Regional action plan for the implementation of the global health sector strategies on HIV, viral hepatitis and sexually transmitted infections

2022–2030

World Health Organization
Eastern Mediterranean Region

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WHO Library Cataloguing in Publication Data

Names: World Health Organization. Eastern Mediterranean Region

Title: Regional action plan for the implementation of the global health sector strategies on HIV, viral hepatitis and sexually transmitted infections, 2022-2030 / World Health Organization. Eastern Mediterranean Region

Description: Cairo: World Health Organization. Eastern Mediterranean Region, 2024

Identifier: ISBN 978-92-9274-337-6 (pbk.) | ISBN 978-92-9274-338-3 (online)

Subjects: Regional Health Planning | HIV Infections - prevention & control | Hepatitis, Viral, Human - prevention & control | Sexually Transmitted Diseases - prevention & control | Global Health | Health Plan Implementation | Pandemic Preparedness | Eastern Mediterranean Region

Classification: NLM WA 541

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Executive summary

The Eastern Mediterranean Region is challenged by growing epidemics of HIV/AIDS, viral hepatitis and sexually transmitted infections (STIs). Although some progress has been made in all three disease areas, the regional response is off-track and most of the 2020 regional targets were not achieved. The HIV/AIDS epidemic is growing faster than the response, with increases in incidence and mortality over the past decade. Similarly, despite progress in hepatitis B third-dose coverage and in testing and treatment for hepatitis C virus, the coverage of other key interventions – including birth-dose vaccination, injection safety, harm reduction, and testing and treatment – is still low. STIs are increasing in the Region, with a limited response that does not match the burden of disease. Furthermore, COVID-19 disrupted services, exposing profound weaknesses in our health systems and their lack of resilience in emergencies. Overall, achieving Sustainable Development Goal 3 and the global targets on HIV, viral hepatitis and STIs by 2030 will be difficult if the Region continues at the current pace. Only a focus and surge of efforts will enable the Region to meet the global targets for the three disease areas by 2030.

In 2022, WHO developed the *Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections 2022–2030*[1] (GHSS 2022–2030). In response, the WHO Regional Office for the Eastern Mediterranean led a consultative and participatory process to develop a regional action plan for the implementation of the GHSS 2022–2030 (RAP-GHSS 2022–2030), tailored to the cultural and epidemiological context, needs and challenges of the Eastern Mediterranean Region. This participatory process included an intercountry consultation, held from 27 to 29 September 2022. The consultation engaged HIV, viral hepatitis and STI programme managers from 20 countries of the Region, representatives of civil society and experts from the Region, as well as representatives from the United Nations and other partners. The process concluded with the development of the RAP-GHSS 2022–2030, which is the present document.

The RAP-GHSS 2022–2030 is aligned with the Eastern Mediterranean Region's strategy to achieve Health for All by All[2] within the framework of universal health coverage. It identifies regional priorities based on current progress in the epidemic state and the response, gaps, challenges and opportunities regarding HIV, viral hepatitis and STIs. It capitalizes on global strategic shifts that require putting people at the centre of rights-based health system responses; addressing the unique priorities for each disease area; taking a shared approach towards strengthening health and community systems; responding to a swiftly changing health and development context; and playing a key role in eliminating stigma, discrimination and other structural barriers. The regional action plan has five strategic directions, with recommended shared and disease-specific actions. These five directions are: 1) delivering high-quality evidence-based, people-centred services; 2) optimizing health systems, sectors and partnerships for impact; 3) generating and using data to drive decisions for action; 4) engaging empowered communities and civil society; and 5) fostering innovations for impact. The regional action plan sets out a monitoring and evaluation framework with targets and milestones to ensure accountability and measure progress towards ending HIV and eliminating viral hepatitis and STI epidemics by 2030. The measurement framework sets targets for 2025 and 2030 for impact and coverage indicators, as well as priority programmatic milestones. Regular monitoring and reporting will ensure accountability targets for the proposed actions.

[1] Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030. Geneva: World Health Organization; 2022 (https://iris.who.int/bitstream/handle/10665/360348/9789240053779-eng.pdf, accessed 31 May 2024). Licence: CC BY-NC-SA 3.0 IGO.

[2] Vision 2023 [website]. WHO Regional Office for the Eastern Mediterranean; 2024 (https://www.emro.who.int/about-who/vision2023/vision-2023.html, accessed 31 May 2024).

1 Development of the regional action plan

1.1 Rationale

The WHO GHSS 2022–2030 build on the achievements on the of the previous GHSS 2016–2021, to guide the health sector in implementing strategically focused responses to achieve the goals of ending AIDS and the epidemics of viral hepatitis and STIs by 2030. They recognize that the social context, burden and distribution of HIV, viral hepatitis and STIs vary across countries and that responses need to be adapted to different epidemiological and health system contexts. Strategic and innovative shifts are needed to protect the progress to date and to bring the world closer to the goal of ending the epidemics. The GHSS 2022–2030 consider the epidemiological, technological and contextual shifts of recent years, foster learnings across the disease areas, and create opportunities to leverage innovations and new knowledge for effective responses to HIV, viral hepatitis and STIs. They recommend country actions that are shared for those diseases, as well as disease-specific actions for the next eight years, supported by actions from WHO and partners.

The WHO Regional Office for the Eastern Mediterranean has developed a regional action plan for the implementation of the GHSS 2022–2030, as presented in this document. This regional action plan adopts the strategic directions in the GHSS 2022–2030, adapts the actions according to the Region's epidemiological and cultural contexts and priorities, and adapts the indicators accordingly. This regional action plan provides a foundation to fast-track progress in HIV, viral hepatitis and STI responses to catch up on the Region's missed targets for 2020. It will guide country actions towards achieving the global targets of 2025 and 2030.

1.2 Purpose and focus

The purpose of the RAP-GHSS 2022–2030 is to build and maintain momentum among the countries/territories of the WHO Eastern Mediterranean Region to accelerate access to prevention, testing and treatment for HIV, viral hepatitis and STIs. It will guide countries/territories and the WHO Secretariat on a roadmap and priority actions towards achieving national, regional and global targets. It provides a strategic framework that focuses on key populations – namely, people who inject drugs, men who have sex with men, male and female sex workers, transgender people, and people in prison and other closed settings, as well as other context-specific vulnerable and priority groups. It proposes shared and disease-specific approaches that are people centred.

The regional action plan aligns with the Eastern Mediterranean Region's strategy of Health for All by All. It will be implemented within the context of universal health coverage, which calls for providing all people with access to the health services they need, when and where they need them, without incurring financial hardships. It is also aligned with the Joint United Nations Programme on HIV and AIDS (UNAIDS) global strategy, which aims to reduce the inequalities that drive the AIDS epidemic and to prioritize people who are not yet accessing life-saving HIV services.

[1] Global AIDS Strategy 2021–2026 – End Inequalities. End AIDS. Geneva: UNAIDS; 2021 (https://www.unaids.org/en/Global-AIDS-Strategy-2021-2026, accessed 31 May 2024).

1.3 Target audience

The primary target audiences of the RAP-GHSS 2022–2030 include ministries of health, policy-makers, health planners, and national and subnational programme officers. Other audiences include implementing agencies, clinicians, civil society organizations, community groups, WHO partner agencies, academia, the private sector and donor agencies.

