WHO-EM/STD/136/E

Report on the

Nineteenth intercountry meeting of national AIDS programme managers

Beirut, Lebanon
13–15 March 2010

World Health Organization
Regional Office for the Eastern Mediterranean

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1. INTRODUCTION

The 19th intercountry meeting of national AIDS programme managers was held in Beirut, Lebanon, from 13 to 15 March 2010. The meeting's objectives were to:

- provide guidance to national AIDS programme managers and health systems experts of ministries of health in carrying out joint situation analysis regarding integration of HIV programmes and interventions in existing health systems
- update national AIDS programme managers, AIDS/HIV/STD Regional Advisery Group (ARAG) members and regional partner organizations on progress with the implementation of the Regional strategy for health sector response to HIV 2006–2010
- solicit input from national AIDS programme managers, ARAG members and regional partner organizations on the development of the Regional strategy for health sector response to HIV 2011–2015.

Dr Hussain A. Gezairy, WHO Regional Director for the Eastern Mediterranean inaugurated the meeting. He welcomed the delegates in his speech and reminded the participants that the most recent UNAIDS/WHO estimates indicated that, at the end of 2008, the estimated number people living with HIV in the Eastern Mediterranean Region had reached 461 000 [403 000–519 000] and that an estimated 60 600 [49 200–75 100] new HIV infections occurred in 2008. Most countries in the Region reported low levels of HIV in the general population. However, the continuing lack of information on HIV prevalence among populations at increased risk, such as injection drug users, sex workers and men who have sex with men, may mask concentrated epidemics in these groups. The good news was that in recent years several countries had made progress towards determining the epidemic's level among these groups, including Afghanistan, Egypt, Islamic Republic of Iran, Lebanon, Morocco, Pakistan, Saudi Arabia, Somalia, Sudan and Tunisia. Most of these countries included community-based surveys among key populations at risk in their HIV surveillance activities. But there were still large information gaps with regard to populations at increased risk in most countries in the Eastern Mediterranean Region.

Dr Gezairy said that in the past few years, efforts and funds invested in expanding the health sector response to the HIV epidemic in the Region had increased substantially. These efforts had resulted in noticeable achievements on the ground in terms of availability of HIV prevention and care services.

In the area of HIV care and antiretroviral therapy provision, he said, in 2008 Afghanistan had established HIV treatment services and now all countries in the Region—including low-income countries—were offering highly active antiretroviral therapy and voluntary HIV testing and counselling services. However, the coverage of antiretroviral therapy in terms of estimated numbers of HIV cases in need of treatment remained with approximately 10% of the *estimated* need, the lowest coverage globally. This contrasts with an almost 80% coverage for HIV cases who were *known* to the health system and needed treatment. There were tens of thousands of people living with HIV in the Region who either did not know that they were HIV infected, or who knew of their HIV infection but did not access treatment. It was crucial to take all the necessary measures to scale up HIV testing and counselling services, particularly in services targeting key populations at risk of HIV; and it

was urgent and important to critically examine whether HIV prevention, treatment and care services were really accessible to the most affected and vulnerable. This was particularly important as stigmatizing attitudes and discriminating regulations and practices against people living with HIV and key populations at increased risk, even among health professionals in the Region, were still challenging service delivery.

Dr Gezairy also introduced the two main topics of the meeting. The first topic was the interaction between HIV programmes and health systems in order to gain better insight into the relationships between them, in particular in terms of integration of HIV programmes in existing systems in different country contexts in the Region. The second topic was the proposed regional strategy for the health sector response to HIV 2011–2015 which the Regional Office was finalizing and would be presented to the Regional Committee for the Eastern Mediterranean at its fifty-seventh session later in 2010. He emphasized that comments and recommendations from participants would be valuable in refining the strategy before its submission to the Regional Committee.

Dr Gezairy mentioned that the Regional Office would continue working with ministries of health, UNAIDS and its co-sponsor agencies, the Global Fund to Fight AIDS Tuberculosis and Malaria and various other international and national partners to facilitate and to foster countries' efforts to scale up their response in order to maintain and increase the momentum to achieve universal access to HIV treatment, prevention, care and support: the so-called Universal Access target.

