

# **2013 REGIONAL REPORT FOR THE MIDDLE EAST AND NORTH AFRICA**



# **2013 REGIONAL REPORT FOR THE MIDDLE EAST AND NORTH AFRICA**



# HIV IN THE MENA REGION, NUMBERS TALKING<sup>1</sup>

**270 000** ADULTS AND CHILDREN LIVING WITH HIV IN MENA IN 2012, A 134 PER CENT INCREASE FROM 114 000 IN 2001<sup>2</sup>

**31 000** NEW INFECTIONS AMONG ADULT POPULATIONS IN 2012, A 76 PER CENT INCREASE FROM 18 000 IN 2001<sup>3</sup>

**16 500** AIDS-RELATED DEATHS IN 2012, A 176 PER CENT INCREASE FROM 6 000 IN 2001<sup>4</sup>

**18%** OF ADULTS AND CHILDREN WHO NEED ANTIRETROVIRAL THERAPY RECEIVE IT BY THE END OF 2012, WITH 20 000 PEOPLE ON TREATMENT

**8%** OF PREGNANT WOMEN RECEIVING EFFECTIVE ANTIRETROVIRAL MEDICINE TO PREVENT TRANSMISSION OF HIV TO THEIR BABIES, WITH LESS THAN 700 PREGNANT WOMEN RECEIVING IT IN 2012

**Notes:** Unless specifically referenced, data and information in this report are drawn from the respective country progress reports or mid-term review reports. Additional information is referenced.

<sup>1</sup> Sources: Data are from the 2013 estimation and projection exercise, countries participated are alphabetically: Algeria, Djibouti, Egypt, Iran, Morocco, Somalia, Sudan, Tunisia and Yemen. There are differences between figures in this report and the UNAIDS Global Report 2013, which is the result of two additional countries included in the current report. Range: [80 000 – 190 000] in 2001 to [200 000 – 380 000] in 2012

<sup>2</sup> Range: [22 000–34 000] in 2001 to [29 000–46 000] in 2012

<sup>3</sup> Range: [3 000–11 000] in 2001 to [11 000–26 000] in 2012

<sup>4</sup> Range: [3 000–11 000] in 2001 to [11 000–26 000] in 2012

# ACRONYMS & ABBREVIATIONS

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ANC</b>	Antenatal Care
<b>ART</b>	Antiretroviral Therapy
<b>CSO</b>	Civil Society Organisation
<b>GCC</b>	Gulf Cooperation Council
<b>GFATM</b>	Global Fund to Fight AIDS, Tuberculosis and Malaria
<b>HIV</b>	Human Immunodeficiency Virus
<b>IBBS</b>	Integrated Biological and Behavioural Surveillance/Survey
<b>IDP</b>	Internally displaced person
<b>MENA</b>	Middle East and North Africa
<b>MENAHRA</b>	MENA Harm Reduction Association
<b>MTR</b>	Mid-Term Review
<b>NAP</b>	National AIDS Programme
<b>NASA</b>	National AIDS Spending Assessment
<b>NGO</b>	Non-Governmental Organisation
<b>PMTCT</b>	Prevention of Mother to Child Transmission
<b>RANAA</b>	Regional/Arab Network against AIDS
<b>STI</b>	Sexually Transmitted Infection
<b>TB</b>	Tuberculosis
<b>UN</b>	United Nations
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNDP</b>	United Nations Development Programme
<b>UNFPA</b>	United Nations Population Fund
<b>UNGASS</b>	United Nations General Assembly Special Session on HIV/AIDS
<b>UNICEF</b>	United Nations Children’s Fund
<b>VCT</b>	Voluntary Counselling and Testing
<b>WHO</b>	World Health Organization

# CONTENTS

**POLICY RECOMMENDATIONS >>8**

**EXECUTIVE SUMMARY >>11**

**STATE OF THE EPIDEMIC >>18**

**REGIONAL SOCIO-POLITICAL LANDSCAPE >>20**

**PROGRESS AGAINST THE 10 TARGETS:**

1. REDUCE SEXUAL TRANSMISSION OF HIV BY 50% BY 2015 >>24
2. HALVE THE TRANSMISSION OF HIV AMONG PEOPLE WHO INJECT DRUGS BY 2015 >>28
3. ELIMINATE HIV INFECTIONS AMONG CHILDREN AND REDUCE MATERNAL DEATHS >>30
4. REACH 15 MILLION PEOPLE LIVING WITH HIV WITH LIFESAVING ANTIRETROVIRAL TREATMENT BY 2015 >>33
5. HALVE TUBERCULOSIS DEATHS AMONG PEOPLE LIVING WITH HIV BY 2015 >>38
6. CLOSE THE GLOBAL AIDS RESOURCE GAP >>41
7. ELIMINATE GENDER INEQUALITIES AND GENDER-BASED ABUSE AND VIOLENCE AND INCREASE THE CAPACITY OF WOMEN AND GIRLS TO PROTECT THEMSELVES FROM HIV >>44
8. ELIMINATE HIV-RELATED STIGMA, DISCRIMINATION, PUNITIVE LAWS AND PRACTICES >>48
9. ELIMINATE HIV-RELATED RESTRICTIONS ON ENTRY, STAY AND RESIDENCE >>53
10. STRENGTHEN HIV INTEGRATION >>55

**REGIONAL INITIATIVES >>56**

**APPENDIX: COUNTRY SNAPSHOTS >>61**

# POLICY RECOMMENDATIONS

The global HIV epidemic is in its fourth decade. The MENA region has had the opportunity to learn from decades of experience with HIV in other countries that have endured more mature, extensive and devastating epidemics. Investment in quality testing and treatment and bringing it to scale brings dividend across many targets. In those MENA countries that have taken lessons learned in other settings and developed them further to adapt to their particular contexts, needs and epidemiological profile, considerable progress has been made. If this is sustained and consolidated, the prospects for delivering the ten 2015 targets are good. However, in some countries, the response to the epidemic is still hampered by denial, resistance to addressing the sensitive issues raised by HIV, as well as by stigma and discrimination.

## **1. REDUCE SEXUAL TRANSMISSION OF HIV BY 50% BY 2015**

### **POLICY**

Commit to the principle of 'know your epidemic' by promoting relevant research and implementing responses based on the many examples of good practice that already exist within the region.

### **PROGRAMME**

Learn from and adapt successful experiences from the region in addressing the needs of key populations at higher risk, bringing to scale effective interventions and integrating action on intimate partner transmission.

## **2. HALVE THE TRANSMISSION OF HIV AMONG PEOPLE WHO INJECT DRUGS BY 2015**

### **POLICY**

Remove specific legal and policy barriers that prevent people who use and inject drugs from accessing the range of services they need, including needle and syringe exchange, condom distribution and opioid substitution therapy.

### **PROGRAMME**

Bring to scale effective interventions, drawing from documented examples of good practice on this issue within the region.



### **3. ELIMINATE NEW HIV INFECTIONS AMONG CHILDREN BY 2015 AND SUBSTANTIALLY REDUCE AIDS-RELATED MATERNAL DEATHS**

#### **POLICY**

Commit to implementation of the 2012 regional strategy to eliminate mother to child transmission.

#### **PROGRAMME**

Expand the availability of HIV counselling and testing to all those attending antenatal services, ensure women remain on life-long ART after delivery.

### **4. REACH 15 MILLION PEOPLE LIVING WITH HIV WITH LIFESAVING ANTIRETROVIRAL TREATMENT BY 2015**

#### **POLICY**

Commit to responding to the UNAIDS and WHO call to accelerate access to treatment throughout the region.

#### **PROGRAMME**

Scale up provision of HIV counselling and testing in order to promote access to and timely initiation of ART.

### **5. REDUCE TUBERCULOSIS DEATHS IN PEOPLE LIVING WITH HIV BY 50% BY 2015**

#### **POLICY**

Promote bi-directional integration of TB and HIV services in order to maximise opportunities for effective diagnosis and treatment.

#### **PROGRAMME**

Integrate action on TB in HIV interventions with refugees and other vulnerable, mobile populations.

### **6. CLOSE THE GLOBAL AIDS RESOURCE GAP BY 2015 AND REACH ANNUAL GLOBAL INVESTMENT OF US\$ 22-24 BILLION IN LOW- AND MIDDLE-INCOME COUNTRIES**

#### **POLICY**

Make strategic and cost-effective use of all available resources by focusing upon interventions that are known to work and to deliver value for money (e.g. abandoning mass screening and promoting access to voluntary testing and treatment).

#### **PROGRAMME**

Use available technical support to build capacity to demonstrate cost effectiveness and value for money of interventions and include these in funding proposals.

## **7. ELIMINATE GENDER INEQUALITIES AND GENDER-BASED ABUSE AND VIOLENCE AND INCREASE THE CAPACITY OF WOMEN AND GIRLS TO PROTECT THEMSELVES FROM HIV**

### **POLICY**

Support research and action that deepens understanding of the relationships between HIV and gender inequality, abuse and violence.

### **PROGRAMME**

Integrate consideration of gender inequality, abuse and violence in all interventions and engage with men and boys as partners in promoting gender equality.

## **8. ELIMINATE STIGMA AND DISCRIMINATION AGAINST PEOPLE LIVING WITH AND AFFECTED BY HIV THROUGH PROMOTION OF LAWS AND POLICIES THAT ENSURE THE FULL REALISATION OF ALL HUMAN RIGHTS AND FUNDAMENTAL FREEDOMS**

### **POLICY**

Promote and support engagement of legal and judicial sectors within national responses to HIV in order to tackle stigma and discrimination and uphold the rights of people living with HIV and members of key populations.

### **PROGRAMME**

Making use of the HIV Stigma Index, encourage people living with HIV to become partners in monitoring and challenging stigma and discrimination and claiming their human rights and entitlements.

## **9. ELIMINATE HIV-RELATED RESTRICTIONS ON ENTRY, STAY AND RESIDENCE**

### **POLICY**

Follow the global trend and withdraw all HIV-related restrictions on travel, entry, stay and residence.

### **PROGRAMME**

Gather and disseminate evidence of the negative impact of discriminatory policies and practices as they relate to travel and mobility.

## **10. STRENGTHEN HIV INTEGRATION**

### **POLICY**

Identify clear national and sub-national, medium-term targets and accountability frameworks for the next two years and beyond, with an overall, final target of ending AIDS by 2030.

### **PROGRAMME**

Identify opportunities for effective and sustainable integration of HIV interventions within existing programmes and services.

# EXECUTIVE SUMMARY

By 2012, UNAIDS estimated that 270 000 people were living with HIV in the countries of the MENA region. With the exceptions of Djibouti and Somalia, the majority of HIV epidemics in this region, are concentrated among key populations at higher risk, typically among people who inject drugs, men who have sex with men and sex workers. While understanding of the nature of the region's HIV epidemics has increased, critical gaps still exist and need to be addressed.

In recent years many countries have been affected by social and political unrest and conflict. Cumulatively, these have potentially serious implications for the region's HIV epidemics. Not only do unrest and conflict disrupt implementation of prevention and advocacy programmes and interfere with service delivery (e.g. including distribution of anti-retroviral therapy), they can also create the kind of conditions and vulnerabilities that exacerbate HIV epidemics. While some countries are primarily affected by internal unrest, others are affected by the consequences of unrest within neighbouring countries. Some, such as Egypt, are affected by both. Several countries have adapted their responses to HIV to reflect these new realities.

Eleven countries undertook Mid-Term Reviews<sup>5</sup> and assessed their progress in relation to each of the ten targets. The table that follows this section demonstrates the extent to which each target has been identified as a priority, whether or not it is included in the national strategic plan and whether or not countries consider themselves to be on track to achieve the target. The overall tone in these self-assessments is one of optimism but for several targets this appears to be unwarranted. As this report shows, some countries have made significant and impressive progress and achievements. However, in still too many countries, denial, stigma and discrimination appear to determine the nature of the response, in some cases even preventing gathering of the basic information necessary to plan appropriate responses.

## 1. REDUCE SEXUAL TRANSMISSION OF HIV BY 50% BY 2015

A range of challenges and constraints - general and country-specific - continue to threaten progress and undermine gains. In many countries, pervasive HIV-related stigma and discrimination continue to impact adversely, both upon individuals accessing HIV prevention knowledge and services, as well as upon effective national and local responses. The culturally and legally prohibited nature of sex work, sex between men, and drug use poses significant challenges

<sup>5</sup> Algeria, Djibouti, Egypt, Iran, Jordan, Lebanon, Morocco, Somalia, Sudan, Tunisia and Yemen.

in terms of understanding the dynamics of local epidemics and identifying, reaching and responding to the needs of members of key populations at higher risk. In a commitment to disseminating lessons learned and good practice, UNAIDS has made an important contribution in the development and dissemination of a region-specific, practical guide on HIV and outreach programmes with men who have sex with men. Further challenges lie in bringing to scale current interventions for key populations and in gaining deeper understanding and addressing intimate partner HIV transmission, which mostly affects female partners of men who inject drugs or who have sex with other men.

## **2. HALVE THE TRANSMISSION OF HIV AMONG PEOPLE WHO INJECT DRUGS BY 2015**

The Middle East and North Africa Harm Reduction Association (MENAHRRA) has made significant contributions to strengthening action on this target. Countries that identified this target as a priority highlight the following challenges: insufficient reach and resources (human and financial) to implement programmes in relation to need, together with stigma and social vulnerability of people who inject drugs. Iran has also highlighted a changing profile of drug use within the country. Of particular concern is the situation in Libya where 85% of people who injected drugs reported sharing needles. HIV prevalence of 87% was reported.

## **3. ELIMINATE NEW HIV INFECTIONS AMONG CHILDREN BY 2015 AND SUBSTANTIALLY REDUCE AIDS-RELATED MATERNAL DEATHS**

By 2012, only 8% [6% – 9%] of the estimated number of pregnant women living with HIV in the MENA region received appropriate treatment to prevent mother-to-child transmission. This reflects perceived lack of relevance of Prevention of Mother to Child Transmission (PMTCT) in countries where the numbers of people living with HIV are small; there is limited awareness of personal risk of HIV among women, uneven distribution of comprehensive quality sexual and reproductive, comprehensive sexual and reproductive health services, and very limited access to HIV testing. While most MENA countries have updated PMTCT guidelines to provide pregnant women living with HIV with life-long anti retroviral therapy (ART), even in countries where antenatal care coverage is good, women attending antenatal care are not routinely offered HIV testing. In recognition of slow progress in increasing coverage of PMTCT, in 2012 WHO and partners launched a region-specific approach.

## **4. REACH 15 MILLION PEOPLE LIVING WITH HIV WITH LIFESAVING ANTIRETROVIRAL TREATMENT BY 2015**

In 2013, the WHO Eastern Mediterranean Regional Office launched a call to action Ending the HIV treatment crisis in response to the fact that by the end of 2011, regional level coverage of people living with HIV with antiretroviral therapy was less than 14%, and as such, the world's lowest. The region has experienced a significant increase

(17%) in mortality from AIDS. Less than one in eight of those eligible for ART are receiving it in Djibouti, Egypt, Iran, Somalia and Sudan and Yemen. Throughout the region, populations at higher risk of HIV infection are not benefiting equitably from ART. As a result, despite the optimism reflected in Mid-Term Review (MTR) reports, few countries in the region appear likely to reach this target, unless they put clear testing and treatment targets and ensure monitoring and accountability mechanisms. Nonetheless, Morocco and a handful of other countries have made significant progress in terms of increasing the number of people receiving ART.

## **5. REDUCE TUBERCULOSIS DEATHS IN PEOPLE LIVING WITH HIV BY 50% BY 2015**

In 2012, tuberculosis (TB) prevalence (including HIV and TB) in the MENA region was estimated at 1 100 000<sup>6</sup> with 63% of cases (all forms) detected. A total of 409 477 new cases were reported during 2012, together with 21 228 retreated cases. Of this total, the HIV status was known for only 14% (58 498). Two thousand and twenty people (3.5%) with tuberculosis were diagnosed with HIV and just over fifteen thousand people living with HIV were screened for TB. The conflict in Syria is posing a challenge to Jordan's success in tackling TB, with several cases identified among refugees.

## **6. CLOSE THE GLOBAL AIDS RESOURCE GAP BY 2015 AND REACH ANNUAL GLOBAL INVESTMENT OF US\$ 22-24 BILLION IN LOW- AND MIDDLE-INCOME COUNTRIES**

MENA includes Somalia which is entirely dependent upon external sources of financial support, as well as high income countries, such as Gulf Cooperation Council (GCC) member countries, that are not only able to fund their own responses to HIV, but also contribute to a regional solidarity plan that supports low or lower-middle income countries in the region. Some countries fund the national response but depend upon UN system partners for technical and strategic support. By 2011, the Global Fund had approved US\$ 1.4 billion to tackle HIV, TB and malaria in the Middle East and North Africa Region and disbursed US\$ 784 million. The majority of these grants are graded as performing well. While significant progress has been made in relation to resource mobilisation, considerable unmet need persists for most interventions. However, it is challenging for governments to maintain commitment to funding responses to the epidemic when HIV is not recognised as a priority and continues to be associated with stigma and discrimination. Funding challenges are exacerbated by political instability and economic crises.

