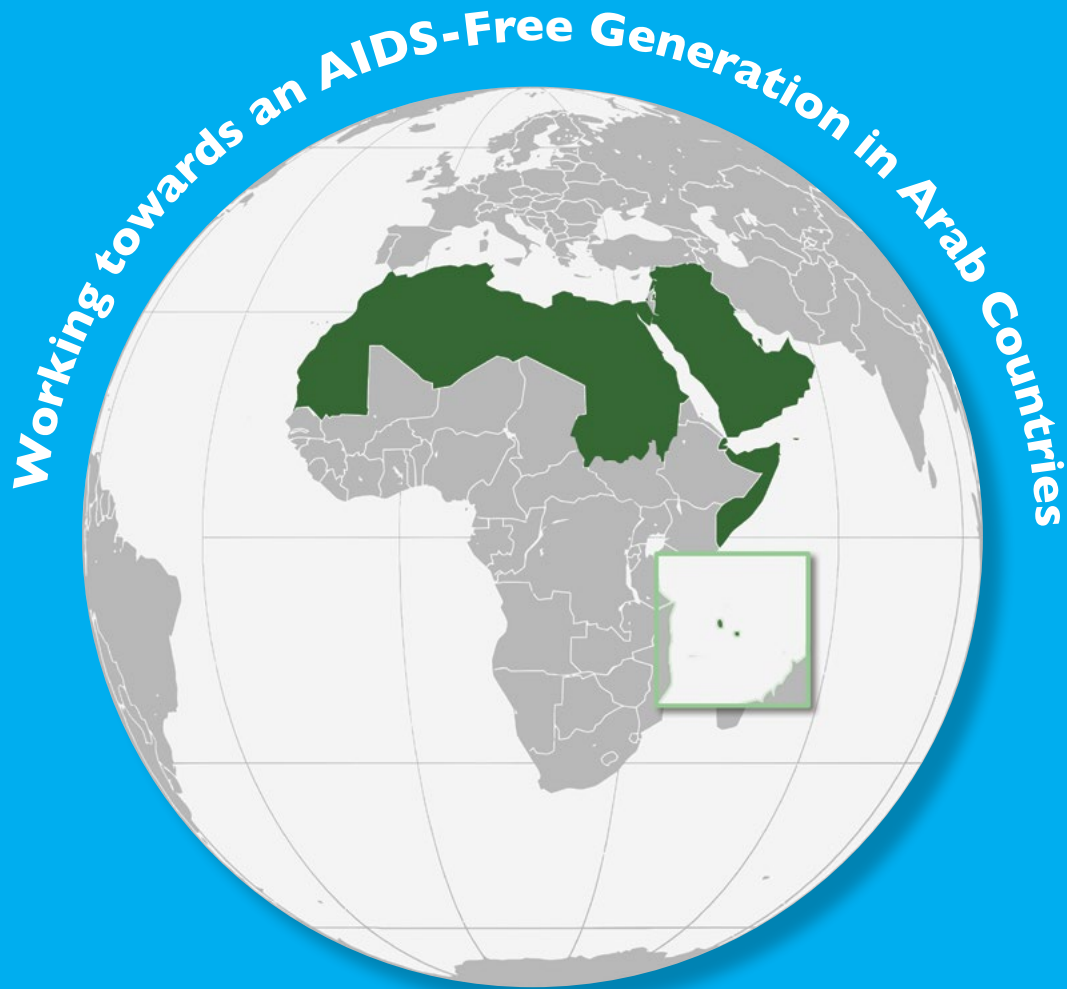




Social Affairs Sector - Directorate of Health and Humanitarian Aid
Technical Secretariat of the Council of Arab Ministers of Health
League of Arab States



March 2014

**Arab Strategic Framework
for the Response to HIV and AIDS
(2020-2014)**





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Working towards an AIDS-Free Generation in Arab Countries

March 2014



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Based on:

- The decision of the Executive Office of the Arab Ministers of Health No. (2) issued in October 2011 in Cairo, Egypt regarding the international and regional developments on HIV/AIDS and which endorsed the initiative of the Kingdom of Saudi Arabia and adopted the Riyadh Charter on combating HIV in the Gulf Cooperation Council issued in April 2011 as a Pan-Arab document.
- The decision of the Council of Arab Ministers of Health No. (2) issued during its 37th ordinary session in Amman, Jordan in March 2012 on uniting Arab countries against AIDS and which adopted the recommendations of the Saudi Forum which took place in Riyadh, November 2011, and agreed to constitute a technical committee under the leadership of the Kingdom of Saudi Arabia which would follow up on the recommendations of the Saudi Forum and develop an Arab AIDS Strategy in coordination with the Technical Secretariat and UNAIDS.
- The Recommendations of the Saudi Forum which called for Arab countries to review their national strategic plans, with particular focus on protecting human rights including the rights of people living with HIV and more vulnerable populations as well as scaling up HIV prevention, treatment, care and support services.
- The results and recommendations of the first meeting of the technical committee which took place in Riyadh, Saudi Arabia in November 2012 to discuss and agree on the outline and components of the Arab AIDS strategy and which was effectively a technical forum to develop the strategy according to the regional context and to global and international strategies.
- The results and findings of the second meeting of the technical committee organized in collaboration with UNAIDS under the leadership of the Kingdom of Saudi Arabia and with the participation of National AIDS Programme managers and other partners to technically validate the strategy and finalize the vision, message, guiding principles, strategic goals and key priorities as well as build consensus on the final document of the Arab AIDS strategy “Working towards an AIDS-Free Generation in Arab Countries” and ensure the full participation of various partners in the finalization process.