1.4 The regional action plan development process

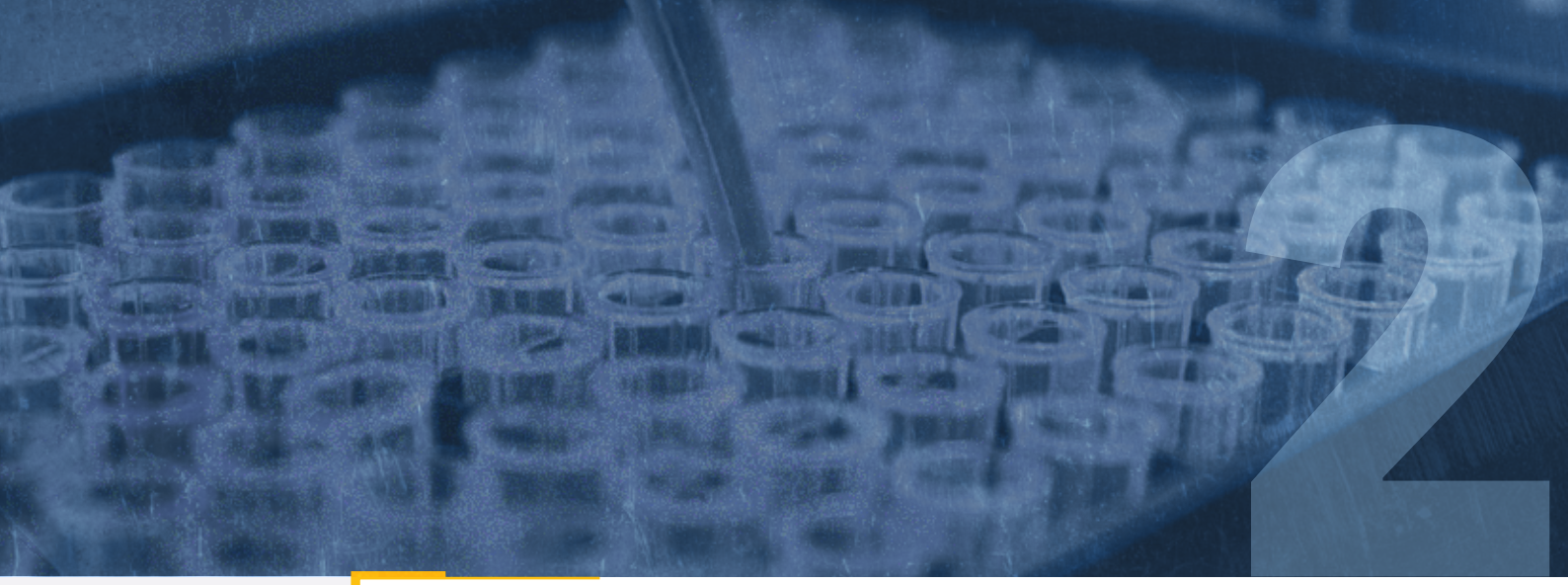
A steering committee was formed, comprising ministry of health directors, representatives of regional civil society organizations and WHO subject-matter experts. The steering committee oversaw the entire process leading to development of the RAP-GHSS 2022–2030, and it provided critical inputs at all stages of development.

The Regional Office for the Eastern Mediterranean developed the regional action plan using a participatory approach, involving all stakeholders and using the following methodology.

- A desk review analysis characterized the regional epidemiological situation and the progress to date of the three disease areas, including identifying challenges, obstacles and opportunities.
- Draft priorities for the regional action plan were identified based on the desk review analysis findings and finalized with the contribution of the key informants from the Region and from the regional steering committee.
- Eight in-depth interviews were conducted with key informants from seven countries, representing diverse stakeholders from national programmes, ministries of health, civil society organizations, partners and WHO subject-matter experts. In those interviews, the WHO Regional Office asked the participants about the relevance of the regional action plan's proposed five strategic directions and the feasibility of their implementation and suggested priority actions.
- The WHO Regional Office presented the draft action plan and discussed it in the regional strategic and technical consultation meeting held in Oman from 27 to 29 September 2022. The draft was also presented at the 69th session of the WHO Regional Committee for the Eastern Mediterranean, which supported the development of the regional action plan. In the present document, the Regional Office has addressed feedback and incorporated suggestions provided by the participating programme managers, civil society organizations and experts.

2

Status of the regional disease epidemics and responses, including key challenges and opportunities

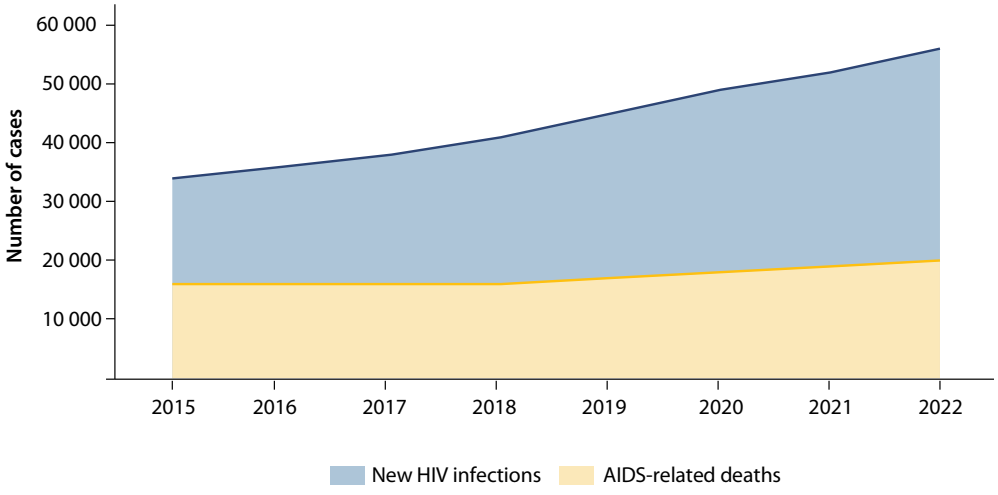


2.1 Regional overview of the HIV, viral hepatitis and STI epidemics and responses to them

2.1.1 HIV/AIDS

Epidemic status

In 2022, WHO and UNAIDS estimated that 39 million people were living with HIV worldwide, 1.3 million people were newly infected, and there were 630 000 AIDS-related deaths. In the Eastern Mediterranean Region, by the end of 2022, there were an estimated 490 000 people living with HIV, including 17 000 children, which accounted for 1% of the global HIV burden (Box 1). Despite this low share of global HIV burden, the Eastern Mediterranean Region is experiencing the fastest growing epidemic of all WHO regions. In 2022, WHO and UNAIDS estimated that 56 000 new HIV infections and 20 000 deaths occurred in the Region. These figures are equivalent to a 65% increase in estimated new HIV infections and a 25% increase in AIDS-related deaths, compared with 2015 (Fig. 1). Among countries of the Region, Djibouti had the highest HIV prevalence among the general population (0.8%) in 2022, followed by Sudan and Pakistan (0.2%). Seven countries (Afghanistan, Egypt, Islamic Republic of Iran, Morocco, Pakistan, Sudan and Yemen) together contributed 90% of the estimated number of people living with HIV in the Region.



Source: AIDSinfo [online database]. UNAIDS; 2022 (https://aidsinfo.unaids.org/).

Fig. 1. Number of new HIV infections and AIDS-related deaths in the Eastern Mediterranean Region, 2015–2022

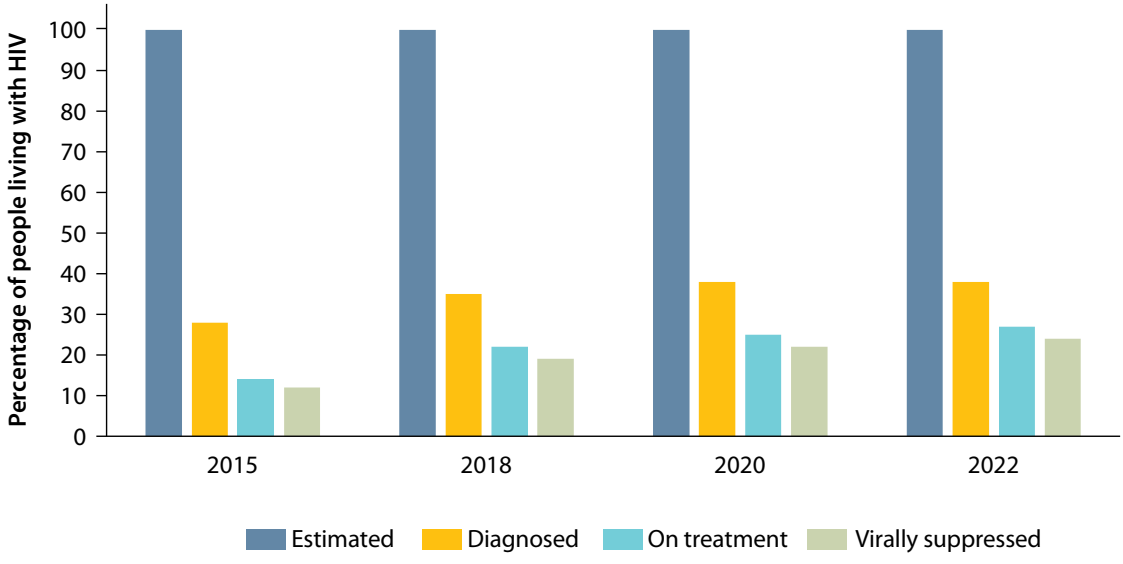
The Region's HIV epidemic is concentrated among key populations – including people who inject drugs, men who have sex with men, transgender people, sex workers, and people in prisons and other closed settings – who have higher HIV prevalence compared to the general public. Integrated biobehavioural surveys conducted among these groups reported a prevalence of up to 9.3% among sex workers in Djibouti, a 9% prevalence among men who have sex with men in Tunisia, and a 21% prevalence among people who inject drugs in Pakistan. In 2020, among newly reported HIV cases, 31% were attributed to heterosexual transmission, followed by injecting drug use (29%). A further 10% were related to blood and blood products, and 6% were attributed to homosexual transmission. The epidemic in the Region mostly affects people aged over 25 years (75% of total HIV cases), and data indicate a male predominance among reported HIV cases, with a male-to-female ratio of 2:1.