## **7. ELIMINATE GENDER INEQUALITIES AND GENDER-BASED ABUSE AND VIOLENCE AND INCREASE THE CAPACITY OF WOMEN AND GIRLS TO PROTECT THEMSELVES FROM HIV**

The political upheaval that has taken place across the region has highlighted the issues of gender inequality and violence. In some countries, conflict has significantly increased the vulnerability of women

<sup>6</sup> Range: 730 000–1 600 000

and girls to violence and abuse. In others, efforts are being made to address gender inequality, for example through possible constitutional change (for example in Tunisia), introduction of a National Gender Policy (Djibouti), or through focused action to decrease vulnerability and increase social and economic independence of women and girls. In recognition of the extent of their experience of stigma, discrimination and socio-economic vulnerability, some countries have focused specifically upon empowering women living with HIV.

## **8. ELIMINATE STIGMA AND DISCRIMINATION AGAINST PEOPLE LIVING WITH AND AFFECTED BY HIV THROUGH PROMOTION OF LAWS AND POLICIES THAT ENSURE THE FULL REALIZATION OF ALL HUMAN RIGHTS AND FUNDAMENTAL FREEDOMS**

Stigma and discrimination are still all too commonly experienced by people living with HIV throughout the region. Beyond the profound impact upon each individual living with HIV, stigma and discrimination encourage denial, complacency and inaction, and as such are critical barriers to realising the ten targets. The People Living with HIV Stigma Index has proven to be a useful tool within the region for articulating and documenting experiences of HIV-related stigma. In some countries, concrete action is being taken: for example, in the workplace in Jordan, within the health system in Egypt and through an integrated national strategy in Morocco. The Regional Arab Network against AIDS (RANAA), and MENA-Rosa (for women living with HIV) have made significant contributions to building capacity among people living with HIV (and members of key populations at higher risk) to articulate their needs and advocate for appropriate action at national, regional and global levels.

## **9. ELIMINATE HIV-RELATED RESTRICTIONS ON ENTRY, STAY AND RESIDENCE**

HIV-related restrictions on entry, stay and residence are neither warranted by public health considerations, nor consistent with the rights-based strategies that experience has shown are most effective in responding to HIV. Such policies waste resources (for example on mass testing) and reinforce stigma and discrimination, together with the perception that HIV is a problem of 'outsiders'.

## **10. STRENGTHEN HIV INTEGRATION**

With growing pressure on available resources, both nationally and globally, emphasis is increasingly placed upon the need for sustainable responses to HIV. This requires streamlining and integration of HIV within broader health systems and other sectors and development efforts. Positive examples exist across the region and demonstrate a variety of approaches. For example, In Morocco integrated of HIV services within public health has increased access to both HIV testing as well as to PMTCT. Djibouti has mainstreamed HIV within the national Health Development Plan 2013-2017 and integrated HIV within Presidential priorities for 2011-2016. Somalia has made progress in terms of integrating HIV within the country's emergency response.

## SUMMARY OF MID-TERM REVIEW REPORTS BY TARGET

Is this target a Priority (P)? Is it reflected in the National Strategic Plan (N)? Is the country On Track (OT)?

	Target 1:			Target 2:			Target 3:			Target 4:			Target 5:			Target 6:			Target 7:			Target 8:			Target 9:					
	P	N	OT	P	N	OT	P	N	OT	P	N	OT	P	N	OT	P	N	OT	P	N	OT	P	N	OT	P	N	OT			
Algeria																														
Djibouti																														
Egypt																														
Iran																														
Jordan																														
Lebanon																														
Morocco																														
Somalia																														
Sudan																														
Tunisia																														
Yemen																														

■ Yes  
■ No  
■ Not relevant  
 +- Partly





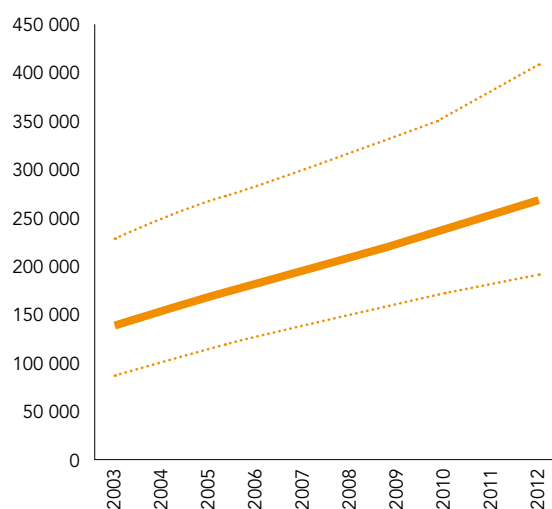


# STATE OF THE EPIDEMIC

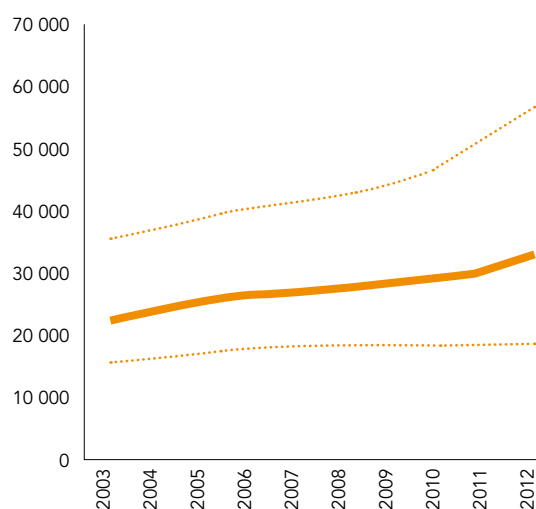
The Middle East and North Africa region is witnessing a fast growing HIV epidemic; the number of new infections has increased by an estimated 55 per cent in the past ten years, from 22 000 [17 000 – 31 000] to 34 000 [24 000 – 46 000]. This is in sharp contrast with other regions where new infections are either in decline or stable. The male to female ratio of new adult HIV infection has decreased from 1.8 to 1.3 in the same period. The total number of adults and children in the region who are living with HIV in 2012 is estimated to be 270 000 (200 000 – 380 000), with 34 000 (24 000 – 46 000) new infections and 16 500 (12 000–26 000) deaths.<sup>7</sup>

Regionally, sexual transmission is the most important route of infection, followed by use of contaminated needles and syringes by persons who inject drugs, and maternal to child transmission. Communities affected by sexual transmission differ within and between countries. Men who have sex with men and women engaged in transactional sex, including sex workers, are at highest risk of HIV infection in many countries, reflected in high prevalence among these groups.

## NUMBER OF ADULTS AND CHILDREN LIVING WITH HIV



## NUMBER OF NEW HIV INFECTIONS IN ADULTS AND CHILDREN



<sup>7</sup> All estimates are based on national estimates from nine countries: Algeria, Djibouti, Egypt, Iran, Morocco, Somalia, Sudan and Yemen. These nine countries account for 74% of the region's total population and for 75% of its adult population.

Intimate partners of these key, at risk, populations are also at high risk of infection. Unfortunately, most surveillance systems do not capture HIV prevalence among intimate partners. In one notable study in Iran (2), HIV prevalence among non-injecting, female sexual partners of men who inject drugs was 2.8% (0.7%-11.3%)<sup>i</sup>, i.e. twenty times higher than estimated adult prevalence in Iran.

As knowledge of the HIV epidemic in the region evolves, so too does its profile. It is estimated that in Egypt and Tunisia new infections among people who inject drugs are rising, while they are falling in both Iran and Morocco. Iran is beginning to see increased numbers of infections among sex workers.

Estimates based on Spectrum models predict that the number of new infections is rising among people who do not belong to recognised key populations at higher risk. Given that the majority of members of key populations also have intimate sexual partners, together with low rates of consistent condom use in the context of these relationships as well as very low ART coverage, this is not surprising.

Djibouti, and to a lesser extent Somalia, are considered to have epidemics in which HIV has spread significantly beyond key populations. However, scarcity of biological data from key populations in these countries makes firm conclusions impossible at this stage.

While there has been considerable progress in the amount of HIV-related research undertaken in the region, there are still critical gaps which need to be addressed if the respective countries are to be able to *know their epidemics* and respond accordingly.

With the exceptions of Djibouti, Morocco, Somalia and Syria, the male-to-female ratio of reported HIV cases is high: from 1.4:1 in Oman to 7:1 in Bahrain. This suggests either that a considerable proportion of HIV transmission has occurred through sex between men or amongst persons who inject drugs, with a considerable male-majority, or else that HIV infections among women are underreported.

Despite these gains in understanding the spread of the epidemic within MENA, HIV prevalence data are still not available for key populations at higher risk in several countries, including: Bahrain, Iraq, Kuwait, Libya, Oman, Qatar, Saudi Arabia, South Sudan, Syria and UAE.

The review of surveillance data highlights the urgent need to address existing gaps in understanding of the region's HIV epidemics and emphasises the importance of building capacity and support for well-designed studies. It also highlights the need for 'de-stigmatisation' of key populations at higher risk in order to facilitate their access to services and support.

**OUR UNDERSTANDING  
OF THE HIV EPIDEMIC  
IN THE REGION IS  
CHANGING AS MORE  
INFORMATION  
BECOMES AVAILABLE  
THROUGH  
SURVEILLANCE AND  
RESEARCH**

# REGIONAL SOCIO-POLITICAL LANDSCAPE<sup>8</sup>

In recent years, many countries in the MENA region have been affected by social and political unrest and conflict, adding to already heightened levels of mobility and displacement.

Cumulatively, these have potentially serious implications for the region's HIV epidemics. Not only do unrest and conflict disrupt implementation of prevention and advocacy programmes and interfere with service delivery (e.g. including distribution of anti-retroviral therapy), they can also create the kind of conditions and vulnerabilities that exacerbate HIV epidemics.

While some countries are primarily affected by internal unrest, others are affected by the consequences of unrest within neighbouring countries. Egypt and Jordan are affected by both.

Ongoing unrest in the Syrian Arab Republic (Syria) has forced hundreds of thousands of refugees to flee to neighbouring countries. More than two million Syrian refugees have fled their homes to Egypt (130 000), Iraq (nearly 200 000), Jordan (more than 500 000), Lebanon (nearly 800 000) and Turkey (500 000), with numbers continuing to rise.<sup>9</sup> Moreover, a further two million Syrians are thought to be internally displaced.<sup>10</sup>

The large number of displaced people from Syria is impacting upon host communities. In Jordan, which hosts more than half a million Syrian refugees, dispersed among the country's main cities and refugee camps, by March 2013 46 cases of tuberculosis (TB), five of them multi-drug resistant, had been identified among refugees. This threatens Jordan's ability to sustain its low TB disease burden.

Following the conflict in Libya in 2011, many of those previously displaced have returned. However, between 65 000 and 80 000 internally displaced persons (IDPs) have so far been unable to return to their homes. Recent fighting has also led to the internal displacement of a further 25,000 people. Libya is also home to many refugees, asylum-seekers and economic migrants. Yemen has also experienced significant levels of population displacement, with almost half a million people internally displaced by conflict and natural disaster. Yemen is also host to 230,000 registered refugees, mostly from Somalia, but also from Ethiopia and Eritrea.

**UNREST AND CONFLICT  
IN THE REGION  
HAS DISRUPTED  
PROGRAMMES  
AND SERVICES AND  
HAS CREATED NEW  
VULNERABILITIES AND  
ENHANCED PRESENT  
ONES**

<sup>8</sup> The information in this section is from the website of the United Nations High Commission for Refugees: <http://www.unhcr.org/pages/4a02db416.html>

<sup>9</sup> <http://reliefweb.int/sites/reliefweb.int/files/resources/UNFPA%20Regional%20SitRep1%20-%2020%20Oct%20%2313%20.pdf>

<sup>10</sup> <http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e486a76&submit=GO>

In Somalia, security challenges not only make it difficult to deliver prevention and other programmes, they also restrict access to services by those on treatment and cause displacement and loss of follow-up.

During 2011, the conflict in Libya, led to significant disruption of the supply of anti-retroviral drugs that lasted more than six months, creating an emergency for people living with HIV who were receiving therapy. Those who were unable to obtain drugs from neighbouring countries reported sharing with others, relying on partial treatment with one- or two-drug regimens, and giving rise to concerns about increasing risk of resistance to first-line ARV drugs. In addition to a nationwide stock-out of ARV drugs, infection control and blood safety systems became unreliable. Sexual and gender-based violence have increased with the breakdown in social ties and cohesion.

With support from the United Nations High Commission for Refugees (UNHCR), Sudan is delivering HIV services in emergency settings through centres that offer comprehensive HIV services, including counseling. Condom distribution and other activities are implemented in refugee camps, including development and distribution of communication materials for internally displaced young people.

### **YEMEN: DELIVERING HIV SERVICES IN EMERGENCY SETTINGS THROUGH NGOS**

With support from the United Nation Office of Humanitarian Affairs (OCHA), HIV services are being delivered in emergency settings by national NGOs.

Comprehensive services include community mobilisation and sensitisation of local authorities, awareness sessions, peer education counselling and voluntary testing.

Condom distribution has been undertaken with internally displaced populations in the governorates of Harad, Hajja and Aden, with more than 13 000 IDPs and members of host communities benefiting from the project.

In the occupied Palestinian territory, checkpoints between major cities of the West Bank and the near complete closure of Gaza result in severe restrictions of movement of both people and goods. Crowding and unemployment induce people to migrate for work, creating conditions conducive to consumption of alcohol and other substances, which has increased rapidly in recent years. A 2011 rapid assessment (3) highlighted extreme vulnerability among women, reflected in high levels of violence, including forced sex work, exacerbated by conditions of war and the occupation.

The war in Iraq that began in 2003 led to a prolonged period of violence, insecurity and instability, resulting in the breakdown of the health-care system and destruction of many health facilities. In this context, most of the programmes and facilities of the National AIDS Programme (NAP) were disrupted or destroyed, including a counseling center at Ibn-Zuhur hospital and VCT centers in other Governorates, as well as several laboratories where HIV testing was conducted. Years of conflict and violence resulted in substantial displacement of large groups of people, There are also 148 000 registered Iraqi refugees in the region together with more than 1.3 million internally displaced persons (IDPs), many of whom are living in challenging conditions. Previously exiled people are returning to a country with enormous social, psychological and economic problems, including poverty, unemployment and the disruption of families and communities. In this context, as in Libya, women and girls are especially vulnerable. However, HIV is not identified as a priority in the country's rehabilitation plans, and no reference is made to it in key planning and policy documents of post-war Iraq, including the National Development Strategy (NDS) and International Contract with Iraq (ICI).

For Somalia, the social and economic consequences of war have been colossal, including some of the lowest human development indicators in the world. In South Central region, home to particularly vicious fighting, factors that could affect the HIV epidemic include; displacement, gender vulnerabilities, establishment of new sexual networks and loss of livelihoods that could, in turn, contribute to sexual exploitation and abuse.

Migration per se is not a risk factor for HIV. However, the conditions in which people migrate can place them in vulnerable situations that increase the risk of HIV infection. These include family separation and low levels of social support, differences in cultural norms and languages, poverty, substandard working and housing conditions (4). Resulting isolation and stress can encourage unsafe, casual and commercial sex, exacerbated by inadequate access to HIV prevention information and services.<sup>11</sup>

## **YOUNG PEOPLE AND HIV IN THE MENA REGION<sup>12</sup>**

Countries in the region are now home to the largest cohort of young people in their history, with a youth population that increased from 45 million in 1985 to 71 million in 2010. This population of young people is characterised by considerable diversity, making it essential to understand the specific needs and challenges facing young people in different communities.

Young people have played a prominent role in the social and political unrest across the region and are making demands for more meaningful participation in economic, social and political life.

<sup>11</sup> [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---ilo\\_aids/documents/publication/wcms\\_127014.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_127014.pdf)

<sup>12</sup> The data in this section is drawn from:

Roudi-Fahimi F, El Feki S. Facts of life: youth sexuality and reproductive health in MENA. Population Reference Bureau, 2011. [www.prb.org/Reports/2011/facts-of-life.aspx](http://www.prb.org/Reports/2011/facts-of-life.aspx).

Young people in Arab States: Changing the world for better. UNFPA Arab States Regional Office, 2012

<http://arabstates.unfpa.org/public/cache/offonce/pid/13020;jsessionid=82237FD9594206C54B0C8D3AE66C6FA2.jahia01>

Securing the future today. Synthesis of strategic information on HIV and young people. UNAIDS, 2011.

While they are staying in school longer, upon leaving, young people face limited job prospects and a high cost of living, which combine to drive up the age at which marriage (the only culturally acceptable context for sexual relationships) is a realistic option.

While the period between reaching sexual maturity and marriage is growing, so too is the possibility of sex before marriage, a conclusion supported by the few available studies within the region which suggest that a majority of young men and a small minority of young women report sex before marriage. Surveys of young unmarried women in Jordan and Tunisia suggest that the incidence of pre-marital sex is increasing and the age of sexual debut decreasing, but that young people remain ill-informed about sexually transmitted infections, contraception and reproductive health. Unlikely to have benefitted from education on sexuality and relationships<sup>13</sup> pre-marital sex is likely to be unprotected. Also, given that gender inequality remains deeply entrenched across the region, limiting girls' choices and opportunities, and harassment is a common experience for young women, there is also considerable risk of sexual coercion.

The tables below highlight the fact that many young people in the region are already living with HIV. While overall prevalence rates are generally low, among young people who are members of key populations at higher risk, they are considerably higher.