The draft framework of the Arab AIDS Strategy 2014–2020 was developed through a consultative process with Member States of the League of Arab States, UNAIDS Cosponsors and Secretariat as well as Civil Society Organizations. The partnership aims to scale up the HIV response at the regional and national levels through the "Arab AIDS Initiative" which emphasizes the political commitment to combat AIDS including the goals, principles and priorities aligned to the United Nations Political Declaration on AIDS.

The Arab AIDS Strategy aims to support Arab States to achieve the goals and targets of the 2011 United Nations General Assembly High Level Meeting on HIV and AIDS, to identify suitable interventions taking into consideration the challenges associated with HIV, support the leadership roles of governments and concerned communities to enable them to achieve the goals and targets of the Strategy and ensure universal access to HIV prevention, treatment, care and support. The Strategy also emphasizes providing support to the most at risk and vulnerable groups and addressing risky behaviours and factors which heighten vulnerability to HIV.



Introduction

The Arab region is comprised of 22 countries with a population of 367 million out of the 7 billion in the world which accounts for about five per cent of world population. According to the medium variant projection, the Arab Region will have 598 million inhabitants by 2050, an increase of two-thirds by 2010¹. In addition, Arab countries have received more than 10% of the world's migrants and the United Nations Economic and Social Commission for Western Asia (UN-ESCWA) estimates that there are more than 25 million migrants in the region. The Gulf region hosts the largest proportion of guest workers to indigenous populations in the world.

While Arab countries have made significant progress on several development fronts over the past 40 years, such as improving life expectancy and school enrolment, the region could have been more effective in transforming its considerable wealth and potential into commensurate development gains. The region faces various socio-political, economic and environmental challenges. HIV and AIDS are considered among these development challenges². Estimates indicate that the number of new infections and AIDS-related deaths has increased markedly in the last decade and recent studies suggest that concentrated epidemics are emerging among key populations at higher risk in many countries. Throughout the region, limited strategic information on the HIV situation, high levels of stigma and discrimination against people living with HIV and limited financial and technical resources are key factors hindering an effective HIV response. Political upheaval and changing social and economic dynamics in many countries have increased the need for tailored and coordinated strategies to address growing epidemics. In this context, it is essential that surveillance be increased to generate more strategic information and to ensure prevention activities are strengthened and countries develop strong, multi-sector and human rights-based responses to the HIV epidemic.

In recent years, some Arab countries have demonstrated increased political will to intensify efforts in the AIDS response. Arab Countries have endorsed a number of important global and regional commitments, declarations and decisions aimed at expanding HIV prevention, treatment, care and support and advancing human rights in the HIV response. These documents served as key reference points for guiding the development of the Arab AIDS Strategy, which is directly aligned with the specific targets, priorities and objectives articulated in each. These documents include:

1- Barry Mirki, Population Levels, Trends, and Policies in the Arab Region: Challenges and Opportunities, Research Paper Series, Arab Human Development report, UNDP, 2010.
2- Arab world competitiveness report, World Economic Forum, 2011-2013.

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- June 2010: Dubai Consensus Statement on scaling up towards universal access in MENA countries;
- June 2010: UNAIDS Strategy (2011-2015);
- September 2010: Djibouti Declaration of Commitment and Call for Action to address HIV among vulnerable and mobile populations;
- October 2010: Regional Strategy for Health Sector Response to HIV 2011-2015;
- December 2010: UNODC and League of Arab States, Regional Programme for Controlling AIDS and Crime 2011-2015;
- April 2011: Riyadh Charter on Scaling National AIDS responses in Gulf Cooperation Council Countries;
- June 2011: United Nations General Assembly Political Declaration on HIV and AIDS 2011-2015
- June 2011: Statement of commitment on the implementation of the ILO Recommendation R.200 from Mashreq countries (Iraq, Jordan, Lebanon and Syria);
- October 2011: Decision Point (No2) of the Executive office of the Arab Ministers on the regional and global developments on AIDS;
- November 2011: Recommendations of the Doha Symposium on AIDS, the Family and the MDGs;
- November 2011: Recommendations of the Saudi Forum, Uniting Arab Countries against AIDS;
- March 2012: Arab Convention on HIV Prevention and Protection of people living with HIV;
- March 2012: Decision Point (No2) of the Council of Arab Ministers in its 37th Ordinary Session; on the development of the Arab AIDS Strategy
- June 2012: UN Security Council Resolution 1983; on addressing HIV in conflict and post-conflict settings;
- October 2012: Regional Framework on Elimination of Mother-to-Child Transmission eMTCT.
- October 2013: The Regional Initiative on Accelerating HIV treatment in the WHO Eastern Mediterranean and UNAIDS Middle East and North Africa regions;
- November 2013: The Regional Forum on HIV prevention among young people in Arab Countries



Situation Analysis

Globally, 35.3 million [32.2 million–38.8 million] people were living with HIV at the end of 2012. Sub-Saharan Africa remains the most severely affected, with nearly 1 in every 20 adults (4.7 per cent) living with HIV and accounting for 71 per cent of the people living with HIV worldwide. Although the regional prevalence of HIV infection is nearly 25 times higher in sub-Saharan Africa than in Asia, almost 5 million people are living with HIV in South, South-East and East Asia combined. After sub-Saharan Africa, the regions most heavily affected, are the Caribbean, Eastern Europe and Central Asia, where 1.0 and 0.7 per cent of adults were living with HIV in 2012, respectively.