Dr Mohammed Jawad Khalife, Minister of Public Health of Lebanon, emphasized in his speech the importance for the meeting of promoting the objectives of HIV prevention and treatment in member countries. He highlighted Lebanon's successes in HIV prevention activities and stressed that several issues remain a priority for the Ministry of Public Health in Lebanon. These included sustained funding for existing HIV prevention, treatment and care plans, creation of a civil society network, strengthening partnerships with nongovernmental organizations, emphasis on harm reduction among injection drug users by finalizing laws governing the implementation of opioid substitution programmes and increased emphasis on groups at highest risk of HIV infection and on ensuring universal access to prevention, care, treatment and support

Dr Hind Khatib-Othman, Director, UNAIDS Regional Support Team for the Middle East and North Africa, noted that the Region was home to well over half a million people living with HIV. The bulk of infections were concentrated among men who had sex with men, people who injected drugs and people who sold sex. These were people who tended to suffer major stigma and discrimination. Discrimination undermined the ability to ensure universal access to prevention, care, treatment and support. As a result less than 10% of people who needed treatment were receiving it, and prevention of mother-to-child transmission services were available to less than 1%. A different kind of engagement was needed in which culture and religion were leveraged to engage all of society to meet the prevention needs of most-at-risk populations.

Preparation for the special session on HIV was an opportune moment for delegates to work on providing the data which will help member countries mobilize resources, mobilize technical assistance and engage with all the relevant stakeholders at national level.

It was time to act as the window of opportunity was narrowing. The epidemic in much of the Region remained concentrated in most-at-risk groups. This was also the case in Ukraine, which initially had an epidemic which was mostly among injection drug users, but only a few years later had spread far beyond as the injection drug users served as a bridge to the general population. HIV had to be a multisectoral response for it to succeed; multisectoral did not mean there should be a number of different strategic plans but a strategic plan was needed which included all the different stakeholders, from ministries of education, interior and *awqaf*, civil society and, most important, the private sector, which was a neglected and an ignored sector in the Region.

The meeting programme and list of participants are attached as Annexes 1 and 2, respectively.

2. UPDATE ON RECENT REGIONAL DEVELOPMENTS WITH REGARD TO THE HIV/AIDS/STI EPIDEMIC AND RESPONSE

2.1 Presentation

Dr G. Riedner, WHO Regional Office for the Eastern Mediterranean
Ms J. Hermez, WHO Regional Office for the Eastern Meditteranean

Latest available estimates are from 2008: there were 460 000 people living with HIV in the Region, among whom 61 000 were newly infected. In the same year, 29 000 deaths were attributed to HIV. The number of countries in the Region collecting and reporting information on HIV prevalence among populations at increased risk through community-based surveillance surveys has increased. In Pakistan, Afghanistan and Islamic Republic of Iran the epidemic is concentrated among injection drug users. HIV prevalence above 5% among sex workers has been observed in Djibouti and Somalia. There is indication of potentially emerging epidemics among men having sex with men in Pakistan, Sudan, Egypt and Tunisia. However, the extent of the epidemic remains unconfirmed in many countries due to limited data regarding HIV prevalence among most-at-risk populations. In low-level and concentrated epidemics, surveillance should be prioritized among these populations. This is in order to identify the types and the size of the populations and to monitor trends in prevalence of risk behaviours and of STI and HIV for efficient targeting of interventions in order to contain the HIV epidemic.

Antiretroviral therapy (ART) coverage increased by approximately 70% in the Region between 2007 and 2009. However, Regional coverage is still low. This is mainly because most-at-risk populations are not targeted by counselling and testing programmes, thus limiting identification of the number of people living with HIV. Among those initiated on ART by 2008, retention levels tend to be high (>70%). ART stock-outs were reported by five countries, representing 36% of countries reporting in the Universal Access report. Successful approaches to achieving good coverage of ART in the Region include: a participatory

approach to ART programme planning and monitoring involving the ministry of health, treatment experts and people living with HIV; targeting services to specific populations based on the epidemic situation; standardized service models; step-wise establishment of treatment centres with attention to quality; and strong linkages to community based prevention and testing/counselling services.

By 2008, the regional coverage of HIV-infected pregnant women with ART prophylaxis was 1%. Prevention of mother to child transmission (PMTCT) is high priority in generalized epidemics: southern Sudan, Djibouti and parts of Somalia.