#### Number of new HIV infections among young people aged 15–24 (2012)

Female (low estimate-high estimate)	Male (low estimate-high estimate)
(3 000 – 11 000)	(3 000 – 11 000)

#### Percentage HIV prevalence among key populations age <25

Country	Year	% of sex workers who test positive for HIV	Year	% of men who have sex with men who test positive	Year	% of people who inject drugs who test positive for HIV
Djibouti	2008	7.89%		(3 000 – 11 000)		
Iran, Islamic Republic					2007	9.4%
Morocco	2009	1.4%				
Sudan	2008	0			2009	0
Tunisia	2009	0.34	2009		2009	

Gender, socio-economic status and cultural affiliation all affect HIV-related vulnerability and need to be taken into consideration in the design of interventions with young people. For example, a study (5) of 857 children and adolescents (aged 12-17 years) living on the streets of Egypt's two largest urban centres reported that the majority (93%) had encountered harassment or abuse, typically by police and other street children. Sixty-two per cent had used drugs. Among older adolescents the majority were sexually active (67%) and 54% of sexually active 15-17-year-olds reported multiple partners and never using condoms (52%). The majority of girls had been sexually abused. There were also substantial overlaps with members of key populations at higher risk for HIV, in particular, men who have sex with men, sex workers and people who inject drugs.

<sup>13</sup> Reflected in low levels of knowledge about HIV transmission and prevention, accompanied in some countries by highly stigmatising attitudes towards people living with HIV.

# 1. Reduce sexual transmission of HIV by 50% by 2015

Throughout the region, there is considerable variation in terms of progress against this target. All eleven countries that undertook Mid-Term Reviews identified reduction of sexual transmission as a national priority. With the exceptions of Iran, Somalia and Tunisia, the majority consider their progress to be 'on track' for achieving the target. While this is encouraging, it may be unrealistic *since new HIV infections are actually increasing in the MENA region.*

A range of challenges and constraints - general and country-specific - continue to threaten progress and undermine gains. In many countries, pervasive HIV-related stigma and discrimination continue to impact adversely, both upon individuals accessing HIV prevention and services, as well as upon effective national and local responses. A further challenge lies in bringing to scale current interventions for key populations, including sex workers and men who have sex with men. Yet another challenge lies in recognising and addressing intimate partner HIV transmission, which mostly affects female partners of men who inject drugs or who have sex with other men.

In terms of key programmatic actions necessary to achieve the 2015 target, most countries that completed MTRs discussed the importance of increasing the availability of strategic information for planning, scaling up interventions to reach all who need them, and supporting these with suitable resources.

Several countries also articulated specific policy actions or changes necessary to make the implementing environment more enabling. For example, both Djibouti and Somalia highlighted the need for integration of HIV-related interventions, both within reproductive health services, as well as within poverty reduction programmes. Egypt, Jordan, Lebanon, Morocco and Sudan have all identified the need to: *implement existing laws* that protect the rights of PLHIV, *create new policies or laws* (for example, to make sexuality education mandatory or expand reproductive health services to address the needs of unmarried women), or else *revoke existing potentially discriminatory policies or laws*, such as those that require pre-marital HIV testing. In particular, Jordan highlighted the need for more intense advocacy to tackle current criminalisation and social exclusion of members of key populations, together with clear protections for service providers who work with these groups.

An important, but neglected issue concerns sexual transmission within the context of intimate partner relationships. Available evidence from IBBSS (6) and other research suggests that many members of key populations at higher risk, as well as engaging in specific risk behaviours, also have intimate relationships with

**PREVENTING SEXUAL TRANSMISSION IN KEY POPULATIONS AND THEIR INTIMATE PARTNERS IS THE KEY FOR REVERSING THE TRAJECTORY OF THE EPIDEMIC**



partners to whom they may or may not have disclosed the extent of their risk. The risk of sexual transmission within intimate relationships needs further consideration.

Supported by UNAIDS and the Global Fund, research (7) undertaken among migrants in Morocco highlights particular vulnerabilities, risks and prevention-related needs of this neglected population. This is of particular relevance given the importance of migration throughout the region.

The culturally prohibited and illegal nature of sex work, sex between men and drug use pose significant challenges in terms of understanding the dynamics of local epidemics and identifying, reaching and responding to the needs of members of key populations at higher risk, for whom social invisibility may be necessary for survival.

While discussion of prohibited behaviours and sexual matters is undoubtedly sensitive and difficult in very conservative societies, it is possible to overestimate the degree of resistance that exists. For example, researchers in Bahrain<sup>14</sup> reported their surprise at the willingness with which participants responded to sensitive questions as part of a study on domestic violence. Similarly in Kuwait findings from a focus group discussion<sup>15</sup> with male students revealed potentially important insights into sexual behaviour and related practices, demonstrating that discussion of sensitive issues can indeed be possible, even in conservative settings. Bahrain, Iraq, Kuwait, Libya<sup>16</sup>, Oman, Qatar, Saudi Arabia, Sudan, Syria and United Arab Emirates still lack reliable, recent HIV prevalence data.

Some countries (Egypt, Iran and Morocco, for example) have made considerable progress, both in terms of identifying the key characteristics of their epidemics<sup>17</sup> and responding accordingly.

In their respective reports, countries describe a range of actions undertaken towards reaching the target of reducing sexual transmission of HIV. Most countries have generated strategically useful information: for example, about the existence and local structure of sex work (e.g. in Kuwait and Oman), of sex between men (in Oman), male sex workers and sexual violence against men in prisons (in Syria) and respective HIV prevalence estimates among sex workers and men who have sex with men in Tunisia and Morocco.<sup>18</sup> Libya's first prevalence study (8) among men who have sex with men and female sex workers recorded rates of 3.1% and 15.7% respectively. More than half of the men reported sexual intercourse with female partners during the previous six months. Nearly 40% of the men reported unsafe sex with both men and women during the past six months, and almost a third had used non-injecting drugs in the past six months.

**SCALING UP THE  
CURRENT SERVICES IS  
THE BOLD STEP NEEDED  
IN THE REGION TO  
MAKE THE CURRENT  
PREVENTIVE INITIATIVES**

<sup>14</sup> Quoted in country progress report.

<sup>15</sup> Quoted in country progress report.

<sup>16</sup> Although some work has been undertaken see later in this section.

<sup>17</sup> Iran and Morocco are the only countries in the region to have completed Modes of Transmission studies.

<sup>18</sup> The respective rates for sex workers, injecting drug users and men who have sex with men in 2009 and 2011 were: 0.4%-0.6%; 3.1%-2.4%; and 4.9%-13%.

Algeria, Djibouti, Egypt and Yemen have all undertaken research and mapping to estimate the size of key populations or to generate evidence in support of interventions. Djibouti has expanded condom distribution beyond health service outlets, taking advantage of existing social networks. Provision of VCT services has nearly tripled from 11 outlets in 2005 to 31 in 2012 and testing is being provided in refugee camps. In Iran, 28 gender-sensitive sexual health centres are now active and specific programmes for transgendered people have been introduced, together with strengthened HIV and STI surveillance systems.

In Jordan, capacity has been built for syndromic management of STIs, while in Lebanon increased efforts have been made to promote condoms and reach those most at risk. In Egypt, combination prevention services are implemented by civil society organisations with men who have sex with men (see box below), female sex workers and people who inject drugs. In Morocco, efforts have been made to expand coverage of combination prevention services for sex workers, men who have sex with men, prisoners and other vulnerable groups. Combination prevention has also been integrated within regional level strategic plans, as well as within NGO programmes. Standards have been set for outreach activities with sex workers as well as for condom distribution. A condom social marketing intervention is also planned.

In Somalia, interventions have been initiated with sex workers and members of other key populations and coverage of VCT has increased. The *community conversations* methodology has been adapted and conducted in key locations in order to support prevention and to reduce stigma and gender based violence.

In Algeria, Lebanon, Morocco, Tunisia and Yemen, NGOs have played a critical role in terms of establishing strong, collaborative relationships with members of key populations at higher risk and their broader communities. The key challenges for these countries now lie in terms of scaling up responses and securing the necessary political will and resources to be able to sustain effective responses over time.

## **EGYPT, LEBANON AND YEMEN: DELIVERING PREVENTION SERVICES TO MEN WHO HAVE SEX WITH MEN**

Countries in the region are now home to the largest cohort of young HIV prevalence is low (<0.1%) among Egypt's general population, but two bio-behavioural surveys revealed relatively high prevalence figures among men who have sex with men: 6.2% in 2006 and 5.7% and 5.9% (in Cairo and Alexandria respectively) in 2010.

Civil society organisations initiated a prevention project in Cairo in 2009 and a parallel project in Alexandria 2010, with support from the UNAIDS country support team and the National AIDS Programme. Following a clear set of guidelines, the project utilises paired teams of street outreach workers who approach and engage with potential beneficiaries in pre-selected sites. Referrals are made to a professional service provider network, a delivery mechanism selected with consideration for cost-effectiveness and longer-term sustainability. Upon enrolment, clients receive a unique codifier that enables them to access subsidised services, including provision of condoms and lubricants, counselling and testing, medical services, psychosocial support and legal services. The coding system also facilitates follow-up and project monitoring. Beneficiaries are encouraged to attend a one-day workshop on HIV which provides more detailed information on transmission and prevention. Outreach workers follow-up beneficiaries to reinforce prevention messages, provide re-supply of prevention commodities and to monitor behaviour change. The two projects are mutually complementary, sharing referrals and exchanging experience through capacity building and mentoring. Scale-up in Alexandria has been initiated (with planned extension to Gharbya) and will be supported until 2017.

In Beirut, a holistic sexual health centre "Marsa" was established in 2011 and immediately became the most popular facility in Lebanon, with large numbers of clients requesting sexual health services, such as VCT and STI screening and treatment. Key factors contributing to the centre's success include the comprehensive nature of services provided, the non-judgemental environment, together with full anonymity and confidentiality. Services are delivered by a highly trained and friendly team with expertise across a wide range of medical, psychological and social fields. Marsa demonstrates the clear need for such a service, particularly in light of increasing visibility of Lebanon's community of men who have sex with men, together with expanding opportunities for sexual activity.

In Yemen, a biological behaviour surveillance study in 2011 revealed HIV prevalence of 5.9% among men who have sex with men in Aden and Hodeida governorates. With support from local stakeholders, the National AIDS Control Programme and the UNAIDS country office, the first comprehensive programme for this population was established in Aden in 2011 and two projects are now running in Hodeida and Sana'a governorates.

## 2. Halve the transmission of HIV among people who inject drugs by 2015

The extent to which injecting drug use is understood to contribute to the region's HIV epidemics varies as do official responses. Since 2007, at both regional and country levels, a substantial contribution to effective responses has been made by the Middle East and North Africa Harm Reduction Association (MENAHRRA).<sup>19</sup>

Of the eleven countries that undertook Mid-Term Reviews, Algeria, Egypt, Iran, Lebanon, Morocco and Tunisia identified reduction of HIV transmission among people who inject drugs as a priority. In all six countries, addressing transmission among this population is included in national strategic plans. Reports from Iran and Morocco reveal progress in terms of expanded reach of harm reduction programmes, including needle distribution to people who inject drugs. All, except Tunisia (which was less certain), assessed themselves as on track to meet the target. However, whether or not this shows meaningful increase in overall programme coverage is not clear. In common with countries in other regions, the majority that undertook MTRs assess themselves as being on track to reach this target. However, this conclusion does not appear to be supported by available data on HIV prevalence and prevention-related indicators.<sup>20</sup>

In terms of challenges, countries that identified this target as a priority highlight the following: insufficient reach and resources (human and financial) to implement programmes in relation to need, punitive laws and policies relating to drug use, together with the social vulnerability of people who inject drugs and the associated stigma and discrimination. Iran has identified gaps in available data and counter-productive policies as challenges, together with the changing profile of drug use within the country (see below).

Of particular concern is the situation in Libya, where a study (9) of HIV prevalence among people who inject drugs reported that 85% reported sharing needles. Correspondingly high prevalence of HIV (87%) and HCV (94%) were reported together with HBV (5%). A 2006 study of prisoners in Libya (10) had already revealed high levels of infection with HIV, hepatitis B and hepatitis C among 6371 male prisoners: 15.3% tested positive for more than one of the infections and 1.5% were positive for all three. A total of 84% of those identified with HIV were also positive for hepatitis C.

Algeria, Egypt and Iran have all made efforts to scale up their interventions for people who inject drugs. Prevention efforts have also continued, for example with young people in Algeria and with prisoners in Egypt.<sup>21</sup> Iran has also promoted increased involvement by civil society.

**STARTING AND SCALING UP SERVICES PROVEN TO BE EFFECTIVE GLOBALLY AND IN THE REGION PUTS THE REGION ON TRACK FOR REACHING THIS TARGET**

<sup>19</sup> See the final section on Regional Initiatives for more information on MENAHRRA.

<sup>20</sup> UNAIDS Global Report 2013 p. 35.

<sup>21</sup> These efforts were stopped in response to prison break-outs and disruption coinciding with social and political unrest. Efforts are underway to support resumption of this important area of work.

In Morocco, risk reduction efforts have been scaled up in Tangier and coverage expanded to include Tétouan and Nador. During 2012, 2231 people who inject drugs benefitted from the risk reduction programme, compared to 1091 in 2011. Opioid Substitution Therapy has also been established in Tangier, Salé and Casablanca, with a total of 293 users on methadone by the end of 2012. Standards and modalities for methadone provision in prison have also been developed.

In Bahrain, no community-based HIV prevalence studies among people who inject drugs have been conducted. Data is limited to reports of mandatory HIV screening at drug rehabilitation centres. In 2011, prevalence among this population was 4.6%. There are currently no programmes for community-based outreach to people who inject drugs. While needles and syringes are available from pharmacies, a prescription is required and users have reported being arrested for possession of drug paraphernalia. Methadone maintenance therapy is not available in Bahrain.

In contrast, in the Occupied Palestinian Territory (OPT), there has been increased engagement by NGOs and civil society with people who inject drugs. Harm reduction guidelines have been developed and peer education undertaken. Research has revealed frequent injecting and needle sharing among people who inject drugs (particularly in the West Bank) together with the locations of shooting galleries and other places where needle-sharing occurs. Many people who inject drugs also report having multiple sexual partners. Drop-in centers exist in Gaza and the West Bank and harm reduction programmes are in place, but in need of scaling up, particularly in Gaza.

### ***IRAN: RESPONDING TO A CHANGING EPIDEMIC***

Throughout the region, Iran's harm reduction programmes are recognised as examples of good practice with demonstrable impact in slowing the spread of HIV among people who inject drugs.

By September 2012, free needle and syringes were being distributed through more than 559 service outlets. According to the 2010 bio-behavioural survey of people who inject drugs, 91.7 per cent reported using a clean needle and syringe on last injection. Coverage of Methadone Maintenance Treatment (MMT) increased steadily from 2001: by September 2012, 4249 outlets were providing services to almost half a million people who use drugs. Nonetheless, the fact that injecting drug use remains the principal mode of HIV transmission in Iran highlights the need for increased and sustained coverage and action.

In recent years, evidence also points to increasing sexual transmission of HIV. Unprotected sex is commonly reported by people who inject drugs. HIV prevalence has risen among female sex workers. Use of amphetamine-type stimulants has increased in recent years, together with associated high-risk sexual behaviours.

### **3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths**

By 2011, less than 10% of the estimated number of pregnant women living with HIV in the MENA region received appropriate treatment to prevent mother-to-child transmission (11). This reflects a number of challenges including: perceived lack of relevance of this target to countries where the numbers of people living with HIV are small, limited awareness of personal risk of HIV among women in the region, uneven distribution of quality, comprehensive sexual and reproductive health services, and very limited access to HIV testing. While most MENA countries have updated Prevention of Mother to Child Transmission guidelines, even in countries where antenatal care coverage is good, women attending antenatal care are not routinely offered HIV testing.

Despite poor performance regionally, there are encouraging examples of countries where progress has been made (see boxes below). For example, Oman began offering HIV testing in 2010 to all women attending antenatal care clinics with an acceptance rate of 99%. The United Arab Emirates has started a similar initiative. This has resulted in these two countries achieving the highest coverage in the region followed by Morocco.

In recognition of the region's slow progress in increasing coverage of PMTCT, in 2012 WHO, UNICEF, UNAIDS and UNFPA and partners launched a region-specific approach (12), based upon four components: primary prevention of HIV infection among women of childbearing age; preventing unintended pregnancies among women living with HIV; preventing HIV transmission from a woman living with HIV to her infant; providing appropriate treatment, care and support to mothers living with HIV and their children and families.

All but two countries (Jordan and Yemen) that undertook MTRs identified this specific target as a priority. In Jordan, increasing coverage of PMTCT is hampered by lack of knowledge among health care providers and, given the low prevalence nature of the epidemic and the correspondingly small number of HIV positive pregnant women, reluctance to implement this intervention. Between 1989 and 2009 a total of nine cases of mother to child transmission were recorded. None have occurred since. Lebanon's response to PMTCT has been hampered by lack of provider initiated testing and costly referral services, compounded by fear, lack of understanding and stigma by pregnant women.

## **MOROCCO: PILOTING A PMTCT PROGRAMME**

In Morocco, A pilot PMTCT programme has been implemented in three regions, reviewed and recommendations made for further expansion. A plan for elimination of MTCT has been developed for the period 2012-16. This includes efforts to engage private health providers in providing HIV testing and awareness for pregnant women.