Worldwide, the number of people newly infected continues to fall: the number of people (adults and children) acquiring HIV infection in 2012 (2.3 million [1.9 million–2.7 million]) was more than 20 per cent lower than in 2001. Here, too, variation is apparent. The sharpest declines in the numbers of people acquiring HIV infection since 2001 have occurred in the Caribbean (52 per cent) and sub-Saharan Africa (38 per cent). In some other parts of the world, HIV trends (for children and adults) are cause for concern. Since 2001, the number of people newly infected in the Middle East and North Africa has increased by more than 62 per cent (from 21 000 [16 000–30 000] to 34 000 [24 000–46 000]).

Though the overall HIV prevalence in the Arab region is comparatively low, the rise in new infections makes the Arab Region home to one of the fastest growing HIV epidemics in the world. HIV prevalence, new HIV infections and AIDS-related deaths are increasing in this region. Between 2001 and 2012, the estimated number of people living with HIV in the League of Arab States Member Countries increased from 140 000 [95 000–230 000] to 210 000 [160 000–310 000]. Since 2001, the number of people newly infected with HIV in the Arab Countries has increased by more than 44 per cent—from 18 000 [14 000–26 000] to 26 000 [17 000–39 000] while between 2001 and 2012, there was a significant increase (69 per cent) in AIDS-related deaths in this region—from 8300 [4600–15 000] to 14 000 [9600–21 000]³.

HIV epidemics in Arab countries can be characterised as either low-level and concentrated, or generalized. The majority of Arab countries demonstrate low-level and concentrated HIV epidemics. Among countries for which there is data, HIV

Situation Analysis



prevalence levels are extremely low, estimated at 0.2 per cent of the population or less. Two Arab countries – with considerable prevalence – experience generalized HIV epidemics, with HIV prevalence exceeding 1 per cent among pregnant women. These include Djibouti and Somalia (only some areas), where HIV prevalence is estimated as 1.2 per cent and 0.5 per cent respectively⁴.

In the region, the virus is mainly spread through sexual transmission among men who are engaged in higher risk sexual behaviour and women engaging in transactional and commercial sex, as well as through the use of contaminated injection equipment among people who inject drugs (PWID). Further spread of the epidemic involves onward transmission of the virus from these key populations to their regular sexual partners.

Increasing prevalence of HIV among key populations reflects data showing an increase in behaviours that put them at higher risk of exposure, including unsafe injection practices and unprotected sex. HIV dynamics in the region are quite heterogeneous. In some countries, the epidemic is primarily concentrated among people who inject drugs; in other countries, it primarily affects men and women who are engaged in higher risk sexual behaviour. The diversity of the epidemic is further amplified by differing attitudes, policies, political commitments and the availability of and access to HIV services⁵.

In addition to key populations at higher risk, vulnerable populations are also important to consider in the context of HIV epidemics in Arab countries. These include mobile people, prisoners, women and young people. Often these populations face economic, social and structural vulnerability to HIV, including stigma and discrimination, social marginalization, gender inequality and lack of legal status. The majority of Arab countries report high HIV vulnerability for at least one of these populations.



Responses to HIV in Arab Countries

Progress is being made in some countries and strong commitments have been made by governments and key stakeholders to scale-up the HIV response. Most of Arab Countries have developed national strategies, supported free treatment programmes for People Living with HIV and included concerned sectors in the response. In addition, some countries have seen an increase in the HIV research and studies as well as a remarkable improvement in information systems and disease surveillance. Nonetheless, the current response to HIV in Arab countries is characterized by:

- ✂ low coverage of prevention, treatment, care and support programmes for key populations at higher risk and other vulnerable populations;
- ✂ widespread stigma and discrimination that undermines access to and utilization of these services and enjoyment of human rights;
- ✂ limited capacity of the multi-sector response to address these challenges;
- ✂ and lack of strategic information and evidence for designing tailored and effective interventions.

Nearly all countries in the region report limited HIV prevention programming, particularly in relation to key populations at higher risk. Often this challenge is related to lack of information about people who inject drugs and men and women who are engaged in higher risk sexual behaviours, difficulties in accessing these populations in high-stigma contexts, and weak capacity of local systems to target and deliver services to these populations. The limited scope of prevention efforts targeting key populations is evidenced by lack of knowledge of HIV risk factors and unsafe sexual behaviour among these groups. However, there is growing awareness of the importance of reaching these populations among governments and civil society organizations and increased willingness to engage with these populations through intensified HIV prevention efforts. While Arab countries are gradually recognizing the importance of addressing the needs of other populations vulnerable to HIV, including mobile people, prisoners, women and young people, interventions for these populations remain limited in scope.

Although all countries in the region offer some services for the prevention of vertical HIV transmission, those services remain fragmented and limited in many settings. In 2012, an estimated 14 per cent [10%–20%] of HIV-positive pregnant women in the low - and middle-income Arab countries had access to such services⁶.

Responses to HIV in Arab Countries



-The Middle East and North Africa is the only region that has yet to see a reduction in the number of children newly infected with HIV.