HIV testing and counselling has steadily increased from 1989 to 2007, during which time 44.6 million HIV tests were reported to WHO (quarterly epidemiological reports). Most HIV testing data stem from blood donors and from labour migrants. HIV prevalence among migrants tested was 0.05%. By contrast, testing was least frequent among injection drug users, sex workers, prisoners and men who have sex with men; this despite a proportionally much higher yield of people living with HIV identified and amenable to HIV prevention, care and treatment interventions among these populations. The proportion of HIV positives among sex workers tested was 2.2% and 1.58% among injection drug users, 1.01% among prisoners, and 1.0% among MSM. These findings highlight the fact that testing and counselling is largely not targeting those at highest risk of infection.

Similarly, activities focusing on prevention of transmission among high-risk groups are limited with the exception of Pakistan and Islamic Republic of Iran, which provide more comprehensive and wider scale coverage (i.e. more than two large cities) for injection drug user prevention activities and in Morocco for sex workers.

2.2 Discussion

There was a general consensus that prevention, including testing and counselling activities, among high-risk groups is low and should be prioritized. Analysis of HIV testing data was thought to be a useful advocacy tool to highlight this gap. Information on country experiences with provider-initiated testing and counselling and mandatory testing was requested.

There was concern among some member countries that estimates of HIV prevalence and ART needs were higher than the actual situation in country. It was noted that despite limitations the estimates enable regional comparisons. Clarifications regarding the estimation techniques were also made, and it was noted that estimates are modelled based on the country data and with continuous improvement of data, estimations will also become more accurate.

3. INTERACTIONS BETWEEN HIV PROGRAMMES AND HEALTH SYSTEMS

3.1 Presentation

Dr J. Perriens, WHO headquarters
Dr K. Dehne, UNAIDS headquarters

Findings from the positive synergies study, which assessed the nature of interactions between global health initiates and health systems, were highlighted. Changes in perceptions in global health may pave the way for increased integration. These changes include concerns about undesirable impacts of HIV funding or programmes on national health systems; revival of primary health care; strengthened focus on child and maternal health (Millenium Development Goals 4 and 5); concerns about the lack of progress in health systems strengthening; and the establishment of a joint health systems funding platform with the World Bank, the Global Fund to fight AIDS, Malaria and Tuberculosis, the Global Alliance for Vaccines and Immunisation. The limited link between national health plans and HIV plans was highlighted. National health plans may focus on health systems strengthening and integrated service packages without details on HIV specific strategies. National plans are usually also less focused on vulnerable groups.

3.2 Discussion

Some in the group felt that integration was an important way forward. As one participant remarked this was because it was “time to remove the exceptionalism around HIV”. HIV programming should thus be more open and not kept “hidden in a back room”. Some thought that integration of services should start by limiting the establishment of special centres for HIV services, while respecting confidentiality in integrated services, training of various health cadres to provide HIV services, and by offering provider-initiated HIV testing and counselling in certain health facilities.

There was however general consensus that, though important, integration would have to be country-specific. The maturation of the health system and the epidemiology of the disease in each country has to be taken into account. Some felt that there should not be an *a priori* assumption that a health system is strong and integration is always necessary and useful.

As external funding increased the scope and ability of national AIDS programmes to integrate within health systems was thought to decrease. Additionally, it was felt that integration of prevention activities among high-risk groups would be challenging as civil society organizations, which often carry out interventions targeting most-at-risk populations, largely operate outside the public health system. HIV prevention activities among most-at-risk populations may be in conflict with the law, which makes integration difficult. Increased governmental financing to civil society, such as in Morocco, may improve the linkage between government and civil society.

3.3 Achieving coverage, quality and sustainability of HIV programmes in the context of existing health systems: country case studies

Dr Shadi Saleh, WHO temporary adviser
Dr Peter Campbell, WHO temporary adviser

Data from a qualitative study carried out in four countries: Yemen, Sudan, Morocco, and the Islamic Republic of Iran were presented. The study found that the overall factors influencing integration of HIV policies were related to political, religious and social priorities; chief among them was the need to provide quality service while responding to donor monitoring and evaluation and procurement requirements.

3.4 Rapid assessment of interaction of HIV programmes with existing health systems

Dr P. Campbell, WHO temporary adviser

A rapid assessment guide and tool was presented, and the tool was reviewed in group work. The assessment aims to explore interaction between HIV programmes and health systems. It is a qualitative study tool using in-depth individual or group interviews with key informants. The draft tool is structured along the six building blocks of a health system: leadership and governance; information support; financing; service provision; workforce; and medicines and technology.

