfusion blood should be mandatorily screened for HIV in all countries, that all blood donors should be pre-counselling and give informed consent to testing before donating blood, and that all blood donors should be initially screened through a questionnaire and that if risk behaviour is identified they should be deferred from blood donation and referred to HIV testing and counselling. The group also recommended that if individuals test HIV positive through blood donation they should be informed, counselled and referred on.
5. GROUP WORK 2: PRACTICAL STEPS TO SCALE UP TESTING AND COUNSELLING IN THE REGION

The aims of this group work session were to articulate the practical steps required to scale up HIV testing and counselling (provider-initiated HIV testing and counselling and client initiated testing and counselling) in the Region with regard to policies and practices and based on country case scenarios involving services for IDUs, tuberculosis patients, STI clients and health care settings. One group continued work from the previous day on developing recommendations on blood safety. Participants were divided into groups and provided with guidelines and questions to address in the group work. The main outcomes and recommendations from the group work are presented below.

5.1 Case study 1: Scaling up HIV testing and counselling among IDUs

This group articulated some of the difficulties faced in attempting to scale up HIV testing and counselling among IDUs, including legal constraints, difficulty locating IDUs, mandatory testing policies, lack of comprehensive harm reduction facilities (e.g. detoxification the only option available), limited capacity of service providers, including nongovernmental organizations leading to low levels of coverage. The importance of empowering IDUs was also discussed within the group as a major factor in scaling up HIV testing and counselling. A number of recommendations for scaling up access to HIV testing and counselling among IDUs were discussed, including the importance of creating an enabling policy environment. This would include the decriminalization of IDUs, ensuring increased access to good quality comprehensive harm reduction services, reviewing and modifying drug treatment policy to ensure different kinds of treatment are integrated, and setting up harm reduction services in prisons. The importance of improving the reporting and surveillance system in relation to HIV in IDUs was also noted. The group also recommended that the capacities of nongovernmental organizations should also be scaled up to enable delivery of services to IDUs. Voluntary testing and counselling would also require scaling up, including ensuring linkages to outreach programme activities and assuring voluntary testing and counselling facilities are located close to IDU populations (or mobile services).

5.2 Case study 2: Scaling up HIV testing and counselling among tuberculosis patients

This group developed a series of recommendations towards scaling up HIV testing and counselling among tuberculosis patients. Firstly, it was recommended that a partnership was necessary between the national AIDS programme and national tuberculosis programmes. This could lead to the development of clear guidelines on integration of voluntary HIV testing and counselling services within tuberculosis settings. Capacity-building and increasing HIV awareness of existing staff within tuberculosis services to be able to conduct voluntary HIV testing and counselling would be needed. It was also recommended that policies for provider-initiated HIV testing and counselling within tuberculosis services would need to be made explicit within national strategic plans. Finally, it was recommended that the monitoring and evaluation system be strengthened to accompany scaling up of HIV testing within tuberculosis settings was also required.
5.3 Case study 4: Scaling up HIV testing and counselling among STI clients

This group developed a series of recommendations towards scaling up HIV testing and counselling among STI clients. Firstly it was agreed that increased knowledge of STI services was required, including enhancing pathways to service use and ensuring that the necessary mechanisms were in place to ensure HIV testing and counselling exists within STI settings. HIV testing should therefore be promoted within the context of integrated services and this should be included in national strategies. The importance of training STI services providers to recognize the need for HIV testing and to be able to communicate with clients about HIV was discussed. In addition to this the need to facilitate links between STI and other services to ensure referral was also highlighted. Finally, the importance of developing and reinforcing partnerships with nongovernmental organizations and civil society organizations reaching most-at-risk populations was also recommended for scaling up HIV testing and counselling among STI clients. Generally, there is a need to scale up the availability of HIV testing within STI services.