Coverage of HIV treatment remains low across the Middle East and North Africa and among the Arab countries, somewhere around 23 per cent [18%-34%]. However, between 2008 and 2011, the number of people accessing HIV treatment in the region nearly doubled, from 9700 to more than 18 000⁷. ART coverage in Arab countries remains so low because of interconnected series of causes, including that so few HIV positive cases have been identified within the health system⁸. The wide disparity between the number of known people living with HIV and the number of estimated HIV positive individuals in the region underscores the importance that must be placed on scaling up targeted HIV testing and counselling services to incorporate stigmatized and hidden populations into the health care system. While the rate of HIV testing has increased steadily since 2006, much of those who are tested are not among those at highest risk of HIV and the overall percentage of people tested remains much lower than the global percentage. Finally, though some countries are making impressive gains, in many Arab countries, ART coverage and efficacy are undermined by poor treatment retention, lack of treatment follow-up, and tenuous connections between treatment, care and support.

Stigma and discrimination seriously undermine the quality of life of people living with and affected by HIV and represent the primary barriers to access and adherence to essential HIV services for people living with HIV and key populations at higher risk. Seventy percent of Arab countries cite stigma and discrimination and difficult social environments experienced by people living with HIV as key challenges in the national HIV response. In their national strategic plans, a number of Arab countries report that gender inequality in accessing HIV services is a major challenge for national responses to HIV. Though there has been progress, at least 10 of the 22 countries in the region still report having laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for vulnerable or marginalized populations. At least 14 countries in the region deport or ban entry of people living with HIV. Punitive laws affect progress by limiting the ability of governments and civil society to provide services; limiting the ability of key populations to access available HIV services; and limiting the amount

7- UNAIDS Regional Fact Sheet, MENA 2012

8- UNAIDS, Middle East and North Africa, Regional Report on AIDS 2013



Situation Analysis

of data available for evidence-informed decision making. The Arab Convention on HIV prevention and protection of the rights of people living with HIV, endorsed by the Arab Parliament in March 2012, represents an important breakthrough in addressing stigma and discrimination. The Convention provides countries with a legal framework to review their national policies and laws to address HIV related stigma and discrimination in a systematic and comprehensive manner.

Health systems, civil society organizations and organizations of people living with HIV are characterized by limited capacity, especially in terms of ability to reach and provide services to key populations at higher risk. A major issue in the Arab region is that civil society lacks the tools and capacity required to work effectively with key populations at higher risk and, as a result, the overall impact of civil society's engagement with these populations is limited. The opportunities and momentum created by regional networks of Civil Society Organizations (CSOs) such as Regional Arab Network Against AIDS (RANAA), Middle East and North Africa Harm Reduction Association (MENAHRRA) and networks of women living with HIV, such as MENARosa, have provided new avenues to enhance the role of CSOs in the region's response.

In terms of partnership and coordination, a number of Arab countries indicate that while political commitment around HIV has increased in recent years, the multi-sector response to HIV must continue to be improved and key challenges must be met including limited partnership, coordination and harmonization of response efforts.

While resources allocated to the HIV response have grown rapidly, many Arab countries still face a shortage of financial resources for the AIDS response, are primarily dependent on a single donor, such as Global Fund, and are facing decreasing fund availability as a result of the global economic crisis. Lack of costed national strategic plans in some countries, and limited financial resources allocated to capacity development and prevention programming, are also cited as key challenges in some countries.

Capacity for surveillance, research and Monitoring and Evaluation (M&E) of national responses is extremely limited in many Arab countries. Many countries

Situation Analysis



acknowledge significant deficiencies in national monitoring and evaluation systems and the urgent need for improvements, especially with regards to increasing the capacity of professionals conducting M&E and improving data collection tools and data management systems. In general, limited capacity of M&E systems means reduced ability of countries to evaluate current approaches and adapt programmes to emerging trends. The lack of strategic information is a primary challenge as cited by nearly every government in the region. In many countries, lack of data on key populations at higher risk and vulnerable populations makes it difficult to develop strategies to reach these populations.



Methodology and Stages of Strategy Development

In March 2012, the Council of the Arab Ministers of Health decided to constitute a technical committee of member states of the League of Arab States (LAS), under the leadership of the Kingdom of Saudi Arabia and in coordination with the Joint United Nations Programme on HIV/AIDS (UNAIDS) and UN partners, to develop the Arab AIDS Strategy aimed at achieving the 2011 United Nations General Assembly Political Declaration targets on HIV and AIDS. Based on existing evidence, the new Strategy will guide the development of a coordinated and consensus-driven regional response to HIV that provides for comprehensive delivery of services and effective monitoring and evaluation of activities. The process of developing the Strategy has provided countries with an opportunity to jointly review progress and identify achievements, constraints and gaps to address in future programming.

The League of Arab States, the Kingdom of Saudi Arabia and UNAIDS have exerted exceptional efforts to ensure a participatory process of strategy development that is informed by evidence, guided by human rights and led and owned by Member States. The process of developing this Strategy has involved the following steps:

Situation and response analyses: UNAIDS provided technical support to the League of Arab States to conduct HIV situation and response analyses in Arab countries as an essential step for the development of the Strategy. The analyses are based on a comprehensive review of declarations, commitments and decisions endorsed by Arab countries between 2010 and 2013, national strategic HIV/AIDS plans from Arab countries; and Global AIDS Progress Reports on HIV/AIDS by Arab countries.

Priority Setting: The findings of the situation and response analyses were presented to government and civil society representatives of Arab countries in the technical meeting on the Strategy development that was convened in Riyadh in November 2012, under the patronage of H.E. the Minister of Health of the Kingdom of Saudi Arabia. During the meeting the participants discussed and agreed on the outline of the Strategy including goals, guiding principles and priorities to achieve strategic goals.

Methodology and Stages of Strategy Development



Drafting the Strategy: UNAIDS provided technical support to the league of Arab States in drafting the Arab AIDS Strategy based on agreements reached during the first and second technical meetings on the Strategy development.