Response

In 2022, global progress in the HIV response led to 84% of people living with HIV knowing their status, 76% being on treatment and 66% being virally suppressed. In contrast to global progress, the Eastern Mediterranean Region is still facing challenges in diagnosis and treatment, and the Region reports the lowest performance globally. Only 38% of the estimated total number of people living with HIV are diagnosed, 27% are on treatment and 24% are virally suppressed (Fig. 2). Countries in the Region missed the interim targets for 2020, which were to diagnose 90% of the total HIV population, treat 90% of those who are diagnosed, and achieve 90% viral load suppression among those on treatment.

There is a scarcity of data on prevention coverage in the Region, with most data reported from a limited number of countries. In 2021, 11 countries in the Region reported adopting WHO recommendations on pre-exposure prophylaxis use; however, implementation remains limited to Morocco (625 users in 2021) and Lebanon (239 users in 2021), with some other countries starting implementation. In 2021, reported condom use among men who have sex with men was 52% in Lebanon and 57% in Morocco.

The WHO policy review in 2020 indicated that most countries in the Region had not adopted the WHO recommendations that emphasize focused testing for key populations. Analysis of HIV case reporting data between 2016 and 2020 indicated that only 5–6% of HIV tests occur among high-risk groups annually. Most of the tests are conducted among low-risk groups such as migrants. Country programmes, such as those in Lebanon and Morocco, that adopted comprehensive key populations programming progressed towards the global fast-track targets (Lebanon: 83% diagnosis, 66% on treatment; Morocco: 83% diagnosis, 80% on treatment). In addition, only four countries implemented or piloted innovative testing approaches such as HIV self-testing, with 14 countries having no policy in place.



Source: AIDSinfo [online database]. UNAIDS; 2022 (https://aidsinfo.unaids.org/).

Fig. 2. HIV cascade of care in the Eastern Mediterranean Region, 2015–2022

In 2021, among the 10 countries that reported on these indicators, the proportion of advanced diseases increased from 27% in 2017 to 37% in 2019. In contrast, baseline CD4 testing decreased from 38% in 2018 to 32% in 2019. This indicates a gap in early diagnosis and linkage to treatment. This low level of CD4 testing compromised the quality of services and, together with late diagnosis, could lead to increasing deaths.

Additionally, there is limited acknowledgement of the burden of disease, and the lack of information about the size of groups at high risk led to programming gaps focused on key populations.

The Eastern Mediterranean Region's efforts towards elimination of mother-to-child (vertical) transmission of HIV remain slow, except in a few countries. In 2022, out of 7800 women living with HIV in the Region, only 1500 (19%) were receiving the needed treatment. Oman is the only country in the Region that has eliminated mother-to-child transmission of HIV and syphilis. This is a result of ensuring universal access to services for women living with HIV and their babies and the establishment of successful maternal, perinatal and child health services within primary health care services.

Further, in 2020 and 2021, COVID-19 challenged HIV services, leading to a shortage of supplies, depleted resources and disrupted services, including prevention, testing and linkage to treatment. In 2020, the number of HIV tests conducted was only 45% of the 2019 total (3.7 million in 2020 versus 8.4 million in 2019). This also contributed to a decrease in HIV diagnosis (16 216 people living with HIV diagnosed in 2020 compared to 19 234 in 2019).

2.1.2 Hepatitis

Epidemic status

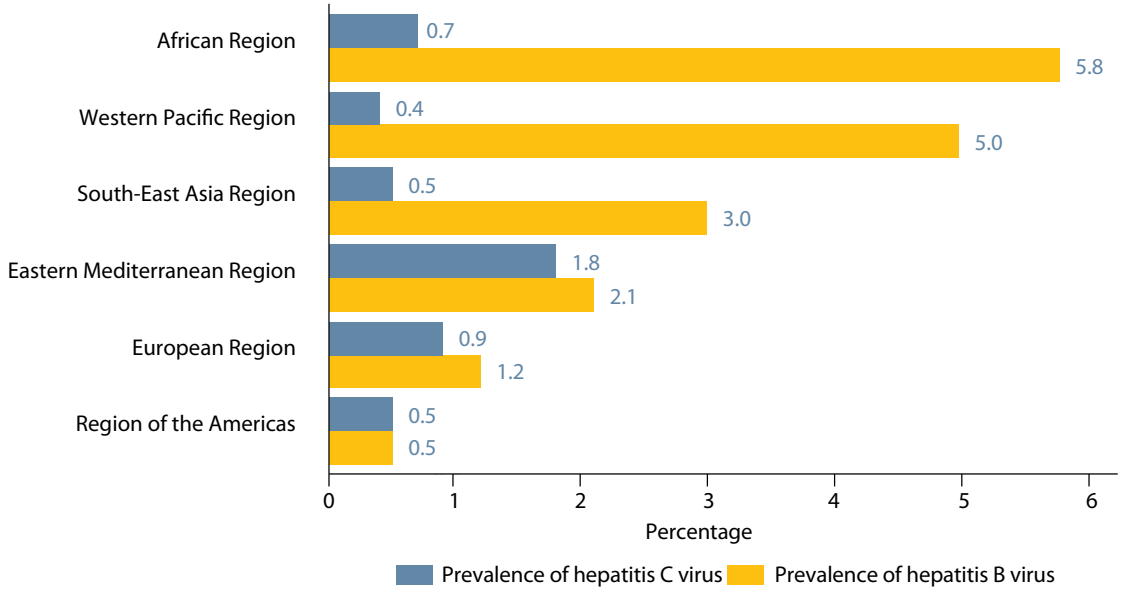
In 2022, WHO estimated that 254 million people were living with chronic hepatitis B virus infection globally, 50 million people were living with chronic hepatitis C virus infection and 2.2 million people were newly infected with viral hepatitis (1.2 million new hepatitis B virus infections, and 1 million new hepatitis C virus infections). Together, the two diseases caused 1.3 million hepatitis-related deaths worldwide that year.

Among WHO regions, the African Region has the highest prevalence of hepatitis B virus infection among the general population (5.8%; 64.7 million), followed by the Western Pacific Region (5%; 96.8 million), and South-East Asia (3%; 61.4 million). The Eastern Mediterranean Region comes fourth, with 2.1% prevalence among the general population (this translates to 15 million chronic infections) (Fig. 3). In the Eastern Mediterranean Region in 2022, 85% of the chronic hepatitis B virus infections were in nine countries: Afghanistan, Egypt, Iraq, Islamic Republic of Iran, Pakistan, Somalia, Sudan, Syrian Arab Republic and Yemen. By the end of 2022, the prevalence of HBsAg in children under 5 years (cumulative incidence of chronic hepatitis B virus infection) was 0.6%, compared to 1.6% in 2016. WHO estimated that 41 000 deaths in the Region were attributable to hepatitis B virus in 2022.

For hepatitis C, WHO estimates that the Eastern Mediterranean Region had the highest prevalence of infection (1.8%) in the general population, followed by the European Region (0.9%) (Fig. 3). The Eastern Mediterranean Region also has the highest incidence of hepatitis C virus infections. WHO estimated that the Region had 12 million chronic hepatitis C cases and that 183 000 new hepatitis C virus infections occurred in 2022. This was mainly driven by unsafe injections. Pakistan

Box 1. Overview of the HIV/AIDS epidemic and status in the Eastern Mediterranean Region, 2022

- Prevalence in the general population: <0.1%.
- Estimated number of people living with HIV: 490 000, including 17 000 children.
- The HIV epidemic is concentrated among key populations: men who have sex with men, sex workers, prisoners, transgender people and people who inject drugs.
- HIV testing is conducted mostly in low-risk population groups.
- A large proportion of people living with HIV are diagnosed late, at advanced disease stage.
- 38% of people living with HIV are aware of their status.
- 27% of people living with HIV are receiving treatment.
- 24% of people living with HIV have viral load suppression.
- 19% estimated percentage of pregnant women living with HIV who received most effective antiretrovirals for preventing mother-to-child transmission.



Source: Global hepatitis report 2024: action for access in low- and middle-income countries. Geneva: World Health Organization; 2024 (https://www.who.int/publications/i/item/9789240091672). Licence: CC BY-NC-SA 3.0 IGO.