Access to HIV testing and counselling for pregnant women has been extended to include 250 basic health facilities. Following a national campaign to promote testing in December 2012, 43 000 women who were either of child-bearing age or pregnant were tested. During 2012, 38 000 tests were conducted among pregnant women (compared to 5630 in 2011). One hundred and ninety five pregnant HIV positive women (representing 48% coverage) benefitted from PMTCT compared to 124 (33% coverage) the previous year. A total of 244 children under 15 years received antiretroviral drugs, including 210 new-borns and infants below 2 years of age.

Challenges to successful implementation of the national plan include reaching all pregnant women with counselling and testing when many live in remote or isolated areas with the associated problems of referral for HIV-related care. Also, stigma and discrimination persist, including among providers.

In Morocco, A pilot PMTCT programme has been implemented in three regions, reviewed and recommendations made for further expansion. A plan for elimination of MTCT has been developed for the period 2012-16. This includes efforts to engage private health providers in providing HIV testing and awareness for pregnant women.

Access to HIV testing and counselling for pregnant women has been extended to include 250 basic health facilities. Following a national campaign to promote testing in December 2012, 43 000 women who were either of child-bearing age or pregnant were tested. During 2012, 38 000 tests were conducted among pregnant women (compared to 5630 in 2011). One hundred and ninety five pregnant HIV positive women (representing 48% coverage) benefitted from PMTCT compared to 124 (33% coverage) the previous year. A total of 244 children under 15 years received antiretroviral drugs, including 210 new-borns and infants below 2 years of age.

Challenges to successful implementation of the national plan include reaching all pregnant women with counselling and testing when many live in remote or isolated areas with the associated problems of referral for HIV-related care. Also, stigma and discrimination persist, including among providers.

**THE BENEFITS OF PMTCT SERVICES CAN GO BEYOND THIS TARGET AND DIRECTLY AFFECT MANY OTHER HLM TARGETS**

## **SOMALIA: REVITALISING PMTCT**

In Somalia since 2010, 34 health facilities (8 in South Central, 6 in Puntland and 20 in Somaliland) have been providing PMTCT. A total of 20 397 women have received counselling and been tested during the MTR reporting period. Of these, 82/96 (85%) of HIV pregnant women received antiretroviral prophylaxis or antiretroviral therapy, and 58/96 (60%) exposed babies were given ARV prophylaxis.

Revitalizing PMTCT in Somalia has been a significant achievement. Nonetheless, considering that there are estimated to be 3 091 women in need, this amounts to only 3% in terms of coverage, with an estimated unmet need of more than 95%.

The country has identified a need to include early infant diagnosis, reproductive health and community level interventions, as well as integration of VCT within MCH centres, in order to expand the scope of counselling and testing. Community mobilisation has increased demand and uptake of PMTCT services.

However, as in many countries throughout the region, stigma, both among pregnant women and health workers, continues to undermine delivery and uptake of services. Home deliveries without skilled birth attendants also potentially increase the risk of HIV transmission.

Institutional weaknesses include inadequate coverage, limited capacity among health workers, logistics and supply shortages, and complexities of health information systems and other competing needs. Furthermore, a single donor supports 85% of the country's response and diversification of funding is necessary.

Access to, and coverage by, PMTCT are further impeded by the deteriorating security situation that prevails throughout much of the country.

In Yemen, a national PMTCT programme was launched in 2009. However, PMTCT is not identified as a national priority and is so far available in relatively few facilities, hampered by weak referral from antenatal units and lack of integration of PMTCT with antenatal services. In Bahrain, antenatal guidelines recommend HIV testing only "if indicated" and thus depend to a considerable extent upon the judgment of individual providers rather than national policy. In Kuwait, in contrast to other population groups who are screened (e.g. premarital, pre-employment, foreign residents) HIV testing is not routinely conducted with pregnant women.



## 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015<sup>22</sup>

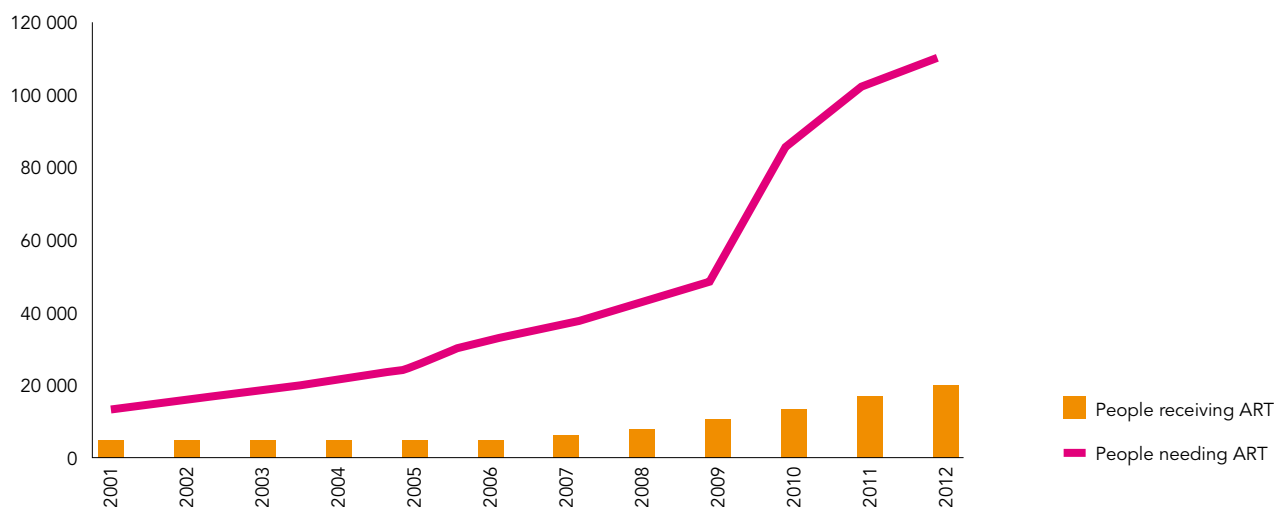
In 2013, the WHO Eastern Mediterranean Regional Office and UNAIDS Regional Support Team for the Middle East and North Africa launched a call to action *Accelerating HIV treatment* to address the fact that by the end of 2012, regional level coverage of people living with HIV with antiretroviral therapy was less than 20 per cent, and as such, the world's lowest.<sup>23</sup> Less than one in eight of those eligible for ART are receiving it in Djibouti, Egypt, Iran, Somalia and Sudan and Yemen, this is based on the 2010 WHO treatment guideline, with people with CD4 counts less than 350 deemed eligible, Algeria is the only country having people with CD4 count less than 500 as eligible.

Throughout the region, populations at higher risk of HIV infection are not benefiting equitably from ART, hampered as they are by stigma, discrimination and punitive laws that combine to deprive them of the multiple benefits of ART.

While the efforts made so far by all countries in the Region are commended and the number of people who are receiving treatment has been rising, the number of new HIV infections is constantly increasing the level of unmet need for treatment.<sup>24</sup> As a result, the region has experienced a significant increase (17%) in mortality from AIDS.

**INNOVATION IN HIV TESTING AND TREATMENT IS THE KEY TO PUTTING MENA ON TRACK OF TREATMENT TARGET**

### TREND OF ART COVERAGE IN THE REGION



<sup>22</sup> Additional data in this section is drawn from WHO/UNICEF/UNAIDS. Global update on HIV treatment 2013: Results, impact and opportunities.

<sup>23</sup> <http://www.emro.who.int/asd/asd-infocus/initiative-treatment-crisis.html>

<sup>24</sup> An increasing number of people in the region are accessing treatment. By the end of 2012, 25 100 people (including 1 100 children) were receiving ART, an increase of 4 800 from 2011.

Increasing access to treatment is identified as a priority for all countries that completed the MTR process with only one country (Somalia) assessing its performance as unlikely to meet the target. Despite the optimism of the MTR reports, few, countries in the region actually appear likely to reach the target.

### **LIBYA: ARV SHORTAGES**

While antiretroviral therapy is free for all Libyan citizens, shortages have led to prolonged treatment interruptions lasting several months. Because of the recent conflict, drug supply was disrupted for more than six months in 2011, creating an emergency situation for those on treatment and potentially facilitating development of resistance to first-line ARV drugs, exacerbated by lack of capacity for resistance monitoring in Libya. Doctors working at the Infectious Diseases Department of the Tripoli Central Hospital reported increasing numbers of individuals admitted in advanced stages of disease with consequently high mortality.

Effective delivery of antiretroviral therapy to those who need it depends upon several related factors. People need to know their HIV status in order to initiate treatment at the optimum time. In turn, this requires access to testing and counselling, as well as appropriate mechanisms for referral and linkage (ideally with minimal travel) to treatment facilities, where non-judgmental and suitably trained staff are equipped with the necessary technology and regular, uninterrupted supply of the recommended range of drugs to be able to apply agreed national treatment protocols.

While adoption of the 2010 WHO treatment guideline resulted in a sudden, significant increase in the number of people needing ART, this was not matched by a similar increase in the number of those receiving it. Adoption of the 2013 guideline (13) will result in a similar increase in the number of people eligible for treatment and this needs to be anticipated and plans made accordingly.

### **MOROCCO: SCALING UP ANTIRETROVIRAL THERAPY**

In less than a decade, Morocco has increased the number of people receiving ART twenty-fold with coverage now among the highest in the region.

During 2012, 222 000 HIV tests were conducted, leading to a 30% increase in the number of people receiving ART. Through public and nongovernmental organization involvement, numerous HIV testing and counselling approaches are used, including fixed-site voluntary counselling and testing, provider-initiated testing across various

secondary and tertiary health services, mobile testing services and HIV testing campaigns. HIV care and treatment services are decentralised, bringing ART closer to people who are eligible. The country's 15 ART sites cover most of its regions.

The costs of ARVs have been lowered through tax exemptions, price negotiations with pharmaceutical companies, the use of generic products, and improved forecasting, procurement and supply systems. Domestic funding for ARV and related commodities has increased.

A national psychosocial support programme was initiated with the involvement of a nongovernmental organization to support ART patients with therapeutic education and various forms of social assistance. A medical assistance scheme that fully subsidises health care services for people living with HIV is being established. Community-support groups provide adherence support, and treatment retention of 90% at 12 months is high.

Early initiation of ART is crucial for success. This, in turn, depends upon people knowing their HIV status. Globally, the number of people who received HIV testing and counselling has increased, with the biggest percentage increase occurring in the WHO Eastern Mediterranean Region, where the number of those tested nearly doubled from the previous year (243 900 to 435 800), but needs to be substantially increased if those eligible for ART are to access it. In Sudan, it is estimated that only one in five people living with HIV are aware of their status.

While the median CD4 count when ART is initiated is rising, it is still too low, indicating late initiation of treatment. All countries in the region have some capacity to offer CD4 tests, mostly offered in static laboratories in private and public sectors. The tests are often performed in batches of 10-12 samples, and are costly. Access to these facilities, particularly by people living with HIV who inject drugs is often difficult because of their legal status, stigma and discrimination. Because of technical challenges and shortages of reagents, several countries (Somalia, Sudan and Yemen) struggle to ensure ready availability of CD4 tests. Experience beyond the region, in Pakistan, demonstrates the potential of newly available portable machines for efficient CD4 counting. These are based on low threshold technology, are easy to calibrate and maintain, and can operate by battery for up to eight hours. The portability of this new technology means that tests can be conducted in clients' homes, potentially making an important contribution to increasing access to ART by those who need it.

Tunisia has encountered challenges in terms of acquiring sufficient and consistent supplies of drugs. The concentration of treatment services in four university centres prompted a feasibility study to consider decentralisation of treatment and care for people living with HIV. Stigmatising and discriminatory attitudes towards people living with HIV are still all too common among health providers.

**THERE ARE STRUCTURAL CHANGES NEEDED BEYOND MERELY PROVIDING MORE TESTING AND TREATMENT SERVICE POINT TO ADDRESS THIS PROBLEM OF LOW ART COVERAGE**

## **ALGERIA: EXPANDING COVERAGE**

In Algeria, the criteria for initiating treatment have been changed in line with the 2013 WHO guidelines.<sup>25</sup> Efforts have been made to promote provider initiated testing and to support those who present late for treatment, as well as strengthening the capacity of HIV treatment facilities in terms of diagnostics, monitoring, resistance management and treatment education. This has been matched by increased cooperation with NGOs, including partnerships with groups of people living with HIV, in order to strengthen psychosocial and economic support for the most vulnerable.

By 2012, the number of people receiving antiretroviral therapy reached almost 3 400, compared to less than 2 900 the previous year. The National AIDS Programme has now adopted a new target of 80% for 2015. With the new guideline also being adopted, this will significantly increase the number of people receiving treatment in Algeria.

Djibouti has increased ARV treatment coverage from 19% of those eligible in 2010, to 36% in 2012, but still faces challenges in terms of delivering consistent quality of care and high rates of patients lost to follow-up. In Yemen, most of the cost of ART provision (covering more than two thirds of those receiving it) is supported by the Global Fund to Fight AIDS, TB and Malaria (GFATM), highlighting the need to increase government support for treatment.

In Bahrain, where the numbers of those receiving treatment are small (38), treatment is free (to nationals) and centralized in a single facility. Nonetheless, stock-outs of drugs occur and those who experience side effects are unlikely to be offered an alternative. Psychosocial support services are available only on request and counseling referrals are made to the psychiatric hospital, with the associated stigma. Neither palliative nor home-based care is available. People living with HIV identify persistent barriers to treatment in terms of accessibility (including fear of stigma and discrimination) and lack of confidentiality within the central hospital itself.

Access to quality healthcare services has been reported as a chronic challenge facing people living with HIV in Egypt: recent studies have revealed that 71% of healthcare providers have stigmatising attitudes towards PLHIV, even to the point of refusing to provide services.<sup>26</sup> This is reflected in the finding from the Stigma Index research<sup>27</sup> that 51% of men and women living with HIV have been denied access to services because of their HIV status. UNAIDS has taken action in response (see Target 8 below).

**PEOPLE LIVING WITH HIV SHOULD BE THE CORE OF ANY ACTION TO MEANINGFULLY INCREASE ART COVERAGE**

<sup>25</sup> From CD4 counts of  $\leq 350$  to  $\leq 500$ .

<sup>26</sup> The impact of AIDS- Related stigma on attitude, behaviour, and practices towards people living with HIV and AIDS in Egypt (2011), ESPSRH

<sup>27</sup> Unpublished

Iran has faced challenges in terms of increasing treatment coverage, at least in part, in response to increasing demand that resulted from improved case finding and changes to the threshold for initiating treatment. A wide range of drugs is available in Iran, enabling provision of a variety of three-drug combination regimens. Antiretroviral therapy prescriptions are free.

Adherence is important for people on ART and creative ways are being adopted to promote this. For example, in Somalia, treatment centre staff have been supplied with mobile phones to track patients and encourage adherence, while in Sudan self-help groups of people living with HIV provide peer support for adherence.

### ***SUDAN: PEOPLE LIVING WITH HIV***

With a view to increasing access to treatment and promoting adherence, Sudan has placed considerable emphasis on the establishment of associations of people living with HIV in all 15 states, each of which has a functional association office staffed by a full-time social worker.

A total of 1 080 PLHIV (30 members from each association) have been trained in counselling, treatment and adherence support. Capacity building for income generation has also been provided. Some people living with HIV also receive cash assistance for nutritional support.

Each local PLHIV association has a vehicle, photocopier and support for rent and operational costs. The associations are represented in all decision making fora (at Federal and State level) and coordinating bodies, including the National AIDS Council, GFATM Country Coordinating Mechanism and other key committees. The PLHIV association contributed significantly to the revision of draft legislation to protect the rights of PLHIV which is now awaiting final endorsement by Cabinet.

## 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015

Of the eleven countries that conducted and reported on their Mid-Term Review, nine identified this target as a priority (Jordan and Yemen being the exceptions), all indicated that tuberculosis (TB) is considered in the national strategic plan and eight considered themselves to be on target for achieving the goal. Somalia and Sudan both reported that the target would not be achieved and Tunisia could not confirm because of lack of necessary data.

In 2012, TB prevalence (including HIV and TB) in MENA region was estimated at 1 100 000<sup>28</sup> with 63% of cases (all forms) detected.<sup>29</sup> A total of 409 477 new cases were reported during 2012, together with 21 228 retreated cases. Of this total, the HIV status was known for 14% (58 498). Two thousand and twenty people (3.5%) with TB were diagnosed with HIV. Of these, 1 010 were provided with co-trimoxazole prevention therapy (69%) and 881 (48%) with ART. Just over fifteen thousand people living with HIV were screened for TB.

### ***DJIBOUTI: CHALLENGES OF TB IN A GENERALISED HIV EPIDEMIC***

Already affected by a generalised HIV epidemic, TB constitutes a major public health problem in Djibouti, with the world's second highest estimated prevalence of 7 700 (2012) and incidence of 5 300. HIV prevalence among TB patients (aged 15-49 years) was 13.6% in 2010, compared to 10.0% in 2009.<sup>30</sup> However, only 15% of HIV-positive new tuberculosis patients are receiving ART.<sup>31</sup>

Those vulnerable to TB are among the most marginalised and include refugees, nomads, prisoners, children, and people living with HIV, who also tend to have limited access to care. The current estimated case detection rate (76%) is a significant improvement from the 59% reported in 2005. Treatment success is estimated at 80%, with high rates of loss to follow up (16%) and the emergence of multi-drug resistance.