Consensus building and validation: The consensus building around the Strategy document involved sharing drafts and soliciting inputs from Member States, UN partners, Civil Society and regional groups of people living with HIV. The input and feedback from the different stakeholders and constituencies were incorporated in the Strategy before final validation by a technical committee in a meeting hosted by the Arab League in June 2013 in Cairo.

Regional Youth Forum on HIV prevention among young people in Arab Countries: The recommendations of this forum and the discussions with various partners provided an opportunity to review the strategy with focus on issues of young people as a key population segment in the HIV response

Final endorsement: The Strategy will be endorsed by the Council of Arab Ministers of Health in its 41st Ordinary Session which will take place in Cairo, Egypt on 13th March, 2014.



Guiding principles of the Arab AIDS Strategy

Appropriate and culturally sensitive: Leverage the constructive roles of culture and religion in shaping the HIV response at the national and regional levels.

Evidence-based: Make the best use of available information to identify strategic priorities.

Comprehensive Coverage: promoting universal access to prevention, treatment, care and support services.

Human rights-based: Ensuring full rights to HIV prevention, treatment, care and support services for people living with HIV and key and vulnerable populations.

Broad and multi-sector participation: Ensure the full involvement of civil society, people living with HIV and all the concerned sectors including health, education, labour, finance, youth, media, etc., in the implementation of the Strategy.

Respect diversity and enhance adaptability: Consider the diversity of the HIV situation and response within different Arab countries including the varied epidemiological, political and legal environments, while fostering the application of common and adaptable approaches.

Collaboration and knowledge sharing: Promote inter-country collaboration and exchange of experiences and best practices.

Quality services and interventions: Ensure that services are efficient, effective, sustainable, and of consistently standard quality. Services and interventions should also be accessible, affordable, and acceptable to the concerned populations.

Integrative: Interventions should enhance the integration of HIV services within multi-sector development and public health programmes.

Gender-sensitive: Ensure that women and men have equal access to HIV services.

Strengthen national capacities: Build national capacities throughout the region.

Shared Responsibility and Regional Solidarity: Promote inter-country collaboration and cooperation for improved financing and leadership of HIV response.

Vision and Strategic Goals



In the 2011 United Nations Political Declaration on HIV and AIDS “Intensifying Our Efforts to Eliminate HIV and AIDS”, Arab countries pledged to take specific steps to achieve ambitious targets and commitments by 2015. Arab countries have agreed on the 10 targets of the Political Declaration to guide their collective actions through the Arab AIDS Strategy.

Vision:

To achieve an AIDS-free generation in the Arab world with zero new infections, zero AIDS-related deaths and zero discrimination.

Strategic Goals and Targets:

1. Reduce the HIV incidence rate through sexual transmission by more than 50% by 2020.
2. Reduce the HIV incidence rate among people who inject drugs by more than 50% by 2020.
3. Eliminate new infections among children and substantially reduce AIDS-related maternal deaths.
4. Accelerate the efforts towards universal access to antiretroviral therapy according to the new WHO guidelines and work towards achieving more than 80% treatment coverage among eligible persons by 2020.
5. Reduce the mortality rate among people living with HIV from tuberculosis by more than 50% by 2020.
6. Mobilize resources and increase reliance on domestic resources in the AIDS response by more than 80% by 2020 in all Arab countries.
7. Eliminate gender inequalities in accessing HIV services, and gender-based violence and increase the capacity of women and girls to protect themselves from HIV.
8. Eliminate stigma and discrimination against people living with and affected by HIV by reviewing and updating laws and policies that ensure full realization of all human rights and fundamental freedoms.
9. Ensuring universal access to HIV prevention, treatment, care and support services for mobile populations including displaced people, refugees and migrant workers.
10. Strengthen integration of the AIDS response in health and development efforts as well as social protection systems.



Key priorities

Goal 1: Reduce the HIV incidence rate through sexual transmission by more than 50% by 2020.

Reducing new HIV infections by 50% will require substantial reductions each year in sexual HIV transmission, which accounts for the overwhelming majority of the people who are newly infected in the Arab Region. Although many Arab countries have developed and implemented prevention programmes targeting key and vulnerable populations, the current pace of progress is insufficient to reach the target of halving sexual transmission. The number of new HIV infections continues to rise in the region underscoring the urgent need to scale up the current response. This will require effective combination prevention: using behavioural, biomedical and structural strategies in combination, focusing on specific populations in concentrated epidemics and targeting the whole population in generalized epidemics. Critical programmatic elements of combination prevention of the sexual transmission of HIV include behaviour change, condom provision, and focused programmes for men and women who are engaged in higher risk sexual behaviour as well as improved access to HIV testing and counselling and to antiretroviral therapy⁹.

The key priorities include:

- 🦋 Develop and implement prevention programmes targeting women, young people, migrants, mobile populations and men and women who engage in high-risk sexual behaviours which are supported by evidence and coordinated by various partners;
- 🦋 Strengthen the multi-sectoral response in the areas of prevention with the involvement of civil society, community and religious leaders and key sectors (youth, media, labour, education, religious endowment and justice);
- 🦋 Ensure high level advocacy and mobilize political and financial support to enhance prevention and treatment programmes;
- 🦋 Developing the capacity of young people and youth organizations for effective involvement and access to youth-friendly services ;
Improve the exchange of experience, knowledge and lessons learned among
- 🦋 Arab countries to facilitate better planning of programmes that engage key and vulnerable populations;
- 🦋 Strengthen the strategic information systems and promote HIV research and studies .