Fig. 3. Prevalence of hepatitis B virus and hepatitis C virus, by WHO region, 2022

bears the highest burden of chronic hepatitis C virus infections, accounting for 70–80% of all such infections in the Region.

Response

As of 2022, the regional coverage of the third dose of hepatitis B vaccine among infants reached 84%, compared with 80% in 2015. Of the 22 countries/territories of the Eastern Mediterranean Region, 18 achieved a coverage exceeding 80%, with Afghanistan, Somalia, Syrian Arab Republic and Yemen being the exceptions. The coverage of the timely hepatitis B vaccine birth dose remains very low in the Region. It was 32% by the end of 2020, despite moderate progress in coverage.

Harm reduction services remain very limited in the Region. The number of syringes per person per year only increased from 25 to 27 between 2015 and 2017, leaving a major gap to reach the 2020 target of 200 syringes per person per year. In 2020, only five countries in the Region had harm reduction programmes, although these were of limited scale and with services mainly offered by civil society organizations (Morocco: 109 syringes/person/year; Afghanistan: 52; Islamic Republic of Iran: 48; and Pakistan: 46. Egypt: data not available). In 2017, WHO estimates indicated that 82% of blood donations were screened appropriately for safety, compared with 81% in 2015. For injection safety, a review of the demographic and health surveys conducted in the Region indicated that 8% of injections were unsafe.

For hepatitis B virus, in 2022, of the estimated 15 million infected persons in the Region, 14% were diagnosed and 2% were on treatment, compared with 2% diagnosed and less than 1% on treatment in 2015 (Fig. 4). There has also been progress in hepatitis C testing and treatment in the Region since 2016, although still at insufficient scale. The proportion of persons diagnosed with hepatitis C virus infection was 49% of total estimated infections in 2022, compared with 18% in 2015. The proportion of persons living with chronic hepatitis C infection who started treatment was estimated to be 35% of total infections in 2022, compared with 12% in 2015. The progress in hepatitis C testing and treatment has mainly been driven by Egypt's efforts to eliminate hepatitis C. Between 2016 and 2022, Egypt implemented a nationwide campaign, screening 60 million people and offering free treatment to 4.1 million people with hepatitis C (Box 2)..

[1] Hayashi T, Hutin YJ-F, Bulterys M, Altaf A, Allegranzi B. Injection practices in 2011–2015: a review using data from the demographic and health surveys (DHS). BMC Health Serv Res. 2019;19(1):600 (https://doi.org/10.1186/s12913-019-4366-9).

2.1.3 STIs

Epidemic status

In 2020, WHO estimated that more than 1 million STIs were acquired every day worldwide, the majority of which were asymptomatic. In the same year, 374 million adults were newly infected with the four curable STIs: gonorrhoea, chlamydia, trichomoniasis and syphilis. In the Eastern Mediterranean Region, the 2022 pooled prevalence estimates of STIs in the general population were chlamydia (3.9%), trichomoniasis (2.5%), syphilis (0.6%) and gonorrhoea (0.5%) (Fig. 5). According to WHO regional estimates of disease burden in 2020, there were 2.4 million cases of syphilis, 1.8 million cases of gonorrhoea, 15 million cases of chlamydia and 9.5 million cases of trichomoniasis (Box 3).

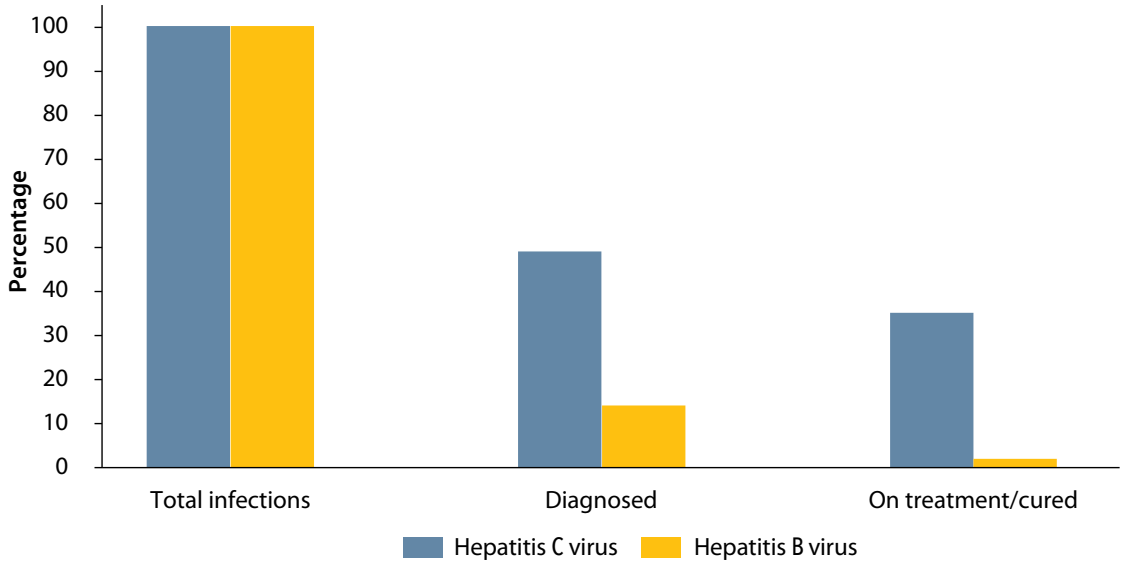
Response

The response to STIs remains largely neglected in the Region, with a limited number of countries having national programmes to address STIs. Predominantly, the response is focused on clinical management of people with STI symptoms, with limited higher-level programming and surveillance, testing and treatment. There is inadequate funding for STI programmes. Few countries in the Region are working actively to eliminate STIs. In 2022, Oman validated the elimination of mother-to-child transmission of syphilis. In addition, Qatar and Morocco are working to eliminate mother-to-child transmission of syphilis. Despite this limited response, opportunities for integration of services exist, such as the use of multiplex technologies for testing, and capitalizing on the primary health care platform for treatment, and could be leveraged to improve programmes.

2.1.4 Key gaps and challenges

In most countries of the Region, the response to HIV, viral hepatitis and STIs faces several challenges that impede progress.

- There has been limited investment in strategic information and surveillance for HIV, viral hepatitis and STIs, which results in gaps in knowledge and also limits monitoring and evaluation at the programme level and progress in the responses to them. In most countries, integrated biobehavioural surveys and population size estimations for key populations have either not been conducted or took place several years ago. Overall, only 16–18 of the 22 countries/territories of the Eastern Mediterranean Region report to the Global AIDS Monitoring annually, with varying completion rates. Only two and four countries reported on the cascade of care for hepatitis B and hepatitis C, respectively. Even less is known about STIs.



Source: Global hepatitis report 2024: action for access in low- and middle-income countries. Geneva: World Health Organization; 2024 (https://www.who.int/publications/i/item/9789240091672). Licence: CC BY-NC-SA 3.0 IGO.

Fig. 4. Hepatitis C virus and hepatitis B virus care cascade, Eastern Mediterranean Region, 2022

- Key and vulnerable populations face stigma and discrimination, aggravated by the unsupportive social and policy environment, which hinders access to and use of HIV, viral hepatitis and STI services. Furthermore, there is an absence of or little engagement, capacity and experience among community-based organizations and civil society organizations for providing HIV, viral hepatitis and STI prevention, diagnosis and treatment services to key and vulnerable populations. Consequently, there is limited coverage of these services among such populations and, therefore, limited impact on the course of the epidemics.
- In most countries, the biggest bottleneck to access HIV, viral hepatitis and STI treatment is that most people living with these diseases remain undiagnosed. Even among people who know their status, there is weak linkage to and retention in treatment.
- Unsafe health care services are still contributing to the pool of new infections of HIV, viral hepatitis and STIs. Blood safety in the Region is compromised by the absence of regulatory and legislative frameworks that ensure access to safe blood transfusion, and unsafe and unnecessary medicinal injections are still common.
- Other dimensions impacting HIV, viral hepatitis and STI responses include weak health systems, which are aggravated in some countries by political instability, economic crises, and large numbers of refugees, migrants and displaced populations. Parallel HIV, viral hepatitis and STI programmes are often donor-driven and work within their own vertical systems, thus missing out on potential efficiencies gained from integration and on opportunities that could be offered by the existing systems. In contrast, the investments made by donors in developing parallel systems further weaken the mainstream health system and minimize the impact of the investment.