5.4 Case study 5: Scaling up HIV testing and counselling in health care settings

This group articulated steps required for scaling up HIV testing and counselling within health care settings. This included ensuring that a comprehensive communication strategy is established to promote and advocate for HIV testing and counselling in health care settings. The group discussed that HIV testing strategies using rapid testing, including more than one assay for confirmation, would be optimal in busy health care settings. HIV testing and counselling could be integrated into a variety of health care systems, including primary health care, antenatal care, pediatric clinics, ART sites and STI and tuberculosis clinics. The importance of ensuring that HIV testing and counselling was established and strengthened within PMTCT and antenatal care services was noted. Health care workers would need training on HIV management and stigma reduction to enable scale up of HIV testing and counselling in health care settings. As the latter is scaled up the importance of ensuring that good referral systems were established to ensure linkage to treatment, care and support was also discussed. Finally, surveillance systems and monitoring and evaluation systems would also require scaling up within health care systems to ensure quality and accurate data and information on the epidemic.

5.5 Further recommendations for blood safety

This group continued to develop recommendations for HIV testing for blood safety. The group advocated for development of a global strategy on blood safety based on strengthening existing national blood services, encouraging voluntary non-remunerated blood donation, ensuring adequate testing with quality assurance, and strengthening monitoring and evaluation in blood donation services. The group emphasized that it is essential for linkages to be strengthened between blood transfusion services and national HIV/AIDS programmes. The group agreed that all donors should be informed that their blood will be tested for STIs and that for those who want to know their status, they should be referred to voluntary testing and counselling. For donors who have a reactive HIV test, they should be referred to HIV testing and counselling services for confirmation of results and referral.
6. CONCLUSIONS

Countries are commended for the progress made in scaling up access to HIV testing and counselling in the last few years. There remain, however, many challenges towards achieving increased access and particularly for marginalized populations. A major bottleneck to increasing access to HIV prevention, treatment and care is that the majority of PLHIV continue not to know that they are infected. Therefore, efforts to increase access to HIV testing and counselling need to be expanded. Two strategies are recommended for expanding access to HIV testing and counselling: (i) client-initiated; and (ii) provider-initiated voluntary and confidential HIV testing and counselling. WHO does not support mandatory HIV testing except for donors of blood, body organs and semen. Within this meeting numerous ideas and recommendations to address these key issues and testing approaches were put forward by the national AIDS programme managers and other organizations. The main recommendations are summarized below. It is hoped that this meeting provided a renewed commitment to mitigate the impact of HIV and AIDS and the need for countries to work together in the Region, including the sharing of best practice.

7. RECOMMENDATIONS

National AIDS programme managers of the Member States of the Eastern Mediterranean Region, national and regional experts, representatives of UN agencies, other international agencies, members of the AIDS Regional Advisory Group and representatives of PLHIV were convened by the WHO Regional Office in the regional consultation on HIV testing and counselling policies and practices in the Eastern Mediterranean/MENA Region in Alexandria, Egypt, on 19 and 20 November 2008. Participants concluded that both client-initiated and provider-initiated testing and counselling should be voluntary.

During 2007 the Regional Office conducted a regional review of testing and counselling policies and practices. This review attempted to document, to the extent possible, the conformity of regional approaches to testing and counselling with public health and human rights. In this regional consultation, the findings of the review have been presented. Participants, including people affected by HIV, attending this consultation discussed the results and agreed on sound and ethical scale-up of HIV testing and counselling.

Participants concluded that a range of models for client- and provider-initiated services needs to be scaled up embedded in a continuum of prevention, care and treatment and all UN agencies should assure coordination and synergies at national and regional levels. Participants stressed that increased access and utilization of HIV testing and counselling services (and consequently to HIV care and treatment) will only be possible if the human rights of PLHIV and marginalized and most-at-risk populations are fully respected.

To Member States

1. Ensure that national HIV strategies, policies and programmes for HIV testing and counselling are in place, including monitoring and evaluation.
2. Explore and address reasons for low access to testing and counselling in each country through reviews/evaluations of HIV testing and counselling elements of HIV programmes and operational research. Document and disseminate the findings.

3. Assess the public health effectiveness and ethical soundness of existing national HIV testing policy and practice with regard to HIV prevention and access to care and treatment. Assessment findings should be used for advocacy for improved and effective policies.

4. Explore what mix of models for client- and provider-initiated HIV testing and counselling are optimal in terms of increasing access and utilization in specific country contexts (e.g. location, populations, approach, benefits and constraints).

5. Implement provider-initiated HIV testing and counselling within a supportive environment. For example: take urgent action to reduce health workers’ stigma.