The country has developed a national co-infection prevention policy and reported an increase in the number of those co-infected who are accessing antiretroviral therapy. Weaknesses identified include lack of decentralisation of the TB programme, especially in rural areas and in refugee camps. The country also lacks capacity in term of monitoring resistant strains and promoting patient adherence and follow-up.

<sup>28</sup> Range: 730 000 – 1600 000

<sup>29</sup> Range: 56-71

<sup>30</sup> 13.7% in 2008, 14.3% in 2007 and 14.9 in 2006

<sup>31</sup> According to the UNAIDS Global Report 2013 p. 63.

## **STRENGTHENING TB/ HIV COLLABORATION IS A SMALL INVESTMENT PROVIDING LARGE DIVIDENDS**

In Somalia, the extent of the risk posed by TB and HIV co-infection is constrained by relatively low prevalence of HIV. Data from Hargeisa Group Hospital reported co-infection rates of 6.3% for 2007 and 7% in 2010. Over the course of the same period, the rate of co-infection was 5.6% among TB patients at the Hargeisa TB clinic, increasing to almost 15% in 2010. Twenty-four (of 66) TB centres are now providing HIV testing and counselling. During the reporting period, 87% of TB patients underwent HIV testing, with 5% found to be positive. Challenges encountered include shortages or erratic supplies of TB test kits, exacerbated by security challenges in South Central. Stigma and denial were reported to impact adversely upon overall demand and uptake of TB/HIV services.

Sudan reported marked improvement in TB/HIV collaborative activities during 2010-2011, with provider-initiated testing & counselling (PITC) adopted in more than 75 TB Management Units in an effort to increase HIV case finding. As a result, 2 245 TB/HIV patients were started on antiretroviral therapy (compared to 648 in 2009). Nonetheless, with less than 5% of estimated HIV-positive incident tuberculosis cases receiving HIV treatment in 2012, the country will not be expected to deliver this target.<sup>32</sup> Similarly, Yemen assesses its performance as unlikely to meet the target.

Since 2010, Algeria has initiated ART for people with HIV and TB, irrespective of CD4 count. In Libya, where national policy is to screen all TB cases for HIV, hepatitis B and C, the number of new TB cases appears to be declining. However, people living with HIV are not routinely screened for TB. In 2010 (most recent data available from the TB Control Programme), 792 new TB cases were detected, among which there were 189 cases of co-infection. In 2011, there were 731 new TB cases, of which 128 were co-infected. However, there are no monitoring data available for quality assessment. Moreover, current practice does not allow for simultaneous treatment with antiretroviral therapy and TB medication for those who are co-infected. In the event that a person living with HIV and receiving antiretroviral therapy is diagnosed with TB, HIV treatment is interrupted and re-started only when the six-month TB treatment is complete. It is not known if preventive TB treatment is provided to PLHIV.

In contrast, Jordan has reported only two cases of co-infection over the past ten years and by 2010 had met the WHO benchmark to reduce the global TB burden ahead of 2015. All people living with HIV are screened for TB. However, the conflict in Syria has led to a massive influx of refugees into Jordan. By March 2013, 46 TB cases (five of which were multi-drug resistant) had been reported among Syrian refugees in Jordan. This represents both a challenge to and burden upon Jordan's limited TB budget. Jordan is also home to a large number of migrant labourers, more than 120 000 may be illegal and thus undergoing neither mandatory TB screening (required of all foreigners residing or working in the country) nor treatment.

Morocco has integrated and expanded provision of HIV counseling and testing within TB facilities, with 5 827 people diagnosed with TB being tested for HIV (compared to 1 856 in 2011), representing

<sup>32</sup> According to the UNAIDS Global Report 2013

21% of those diagnosed with TB in 2012. Three quarters of those people living with HIV who are newly diagnosed with TB receive both antiretroviral therapy and TB treatment, compared to less than half in 2010. National guidelines on the management of HIV/TB co-infection are under preparation and will standardise diagnosis and treatment of co-infection. Training in diagnosis and management of coinfection has also been provided for managers and service providers. In addition to the low coverage of testing, challenges include late presentation for treatment by people diagnosed with TB and delays in introducing isoniazid prevention.



## **6. Close the global AIDS resource gap by 2015 and reach annual global investment of US\$ 22-24 billion in low- and middle-income countries**

MENA includes high income countries, such as Gulf Cooperation Council (GCC) member Countries that are not only able to fund their response to HIV, but also contribute to a regional solidarity plan to support low or lower-middle income countries in the region. In contrast, Somalia is entirely dependent upon external sources of financial support. Some countries, Iraq for example, fund the national response, but depend upon UN system partners for technical and strategic support. Governments in other countries, Egypt and Morocco, contribute substantially to the funding of their responses (at roughly 50% and 37% respectively) but also depend to a significant extent upon external sources, in particular the Global Fund to Fight AIDS, Tuberculosis and Malaria.

By 2011, the Global Fund had approved US\$ 1.4 billion<sup>33</sup> to tackle HIV, TB and malaria in the Middle East and North Africa Region and disbursed US\$ 784 million. While significant progress has been made, considerable unmet need persists for most interventions. Global Fund investments have also helped to strengthen health systems and develop supportive environments for programmes. The majority of grants in the Middle East and North Africa Region are performing well with none assessed as performing unacceptably.

Nonetheless, it is challenging to maintain commitment to funding responses to HIV in countries where it is not perceived to be a priority and continues to be associated with stigma and discrimination. Given such negative associations, the private sector – which might otherwise represent a potential source of support – may be disinclined to invest in responses to HIV. Funding challenges are exacerbated by political instability and economic crises.<sup>34</sup>

In Morocco, under Royal patronage, l'Association de Lutte Contre le Sida (ALCS) implements a biennial national campaign<sup>35</sup> to raise funds for HIV-related action. The national response has been integrated within the National Initiative for Human Development

<sup>33</sup> With more than US \$370 million for HIV.

<sup>34</sup> According to the Sudan MTR report, the secession of the south has led to a loss of 90% of domestic resources, including those allocated to HIV/AIDS.

<sup>35</sup> The most recent was in 2012.

(NIHD), which provides support to several NGO projects, while the Mohammed V Solidarity Foundation has funded construction and equipment of community centers for people who use drugs.

In some countries the challenge lies less in terms of the source of funding than in how available funding is allocated. In the United Arab Emirates, for instance, screening, for example of labour migrants, consumes 96.4% of all funds. Care and treatment are allocated 3.4% of the budget, with 0.2% devoted to prevention.

#### GFATM HIV-funding to MENA countries<sup>36</sup>

Country	Funding Round	Amount	Year
Algeria	3	6,945,289	2005
Djibouti	4	11,998,400	2005
	6	13,755,157	2007
Egypt	6	10,238,211	2008
Jordan	2	2,427,408	2003
	6	5,996,658	2007
Morocco	1	9,230,662	2003
	6	24,876,599	2007
	10	14,672,516	
Somalia	4	24,922,007	2005
	8	23,962,544	2010
Sudan	3	20,682,531	2005
	4	26,935,365	2006
	5	84,976,035	2007
	9	27,230,100	2010
	10	21,944,538	
Syria	10	1,723,169	
Tunisia	6	16,180,346	2007
Occupied Palestinian territory <sup>37</sup>	7	5,014,330	2008
Yemen	3	14,460,517	2005
Multi-country (MENAHR)	10		
<b>Total</b>		<b>3,209,492</b>	

<sup>36</sup> GFATM. Making a difference: Middle East and North Africa. Regional Results Report 2011.

<sup>37</sup> West Bank and Gaza in GFATM.

## **SOMALIA: CHALLENGES IN DIVERSIFYING FUNDING**

Somalia illustrates the challenges faced by a country that depends entirely upon external sources to fund its national HIV response, particularly when it is disproportionately dependent upon a single source.

With 15% of funding for Somalia's national response coming from UN partners, International NGOs and bilateral donors and 85% from the GFATM, changes in the availability of funds (i.e. cuts) or introduction of new funding modalities can have significant impact upon the country's ability to sustain its response, and can disrupt key activities including treatment.

By the end of 2012, only 30% of planned activities had been funded. Since many bilateral donors channel support through the Global Fund, this potentially reduces the range of available funding sources for countries attempting to diversify their funding portfolio. With other clear and pressing health needs, some donors prefer to provide broader support to the country's health sector, rather than focusing more narrowly upon HIV. However, HIV is not considered a priority within the health sector.

Strategies identified for addressing the current funding situation and establishing a more sustainable response include more concerted efforts to solicit private sector support (some work has already been undertaken in Somaliland) together with identification of non-traditional funding sources, such as through the diaspora. Concerted efforts also need to be made to integrate HIV within national development plans.

The 2008 National AIDS Spending Assessment (NASA) reported that a considerable proportion of HIV funding was taken up by human resources and a clear need was identified for a greater proportion of funds to be allocated directly to programme and key service delivery. This imbalance in terms of allocation of resources also highlighted the need for coordination and harmonisation (for example in relation to health worker incentives) across the range of agencies and projects involved in the country's health sector.

In its MTR report, the country identified the need to re-align its national response to today's funding realities, promoting a cost-conscious culture to ensure that the largest proportion of resources go to programme implementation and service delivery. Capacity also needs to be built among local organisations, both in relation to fund-raising and financial management.

## 7. Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV

According to the World Bank (14), over the course of the last two decades, the Middle East and North Africa (MENA) region has successfully closed several critical gender gaps, in particular, ensuring equal access for girls and boys to education and healthcare.

Nonetheless, only one in four women of working age are employed or looking for work. Many find it difficult to secure employment, with unemployment rates as high as 50 percent. Women also face considerable constraints, reflected in legal barriers and gender norms, in relation to decision-making, choice, mobility and opportunities.<sup>38</sup> Young, educated women are calling for greater access to economic opportunities and a more equal, inclusive society.

Women account for 44% of adults living with HIV in the region, their risk primarily a consequence of the behaviour of their partners. However, with most of the HIV epidemics in the region (apart from Djibouti and Somalia) concentrated among key populations at higher risk, insufficient attention has been paid to the issue of intimate partner transmission of HIV.

### **MENA-ROSA: WOMEN LIVING WITH HIV SPEAK OUT**

A recent UNAIDS report concluded that HIV-related stigma and discrimination are greater for women because of the social and cultural expectations concerning women's behaviour, together with the association in the popular imagination between HIV and unlawful or prohibited practices, including sex work and drug use.

MENA-Rosa was launched in 2010 by a group of women living with HIV who established a regional organisation through which women and girls living with HIV would be able to articulate and advocate for their particular needs and concerns. In so doing, women living with HIV are challenging the stigma and prejudice that have silenced them for too long.

<sup>38</sup> The 2013 Global Gender Gap Report produced by the World Economic Forum quantifies the scale of gender disparities and monitors change over time. Out of 136 countries ranked, 14 MENA countries lie between 109-136th positions.

During 2011-2012, MENA-Rosa conducted research on the experiences of women and girls across 10 countries, and reported that common challenges include access to treatment, care and sexual/reproductive health services, as well as persistent stigma and frequent violations of human rights. These are compounded by women's economic dependence, low literacy and exposure to sexual coercion and violence that both increase vulnerability to HIV while simultaneously impeding socioeconomic, cultural and political participation.

MENA-Rosa promotes leadership by and empowerment of women infected and affected by the HIV, both within their communities through local and national campaigns, but also at regional and global levels through representation, participation and advocacy in relevant fora.

*"MENA-Rosa is a group of women who works for the rights of women for dignity and love. The name of the network originates from MENA [Middle East and North Africa], and Rosa as the first black woman on a bus in the US who refused to give up her seat to a white man, starting the civil rights [movement] for black Americans. Rosa is also a feminine symbol. Our friend Zouheira started this process in Algeria seven years ago, as the first woman to raise her voice. She demonstrated to us, by her courageous actions, that we are able to have a group and to raise our voices as well. Our objectives are numerous, as we find that the particular needs of women are, in fact, different from men's, i.e., sexual and reproductive health, children and families. The outcome would be to impact the health of the woman and her family in the MENA region"*<sup>39</sup>

Women living with HIV are more likely than their male counterparts to face severe stigma and discrimination. It is therefore likely that any proposed action towards criminalisation of HIV transmission will disproportionately affect women.

A ten-country survey of stigma experienced by women living with HIV in the region (15) found that one third had been verbally insulted, harassed and or threatened more than once over the last 12 months. Almost one in five had been physically assaulted in the same period, and for nearly 70%, the assailant was a member of their own households.

The vulnerability of girls and women to HIV is a reflection of deeper, gendered inequalities, many of which are embedded in law, culture and traditional practices. The latter includes child marriage<sup>40</sup>, which is most common in the region's poorest countries, Yemen, Sudan and Somalia. Egypt is home to the largest number of child brides in the region and in Iraq, 25% of girls marry before age 18, and 6% before age 15. Female genital mutilation continues in Djibouti, Egypt, Iraq, Sudan and Yemen.<sup>41</sup>

**ADDRESSING  
INTIMATE PARTNER  
HIV TRANSMISSION  
IS ESSENTIAL IN THE  
REGION AND CANNOT  
BE REACHED WITHOUT  
ADDRESSING GENDER-  
BASED VIOLENCE**

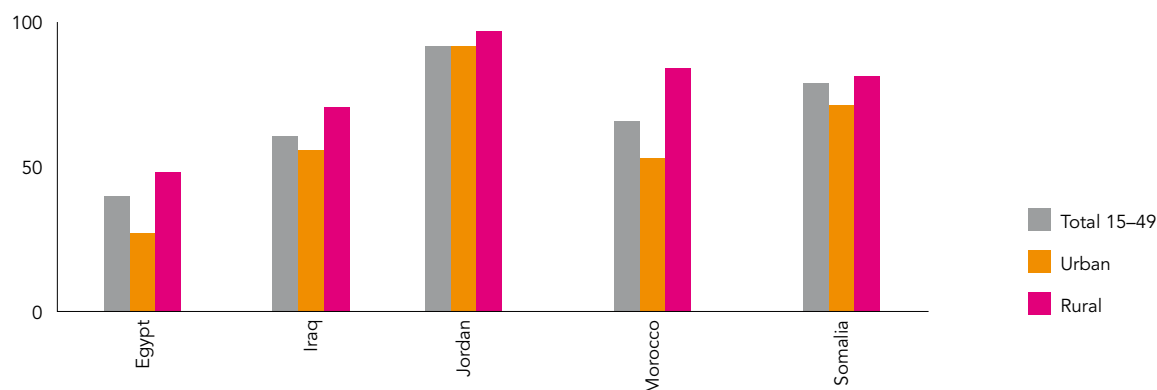
<sup>39</sup> MENARosa Report. Standing up.Speaking out.

<sup>40</sup> Roudi-Fahimi F, Ibrahim S. Ending child marriage in the Arab region. Population Reference Bureau. Washington, May 2013. <http://www.prb.org/pdf13/child-marriage-arab-region.pdf>

<sup>41</sup> Female genital mutilation/cutting: a statistical overview and exploration of the dynamics of change. UNICEF, 2013. [http://www.unicef.gr/pdfs/FGM\\_Report\\_July13.pdf](http://www.unicef.gr/pdfs/FGM_Report_July13.pdf)

In MENA, gender-based violence is high, with lifetime prevalence of intimate partner violence estimated between 30-40%.<sup>42</sup> This is based on data review in Egypt, Iran, Iraq, Jordan and Palestine. Tradition and cultural norms mediate women's experience of violence as reflected in the table below:

## PERCENTAGE OF WOMEN WHO THINK THAT A HUSBAND IS JUSTIFIED IN BEATING HIS WIFE UNDER CERTAIN CIRCUMSTANCES



Source: UNICEF Global Databases

A 2009 study<sup>43</sup> of domestic partner violence among married Bahraini women reported that almost half had experienced violence by a current or previous spouse. The most commonly reported abusive behaviors were demanding or forced sex, shouting at or threatening children, and damaging property. Some reported being threatened with death, attempted burning, strangling or drowning, choking and injury with a weapon.

Despite the scale of the problem, the links between different forms of gender-based violence and HIV within the region are relatively unexplored and responses to HIV and gender based violence need to be better integrated.

Some countries are taking action to address gender-based inequality and abuse. In Somalia, conflict, war and displacement have all substantially increased the vulnerability of women and girls to sexual and gender based violence and stigma. The *Community Conversations* methodology is being used to address both HIV and sexual and gender based violence. In Somaliland, the Ministry of Social and Family Affairs has endorsed a law that protects women from any forms of violence, including sexual assault and female genital cutting/mutilation.<sup>44</sup> Establishing security and protection from violence are critical steps if women's participation in civil society is to be promoted and realised.

<sup>42</sup> WHO Global and regional estimates of violence against women, Prevalence and health effects of intimate partner violence and non-partner sexual violence (2013)

<sup>43</sup> See: Kingdom of Bahrain UNGASS Country Progress Report 2012

<sup>44</sup> Reported in Somalia's 2012 National Commitments and Policy Instruments Report.

Algeria has institutionalised the empowerment of women living with HIV as part of a national system of access to income, driven by several governmental sectors in partnership with people living with HIV organisations.

Djibouti has introduced a National Gender Policy which includes a focus on HIV. Both a National Gender and HIV Assessment (using the UNAIDS Gender Assessment tool) and a mid-term review of the UNAIDS Agenda for girls and women have been conducted. Efforts are focused on integrating gender within the operational plans of key sectors, including health, education and justice. Particular emphasis is given to increasing enrollment and retention of girls in the education system.