2.1.5 Opportunities

Despite the numerous challenges, there are some opportunities to build a strong response for the future in the Eastern Mediterranean Region:

- The role of civil society and community-based organizations in creating regional networks to mobilize resources and implement community-led responses can be increased.
- Countries could build on the experience within the Region in ensuring continuity of HIV services during the COVID-19 pandemic and the response adaptations to expand HIV, viral hepatitis and STI interventions and services.
- Most countries have high coverage of the hepatitis B third dose, but the coverage of the birth dose can be increased to maximize the prevention benefit for children.
- Thirteen countries in the Region have national strategic plans for viral hepatitis, which provide a strong foundation for national viral hepatitis responses. Other countries that do not yet have national plans can develop them to guide their national responses.
- The success story from Egypt on viral hepatitis B and C testing and treatment can be a best practice to replicate for other countries.
- Renewed commitment is needed from ministries of health and partners to strengthen national responses to the three

Box 2. Overview of the viral hepatitis epidemic and status in the Eastern Mediterranean Region, 2022

- Some countries in the Region have established governance mechanisms, policies and strategies for viral hepatitis elimination.
- Implementation remains poor, with insufficient financing outside of Egypt.
- Strategic information is limited.
- Fifteen million people were chronically infected with hepatitis B virus as of 2022.
- The prevalence of hepatitis B infection among children younger than 5 was 0.6% [0.5–1.1].
- An estimated 41 000 [26 000–60 000] people died from hepatitis B virus infection in 2022.
- Hepatitis B third-dose coverage was 84%, and birth-dose coverage was 32%.
- 14% of estimated hepatitis B virus infections are diagnosed, and 2% are on treatment.
- Twelve million people were chronically infected with hepatitis C virus as of 2022.
- An estimated 56 000 [31 000–74 000] people died from hepatitis C virus infection in 2022.
- 49% of estimated hepatitis C virus infections are diagnosed, and 35% are treated.
- 82% of blood donations are screened appropriately for safety.
- 8% of injections are unsafe.

disease in their respective countries, especially STIs.

- Access to advances in diagnostics and medications – including self-testing, affordable pricing, and optimized and long-acting medications for prevention and treatment – can be improved.
- Efficiencies in national responses through integrated service delivery approaches to HIV, viral hepatitis and STIs and use of primary health care can make the available funding more effective and sustainable.

Box 3. Overview of STIs in the Eastern Mediterranean Region

- Country STI data are scarce.
- The burden of chlamydia, trichomoniasis, gonorrhoea and syphilis in the Region is estimated at 29 million cases.
- STI were largely addressed through HIV programmes; however, they remain largely neglected.
- There is a lack of financing for STIs.

2.1.6 Key features of the regional epidemic response and way forward

In a nutshell, the HIV epidemic is growing faster than the response to it. For hepatitis, the Eastern Mediterranean Region countries made progress in governance, policy development, hepatitis B third-dose coverage, and testing and treatment for hepatitis C virus. However, birth-dose vaccination, injection safety, harm reduction, and testing and treatment are limited. There are reports by national programmes and experts that STIs are rising in the Region; however, there is a lack of data on and weak response to STIs. The regional progress in responding to HIV, viral hepatitis and STIs generally remains slow, with exceptions in a few countries. Cultural and political barriers, weak health systems and weak engagement of communities, as well as protracted emergencies and conflicts, are major contributors to the sluggish progress. Overall, elimination of HIV, viral hepatitis and STIs by 2030 will be challenging to achieve if the Region continues at the same pace. A strategic shift in responding to these disease areas is needed to test groups at high risk, transition to optimized treatment and deliver patient-centred services. The RAP-GHSS 2022–2030 has been developed with a view to help countries to take the necessary steps to achieve the desired goals by 2030.

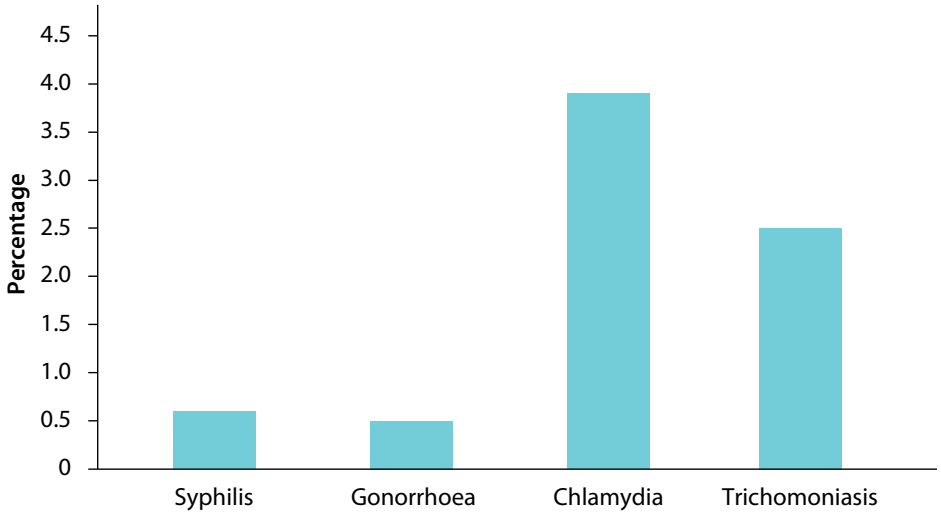
2.2 Key priorities for reorienting the regional response to address gaps identified

The key priorities have been based on the regional situation and response analysis of HIV, viral hepatitis and STIs. These priorities address the main challenges the Region is facing in increasing prevention, testing and treatment coverage. A focus on these priority areas will help put the response back on track rapidly, to make up for the missed targets of 2020 and advance towards achieving the 2025 and 2030 global goals.

Achieving the global, regional and national targets on prevention, testing and treatment will require robust health systems that can engage and retain people along the entire continuum of HIV, viral hepatitis and STI prevention, testing and treatment services. Health systems must ensure that people can access effective HIV prevention services; are tested, receive and understand their HIV, viral hepatitis and STI diagnosis; are initiated on treatment early if diagnosed positive; and are retained on effective treatment to achieve cure or sustained viral suppression. The main priorities are outlined in the following subsections.

2.2.1 Data availability, analysis and use

The national programmes should harmonize the current HIV, viral hepatitis and STI strategic information systems by leveraging opportunities for introducing or scaling up integrated strategic information platforms across broader health systems. Such efforts can improve data availability for robust monitoring and evaluation and effective analysis and use to develop and implement data-driven policies, responses and interventions to address gaps.



Source: Global progress report on HIV, viral hepatitis and sexually transmitted infections, 2021. Accountability for the global health sector strategies 2016–2021: actions for impact. Geneva: WHO; 2021 (https://iris.who.int/bitstream/handle/10665/342808/9789240030985-eng.pdf). Licence: CC BY-NC-SA 3.0 IGO.

Fig. 5. Prevalence of STIs in the Eastern Mediterranean Region, 2022

2.2.2 High-impact prevention, testing and treatment interventions

Reaching diverse populations, especially key populations, with high-impact prevention, testing and treatment services in many different settings requires strong, well-supported health and community systems and an enabling environment that promotes health equity, gender equality and rights-based approaches.

Countries will need to review and address policies and practices that reinforce stigmatization and discrimination (especially in health care settings), particularly for people living with HIV, viral hepatitis and STIs and key populations. Communities and civil society organizations must be involved in the planning and delivery of HIV, viral hepatitis and STI services and in creating institutional and community environments that make it safe for key populations and other vulnerable populations to access those services without fear of discrimination. This is a key priority in order to scale up targeted high-impact prevention, testing and treatment interventions towards key populations and vulnerable populations.

Promoting and implementing integrated services to improve and strengthen the HIV, viral hepatitis and STI prevention–testing–treatment cascade is key to reducing mortality and improving quality of life. Ensuring that testing services provide an entry point for both prevention and treatment services, as appropriate, and building effective and efficient referral mechanisms among prevention, testing and treatment services is needed to improve coverage of these services.

Where feasible and appropriate, services for HIV, viral hepatitis and STIs, and their related coinfections and comorbidities, should be integrated into primary health care platforms, including through decentralized and community-based service delivery. This integration is key to strengthening these platforms for sustainable progress towards universal health coverage and increasing HIV, viral hepatitis and STI prevention, testing and treatment coverage.

2.2.3 Health security

Countries, particularly those with humanitarian and emergency situations, need to strengthen the resilience of their health systems and develop specific plans to ensure access to HIV, viral hepatitis and STI prevention, testing and treatment services, focused on key populations and inclusive of other vulnerable populations such as migrants, refugees and displaced populations (depending on the context).