6. Put in place and reinforce policies to ensure rights of people living with HIV to protection from human right violations and breaches of confidentiality and highlight the benefits of knowing one’s HIV status to increase uptake of HIV testing and counselling. Respect the principle of non-divisibility of human rights.

7. Enhance the involvement and capacity of civil society organizations for outreach and provision of targeted services to at-risk populations, including drug users, men having sex with men, sex workers and prisoners across the Region.

8. Include HIV testing and counselling for drug users in a comprehensive package of harm reduction services in order to avoid cumbersome processes that require commuting between services.

9. Update and simplify HIV testing algorithms to include rapid testing and delivery of same day results by public health and/or qualified community-based services in a quality assured manner.

10. Mobilize resources for operational research, e.g. include operational research projects in GFATM proposals.

11. Establish a liaison between the national AIDS programme and national blood transfusion authorities to establish evidence-based policy and practice for blood safety.

12. Involve private health service providers to ensure that all health service providers abide by national policies for HIV testing.

To UN agencies

13. Allocate resources for operational research on HIV testing and counselling in the Region.
14. Provide technical assistance to countries to develop policies on HIV testing and counselling and implement HIV testing and counselling programmes on countries’ request.

15. Inform national AIDS programmes on HIV focal points in UN agencies.

16. Encourage the involvement of civil society organizations in planning, implementing and monitoring HIV testing and counselling activities.

17. Identify effective policies and practices in countries of the Region and support documentation and dissemination.
Annex 1

PROGRAMME

Wednesday 19 November 2008

Session 1

08:30–09:00 Opening session
Registration

09:00–10:00 Opening remarks
Objectives and expected outcomes
Introduction of participants

Dr J. Mahjour, EMRO
N Massaoud, UNAIDS
Dr G. Riedner, EMRO

Session 2

HIV testing and counselling policies and practices

10:00–10:15 Introduction and background
preparations for the consultation

Dr G. Riedner, EMRO

10:15–11:00 UN globally recommended HIV
testing and counselling policies with
respect to: client-initiated testing and
counselling, provider-initiated testing
and counselling, mandatory testing

Dr A. Okero WHO/HQ

11:15–11:45 Discussion All participants

11:30–12:30 Results of the reviews of testing and
counselling policies and practices in
the Region

Dr Mehdi Karkouri, Consultant
Dr Janet Petrak, Consultant

12:30–12:45 Testing data in the Region, what does
it reveal?

Ms J. Hermez, EMRO

12:45–13:00 Discussion

14:00–15:30 Group work 1:
Review of current practices in the
Region and their ethical and public
health soundness

All participants

16:00–17:00 Group work presentations

Group rapporteurs

17:00–17:30 Discussion

All participants
### Thursday 20 November 2008

#### Session 3
Scaling up testing and counselling

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Presenter/Leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00–09:15</td>
<td>Challenges in scaling up testing and counselling</td>
<td>Ms J. Hermez, EMRO</td>
</tr>
<tr>
<td>09:15–10:00</td>
<td>Discussion</td>
<td>All participants</td>
</tr>
<tr>
<td>10:00–10:15</td>
<td>Group work 2: Practical steps to scale up testing and counselling (PITC and CITC) in the Region.</td>
<td>Ms J. Hermez, EMRO</td>
</tr>
<tr>
<td>10:45–12:00</td>
<td>Group work 2</td>
<td>All participants</td>
</tr>
<tr>
<td>12:00–13:00</td>
<td>Group work presentations</td>
<td>Group rapporteurs</td>
</tr>
<tr>
<td>13:00–13:30</td>
<td>Discussion</td>
<td>All participants</td>
</tr>
<tr>
<td>14:30–14:45</td>
<td>Introduction to WHO tools for operational research on HIV testing and counselling</td>
<td>Dr C. Makhlof-Obermeyer, WHO HQ</td>
</tr>
<tr>
<td>14:45–15:45</td>
<td>Conclusions and recommendations</td>
<td>Dr G. Riedner, EMRO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms J Hermez, EMRO</td>
</tr>
<tr>
<td>15:45–16:00</td>
<td>Closing remarks</td>
<td>Dr J. Mahjour, EMRO</td>
</tr>
</tbody>
</table>
Annex 2