3.5 Discussion

Member countries, divided into groups, discussed the aim of the study and briefly tested the draft tool. The groups observed that levels of integration of HIV programmes in the main health systems functions vary; countries with less external funding of HIV programmes, especially Gulf Cooperation Council countries, had higher levels of integration; and that this was in contrast to countries such as Somalia and Sudan where >80% of funding for HIV programmes comes from external sources. In these countries HIV programmes tend to operate parallel to the health system. In essence external funding correlated with less integration There were weaknesses of national medicines procurement and supplies systems, which led to drug stock-outs, in highly integrated as well as in separate programmes. Linkage with other sectors and institutions providing HIV services was weak. There was a consensus that pilot studies to test the approach and the tool would be useful and that all countries were ready to carry out such pilot studies.

Suggestions for improvement of the methodology made by the groups included the following.

- Views of clients of services should be explored, and a separate tool should be developed for this purpose.
- The assessment study should be carried out repeatedly to explore change over time.
- Limitations of the methodology should be discussed and acknowledged.
- Language should be checked for bias towards favouring integration.

- Additional questions should be included regarding availability of a defined package of health services at every level, integration of pre-service training.
- Modalities of the use of diagrams to describe components of the existing health system should be clarified in order to respond appropriately to the questionnaire.
- Filter questions should be added where appropriate.
- Prompts should be explained in the guide and more prompts would be useful.
- The document should be translated into French.

The plenary discussed possible avenues for integration of HIV programmes and interventions in health systems. The following ideas were shared:

- use of the existing primary health care structure structure
- harmonization and integration of different in-service training (e.g. HIV/tuberculosis/malaria/sexually transmitted illnesses)
- harmonization of multiple donor requirements, which needs to be negotiated with funding agencies

Once the tool is updated based on the group suggestions, it should be piloted in two or three countries.

4. REGIONAL STRATEGY FOR THE HEALTH SECTOR RESPONSE TO HIV 2011–2015

4.1 Proposed regional strategy for the health sector response to HIV 2011–2015

Dr H. Khattabi, WHO Regional Office for the Eastern Mediterranean

Participants were introduced to the proposed structure and contents of a Regional strategy for health sector response to HIV/AIDS 2011–2015, which would be presented for endorsement to the Fifty-seventh Session of the Regional Committee for the Eastern Mediterranean in October 2010.

The purpose of the strategy is to advocate for urgent action by member countries to enhance the contribution of the health sector to achieving universal access to HIV prevention, treatment, care and support. The goal of the strategy is to reduce transmission of HIV and to improve the health of people living with HIV.

The objectives cover four areas: strategic information, access to treatment, access to prevention and health systems strengthening. The strategy has five components: strengthen health information systems for HIV; foster political support, broad participation, coordination and adequate sustained financing; provide quality HIV prevention, care and treatment and enhance use; strengthen the capacity of health systems for effective integration; promote an enabling policy environment.

4.2 Discussion

Country representatives, ARAG members and UN agency representatives were divided into groups to discuss selected sections of the strategy: to review the Regional situation, current response and challenges; review objectives and targets: participants' comments and suggestions; and review components of the strategy: participants' comments and suggestions. In the following suggestions for improvements of each section of the strategy are summarized.

Epidemic and response

Limitations of data should be elaborated on. National AIDS programme managers recognized that some data were outdated and other data were missing because they had not yet been made available to the Regional Office. Data tables were circulated to national AIDS programme managers to make necessary updates of data, and programme managers made editorial suggestions for several of the tables.

Participants pointed out a number of issues that should be referred to or elaborated in the situation analysis including developments regarding political commitment, socioeconomic factors in countries that contribute to vulnerability and that influence the nature of the response across countries, including complex emergency situations, information on risk behaviour, the role of civil society and the private sector, human rights issues and HIV in prison settings; success stories from countries should be highlighted.

Suggestions to include additional information and aspects would be accommodated as much as possible; however, since the strategy would be presented to the Regional Committee as a technical paper, the length of which was limited, it might not be possible to include everything.

Goals, objectives, targets

Participants agreed with the goals, objectives and targets of the draft strategy. They made some suggestions for consideration including separating the goal into two goals with two impact indicators and reviewing the measurability of targets and adding targets covering issues such as "retention on ART". A clear baseline for each target ought to be indicated. Regional Office unit staff clarified that this was not possible for all targets at this stage since baselines must be determined first, which was a strategic priority under component 1 of the strategy. Regional Office staff explained that targets were kept limited to a small number on purpose, while indicators for monitoring of the implementation of the strategy covered a wider range of issues, including "retention on ART".