With support from UNAIDS and partners, Morocco has been addressing gender-based violence for several years. Key activities have included prevalence studies of violence, reviews of relevant legislation, research on women's access to quality services and empowerment structures, together with campaigns to raise awareness and build support to address gender-based violence.

Women have played a significant role in movements for social and political action throughout the region. What is less clear is the extent to which the changes that result will lead either to the eradication of gendered inequalities or to their consolidation.

**GRASS-ROOT WOMEN ORGANIZATION ARE PIVOTAL IN ADDRESSING GENDER INEQUALITIES AT COMMUNITY LEVEL**

## **8. Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms**

Stigma and discrimination are still all too commonly experienced by people living with HIV throughout the region. They run deep and are manifested in exclusion, judgement and blame that potentially permeate every aspect of life. Moreover, they encourage denial, complacency and inaction, and as such, constitute significant barriers to achieving the ten targets. However, with most of the HIV epidemics in the region (apart from Djibouti and Somalia) concentrated among key populations at higher risk, insufficient attention has been paid to the issue of intimate partner transmission of HIV.

### ***MEASURING STIGMA: FINDINGS FROM EGYPT<sup>45</sup>, SUDAN AND YEMEN(16,17)***

Using the Stigma Index questionnaire, Egypt, Somalia and Sudan have commissioned studies to investigate the nature and scale of stigma in their countries.

In Sudan, where almost one half of all women living with HIV are heading households, a variety of forms of stigma and discrimination are encountered, including substantial self stigma. Similarly, in Egypt the level of self-stigma is significant and concepts of 'innocence' and 'guilt' continue to dominate popular perceptions of HIV.

In Yemen, researchers reported that all those interviewed, male and female, had experienced stigma, with one fifth excluded from social activities and 15% excluded from communal sleeping and eating with family members. Almost one fifth reported physical harassment or assault, with men significantly more likely to be victimised in this way.

<sup>45</sup> So far unpublished.



Levels of discrimination are high. A third of respondents reported having to change residence or being unable to rent accommodation during the last 12 months. As in the other countries, levels of self-stigma are high and few are familiar with their rights and entitlements. Despite a range of available options for seeking redress for discrimination, one third of respondents described feeling intimidated or scared and a similar proportion reported little or no confidence in actions taken. Respondents also felt unable to influence policies or programmes addressing HIV.

Confidentiality emerged as a critical issue, with half of respondents unaware whether or not their records were kept confidential. One third reported that a health professional had disclosed their HIV status without consent. More than a quarter experienced their HIV status being disclosed to a spouse without consent, more commonly among women than men (35% and 9% respectively).

Nonetheless, half of the respondents described disclosing their HIV status as an empowering experience and at least half of all spouses and families were found to be supportive.

People living with HIV in the region also report being stigmatised and refused access to services by healthcare providers (18). Anticipation of such responses can be powerful disincentives to seeking testing and treatment.

Throughout the region, the behaviours associated with HIV transmission are culturally prohibited and (to varying extents) illegal, with laws prohibiting drug use, commercial sex and sex between men. Five of the seven countries in the world where homosexual acts are punishable by death are in the MENA region (Iran, Saudi Arabia, Sudan, some parts of Somalia and Yemen).<sup>46</sup> Drug use and possession for personal use are both criminalised in most countries of the region.<sup>47</sup> Tunisia is the only country in the region where some forms of commercial sex are legal, and condom distribution is permitted in regulated establishments. In addition to further fuelling stigma and discrimination against key populations, these laws are often used as justifications for illegal police conduct, including torture.<sup>48</sup>

Responses to stigma and discrimination vary across the region, but typically include provision of legal services, introduction of legislation or policy to protect the rights and dignity of people living with HIV, public campaigns and social communication interventions to tackle prejudice and raise the profile of people living with HIV. Other responses include awareness training for professionals and education in schools and colleges.<sup>49</sup>

**IF THERE IS ONE SINGLE GAME-CHANGER FOR THE REGION TO BE ON TRACK OF REACHING TO HLM TARGETS, IT IS ADDRESSING STIGMA AND DISCRIMINATION**

<sup>46</sup> ILGA State-sponsored homophobia: A world survey of laws prohibiting same sex activity between consenting adults. May 2013

<sup>47</sup> Al-Shazly, F. (2011), How to Best Reach HIV-Vulnerable Groups in Arab States: Drug Abuse in International Laws and Arabic Legislations. Working Paper prepared for the Middle East and North Africa Regional Consultation of the Global Commission on HIV and the Law, 27-29 July 2011.

<sup>48</sup> See for example: Human Rights Watch report on Lebanon, June 26, 2013. <http://www.hrw.org/news/2013/06/26/lebanon-police-torturing-vulnerable-people>

<sup>49</sup> In Algeria, for example, students are taught the importance of concepts such as mutual respect and tolerance. In Egypt, in response to high reported levels of health providers refusing services to people living with HIV, a project on HIV awareness has targeted university staff, medical, nursing and paramedical staff and students in order to promote stigma and discrimination free services.

## **MOROCCO: A NATIONAL STRATEGY TO ADDRESS HIV-RELATED HUMAN RIGHTS, 2013-2016**

Tackling stigma and discrimination, for example through national social communication campaigns, has been a key component of the Moroccan national HIV programme since 2004.

With support from GFATM and UNAIDS, following review of the human rights component of the national strategic plan, a partnership with the National Council for Human Rights (CNDH) has been initiated and an integrated strategy on human rights is now incorporated within the 2012-2016 national plan. This is intended to establish an enabling environment for implementation of interventions, including prevention among high-risk populations, access to HIV care and support for people living with HIV.

This represents the country's first specific strategy on HIV-related human rights, stigma and discrimination and partnership with CNDH, NGOs and other institutions engaged in human rights. A national committee on human rights will be established to direct the implementation of the strategy. In order to promote relevance to local conditions, regional-level plans will be prepared.

Another initiative led by the NGO ALCS is focusing on addressing the contradiction between national policies and laws that exists in relation to drug use in Morocco. Drug use is criminalised and the law strictly enforced, while the national strategy for harm reduction (HR) 2008-2011 considers people who use drugs as in need of care rather than criminalisation.

A study of 300 people who use drugs was undertaken in 3 cities and reported that 84% had been to prison, often on multiple occasions. All respondents reported violations of rights by police (e.g. illegal detention) and three quarters by the health system, such as exclusion from emergency hospital facilities. Violations of rights also occur within the family and household.

ALCS will work in collaboration with organisations involved in harm reduction and human rights (including CNDH) and engage with officials of the prison administration and Ministry of Justice to present the case for more consistent, appropriate legal responses to drug use. Efforts will also be made with the Ministry of Health to advocate for the introduction of methadone in prisons.

In several countries, support has been provided to people living with HIV to improve their living conditions, facilitate access to care, and form self-help groups and organisations to advocate for their own needs and represent their constituencies in decision-making fora, including the Country Coordinating Mechanism of the GFATM. These kinds of self-help and advocacy groups are important not only in themselves but also more broadly by helping people living with HIV to become agents of change.

On the other hand, in Kuwait, while the rights of people living with HIV are protected by law and policies, the experience of stigma and discrimination (manifested for example by their exclusion from employment in clinical health care, the military and oil business) discourages them from organising and taking the risk of public visibility.

In recognition of the importance of religion in everyday life throughout many of the region's countries, religious leaders have also been acknowledged as powerful advocates of positive changes in attitudes and behaviour. The stigma index research in Egypt highlighted the value of support provided by religious leaders to individuals. More encouragement may be necessary for religious leaders to speak out publicly against stigma and discrimination.

In addition to community mobilisation to address stigma, some countries, such as Jordan (see box below) have focused specifically on protecting the rights of people living with HIV in the workplace.

**RELIGIOUS LEADERS  
ARE ONE OF THE MOST  
IMPORTANT PARTNERS  
IN ADDRESSING STIGMA  
AND DISCRIMINATION  
AT ALL LEVELS**

### **JORDAN: NATIONAL POLICY ON HIV IN THE WORKPLACE<sup>50</sup>**

In Jordan, a recent study reviewing the conformity of legislation and policies with international standards relating to HIV in the workplace, revealed that while the law does not explicitly discriminate against PLHIV, significant discrepancies exist. These include requirements pertaining to mandatory HIV testing for blood donors, individuals working in the public medical sector and private hospitals, all army employees returning from United Nations peace keeping missions, and individuals admitted to public treatment and rehabilitation centres for substance abuse. Moreover, employees working in the public sector are also expected to undergo HIV testing before recruitment.

In response, Jordan has become the first Arab country to adopt a national policy targeting HIV in the workplace since the adoption of the international labour standard on HIV and the world of work in 2010. Under the patronage of the Ministry of Labour and in collaboration with the Ministries of Health and Tourism, the General Federation of Jordanian Trade Unions and the Chamber of Industry, the *National Tripartite Policy on HIV/AIDS and the World of Work* marks an important step towards safeguarding the rights of workers living with HIV and preventing the spread of HIV. As part of Jordan's National Strategic Plan on HIV and AIDS 2012-2016, the new policy spells out workplace issues, protects against employment discrimination, prevents the occupational risk of HIV transmission and ensures the participation of people living with HIV in the policy-making process.

<sup>50</sup> Hashemite Kingdom of Jordan. National Tripartite Policy on HIV and AIDS and the World of Work, 2013.

Algeria, Djibouti, Saudi Arabia and Yemen have introduced protective laws and policies. Tunisia has established an Observatory for Human Rights with a view to monitoring and addressing human rights violations with key populations and proposing appropriate changes to existing laws.

In Algeria, Egypt, Tunisia, Lebanon, Jordan and Morocco, NGOs are collaborating with lawyers to increase access to justice for people living with HIV and members of key populations. Through a review of experiences in the region (19), a range of promising practices were documented<sup>51</sup>, including: services for people living with HIV or members of key affected populations, examples of creative litigation to address HIV-related issues, informal dispute resolution (such as mediation) that does not involve courts, and negotiations with police or prison authorities to support public health approaches to HIV. These services need to be integrated and supported within national HIV responses.

**INCREASING THE  
LEGAL LITERACY OF KEY  
POPULATIONS AND  
PLHIV IS INTEGRAL TO  
ANY PROGRAMME WITH  
THESE POPULATIONS**

### **TUNISIA: PROVIDING HIV-RELATED LEGAL SERVICES AND LEGAL LITERACY PROGRAMMES FOR PEOPLE LIVING WITH HIV**

The Association of Resistance to Sexually Transmitted Diseases and AIDS (ATL)

provides support and legal guidance to people living with HIV. A dedicated lawyer is employed with responsibility for defending their rights of those living with and affected by HIV.

The Association offers informal dispute resolution as well as free legal representation in court. Legal guidance is provided on discrimination, violations of privacy and breaches of confidentiality, violence, custody and alimony disputes. ATL also responds to illegal police activities and defends the rights of prisoners living with HIV.

In 2012, with funding from the International Development Law Organization, the Association provided the country's first training course on legal issues for people living with HIV and members of key populations.

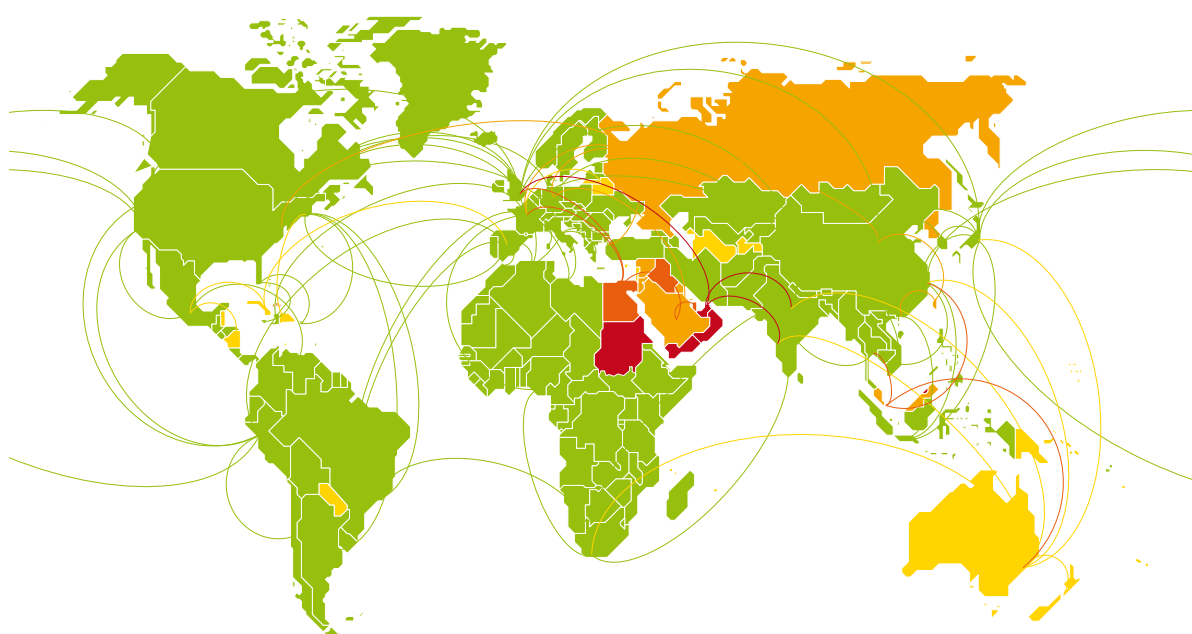
Challenges include insufficient funding and human resources to scale up service provision. To this end, efforts are being made to build the capacity and expand the pool of legal specialists who cooperate with the Association, as well as promoting HIV-related legal education for judges and lawyers.

<sup>51</sup> This study will supplement the 2012 Arabic version of the Toolkit on scaling up HIV-related legal services (IDLO, UNAIDS, UNDP, 2009).

# 9. Eliminate HIV-related restrictions on entry, stay and residence

The clear global trend is towards repeal of HIV-related travel restrictions, with the number of countries and territories maintaining such regulations and policies declining from 96 in 2000 to 41 as of October 2013.<sup>52</sup> Unfortunately there has been no recent progress to report in MENA, where most of the countries still retain these unsound and counterproductive policies.

## THE WORLD MAP OF HIV-RELATED TRAVEL RESTRICTION



<sup>53</sup> Information provided by UNAIDS website, 2013.

## UNAIDS INFOGRAPHIC ON HIV RELATED TRAVEL RESTRICTIONS *WELCOME (NOT)*<sup>53,54</sup>

In Bahrain, Egypt, Iraq, Jordan, Kuwait, Oman, Qatar, Saudi Arabia, Sudan, Syria, the United Arab Emirates and Yemen, the law allows for deportation of any non-national discovered to be living with HIV. Of the world's five countries that impose a complete ban on entry and stay of people living with HIV, four are in the MENA region: Sudan, Oman, UAE and Yemen.

HIV-related restrictions on entry, stay and residence are neither warranted by public health considerations, nor consistent with the rights-based strategies that experience has shown are most effective in responding to HIV. They are also fundamentally incompatible with the demands of the global economy.<sup>55</sup> Being refused entry or facing deportation on the sole basis of HIV status are violations of human rights. Such policies reinforce stigma and discrimination and encourage the perception that HIV is a problem of 'outsiders'.

Investment in mass testing<sup>56</sup> not only diverts resources from much needed prevention and treatment programmes for key populations, it represents a significant, missed financial opportunity, since evidence clearly demonstrates that treatment contributes to prevention, making investment in prevention and treatment doubly effective and prudent.

Restrictions in the MENA region not only affect those who migrate from other regions, but also impact adversely upon people living with HIV within the region. Reporting the findings of its mid-term review, Jordan highlights the practice of imposing national restrictions on migrants from neighbouring countries (notably Egypt, Iraq and Syria), as well as the effect of mandatory HIV screening policies on the estimated one million Jordanians working abroad, mostly in GCC countries.

UNAIDS and partners are working with the League of Arab States to support more rapid progress towards reviewing and repealing HIV-related travel restrictions. On a positive note, Egypt and Jordan have indicated in their Mid Term Review reports that lifting these restrictions is a priority, with Egypt on track to achieve this by 2015.

***THERE IS HARDLY  
ANY EVIDENCE  
SUPPORTING PUBLIC  
HEALTH BENEFITS OF  
HIV-RELATED TRAVEL  
RESTRICTIONS AND  
THEIR NEGATIVE  
IMPACTS ON HIV  
RESOURCES IS  
ENORMOUS***

<sup>53</sup> Accessed 15 November 2013: <http://www.unaids.org/en/resources/infographics/20120514travel/>

<sup>54</sup> Note: there is conflicting information for some of the MENA countries, in particular Iran, Libya, Somalia and Tunisia in relation to HIV-related travel restrictions.

<sup>55</sup> Given that Gulf Cooperation Council (GCC) countries are major destinations for migrant workers.

<sup>56</sup> For example, of migrant workers.

# 10. Strengthen HIV Integration

With growing pressure on available resources, both nationally and globally, emphasis is increasingly placed upon the need for sustainable responses to HIV. This requires streamlining and integration of HIV within broader health systems, other sectors and development efforts.

Integration needs to occur at three distinct but mutually complimentary levels: *service delivery* (e.g. incorporation of HIV within school curricula, integration of HIV within sexual and reproductive health services, integration of HIV and TB services and of PMTCT within antenatal care); *management and policy and planning*.

In Morocco, for example, integrating HIV within public health services has expanded the number of people receiving HIV counselling and testing from 46 000 in 2010 to 222 620 people in 2012. Coverage of services for HIV-positive pregnant women to prevent mother-to-child HIV transmission also rose from 29% in 2010 to 48% in 2012.