2.2.4 Strategic shifts

In order to effectively address the regional gaps and priorities related to HIV, viral hepatitis and STIs, a strategic shift is needed in the response. The regional action plan proposes five strategic shifts towards ending these epidemics:

- Putting people at the centre of rights-based health system responses. This strategic shift could be achieved by organizing services around people's needs rather than around disease programmes, and by promoting integrated patient-centred approaches with linkages with primary health care services.
- Addressing unique priorities for each disease area. Despite the interrelation between the three areas, they present different challenges and responses. Therefore, in addition to shared priorities, the unique needs and priorities of each area should be considered to accelerate progress.
- Taking a shared approach towards strengthening health and community systems. This strategic shift can be achieved by emphasizing the need for coordinated action to strengthen health and community systems, ensure strong linkages among health and community system actors, and expand collaboration within and across systems and sectors.
- Responding to a swiftly changing health and development context. The COVID-19 pandemic has exposed the gaps in health systems. It exposed and exacerbated the disparities and inequalities that make some people (including key populations) more vulnerable to disease. This draws attention to the importance of integrating a rights-based public health response to mitigate the impact of public and social measures, in addition to the need for a strong and well-supported health workforce to maintain service continuity.
- Eliminating stigma, discrimination and other structural barriers. This strategic shift can be achieved by generating data on how stigma and discrimination affect the key populations and ways to address this, convening multisectoral partnerships to address the broader determinants of health, and raising awareness about the importance of addressing and overcoming taboos and discriminatory or stigmatizing behaviour.

3 Regional action plan for the implementation of the global health sector strategies on HIV, viral hepatitis and sexually transmitted infections 2022–2030

3

3.1 Vision and goals

The vision and goals of the regional action plan are aligned with those of the *Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030.* The three disease strategies share a common goal: "End AIDS and the epidemics of viral hepatitis and sexually transmitted infections by 2030".

3.2 Regional impact and coverage targets

Progress towards the global goals will be measured by a set of both shared and disease-specific global targets and milestones for 2025 and 2030. Consequently, the regional action plan sets out regional impact and coverage targets to contribute to the achievement of the global targets.

These targets will require a radical change in the Region's HIV, viral hepatitis and STI responses.

3.3 Strategic directions, key results and priority actions

The GHSS 2022–2030 recommended five strategic directions. These strategic directions provide the overall guiding framework for country actions for the implementation of the three strategies. The RAP-GHSS 2022–2030 adopts the same strategic directions. However, it identifies priority actions based on the Region-specific cultural and epidemiological context. Each strategic direction presents priority actions that follow a health system approach and seek integration in accordance with guiding principles where relevant. Shared actions across HIV, viral hepatitis and STIs, and other related health areas, are also proposed, for a more effective people-centred response. Furthermore, where needed, disease-specific priority actions are recommended along the continuum of HIV prevention, diagnosis, care and treatment services.

3.3.1 Strategic direction 1: Deliver high-quality evidence-based people-centred services

Key result: Access to and the uptake of high-quality essential services for HIV, viral hepatitis and STIs and other related health services are accelerated and tailored to meet the needs of people in diverse populations and settings, ensuring that no one is left behind.

Shared priority actions

Action 1: Initiate/scale up delivery of primary prevention interventions tailored to the needs of affected and key populations in various contexts to reduce the number of people newly infected, in accordance with global targets.

Action 2: Implement a comprehensive package of harm reduction services for people who inject drugs, where appropriate, along with targeted information and communication, and testing, diagnosis and management of HIV, hepatitis B and C viruses, and STIs.

Action 3: Advance the triple elimination of vertical (mother-to-child) transmission of HIV, syphilis and hepatitis B virus by delivering comprehensive and accessible prevention, testing, treatment and follow-up services for women, children and their families and focus on introducing and scaling up universal hepatitis B birth dose and completion of the three-dose infant vaccination programme.

Action 4: Strengthen injection safety, blood safety and infection control to prevent pathogen transmission in formal and informal health care settings, and in community settings (depending on community practices), prisons and other settings.

Action 5: Develop and expand people-centred HIV, viral hepatitis and STI testing through decentralized and differentiated service delivery and a combination of testing approaches, including through clinical settings, community-based approaches, or self-testing with timely linkage to treatment and care.

Action 6: Integrate testing and treatment for HIV, hepatitis B, hepatitis C and STIs, as part of comprehensive sexual and reproductive health services. Where appropriate, integrate with other communicable and noncommunicable diseases and establish the necessary linkage to care.

Action 7: Develop and implement human rights-based and gender-sensitive strategies for voluntary partner services and other services for sexual and injecting partners of people diagnosed with HIV, hepatitis B, hepatitis C and STIs.

Action 8: Eliminate stigma and discrimination and alleviate inequalities in access to health care and strengthen accountability for discrimination-free health services.

Action 9: Provide the necessary HIV, viral hepatitis and STI prevention, diagnosis and management interventions for the victims of gender-based violence, including sexual violence.

Action 10: Provide equitable access to services in special settings, including prisons and other closed settings, and settings of humanitarian concern.

Disease-specific priority actions

HIV

Action 1: Implement a strategic combination of pre-exposure prophylaxis and post-exposure prophylaxis with other prevention interventions to maximize the prevention benefits of antiretroviral drugs. A vaginal ring releasing an antiretroviral drug provides an additional prevention choice for women who are unable or do not want to use oral daily pre-exposure prophylaxis.

Action 2: Rapidly initiate HIV treatment with WHO recommended treatment regimens for all people living with HIV through differentiated service delivery models that provide people-centred care, monitoring and support for adherence, retention and re-engagement in care.

Action 3: Reinforce screening, diagnostics, treatment and/or prophylaxis to address major causes of morbidity and mortality among people with advanced HIV disease.

Viral hepatitis

Action 1: Scale up treatment for chronic hepatitis B and C virus infection to all adults, adolescents and children who are eligible for treatment, ensuring that the most effective treatment regimens are accessible and affordable to all populations.

Action 2: Ensure provision of and access to care and management of hepatocellular carcinoma and cirrhosis for people living with hepatitis B and C who are in need.

Action 3: Strengthen vaccination programmes to increase hepatitis B vaccination coverage for children and adults at higher risk of hepatitis B – for example, key populations and health care workers and people receiving regular multiple transfusions – within a comprehensive package of prevention and care.

STIs
Action 1: Provide effective and comprehensive case management for people with STIs.

Action 2: Implement a comprehensive human papillomavirus vaccination programme and rapidly increase its coverage.

3.3.2 Strategic direction 2: Optimize systems, sectors and partnerships for impact

COVID-19 demonstrated that strengthening health systems and leveraging their strengths is imperative to ensuring the continuity of essential health services in the context of pandemics and other emerging health, conflict and natural threats, by building health and community system resilience.

Key result: Health systems are strategically leveraged to deliver essential HIV, viral hepatitis and STI services using a people-centred approach as part of universal health coverage, by aligning disease-specific and health system efforts at the policy, programme and service levels.

Shared priority actions

Action 1: Strengthen national HIV, viral hepatitis and STI governance structures by integrating HIV, viral hepatitis and STI programmes within broader national health plans and universal health coverage packages, and by coordinating the HIV, viral hepatitis and STI response across relevant sectors.

Action 2: Develop costed strategic plans to guide national responses to HIV, viral hepatitis and STIs, with institutionalized engagement of communities and aligned with international human rights principles and standards.

Action 3: Ensure sustainable financing of HIV, viral hepatitis and STI responses through national health financing systems, avoiding fragmented funding. Maximize the efficient use of resources, and minimize overall catastrophic health expenditures for households.

Action 4: Foster an effective multisectoral HIV, viral hepatitis and STI response – with the participation of all relevant sectors, including community-based and civil society organizations as well as the private and academic sectors – and strengthen coordination mechanisms.

Action 5: Integrate HIV, viral hepatitis and STI services and their key coinfections and comorbidities, including into primary health care platforms – where feasible and appropriate – and into community-based services through decentralization.

Action 6: Identify and optimize opportunities to use differentiated service delivery models for HIV, viral hepatitis and STI services, guided by strategic information to understand the diverse needs and preferences of beneficiary populations in various settings, as a means to expand access to comprehensive people-centred services.

Action 7: Identify and optimize opportunities to decentralize and simplify the delivery of HIV, viral hepatitis and STI services and, where appropriate, diversify their provision to include lower administrative levels and nonspecialized personnel and simplify protocols and point-of-care diagnostics as a means to expand access to comprehensive people-centred services.

Action 8: Enhance laboratory capacity to improve the case management and surveillance of HIV, viral hepatitis and STIs.