Component 1: strengthening health information systems for HIV and operational research

The majority of comments were editorial in nature (see Annex 3). A better definition of the linkage between HIV programme monitoring and the health information system (e.g. shared indicators) was suggested.

Component 2: foster political support, broad participation, coordination and adequate and sustained financing

A stronger emphasis on the engagement of civil society in the heath sector response was suggested.

Component 3: access to prevention

A focus on expanding coverage of known prevention interventions for key populations and their partners was suggested. Stronger emphasis on promotion of voluntary counselling and testing and advocacy for a legal framework for harm reduction should be considered.

Component 4: strengthen the capacity of health system for effective integration of HIV services

Several editorial suggestions were made and will be noted in the revision. Condoms and lubricants could be added to commodity management.

Component 5: promote a supportive policy environment and stigma reduction to facilitate the health sector response

Improving the definitions of components 2 and 5 or alternatively merging the two components together should be considered.

Monitoring and evaluation framework

Participants were supportive of the use of UNGASS and Universal Access indicators, since countries already reporting these. UNGASS and Universal Access indicators are being updated, and strategy indicators will be updated accordingly when the process is completed. The development and addition of indicators that monitored the component on strengthening health systems were suggested.

5. CONCLUSIONS

Participants concluded that it was timely to assess the situation in countries regarding the interaction between the HIV programmes and health systems, including the status of integration of HIV programmes and services in health systems. Integration of HIV in the general health system is desirable and necessary. It should take into consideration the large

differences in health systems maturity, contextual features and epidemiological characteristics of the countries in the Region.

National AIDS programme managers, ARAG, UN agencies, nongovernmental organizations, WHO staff, and health systems experts from the Region agreed in principle to the structure and contents of the draft Regional health sector strategy for HIV. The meeting participants provided valuable and constructive comments that will be used by the Regional Office to develop the final draft for endorsement by the Regional Committee

6. RECOMMENDATIONS

To Member States

1. Member States should improve epidemic information on HIV epidemic in order to achieve more accurate estimates. This will enhance ownership and help to ensure consensus between local and international stakeholders
2. National AIDS programme managers should share with health systems department in ministries of health the outcome of the 19th NAP Managers' meeting and discuss possibilities for piloting the assessment tool for interaction between HIV programmes and health systems.

To WHO

3. Assist countries in reporting on HIV testing and counselling by clarifying indicator definitions with aim of increasing accuracy of reports.
4. Finalize the tool on assessment of interaction between HIV programmes and health systems taking into account the comments and suggestions of the participants of this meeting.
5. Make the tool available to countries after finalization.
6. Support piloting of the tool in selected countries.
7. Finalize the regional strategy for the health sector response to HIV (2011–2015) taking into account the comments and suggestions of the participants of this meeting.

Annex 1

PROGRAMME

Saturday 13 March 2010

09:00–10:00	Opening session Address by Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean Address by Dr Mohammed Jawad Khalife, Minister of Public Health, Lebanon Opening remarks By Dr T Guerma, WHO headquarters Opening remarks By Dr H Khatib, UNAIDS Objectives and expected outcomes	*Moderated BY Dr J. Mahjour, EMRO* *Dr G. Riedner, EMRO*
Update on recent regional developments with regard to HIV/AIDS/STI epidemic and response		
10:30–11:00	Review of agenda Introduction of participants	
11:00–11:30	Update on recent regional developments with regard to HIV epidemic and response	*Dr G Riedner, EMRO*
11:30–12:00	Discussion	
HIV programme and health system interaction		
12:00–12:30	Global perspectives on HIV programmes in the context of health systems	*WHO headquarters UNAIDS headquarters*
12:30–13:00	Discussion	
14:00–14:45	Introduction to the project “achieving coverage, quality and sustainability of HIV programmes in the context of existing health systems” and presentation of country case study results	*WHO temporary advisers*
14:45–15:00	Discussion	
15:00–15:30	Methodology and tool for rapid assessment of interaction of HIV programmes with existing health systems	*WHO temporary advisers*
15:30–16:00	Discussion	
16:30–17:30	Reading and questions/answers of the tool for rapid assessment of interaction of HIV programmes with existing health systems	