LIST OF PARTICIPANTS

AFGHANISTAN
Dr Saif-ur-Rehman
Ministry of Public Health
Kabul

ALGERIA
Dr Amrane Achour
National AIDS Programme Manager
Ministry of Health
Algiers

BAHRAIN
Dr Somaya AbdulRahman Al-Jowder
Head of National AIDS Committee
Ministry of Health
Manama

DJIBOUTI
Dr Ibrahim Mohamed Ibrahim
Director National AIDS Programme Manager
Ministry of Health
Djibouti

EGYPT
Dr Zein El Abdin Al Taher Al Kamel
National AIDS Programme Manager
Ministry of Health and Population
Cairo

ISLAMIC REPUBLIC OF IRAN
Dr Abbas Sedaghat
National AIDS Programme Manager
Ministry of Health and Medical Education
Tehran
JORDAN
Dr Mohammed Bassam Qasem
Director of Disease Control
National AIDS Programme Manager
Ministry of Health
Amman

KUWAIT
Dr Osama Al Baksami
Specialist
Clinical Infectious Diseases
Ministry of Health
Kuwait

LEBANON
Dr Mostafa El Nakib
National AIDS Programme Manager
Ministry of Public Health
Beirut

LIBYAN ARAB JAMAHIRIYA
Dr Mohamed Ahmed Sammud
National AIDS Programme Manager
General People’s Committee for Health and Environment
Tripoli

MOROCCO
Dr Aziza Bennani
National AIDS Programme Manager
Ministry of Health
Rabat

OMAN
Dr Ali Ba Omar
Head of Control
HIV/AIDS/STI Section
National AIDS Programme Manager
Ministry of Health
Muscat
PALESTINE
Dr Mahmoud Salem
Director
Department of Epidemiology
Ministry of Health
Ramallah

PAKISTAN
Dr Ali Razzaque
Provincial Programme Manager
Provincial AIDS Control Programme
Punjab

QATAR
Dr Mohammad Mohammad Al Hajri
Specialist
Community Medicine
Preventive Health Department
Ministry of Public Health
Doha

SAUDI ARABIA
Dr Khalid Aly Abou Alwah
Director
National AIDS Programme
Ministry of Health
Riyadh

SUDAN
Dr Mohamed Ahmed Abdalhafeez
Manager
Sudan National AIDS Programme
Federal Ministry of Health
Khartoum

SYRIAN ARAB REPUBLIC
Dr Bassam Shamas
Deputy Manager of
National AIDS Programme
Ministry of Health
Damascus
TUNISIA
Dr Ahmed Maamouri
National AIDS Programme Manager
Directorate of Primary Health Care
Ministry of Public Health
Tunis

UNITED ARAB EMIRATES
Dr Nada Al Marzouqi
Preventive Medicine Department
National AIDS Programme Manager
Ministry of Health
Sharjah

YEMEN
Dr Abdul Hamid Nagi Al Suhaiby
National AIDS Programme Manager
Ministry of Public Health and Population
Sana’a

AIDS/HIV/STD REGIONAL ADVISORY GROUP (ARAG)

JORDAN
Dr Ali As’ad
Public Health Adviser
Friends of Global Fund MENA
Amman

ISLAMIC REPUBLIC OF IRAN
Dr Ahmad Mohit
Expert on Mental Diseases and Harm Reduction
Tehran

Dr Mohammed Mehdi Gouya
Director General of Centre for Disease Control
Ministry of Health and Medical Education
Tehran
OMAN
Dr Salah Al Awaidy
Director of Disease Control
Ministry of Health
Muscat

OTHER ORGANIZATIONS

UNICEF
Mr Samir N. Anouti
Regional HIV/AIDS Adviser
UNICEF Middle East and North Africa Regional Office
Amman

JORDAN

UNAIDS
Ms Nicole Massoud
Regional Programme Adviser
Regional Support Team
For Middle East and North Africa
Cairo

EGYPT

Dr Abdullah Sid Ahmed Osman
Policy Adviser
Regional Support Team
For Middle East and North Africa
Cairo

Family Health International (FHI)
Dr Cherif Soliman
Country Director
Family Health International
Cairo

Family Health International
Ms Karina H. Shalaby
Associate Program Officer
Family Health International
Cairo