Action 9: Ensure equitable and reliable uninterrupted access to quality assured and affordable medicines, diagnostics and other health products for HIV, viral hepatitis and STIs. Where local production ensures

better access to those products, address intellectual property barriers to local production and strengthen national capacity to produce quality assured medicines and diagnostics for HIV, viral hepatitis and STIs.

Action 10: Address immediate and future health workforce needs in relation to HIV, viral hepatitis and STIs in ways that are synergistic with efforts to strengthen the overall health workforce at different levels.

Action 11: Create an enabling environment by reviewing and reforming policy frameworks, as needed, that enable equitable and safe access to services, including in community and health care settings, especially for the most affected and at-risk populations.

Action 12: Leverage the lessons from the COVID-19 response to ensure HIV, viral hepatitis and STI service continuity in the case of other ongoing or future emergencies, by integrating HIV, viral hepatitis and STIs into national emergency preparedness and response plans to ensure sustained resources and services.

3.3.3 Strategic direction 3: Generate and use data to drive decisions for action

Gather, analyse and use evidence and data, with disaggregation by sex, age and other relevant population characteristics, to monitor and evaluate progress; to guide action, innovation, research and development; and to promote data transparency and accountability.

Key result: The availability and use of strategic information disaggregated by sex, age and other relevant population characteristics are strengthened to monitor and evaluate progress; to guide action, innovation and research; and to promote data transparency and accountability.

Shared priority actions

Action 1: Generate high-quality, accurate, timely, detailed and disaggregated data to inform national strategic planning, resource allocation, health service delivery, advocacy and accountability.

Action 2: Expand person-centred monitoring, including community-led monitoring to support service provision, by ensuring data availability across the continuum of prevention, diagnosis, treatment and care.

Action 3: Align information systems related to specific diseases or infections with broader health information systems and integrated disease surveillance; support the transition to digital information systems with appropriate attention to data governance, security and interoperability.

Action 4: Leverage digital platforms for data collection, analysis and visualization for increasing timeliness, completeness and accuracy of data and facilitating their use.

3.3.4 Strategic direction 4: Engage empowered communities and civil society

Engage communities and civil society, including key and affected populations, and support their empowerment and pivotal role in advocacy, service delivery and policy-making, including to ensure that services are culturally appropriate and responsive to community needs, and to address stigma and discrimination and tackle social and structural barriers.

Key result: HIV, viral hepatitis and STI services are culturally appropriate and responsive to community needs, and stigma and discrimination and social and structural barriers are addressed.

Shared priority actions

Action 1: Engage and support communities and civil society to enhance their pivotal contributions to advocacy, service delivery, policy-making, monitoring and evaluation, and initiatives to address social and structural barriers.

Action 2: Provide adequate regulation, training, supervision and support for community-based organizations to be recognized as part of the health workforce.

3.3.5 Strategic direction 5: Foster innovations for impact

Key result: Countries of the Region are contributing to defining and implementing national, regional and global research and innovation agendas that give priority to developing new technologies, service delivery models and health system practices that will overcome key barriers to achieving progress against HIV, viral hepatitis and STIs.

Shared priority actions

Action 1: Accelerate adoption of innovations, including new diagnostics, treatment regimens and prevention approaches.

Action 2: Contribute to a global research agenda that addresses earlier diagnosis and more effective and equitable prevention and treatment, through sharing data and participating in local and international clinical trials, market research and other relevant research.

Action 3: Generate local information and evidence, and expand the global, regional and local knowledge base through publishing data, best practices and implementation results.

4 Monitoring and evaluation framework

4.1

Table 1. RAP-GHSS 2022–2030 **Monitoring and evaluation results framework: expected impact (goals) and expected results/outcomes and milestones**

Goals	Disease areas	Impact indicators	Baseline		2025 and 2030 targets	
			Value	Year	2025	2030
End AIDS and the epidemics of viral hepatitis and STIs by 2030.	HIV	Number of people newly infected with HIV per year	42 000	2021	10 000	6000
		Number of people newly infected with HIV per 1000 uninfected population per year	0.06	2021	0.05	0.025
		Number of people dying from HIV-related causes per year	19 000	2021	3600	3000
	Viral hepatitis	Hepatitis B surface antigen prevalence among children 0–4 years of age	0.8%	2020	0.5%	0.1%
		Number of new hepatitis B infections per year	100 000	2020	50 000	10 000
		Number of new hepatitis C infections per year	470 000	2020	282 000	196 000
		Number of new hepatitis C infections among persons who inject drugs per year	No data	2020	3 per 100	2 per 100
		Number of people dying from hepatitis B per year	4 per 100 000	2020	3 per 100 000	2 per 100 000
		Number of people dying from hepatitis C per year	4 per 100 000	2020	3 per 100 000	2 per 100 000
	STIs	Number of new cases of syphilis among people 15–49 years old per year	640 000	2020	250 000	60 000
		Number of new cases of gonorrhoea among people 15–49 years old per year	5 300 000	2020	3 000 000	500 000
		Number of congenital syphilis cases per 100 000 live births per year	No data		<200	<50
Strategic direction 1: Deliver high-quality evidence-based people-centred services	**Disease areas**	**Coverage indicators and milestones**	**Baseline**		**2025 and 2030 targets**	
Key result: Access to and the uptake of a continuum of high-quality essential services for HIV, viral hepatitis and STIs and other related health services are accelerated and tailored to meet the needs of people in diverse populations and settings, ensuring that no one is left behind.						
Key priority actions			**Value**		**2025**	**2030**
Implement a strategic combination of pre-exposure prophylaxis and post-exposure prophylaxis with other prevention interventions to maximize the prevention benefits of antiretroviral drugs.	HIV	Percentage of condom use among key populations and pre-exposure prophylaxis	No data		TBD	TBD

Rapidly initiate HIV treatment with WHO recommended treatment regimens for all people living with HIV through differentiated service delivery models that provide people-centred care, monitoring, and sup13.580 deliv IS 1 0 0 1 490.674 756.4754 cm0 0 m39.516 (e)]TJ0 -1.1 Td[del, monit)3entr8ory models that del, monitt provide peo 41%2021 95%pt95Td[(pr)t 7 TdB - peo182.9375 69.29875 liv(e)1		

Key priority actions			Value		2025	2030
Expand people-centred HIV, viral hepatitis and STI testing through decentralized and differentiated service delivery and the combination of testing approaches, including through clinical settings, community-based approaches, or self-testing with timely linkage to treatment and care.	Shared	Percentage of people living with HIV who have been diagnosed	41%	2021	95%	95%
		Percentage of persons with chronic hepatitis B virus diagnosed	14%	2020	60%	90%
		Percentage of persons with chronic hepatitis C virus diagnosed	37%	2020	60%	90%
		Percentage of pregnant women attending antenatal care screened for syphilis	No data		>85%	>95%
		Percentage of priority populations screened for syphilis	No data		>80%	>90%
		Percentage of priority populations screened for gonorrhoea	No data		>20%	>90%
Implement a comprehensive package of harm reduction services for people who inject drugs, where appropriate, along with targeted information and communication, and testing, diagnosis and management of HIV, hepatitis B and C viruses, and STIs.		Number of sterile needles provided per person who injects drugs per year	27	2021	200	300
Strengthen injection safety, blood safety and infection control to prevent pathogen transmission in formal and informal health care settings, community settings (depending on community practices), prisons and other settings.		Percentage of safe injections administered (both in and out of health facilities)	92%		98%	100%
Integrate testing and treatment for HIV, hepatitis B, hepatitis C and STIs, as part of comprehensive sexual and reproductive health services. Where appropriate, integrate with other communicable and noncommunicable diseases and establish the necessary linkage to care.		Percentage of people living with HIV, viral hepatitis and STIs linked to other integrated health services	No data	2022	TBD	TBD
Advance the triple elimination of vertical (mother-to-child) transmission of HIV, syphilis and hepatitis B virus by delivering comprehensive and accessible prevention, testing, treatment and follow-up services for women, children and their families and focus on universal hepatitis B birth dose and completion of three-dose infant vaccination programme.		Number of countries validated for the elimination of vertical transmission of HIV, hepatitis B or syphilis	1	2022	6	14

Key priority actions			Value		2025	2030
Eliminate stigma and discrimination and alleviate inequalities in access to health care and strengthen accountability for discrimination-free health service.		Percentage of people living with HIV, viral hepatitis and STIs and priority populations who experience stigma and discrimination	No data	2022	<25%	<5%