Sunday 14 March 2010

09:00–09:15	Introduction to working group session	*EMRO*
09:15–11:15	Working group session: exercises on rapid assessment methodology	
11:15–12:45	Group work presentations and discussion	
12:45–13:00	Conclusions and way forward	*EMRO*

Regional strategy for the health sector response to HIV 2011–2015

14:00–14:30	Presentation of the proposed regional strategy for the health sector response to HIV 2011–2015	*EMRO*
14:30–14:45	Introduction to working group sessions	*EMRO*
14:45–16:00	Working group session: review of the regional situation, current response and challenges Review of objectives and targets: participants' comments and suggestions	
16:30–17:30	Group work presentations and discussion	*Plenary*

Monday 15 March 2010

09:00–09:15	Summary outcomes of day 2 and introduction to group work	*Rapporteur, EMRO*
09:15–10:30	Working group session:review of components of the strategy	
11:00–12:00	Group work presentations and discussion	*Plenary*
13:00–13:30	Summary of main recommendations	*EMRO*
13:30–14:00	Concluding remarks and next steps	*EMRO and UNAIDS*
14:00	Closing session	

Annex 2

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Annex 3

FEEDBACK FROM GROUP DISCUSSIONS ON THE REGIONAL STRATEGY FOR HIV RESPONSE

Epidemic and response

Data accuracy

- Table 1 page 3: Remove “not confirmed” column.
- Refer to limitations of data presented

Data sources

- Sentinel surveillance data used for some countries. Additional GCC surveillance data are available, and if sent to the Regional Office will be included in the report

Presentation

- Table 1: add year and source of data
- Table 3: Define roughly, what low, medium and high coverage means
- Improve readability if subtitles are used more

Additional information needed on:

- National commitment (e.g. Page 3 para 1: should mention progress on political commitment providing OST to injection drug user). EMRO will use UNGASS data to add information on national commitment
- Mention complex emergencies setting of several countries
- Blood safety situation
- Vertical transmission not mentioned
- Describe socio-economic factors and context of the countries has a bearing on vulnerability and nature of responses across countries.
- Information on migrant workers is needs rephrasing and some changes or corrections
- Page 2, paragraph2, line 5–6: the risk is not just living in the country with high prevalence but high risk behaviours in these settings
- Identify success stories within the region (e.g. VCT and outreach)–however, this has to be weighed with length of the document and also the fact that this information is described in detail elsewhere
- HIV prevalence among MARPs tested since 1997 (Joumana’s presentations). Table is very important for advocacy
- Strengthen part on MARPs with a stronger reference to prison settings
- Include reference to young people in the context of access to information and services.
- Need to review and or add some available key estimates (e.g. paediatric treatment coverage, PMTCT, etc.)

- Clarification from the Regional Office: RC strategy paper length is limited–will try to accommodate as much as possible, however possibly not all information can be included.

Goals, objectives, targets

- Consider separating the two goals → two separate impact indicators
- Include reference to the importance of partnerships with other UN agencies to achieve the set respective objectives and targets in the guiding principles section (e.g. targets 3 and 4 with UNODC; Target 1 with UNICEF, etc.)
- Indicate clear baseline for each target. (Clarification: not possible–baselines must be determined first)

Objectives

- Consider additional objectives covering the following 1) population size estimation, 2) increasing knowledge of HIV status. The Regional Office clarified that this is accommodated under the 4 objectives.
- Improve measurability and time dimension. The Regional Office clarified that this is taken care of by including targets in the strategy.

Targets

1. Add outcome targets, e.g. retention on ART
2. Some outcome measurement are challenging to measure (e.g. reduction in transmission)
3. Not every objective has an indicator. This is because few, clear indicators used to measure progress in more than one objective (e.g. ART coverage and reaching MARPs will serve as a proxy measures for other activities)

Components

Component 1: Strengthening HIS for HIV and operational research

1. Question: where uptake of HIV testing is above 80% in PMTCT, this can be used for HIV surveillance? Also if we push towards universal access PMTCT how can we use that information for surveillance?
2. Edit statement at bottom of pg 7: “WHO and UNAIDS discourage countries from investing substantial resources in HIV testing of low risk populations for surveillance unless indicated for prevention of HIV transmission, blood safety, and PMTCT“
3. Pg 8 under programme monitoring, add sentence: More advanced monitoring should include standardised periodic assessment of quality of services, care and treatment outcomes and in-depth programme reviews (draw lessons from tuberculosis programme review approach).
4. There should be a defined linkage between HIV programme monitoring and the Health information system: shared indicators and modalities of mutual strengthening.