Djibouti has mainstreamed HIV within the national Health Development Plan 2013-2017 and integrated HIV within Presidential priorities for 2011-2016. Action has also been taken to promote integration of HIV in the social development initiative 2013-2017. However, challenges identified include enduring vertical, centralised vision of sectoral programmes on HIV, limited allocation of technical and financial resources to support integration in relevant development plans, and the need for broader ownership, including by women, beyond the health sector.

Somalia, has reported some success in relation to integrating HIV within the country's emergency response. The joint UN team participates in the protection and health clusters of the Interagency Standing Committee (IASC) which is the mechanism through which the emergency response is coordinated in the country. However, more generally, integration of HIV in different sectors within Somalia lacks support and guidance from respective line ministries with the result that responses continue to be uncoordinated. Also, GFATM funding, the country's most substantial source of HIV support, is focused upon specific targeted interventions and no other funds are available to support integration of HIV in other relevant sectors. Remedial actions proposed to foster integration include: institutional strengthening of the AIDS commissions and intensifying engagement of key line ministries, expanding the range of stakeholders to engage with private sector, research and academic institutions. Also continued support of integration of HIV within recovery efforts is critical.

**STAINABILITY OF HIV SERVICES IN THE REGION DEPENDS ON HOW THEY BECOME INTEGRATED INTO BROADER HEALTH AND DEVELOPMENT SECTORS**

# REGIONAL INITIATIVES AND NETWORKS

## REGIONAL INITIATIVES

### *REGIONAL CONSENSUS STATEMENTS, COMMITMENTS AND STRATEGIES*

- June 2010 Dubai Consensus Statement
- MENA Regional Health Sector Strategy 2011–2015
- September 2010 Djibouti Declaration of Commitment and Call for Action
- April 2011 Riyadh Charter on Strengthening HIV Response in the Gulf Cooperation Council Countries.
- October 2011 UNAIDS 5-year strategy for Enhanced response to the HIV epidemic in the Middle East and North Africa through stronger partnerships with civil society
- Towards the elimination of mother-to-child transmission of HIV: Conceptual framework for the Middle East and North Africa Region
- Accelerating HIV treatment in the WHO Eastern Mediterranean and UNAIDS Middle East and North Africa regions
- Arab AIDS Initiative

At the 2012 37<sup>th</sup> Session of the Council of Arab Ministers of Health in Jordan, the Council of the Arab Ministers of Health, representing the member countries of the League of Arab States, officially launched the *Arab AIDS Initiative* intended to accelerate national and regional responses to HIV to achieve the ten targets. Central to this initiative are the development of a *Unified Arab AIDS Strategy on HIV* and AIDS and the constitution of a technical committee that will follow up the development and implementation of the strategy. The strategy will assist countries in deepening understanding of their epidemics, create stronger political commitment and higher investment on HIV and contribute to streamlining HIV within the broader development agenda. The technical committee will review the global targets of the Political Declaration and develop a regional roadmap to accomplish them by 2015.



In 2012, UNAIDS published a practical guide (20) on HIV and outreach programmes with men who have sex with men in the Middle East and North Africa. The guide is a response to the concentrated epidemics that exist among this population within the region. It highlights and addresses key challenges involved in reaching and working with men who have sex with men.

The *People Living with HIV Stigma Index* was developed by and for PLHIV to measure and monitor the experience of HIV-related stigma. Through use of the index, advocates can translate anecdotal evidence into measurable data to track changes, support advocacy and inform and improve policies and programmes. The Stigma Index was developed by International Planned Parenthood Federation (IPPF), the Global Network of People Living with HIV (GNP+), International Community of Women Living with HIV (ICW) and United Nations Joint Programme on AIDS (UNAIDS).

## REGIONAL NETWORKS

There are several HIV-focused regional networks within MENA. These include the Regional Arab Network against AIDS (RANAA), the Middle East and North Africa Harm Reduction Association (MENAHRRA) and MENA-Rosa for women living with HIV.<sup>57</sup> UNAIDS has supported a number of these networks, together with other initiatives across or within the region.

The *Regional Arab Network against AIDS* (RANAA) was established in December 2002, representing 51 Arab civil society organizations (including associations of people living with HIV) from 14 countries.<sup>58</sup> RANAA also includes regional and international organizations such as the Arab Scout Bureau and International Federation of Red Cross and Red Crescent Societies. RANAA is committed to promoting the involvement of civil society organizations (CSOs), people living with HIV groups and key populations at higher risk in responses to HIV, as well as in planning, implementation and decision making of many initiatives. In 2010, with the support of UNAIDS and USAID, RANAA convened the 3rd regional meeting of PLHIV in Lebanon. During 2011, RANAA organised exchange visits among associations of people living with HIV in Lebanon, Tunisia and Egypt. RANAA continues to strengthen capacity of PLHIV associations to be meaningfully engaged in the national response within their respective countries. During its 4<sup>th</sup> General Assembly in 2012, seven people living with HIV were elected to the RANAA board (out of 14 places), indicating a new level of involvement of people living with HIV in the regional response.

The *Middle East and North Africa Harm Reduction Association* (MENAHRRA) was launched in 2007, funded by the Drosos Foundation, as a collaborative initiative by the World Health Organisation and Harm Reduction International (HRI, formerly IHRA) to prolong and improve the quality of life of people who inject drugs in the region. It covers 20 countries and has a secretariat based in Beirut, together with three knowledge hubs in Iran, Lebanon and Morocco.

**THE ARAB AIDS STRATEGY PROVIDES A UNIQUE OPPORTUNITY TO PUT HIV ON THE DEVELOPMENT AGENDA IN THIS REGION**

**THE REGIONAL NETWORKS OF CIVIL SOCIETY ORGANIZATIONS HAS BEEN PIVOTAL IN MAKING THE VOICE OF CIVIL SOCIETY HEARD, THEY HAVE TO EXPAND AND STRENGTHEN THEIR ROLE IN ALL ASPECTS OF HIV POLICY AND RESPONSE IN THE REGION**

<sup>57</sup> See the box in section 7

<sup>58</sup> Algeria, Bahrain, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Saudi Arabia, Syria, Tunisia and Yemen

The organisation is reshaping the regional agenda on harm reduction by establishing sustainable structures to deliver capacity building, advocacy and information resources on harm reduction, facilitating information sharing and mutual support, and providing support to civil society organizations to initiate or expand harm reduction activities. Through these key activities, MENAHRA is able to identify and support emerging model programmes capable of demonstrating the feasibility and effectiveness of harm reduction activities in the MENA region.

MENAHRA has trained CSOs in Algeria, Egypt, Iran and Tunisia to provide needle and syringe distribution programmes and VCT (on-site or by referral). CSOs report that their activities have contributed to a growth in harm reduction service provision beyond these individual projects.

# REFERENCES

## EXECUTIVE SUMMARY

1. Global update on HIV treatment 2013: results, impact and opportunities. Geneva: World Health Organisation, 2013.

## THE STATE OF THE HIV EPIDEMICS IN THE REGION

2. Alipour A, Haghdoost AA, Sajadi L, Zolala F. HIV prevalence and related risk behaviours among female partners of male injecting drugs users in Iran: results of a bio-behavioural survey, 2010 *Sex Transm Infect* published online September 24, 2013. doi:10.1136/sextrans-2013-051201.

## REGIONAL SOCIO-POLITICAL LANDSCAPE

3. Palestinian National AIDS Committee. Exploring the dynamics and vulnerabilities of HIV transmission amongst sex workers in the Palestinian context. UN Women, 2011.
4. Weine SM, Kashuba AB. Labor Migration and HIV: a systematic review of the literature. *AIDS Behav.* 2012 Aug;16(6):1605-21. doi: 10.1007/s10461-012-0183-4.
5. Nada KH, Suliman el DA. Violence, abuse, alcohol and drug use, and sexual behaviors in street children of Greater Cairo and Alexandria, Egypt. *AIDS.* 2010 Jul;24 Suppl 2: S39-44. doi:10.1097/01.aids.0000386732.02425.d1.

## REDUCE SEXUAL TRANSMISSION OF HIV BY 50% BY 2015

6. Bozicevic I, Riedner G, Calleja J, HIV surveillance in MENA: recent developments and results. *Sex Transm Infect* published online February 23, 2013. doi:10.1136/sextrans-2012-050849.
7. Sub-Saharan Migrants in an irregular administrative situation in Morocco. HIV Integrated Behavioral and Biological Surveillance Surveys. Morocco National HIV/AIDS Programme, 2013.
8. Valadez JJ, Berendes S, Jeffery C, Thomson J, Ben Othman H, Danon L, et al. Filling the knowledge gap: measuring HIV prevalence and risk among men who have sex with men and female sex workers in Tripoli, Libya. *PLoS ONE* 8(6): e66701. doi:10.1371/journal.pone.0066701

## HALVE THE TRANSMISSION OF HIV AMONG PEOPLE WHO INJECT DRUGS BY 2015

9. Mirzoyan, L. New evidence on the HIV epidemic in Libya: why countries must implement prevention programmes among people who inject drugs. *J Acquir Immune Defic Syndr.* 2013 Apr 15;62(5):577-83. doi: 10.1097/QAI.0b013e318284714a.

10. Ziglam, h et al. Prevalence of antibodies to human immunodeficiency virus, hepatitis B, and hepatitis C in prisoners in Libya. *Libyan J Med* 2012, 7: 19713 <http://dx.doi.org/10.3402/ljm.v7i0.19713>.

### **ELIMINATE HIV INFECTIONS AMONG CHILDREN AND REDUCE MATERNAL DEATHS**

11. Global update on HIV treatment 2013: results, impact and opportunities. Geneva: World Health Organisation, 2013.
12. Towards the elimination of mother-to-child transmission of HIV: conceptual framework for the Middle East and North Africa. Regional Office for the Eastern Mediterranean: World Health Organization, 2012.

### **REACH 15 MILLION PEOPLE LIVING WITH HIV WITH LIFESAVING ANTIRETROVIRAL TREATMENT BY 2015**

13. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach. Geneva: World Health Organisation, June 2013.

### **ELIMINATE GENDER INEQUALITIES AND GENDER-BASED ABUSE AND VIOLENCE AND INCREASE THE CAPACITY OF WOMEN AND GIRLS TO PROTECT THEMSELVES FROM HIV**

14. Opening Doors: gender equality and development in the Middle East and North Africa. Washington: World Bank, 2013.
15. Setayesh H., et al. (on behalf of MENA-Rosa Group of Women Living with HIV). HIV-related stigma perceived by women living with HIV in the Middle East and North Africa; a multi-country cross sectional survey. 2012.

### **ELIMINATE HIV-RELATED STIGMA, DISCRIMINATION, PUNITIVE LAWS AND PRACTICES**

16. Sudan Family Planning Association. The People living with HIV Stigma Index in Sudan (undated).
17. UNAIDS. The Yemen Stigma Index Report. October 2012.
18. Bernard BL, Hermez J. HIV stigma and discrimination in health care settings in the Eastern Mediterranean Region. Paper presented: November 2, 2011, at the symposium "Family, the Millennium Development Goals and AIDS in the Middle East and North Africa region: linkages, challenges and opportunities," in Doha, Qatar, hosted by the Doha International Institute for Family Studies and Development, UNAIDS, and UNICEF.
19. International Development Law Organization/UNAIDS, Report on best practices of HIV-related legal services in the MENA region. Rome: IDLO, 2012.

### **REGIONAL INITIATIVES**

20. HIV and outreach programmes with men who have sex with men in the Middle East and North Africa: from a process of raising awareness to a process of commitment. UNAIDS, 2012.

# COUNTRY SNAPSHOTS

# ALGERIA



## COUNTRY OVERVIEW

Human Development Index	Medium	GNI (per capita - PPP)	7 418 US\$
Life expectancy	73.4	Population	39 200 000

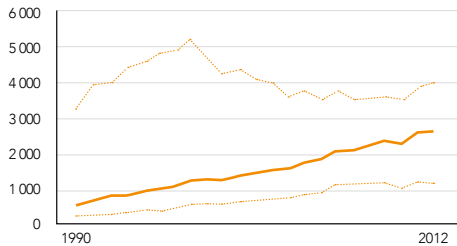
## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

Existence of a national strategic plan  Yes  No

**2012** NSP DURATION **2015**

## EPIDEMIOLOGY FACTS

### • Estimated number of new HIV infection 1990 - 2012



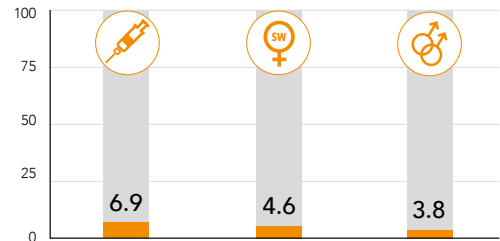
**23 000**

ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2012 data)

**12 000 - 41 000**

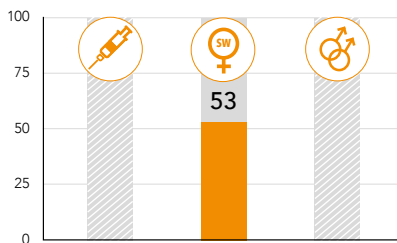
[LOW - HIGH ESTIMATE]

### • HIV prevalence among Key Populations (%)

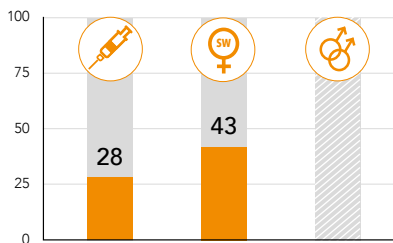


## HIV PREVENTION PROGRAMMES

### • Key population tested for in the past 12 months and received the results (%)

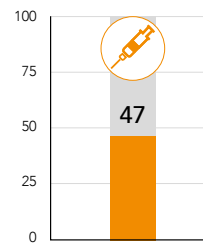


### • Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



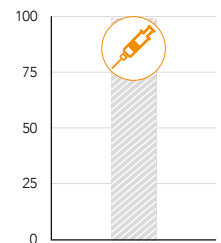
\* for sex workers is the sexual intercourse with the most recent client

### • Use of Sterile Injecting Equipment among people who inject drugs\* (%)

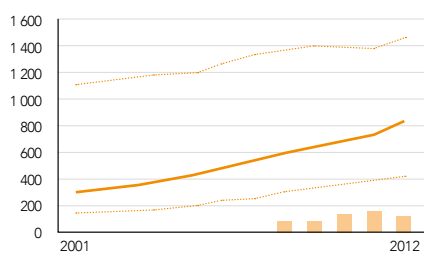


\* the indicator refers to the last time injecting

### • Number of syringes distributed per person

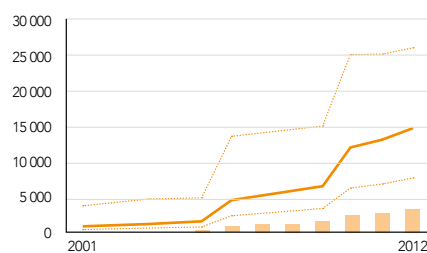


## eMTCT COVERAGE



Receiving ARV

## ADULT ART COVERAGE



Receiving ARV

Eligibility criteria for ART is based on the WHO 2013 Guideline and the estimated number of adult living with HIV is correspondingly higher

(2012 data)  
ADULT ART NEED

**14 440**  
[7 867 - 25 933]  
[LOW - HIGH ESTIMATE]

RECEIVING ART  
**3 134**

(2012 data)  
PEDIATRIC ART NEED

**1 145**  
[552 - 2 682]  
[LOW - HIGH ESTIMATE]

RECEIVING ART  
**262**

## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

	GOVERNMENT RESPONSE	CIVIL SOCIETY RESPONSE
Women	<input type="checkbox"/>	<input type="checkbox"/>
Young people	<input type="checkbox"/>	<input type="checkbox"/>
People who inject drugs	<input type="checkbox"/>	<input type="checkbox"/>
Men who have sex with men	<input type="checkbox"/>	<input type="checkbox"/>
Female Sex Workers	<input type="checkbox"/>	<input type="checkbox"/>
Prisoners	<input type="checkbox"/>	<input type="checkbox"/>
Migrants/Mobile populations	<input type="checkbox"/>	<input type="checkbox"/>

Yes  
 No  
 No data

## HIV EXPENDITURE



## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



**YES**

# BAHRAIN



## COUNTRY OVERVIEW

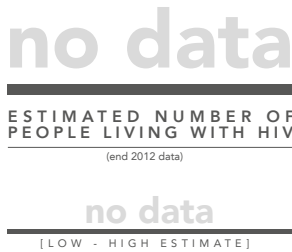
Human Development Index	High	GNI (per capita - PPP)	19 154 US\$
Life expectancy	75.2	Population	1 300 000

## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

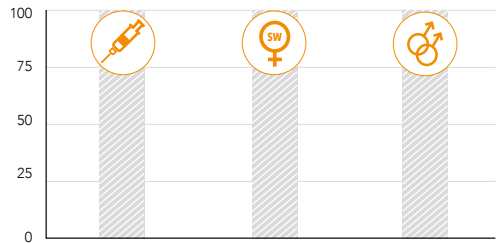
	Yes	No
Existence of a national strategic plan	<input checked="" type="checkbox"/>	<input type="checkbox"/>