Strategic direction 2: Optimize systems, sectors and partnerships for impact	Disease areas	Coverage indicators and milestones	Baseline		2025 and 2030 targets	
Key result: Health systems are strategically leveraged to deliver essential HIV, viral hepatitis and STI services using a people-centred approach as part of universal health coverage, by aligning disease-specific and health system efforts at the policy, programme and service levels.						
Key priority actions			**Value**	**Year**	**2025**	**2030**
Develop costed strategic plans to guide national responses to HIV, viral hepatitis and STIs, with institutionalized engagement of communities and aligned with international human rights principles and standards.		Number of countries with costed HIV plans	16	2022	18	20
		Number of countries with costed hepatitis elimination plans	5	2022	12	22
		Number of countries with national STI plans updated within the past 5 years	7	2022	12	22
Ensure equitable and reliable uninterrupted access to quality assured and affordable medicines, diagnostics and other health products for HIV, viral hepatitis and STIs. Where local production ensures better access to those products, address intellectual property barriers to local production and strengthen national capacity to produce quality assured medicines and diagnostics for HIV, viral hepatitis and STIs.		Percentage average reduction in hepatitis C virus drug prices (to equivalent generic prices by 2025)	TBD	2022	TBD	TBD
		Percentage average reduction in hepatitis B virus drug prices (to reach the HIV drug prices by 2025)	TBD	2022	TBD	TBD
Identify and optimize opportunities to use differentiated service delivery models for HIV, viral hepatitis and STI services, guided by strategic information to understand the diverse needs and preferences of beneficiary populations in various settings, as a means to expand access to comprehensive people-centred services.		Number of countries that have implemented three- to six-month refill of HIV drugs	16	2022	20	22

Key priority actions			Value		2025	2030
Integrate HIV, viral hepatitis and STI services and their key coinfections and comorbidities, including into primary health care platforms, where feasible and appropriate, and community-based services through decentralization.		Number of countries that integrated HIV, viral hepatitis and STI services and their key coinfections and comorbidities into primary health care	10	2022	12	18

Strategic direction 3: Generate and use data to drive decisions for action	Disease areas	Coverage indicators and milestones	Baseline		2025 and 2030 targets	
Key result: Availability and use of strategic information disaggregated by sex, age and other relevant population characteristics are strengthened to monitor and evaluate progress; to guide action, innovation and research; and to promote data transparency and accountability.						
Key priority actions			**Value**	**Year**	**2025**	**2030**
Generate high-quality, accurate, timely, detailed and disaggregated data for informing national strategic planning, resource allocation, health service delivery, advocacy and accountability.		Number of countries reporting burden and cascade annually	17	2022	22	22
Align information systems related to specific diseases or infections with broader health information systems and integrated disease surveillance; support the transition to digital information systems with appropriate attention to data governance, security and interoperability.		Number of countries that integrated information systems related to specific diseases or infections within broader health information systems and integrated disease surveillance	14	2022	18	22

Strategic direction 4: Engage empowered communities and civil society	Disease areas	Coverage indicators and milestones	Baseline		2025 and 2030 targets	
Key result: Social and structural barriers are addressed to ensure HIV, viral hepatitis and STI services are culturally appropriate and responsive to community needs.						
Key priority actions			**Value**	**Year**	**2025**	**2030**
Engage and support communities and civil society to enhance their pivotal contributions to advocacy, service delivery, policy-making, monitoring and evaluation and initiatives to address social and structural barriers.		Number of countries with community and civil society organizations involved in planning, implementing and monitoring the national HIV, viral hepatitis and STI responses	14	2022	18	22
Strategic direction 5: Foster innovations for impact	**Disease areas**	**Coverage indicators and milestones**	**Baseline**		**2025 and 2030 targets**	
Key result: Countries from the Region are contributing to defining and implementing national, regional and global research and innovation agendas that give priority to developing new technologies, service delivery models and health system practices that will overcome key barriers to achieving progress against HIV, viral hepatitis and STIs.						
Key priority actions			**Value**	**year**	**2025**	**2030**
Accelerate adoption of innovations, including new diagnostics, treatment regimens and prevention approaches.		Number of countries adopting innovations, including new diagnostics and treatment regimens that are aligned with the latest WHO guidelines and recommendations	14	2022	20	22

Note: TBD = To be determined

Implementation of the regional action plan

5

5.1 Guiding principles

The following guiding principles will direct the implementation of the RAP-GHSS 2022–2030 to achieve the greatest impact of the regional and national responses to HIV, viral hepatitis and STIs.

Guiding principle 1: Alignment with the Eastern Mediterranean Region strategy of Health for All by All

The Eastern Mediterranean Region strategy for health aims at achieving Health for All by All. This strategy promotes a health system approach to achieving disease-specific targets, while building resilient systems that are responsive to emergencies.

Guiding principle 2: Universal health coverage

Ensuring financial security and health equity are key concerns to address in the 2030 Agenda for Sustainable Development. Universal health coverage provides a framework to address them. Universal health coverage is achieved when all people receive the health services they need, which are of sufficient quality to make a difference, without incurring financial hardship.

Guiding principle 3: Data for decision-making

Strong surveillance systems will generate adequate data to understand the true public health dimensions and impact of HIV, viral hepatitis and STIs and to plan for focused action and prioritize the allocation of resources.

Guiding principle 4: The continuum of HIV, viral hepatitis and STI services – an organizing framework

The continuum of HIV, viral hepatitis and STI services provides the organizing framework for the specific actions proposed in this regional action plan. Steps along the continuum of prevention, diagnosis and treatment are interconnected and are all needed to achieve the regional action plan's targets.

Guiding principle 5: Equitable access to services and conservation of human rights

The RAP-GHSS 2022–2030 is supported by internationally agreed frameworks of ethics and human rights and gender equality, which recognize the right of all persons to the highest attainable standards of health, including sexual, reproductive and mental health, along with existing protective religious and cultural values and practices. All people receive the health services they need, including populations that may be criminalized and marginalized and who are at higher risk of HIV, viral hepatitis and STIs, such as people who inject drugs, men who have sex with men, prisoners and sex workers.

Guiding principle 6: Partnership and multisectorality

The RAP-GHSS 2022–2030 emphasizes broad engagement of all sectors, including the public and private sectors and civil society, to expand access to effective prevention and care as widely as possible. The restructuring of the response to HIV, viral hepatitis and STIs will be relevant only if it considers the involvement of all stakeholders and partners, according to their mandate and commitment.

Guiding principle 7: Accountability

A well-functioning and transparent accountability mechanism is needed, through which all stakeholders are accountable to each other as they work towards a comprehensive response. In this context, a key building block entails nurturing strong leadership and governance that ensures full engagement with all relevant stakeholders, including civil society; setting clear targets; using appropriate indicators to track progress; and establishing transparent and inclusive assessment and reporting processes at the regional and national levels.

5.2 The role of WHO

Based on its core functions of providing global health stewardship, promulgating evidence-based norms and standards, and supplying technical assistance to countries, WHO will implement the following actions in support of the country implementation of the RAP-GHSS 2022–2030.

Action A: Provide global strategic direction for the health sector effort to end epidemics of HIV, viral hepatitis and STIs, including through leadership, multisectoral partnerships and health diplomacy at the highest political levels.

Action B: Raise and sustain global awareness and commitment regarding the need for urgent action to end these epidemics, including measures to close gaps in the response to HIV, accelerate momentum to address viral hepatitis and revitalize the response to STIs.

Action C: Develop evidence-based norms, standards and other global public health goods across the range of thematic areas related to HIV, viral hepatitis and STIs, and promote the use of up-to-date guidelines, tools and service delivery approaches by all countries.

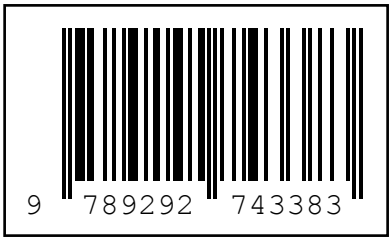
Action D: Provide leadership to shape the global research agendas for HIV, viral hepatitis and STIs, and support the availability and scaling-up of effective health innovations in all countries.

Action E: Provide technical support to countries to review, adapt and implement their national responses to HIV, viral hepatitis and STIs and strengthen primary health care and health systems.

Action F: Monitor and report on progress towards achieving global targets for HIV, viral hepatitis and STIs in order to promote evidence-based decision-making and ensure accountability.

5.3 Accountability, monitoring and reporting

The implementation of the regional action plan and monitoring progress in its implementation requires collective accountability and transparent accountability mechanisms at all levels, including among disease-specific and broader health system actors at the national and regional levels. The regional framework emphasizes a set of core indicators to monitor progress towards the achievement of the targets set out in the regional action plan along a public health programme results chain. Accountability for the regional priority actions will be ensured through biannual regional monitoring and reporting against the selected indicators. Countries, WHO and their partners should strengthen reporting, transparency and accountability.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