Key priorities



Goal 2: Reduce the HIV incidence rate among people who inject drugs by more than 50% by 2020.

Drug-related HIV transmission is driving the epidemic and people who inject drugs (PWID) are one of the population groups most severely affected by HIV infection in many Arab countries. Throughout the region, there is a convergence of high-risk behaviours among PWIDs, where unsafe injecting practices are accompanied by unsafe sexual behaviours, and overall risk of exposure increases. Available evidence indicates that the Arab countries are far from being on track in achieving the global target for people who inject drugs. Significantly stronger commitment is urgently needed to bring evidence-informed responses to scale programmes targeting PWID. Arab countries with documented epidemics among PWID and which do not currently address the needs of PWID in their national AIDS strategies, should take immediate steps to rectify this¹⁰. Governments must urgently commit major new resources to comprehensive, evidence-informed prevention programmes for PWID and intensify efforts to increase the scale of HIV testing, and harm reduction programmes.

The key priorities include:

- 🦋 Provide an integrated package of services to people who inject drugs, including harm reduction programmes, and programmes at prison settings;
- 🦋 Develop the capacity of civil society, service providers, concerned security authorities and the judiciary and involve them in the provision of support and services targeting PWID;
- 🦋 Review laws and regulations in relation to drug use and HIV to promote comprehensive and evidenced based programming focusing on the health aspect in service provision rather than the punitive dimension;
- 🦋 Undertake scientific research to estimate the size and modes of transmission, surveillance and information systems.







Key priorities

Goal 3: Eliminate new infections among children and substantially reduce AIDS-related maternal deaths

The Arab countries have embarked on an historic Initiative towards the elimination of mother-to-child transmission of HIV (eMTCT). This Initiative was launched in October 2012 on the margins of the 59th Session of the WHO Regional Committee for the Eastern Mediterranean. The Initiative is part of a larger Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive. It provides the Region with a common systematic approach to guide countries in developing elimination plans consistent with their HIV epidemic profile and local realities. The bold targets of the Initiative are intended to catalyse the implementation at country level of quality interventions to prevent mother-to-child transmission on a scale required to guarantee impact. The framework of the Initiative is based on the four-pronged approach to preventing mother-to-child transmission comprising of: Primary prevention of HIV among women of childbearing age; prevent unintended pregnancies among women living with HIV; prevent HIV transmission from a woman living with HIV to her infant; and provide appropriate treatment, care and support to women living with HIV and their children.

The key priorities include¹¹:

-  Ensure enhanced political commitment to eMTCT;
-  Improve coverage and quality of Preventing Mother to Child Transmission (PMTCT) services;
-  Ensure access to comprehensive services for women of child bearing age and especially vulnerable women;
-  Promote integration/ linkages of PMTC services with relevant health programmes.

11- Towards the elimination of mother-to-child transmission of HIV: conceptual framework for the Middle East and North Africa / World Health Organization.

Key priorities



Goal 4: Accelerate the efforts towards universal access to antiretroviral therapy according to the new WHO guidelines and work towards achieving more than 80% treatment coverage among eligible persons by 2020.

With the aim of achieving universal access to HIV prevention, care, treatment and support, it is the health sector's responsibility to ensure the availability, quality, accessibility, affordability, acceptability and utilization of health services through the involvement and regulation of public and private providers¹². With the low coverage of ART in the region, urgent and intensified efforts to improve the efficiency and effectiveness of treatment programmes are needed to end the treatment crisis and close the gaps in the treatment continuum. People living with HIV need to be diagnosed earlier in the course of infection through testing services that are simple and easy to access. Those who test positive must be linked to care that they can easily access. Antiretroviral therapy must be initiated in a timely manner, and individuals must receive support to adhere to prescribed regimens. Drug supply systems must become more reliable, programmes must better leverage opportunities to link treatment to other health system strengthening efforts and communities need to be better engaged in supporting treatment initiatives. Further reduction in the cost of antiretroviral therapy will be essential, particularly for intensifying efforts to improve treatment coverage among children, especially the poor, and to reach more men and women earlier in high-prevalence settings. Health systems need to be more responsive to the needs of vulnerable populations. Health reporting systems need to be strengthened to monitor treatment retention by age and gender. Finally, greater efforts are needed to speed the next phase of HIV treatment by accelerating implementation research and heeding the lessons learned in different parts of the world¹³. In October 2013, WHO and UNAIDS launched a regional initiative on "Accelerating HIV treatment in the WHO Eastern Mediterranean and UNAIDS Middle East and North Africa regions". This promising initiative aims to achieve universal coverage of HIV treatment by 2020 through mobilizing urgent remedial actions to accelerate treatment scale-up in order to end the treatment crisis in the Region.

Guided by the regional initiative on "Accelerating HIV treatment in the WHO Eastern Mediterranean and UNAIDS Middle East and North Africa regions",

12- Regional strategy for the health sector response to HIV 2011–2015
13- Global report: UNAIDS report on the global AIDS epidemic 2012



Key priorities

The key priorities include:

1. Commit to urgent action:

- 🦋 Set ambitious annual targets for HIV testing and treatment at national and local levels, monitor progress closely and take urgent remedial action if targets are not met.