EGYPT
UNODC
Ms Sally Fikry
UN Office on Drugs and Crime
Cairo
EGYPT

UNDP
Dr Khadija Moalla
Regional Programme Coordinator
HIV Practice Leader and
HIV/AIDS Regional Programme
in the Arab States (HARPAS)
Cairo
EGYPT

UNDP
Dr Ehab Elkharrat
Senior Programme Adviser
HIV/AIDS Regional Programme
in the Arab States (HARPAS)
Cairo
EGYPT

WHO SECRETARIAT
Dr Zuhair Hallaj, Special Adviser to the Regional Director (Communicable Diseases),
WHO/EMRO
Dr Jaouad Mahjour, Director, Division of Communicable Disease Control, WHO/EMRO
Dr Gabriele Riedner, Regional Advisor, AIDS and Sexually Transmitted Diseases, Division of
Communicable Disease Control, WHO/EMRO
Dr Ousmane Diouf, Responsible Regional (Francophone Africa), HIV/AIDS Department,
WHO/HQ
Dr Hany Ziady, Medical Officer, AIDS and Sexually Transmitted Diseases, Division of
Communicable Disease Control, WHO/EMRO
Dr Hamida Khattabi, Medical Officer, AIDS and Sexually Transmitted Diseases, Division of
Communicable Disease Control, WHO/EMRO
Dr Veronique Bortolotti, Medical Officer, AIDS and Sexually Transmitted Diseases, Division
Communicable Disease Control, WHO/EMRO
Ms Joumana Hermez, Technical Officer, AIDS and Sexually Transmitted Diseases, Division of
Communicable Disease Control, WHO/EMRO
Dr Khaled Saeed, Technical Officer, Mental Health and Substance Abuse, Division of Health
Protection and Promotion, WHO/EMRO
Ms F. Amolo Okero, Technical Officer, Prevention in the Health Sector Unit, HIV/AIDS
Department, WHO/HQ
Dr Carla Makhlouf Obermeyer, Scientist, Strategic Information Unit, HIV/AIDS Department,
WHO/HQ
Dr Sayed Azam Sajid, National Professional Officer/HIV, WHO Afghanistan
Dr Mitra Motamedi, National Professional Officer/HIV, WHO Islamic Republic of Iran
Dr Sevil Huseynova, Medical Officer/STB, WHO Iraq
Dr Abdalla Ismail El Gzoli, Medical Officer HIV/AIDS, WHO Somalia
Dr Rogers Busulwa, Medical Officer/HIV, WHO Sudan
Dr Endalamaw Tegegne, Medical Officer, HIV Treatment/Care, WHO Sudan
Dr Kaddu John Basco, Technical Officer/HIV Counselling and Testing, WHO Sudan
Dr Quaid Saeed, National Professional Officer, HIV/AIDS, WHO Pakistan
Dr Katja Schemioneck, Public Health Officer, WHO Office for West Bank and Gaza
Dr Moses Mutebi, Medical Officer, HIV/AIDS, WHO Yemen
Dr Amir Reza Moradi, Zendegi Mosbat Iranian, WHO/Temporary Adviser
Ms Zohira Merah, Vice President, Al Hayat Association, WHO/Temporary Adviser
Ms Fouzia El Qejlaji, WHO/Temporary Adviser
Ms Nadia Badran, WHO/Temporary Adviser
Ms Lalia Agatha, WHO/Temporary Adviser
Dr Youssef Wahba, WHO/Temporary Adviser
Dr Mervat El Guneidi, WHO/Temporary Adviser
Dr Mehdi Karkouri, WHO/Temporary Adviser
Professor Minoo Mohraz, WHO/Temporary Adviser
Dr Janet Petrak, WHO/Temporary Adviser
Mr Mohamed Abdel Moteleb, Technical Assistant, WHO/EMRO
Mr Mohamed Adam Aboubakr, Technician, WHO/EMRO
Mrs Omneya Mahmoud, Senior Administrative Assistant, Division of Communicable Disease Control, WHO/EMRO
Mrs Hanan Awad, Secretary, Division of Communicable Disease Control, WHO/EMRO
Mrs Noha Hassanein, Secretary, Division of Communicable Disease Control, WHO/EMRO