5. Under size estimations, edit sentence: “HIV prevalence and behavioural surveys must strictly follow the ethical principles of voluntary participation and informed consent, and care should be taken that there are no negative repercussions for the study participants”.

Component 2: Foster political support, broad participation, coordination and adequate and sustained financing

1. Add: Coordinating mechanism or steering committee for decision making
2. Emphasize civil society engagement; however, how to involve them?

Component 3: Providing quality HIV prevention, care and treatment services and enhancing their utilization

1. In the introduction emphasize that the health sector includes public and private sector
2. Blood safety (p9): Collaboration/linkage with other similar programmes working on blood safety and infection control
3. Access and utilization of testing and counselling: More explicit emphasis is recommended on promotion of voluntary testing
4. Due to resource limitation step wise implementation with linkage to higher risk groups should be emphasized and prioritized
5. Integrate information and education on HIV/STI prevention in reproductive health services, mother and child health services and STI case management. The wording “safe sexual behaviour” may not be acceptable.
6. PMTCT: Double check is needed for box I with comprehensive guideline, about ARV prophylaxis and treatment of exposed children
7. New ARV guide for lactating mothers should be considered (annex of PMTCT package)
8. Apply standardized treatment regimens and patient monitoring (instead of laboratory monitoring)
9. Other opportunistic co-infections is better to be considered in additional points or integrated into the existing points
10. Ensure blood safety, safety of medical procedures, PEP: PEP should be available/accessible and should expand non occupational exposure prophylaxis
11. Testing for blood safety should be reported separately
12. Increase access to and utilization of HIV testing and counselling: Outreach HIV testing targeting MARPS, standards for voluntary counselling and testing for outreach
13. Instead of “clinicians” use health care workers (page 10 bullet 2)
14. Focus on expanding coverage of known prevention interventions for key populations and their partners
15. Add as a key element that countries should advocate for a legal framework for harm reduction
16. Integrate information and education of safe sexual behaviours in reproductive health , maternal and child health and STI services

Component 4: Strengthen the capacity of health system for effective integration of HIV services

1. Add: condoms and lubricants in the commodity management and prevention before care and treatment in strengthening of quality assurance
2. Remove “in particular in lower income countries” from priority 2 (strengthen health infrastructure). This is important for all countries.
3. “Strengthen commodity management” is a very long sentence; leads to confusion, be careful from putting financial burden on NAP. Suggestion: replace “HIV programmes should contribute to coordination and mutual support“
4. Add “internal and external quality assurance“

Component 5: Promote a supportive policy environment and stigma reduction to facilitate the health sector response

1. Move Ensure affordability of HIV medicines and diagnostics to component 3
2. Add ensure affordability of preventive methods (condoms, NSP, OST)
3. Components 2 and 5 need to either be clearly defined as separate or merged if need be.
4. In priority 3: edit the sentence to be: policies and laws should protect people living with HIV, without mentioning all the parts
5. In priority 5: change into: policies and laws should promote voluntarism and ensure it in HIV testing

Monitoring and evaluation framework

1. Overall: Recommend using UNGASS and universal access indicator formulation since countries already reporting by these. Dr Riedner followed up that UNGASS and universal access indicators may be updated and strategy indicators will be updated accordingly when this happens.
2. Indicator 3 (PMTCT): Adapt the more clear UA/UNGASS definition: Percentage of pregnant women who were tested for HIV and received their results- during pregnancy, during labour and delivery, and during the post-partum period (< 72 hours), including those with previously known HIV status.
3. Indicator 7: Delete this. It is not in UNGASS and replace with the indicator on Number I17 from universal access/UNGASS framework
4. Indicator 17: Add 24, 36, 48 time points
5. Indicator 24: Difficult to measure
6. Indicator 29: Break it into sub indicators for each group, don’t lump them all together
7. Indicator 32: Add quantitative threshold e.g 75% of UNGASS indicator
8. Add Numerators and Denominator definitions to the indicator framework (take standard universal access/UNGASS definitions current reporting forms)
9. Data arising from these indicators should be used by countries for planning, monitoring and advocacy
10. Check to cover more of the HSS building blocks: e.g finance, linkage to health information system (brainstorm further on appropriate human resource, stewardship indicators)