2. Create demand for testing and treatment:

- 🦋 Implement bold action plans to overcome stigma and discrimination in health services.
- 🦋 Adopt and implement rapid testing technologies that permit same-day test results.
- 🦋 Provide HIV testing services in community settings in order to reach key populations at higher risk of HIV exposure.
- 🦋 Normalize HIV testing in health-care settings by routinely offering it as a component of regular health care in appropriate services including antenatal care, tuberculosis, STI, drug prevention and treatment, and other relevant services.
- 🦋 Adopt, client-friendly, standardized, free-of-charge HIV treatment and care services to facilitate prompt linkage to care upon HIV diagnosis, earlier initiation of ART, treatment adherence and retention in care.

3. Mobilize sustained investments:

- 🦋 Increase the share of domestic investment for HIV through sustainable and predictable financing mechanisms at country level.
- 🦋 Reduce costs associated with antiretroviral medicines, including expanded use of generic medicines, exploration of bulk purchasing and investments to build regional pharmaceutical manufacturing capacity.
- 🦋 Track and develop opportunities to increase the efficiency and effectiveness of testing, treatment and care activities, starting with an increased focus of resources on key populations specific for each country and locality.
- 🦋 Build community capacity to help design and support testing and treatment scale-up and to improve long-term treatment outcomes.
- 🦋 Develop health system capacity to deliver chronic care inclusive of HIV.

Key priorities



4. Deliver results in an equitable manner:

- 🦋 Simplify treatment protocols and move towards fixed dose combinations with “one pill per day” regimens.
- 🦋 Offer ART, irrespective of immunological status, to the following groups of people living with HIV: those in discordant couples, pregnant and breastfeeding women, children aged five years and below, those with active tuberculosis and those with hepatitis B with severe chronic liver disease.
- 🦋 Avoid service interruptions as a result of stock-outs of medicines and laboratory supplies.
- 🦋 Strengthen and expand laboratory services for monitoring of the response to treatment, including CD4 and viral load monitoring.
- 🦋 Decentralize routine patient care and HIV treatment monitoring to selected primary care and community-based settings based on need assessment, with consideration to the involvement of both public and private providers.
- 🦋 Integrate HIV treatment and care in other health services such as mother, neonatal and child health services, tuberculosis clinics and drug use harm reduction services.



Key priorities

Goal 5: Reduce the mortality rate among people living with HIV from tuberculosis by more than 50% by 2020.

Testing everyone living with TB for HIV provides an essential entry point to care for undiagnosed HIV. Similarly, scaling up the “three I’s” for HIV and TB (intensified TB case-finding; isoniazid preventive therapy and infection control for TB and initiating antiretroviral therapy early) are crucial for HIV programmes in preventing and reducing the burden of TB among people living with HIV. Everyone enrolled in HIV care should be screened for TB; people living with HIV without active TB should receive isoniazid preventive therapy and antiretroviral therapy should be provided to everyone living with HIV and TB regardless of their CD4 count. All HIV care facilities should ensure that adequate TB infection control measures are in place to limit the transmission of TB and ensure a safer environment for service users and health care staff. Further efforts are also needed to strengthen case reporting and tracking progress of the collaborative HIV and TB activities by HIV stakeholders through harmonized indicators and globally recommended patient monitoring systems¹⁴.

The key priorities include:

- 🦋 Update the guidelines on TB/HIV confection including prophylaxis, testing and early initiation of ARVs, patient monitoring and case findings;
- 🦋 Promote collaboration between TB and HIV programmes;
- 🦋 Enhance infection control measures and strengthen referral systems within the health system for improved management of TB/HIV infections.

Key priorities



Goal 6: Mobilize resources and increase reliance on domestic resources in the AIDS response by more than 80% by 2020 in all Arab countries.

Based on available data, it is clear that Arab countries should increase their investments in HIV and diversify funding as well as reallocate it to more effective interventions within their response. For many countries, including those with the financial capacity to support an expanded response to HIV, the problem appears to be one of resource allocation, both in terms of governments’ willingness to provide funding and to allow public health experts to use those funds where they would be most effective. Without the necessary political leadership and will, it is likely that critical programmes in these countries will not receive sufficient funding to make a significant impact on the spread of HIV. Countries should ensure that HIV investments are targeted to the most effective interventions and towards populations that would benefit most. Steps should be taken to further diversify investment sources, increase domestic investments, including developing innovative and sustainable AIDS funding sources. In the context of shared responsibility and global solidarity, international donors must remain engaged in closing the resource gap for countries in need and greater efforts made for regional solidarity.

The key priorities include:

- 🦋 Increase domestic investments in HIV to reduce reliance on external funding sources;
- 🦋 Call for a regional mechanism to fund bilateral projects among Arab states in the context of regional solidarity with focus on least developed countries; Call for an increased focus on the mobilization of resources for capacity development initiatives to improve the sustainability and self-sufficiency of HIV programmes;
- 🦋 Encourage the participation of the private sector and foundations to finance national responses;
- 🦋 Strengthen public-private partnerships and mobilize additional resources for CSOs work in the region.



Key priorities

Goal 7: Eliminate gender inequalities in accessing HIV services and gender-based violence and increase the capacity of women and girls to protect themselves from HIV.

Countries need to empower women and girls in all their diversity, including women living with HIV, as leaders to catalyse shifts towards gender equality and improve access to quality services. HIV programmes should ensure that they reach all those in need, including more vulnerable women and men. Efforts to combat gender-based violence, which enhance women's access to integrated HIV and reproductive health services, should be strengthened. In addition, the economic empowerment of women living with HIV is also a critical element of an effective HIV response and broader sustainable development as a whole¹⁵.

The key priorities include:

- 🦋 Enhance local and national efforts to address gender inequality in accessing HIV services and gender-based violence and increase women's access to reproductive health information and services;
- 🦋 Support civil society organizations working with vulnerable women and women affected by HIV to scale-up outreach and services related to gender-based violence, HIV prevention, treatment and care, as well as support for women to know and claim their legal rights;
- 🦋 Promote a comprehensive review of existing laws and policies hindering an effective HIV response and reform legal frameworks to promote the implementation of international agreements and conventions on human rights and gender equality in the context of HIV and AIDS;
- 🦋 Address the needs of vulnerable women and girls and other vulnerable groups in national HIV strategic plans and programmes with involvement of key sectors such as media and religious leaders.

Key priorities



Goal 8: Eliminate stigma and discrimination against people living with and affected by HIV by reviewing and updating of laws and policies that ensure full realization of all human rights and fundamental freedoms.

The persistence of stigma and discrimination underscores the need for integrating the AIDS response in a human rights framework. Countries should take steps to: better understand and address the factors that contribute to vulnerability to HIV and impede service access; measure and reduce stigma and discrimination; initiate legal reform, enforce existing protective laws and improve access to justice; and work to ensure a safe and dignified space to permit people living with HIV and affected by HIV to lead the work against stigma and discrimination¹⁶.

The key priorities include:

- 🦋 Conduct a comprehensive review of laws and policies that hinder effective responses to HIV and reform legal frameworks for the promotion of rights of people living with HIV, more at risk populations and all inhabitants in accessing prevention, support, treatment and care services;
- 🦋 Develop new and bold strategies and strengthen partnerships to reduce stigma and discrimination at all levels to improve universal access to and availability of services for people living with HIV and key and vulnerable populations;
- 🦋 Implement programmes to address stigma in health care, concerned sectors, workplaces and other settings;
- 🦋 Strengthen the involvement of media and religious leaders in stigma and discrimination reduction programmes;
- 🦋 Promote the ratification and implementation of the “Arab Convention on HIV Prevention and Protection of the Right of People Living with HIV” as a comprehensive framework to advance the rights of people living with HIV in the region.



Key priorities

Goal 9: Ensuring universal access to HIV prevention, treatment, care and support services for mobile populations including displaced people, refugees and migrant workers.

The Arab region is witnessing intense population movement as a result of political, economic and environmental factors. It is important to take into account the growing number of immigrants, refugees and displaced people in many Arab countries and the need to provide a comprehensive response targeting these important groups. There is a need for swifter progress in the review and updating of policies and national plans, to ensure access for these groups to the prevention, treatment, care and support services and eliminate all restrictions that hinder their right to health as an essential element of human rights. Moreover, government officials, especially in the Ministries of Health, have an important role in showing how such restrictions do not protect public health. The role of Ministries of Labour is equally important in addressing negative practices against migrant workers. It is also essential to study and review the policies concerning the right of movement and residence of people living with the HIV in light of international experiences, the economic impact and human rights. Instead of such restrictions, sufficient HIV information and services for HIV prevention and treatment should be ensured for all those entering and leaving each country – nationals and non-nationals alike¹⁷.

The key priorities include:

- 🦋 Updating policies and plans to ensure access of mobile populations to prevention, treatment, care and support services;
- 🦋 Updating existing policies and study the costs and the impact of travel restrictions on people living with the HIV;
- 🦋 Cooperation with international organizations and the private sector to provide services for prevention, treatment, care and support;
- 🦋 The inclusion of HIV and AIDS within the emergency plans and humanitarian work in conflict-affected countries.

Key priorities



Goal 10: Strengthen integration of the AIDS response in health and development efforts as well as social protection systems.

With the aim of taking AIDS out of isolation, the 2011 United Nations General Assembly Political Declaration on HIV and AIDS states: Intensifying Our Efforts to Eliminate HIV and AIDS, calls for eliminating parallel systems for HIV-related services, broader health systems strengthening and integrating the AIDS response in health and development efforts. A more integrated approach will strengthen the reach and impact of the AIDS response, leverage HIV-related gains to generate broader health and development advances and enhance the long-term sustainability of the AIDS response. Maximizing synergy and integrating HIV responses into wider health and development efforts are critical to the effectiveness and sustainability of the response.

The key priorities include:

- 🦋 Integrate HIV services in social, development and other health care programmes;
- 🦋 Promote partnership at all levels and strengthen national multi-sectoral committees with membership of key sectors such as education, youth, labour and media;
- 🦋 Ensure the alignment of national and regional strategies with global and regional commitments;
- 🦋 Development and implementation of coordinated systems for strategic information including operational research to provide evidence on the quality and feasibility and effectiveness of different approaches to HIV;
- 🦋 Facilitate the exchange of lessons learned and best practices in monitoring and evaluation across the region, particularly with regard to key populations and groups most vulnerable to infection.



Recommendations to Member States

- Review and update national HIV policies, strategies and plans to ensure alignment with the Arab AIDS Strategy and ensure that national strategies and plans are evidence-informed and human rights based.
- Enhance political commitment to universal access to HIV prevention, treatment, care and support.
- Allocate adequate human and financial resources to ensure implementation of the priorities identified in the national and regional strategies.
- Develop and/or strengthen legislative, regulatory and/or other effective measures to enhance the national AIDS responses.
- Scale up interventions to prevention HIV among key populations at higher risk in an integrated and sustainable manner.
- Strengthen HIV surveillance systems and monitor the progress towards the achievement of the targets of this Strategy as aligned to the targets of the 2011 UN General Assembly Political Declaration on HIV and AIDS.