## EPIDEMIOLOGY FACTS

### Estimated number of new HIV infection 1990 - 2012

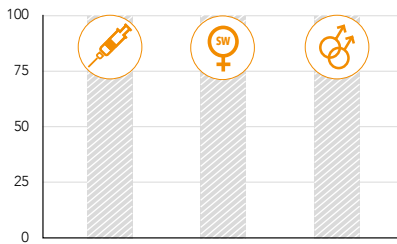


### HIV prevalence among Key Populations (%)

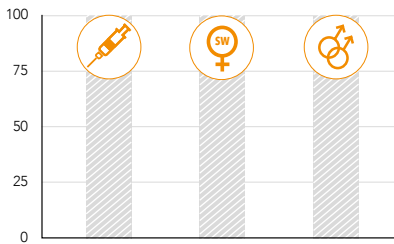


## HIV PREVENTION PROGRAMMES

### Key population tested for in the past 12 months and received the results (%)

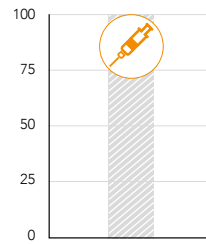


### Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



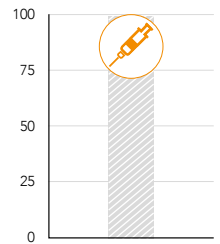
\* for sex workers is the sexual intercourse with the most recent client

### Use of Sterile Injecting Equipment among people who inject drugs\* (%)

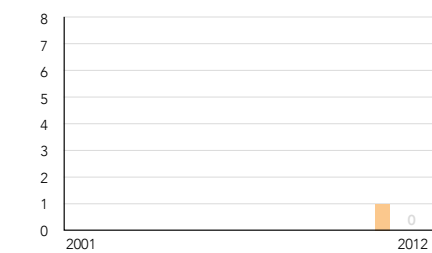


\* the indicator refers to the last time injecting

### Number of syringes distributed per person

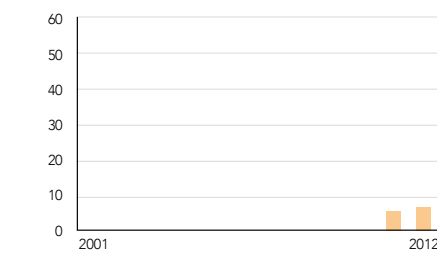


## eMTCT COVERAGE



Receiving ARV

## ADULT ART COVERAGE



Receiving ARV

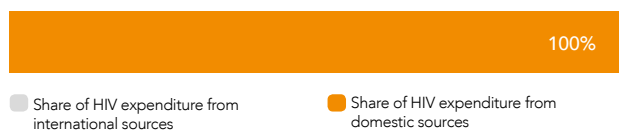


## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

	GOVERNMENT RESPONSE	CIVIL SOCIETY RESPONSE
Women	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Young people	<input type="checkbox"/>	<input checked="" type="checkbox"/>
People who inject drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Men who have sex with men	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Female Sex Workers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prisoners	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Migrants/Mobile populations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Yes No No data

## HIV EXPENDITURE



## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



NO

Source of information: Global AIDS Response Country Progress Reports 2012 and 2013 / The Human Development Report 2013 / Spectrum Estimation/Projection country files

# DJIBOUTI



## COUNTRY OVERVIEW

Human Development Index	Low	GNI (per capita - PPP)	2 350 US\$
Life expectancy	58.3	Population	900 000

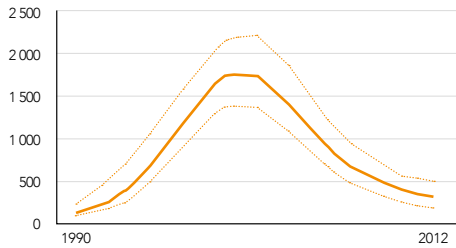
## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

Existence of a national strategic plan  Yes  No

**2012** NSP DURATION **2016**

## EPIDEMIOLOGY FACTS

• Estimated number of new HIV infection 1990 - 2012



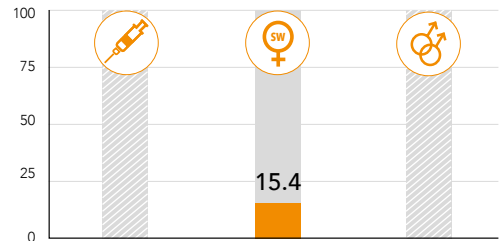
**8 000**

ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2012 data)

**6 000 - 9 000**

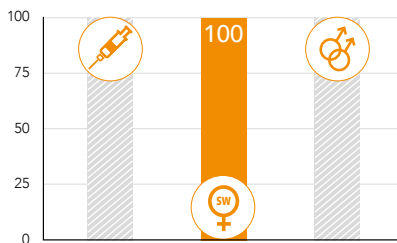
[LOW - HIGH ESTIMATE]

• HIV prevalence among Key Populations (%)

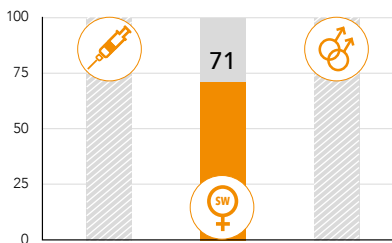


## HIV PREVENTION PROGRAMMES

• Key population tested for in the past 12 months and received the results (%)

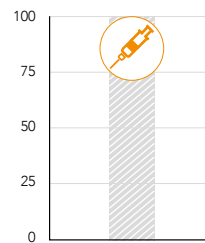


• Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



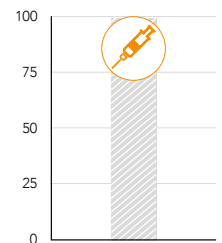
\* for sex workers is the sexual intercourse with the most recent client

• Use of Sterile Injecting Equipment among people who inject drugs\* (%)

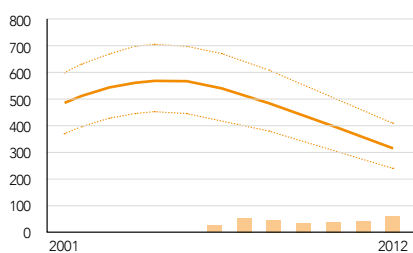


\* the indicator refers to the last time injecting

• Number of syringes distributed per person

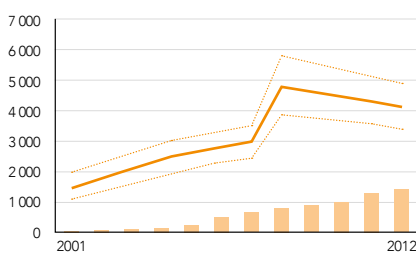


## eMTCT COVERAGE



Receiving ARV

## ADULT ART COVERAGE



Receiving ARV

(2012 data)  
**ADULT ART NEED**  
**4 067**  
[3 388 - 4 851]  
[LOW - HIGH ESTIMATE]

**RECEIVING ART**  
**1 442**

(2012 data)  
**PEDIATRIC ART NEED**  
**652**  
[515 - 814]  
[LOW - HIGH ESTIMATE]

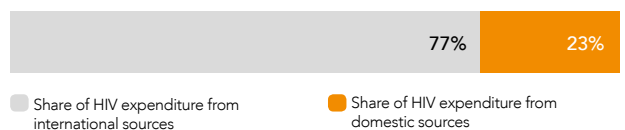
**RECEIVING ART**  
**40**

## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

	GOVERNMENT RESPONSE	CIVIL SOCIETY RESPONSE
Women	<input type="checkbox"/>	<input type="checkbox"/>
Young people	<input type="checkbox"/>	<input type="checkbox"/>
People who inject drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Men who have sex with men	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Female Sex Workers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prisoners	<input type="checkbox"/>	<input type="checkbox"/>
Migrants/Mobile populations	<input type="checkbox"/>	<input type="checkbox"/>

Legend:  Yes,  No,  No data

## HIV EXPENDITURE



## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



**YES**

Source of information: Global AIDS Response Country Progress Reports 2012 and 2013 / The Human Development Report 2013 / Spectrum Estimation/Projection country files



# EGYPT



## COUNTRY OVERVIEW

Human Development Index	Medium	GNI (per capita - PPP)	5 401 US\$
Life expectancy	73.5	Population	82 100 000

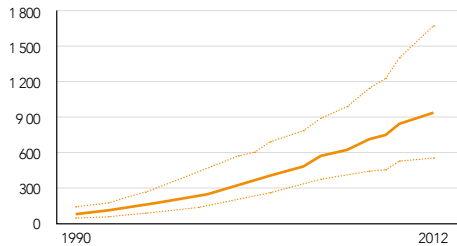
## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

Existence of a national strategic plan  Yes  No

**2012** NSP DURATION **2016**

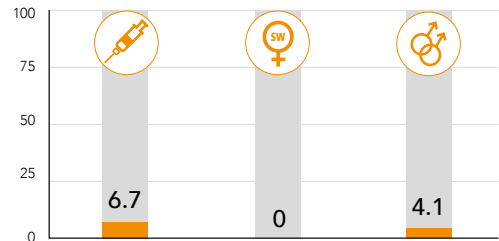
## EPIDEMIOLOGY FACTS

### • Estimated number of new HIV infection 1990 - 2012



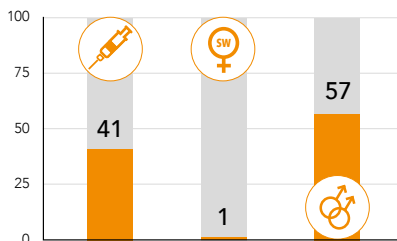
**7 000**  
ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2012 data)  
**4 000 - 10 000**  
[LOW - HIGH ESTIMATE]

### • HIV prevalence among Key Populations (%)

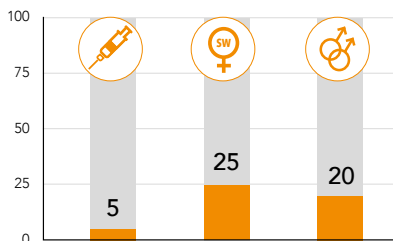


## HIV PREVENTION PROGRAMMES

### • Key population tested for in the past 12 months and received the results (%)

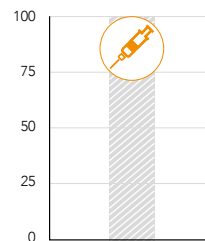


### • Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



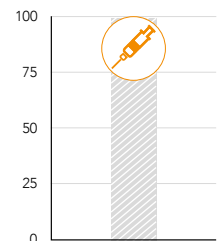
\* for sex workers is the sexual intercourse with the most recent client

### • Use of Sterile Injecting Equipment among people who inject drugs\* (%)

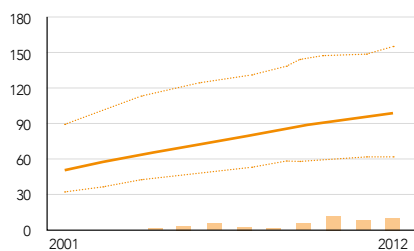


\* the indicator refers to the last time injecting

### • Number of syringes distributed per person

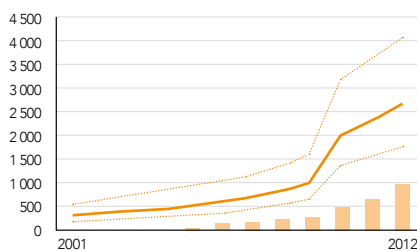


## eMTCT COVERAGE



Receiving ARV

## ADULT ART COVERAGE



Receiving ARV

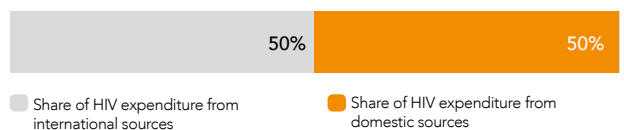
(2012 data)  
**ADULT ART NEED**  
**2 643**  
[1 818 - 4 032]  
[LOW - HIGH ESTIMATE]  
**RECEIVING ART**  
**954**

(2012 data)  
**PEDIATRIC ART NEED**  
**137**  
[97 - 214]  
[LOW - HIGH ESTIMATE]  
**RECEIVING ART**  
**42**

## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

	GOVERNMENT RESPONSE	CIVIL SOCIETY RESPONSE
Women	No	No
Young people	No	No
People who inject drugs	No	Yes
Men who have sex with men	No	Yes
Female Sex Workers	No	Yes
Prisoners	No	No
Migrants/Mobile populations	No	No data

## HIV EXPENDITURE



## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



**YES**

# IRAN



## COUNTRY OVERVIEW

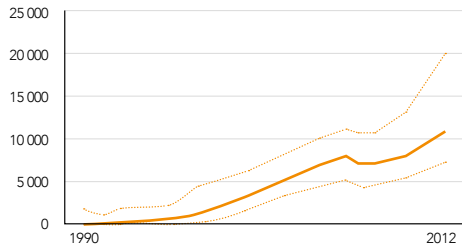
Human Development Index	High	GNI (per capita - PPP)	10 695 US\$
Life expectancy	73.2	Population	77 400 000

## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

	Yes	No
Existence of a national strategic plan	<input checked="" type="checkbox"/>	<input type="checkbox"/>

## EPIDEMIOLOGY FACTS

### • Estimated number of new HIV infection 1990 - 2012

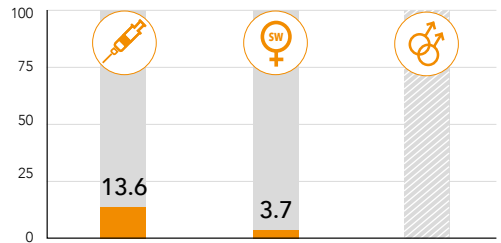


**71 000**

ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2012 data)

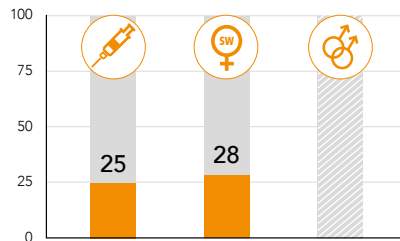
**53 000 - 103 000**  
[LOW - HIGH ESTIMATE]

### • HIV prevalence among Key Populations (%)

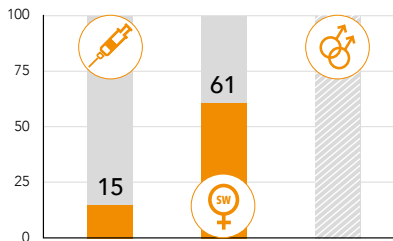


## HIV PREVENTION PROGRAMMES

### • Key population tested for in the past 12 months and received the results (%)

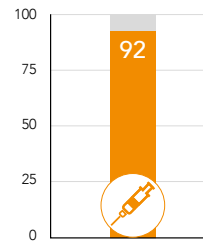


### • Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



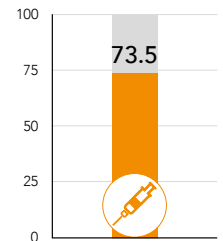
\* for sex workers is the sexual intercourse with the most recent client

### • Use of Sterile Injecting Equipment among people who inject drugs\* (%)

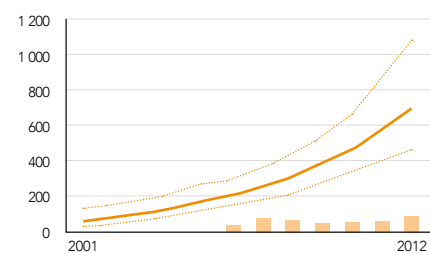


\* the indicator refers to the last time injecting

### • Number of syringes distributed per person

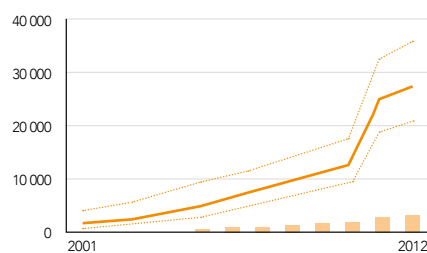


## eMTCT COVERAGE



Receiving ARV

## ADULT ART COVERAGE



Receiving ARV

(2012 data)  
ADULT ART NEED

**27 312**

20 789 - 35 910  
[LOW - HIGH ESTIMATE]

RECEIVING ART

**3 417**

(2012 data)  
PEDIATRIC ART NEED

**602**

408 - 948  
[LOW - HIGH ESTIMATE]

RECEIVING ART

**141**

## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

	GOVERNMENT RESPONSE	CIVIL SOCIETY RESPONSE
Women	<input type="checkbox"/>	<input type="checkbox"/>
Young people	<input type="checkbox"/>	<input type="checkbox"/>
People who inject drugs	<input type="checkbox"/>	<input type="checkbox"/>
Men who have sex with men	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Female Sex Workers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prisoners	<input type="checkbox"/>	<input type="checkbox"/>
Migrants/Mobile populations	<input type="checkbox"/>	<input type="checkbox"/>

Yes  
No  
No data

## HIV EXPENDITURE



## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



**YES**

Source of information: Global AIDS Response Country Progress Reports 2012 and 2013 / The Human Development Report 2013 / Spectrum Estimation/Projection country files

# IRAQ



## COUNTRY OVERVIEW

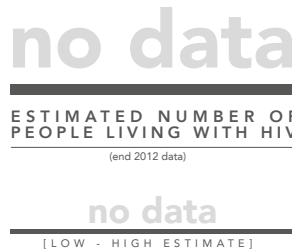
Human Development Index	Medium	GNI (per capita - PPP)	3 557 US\$
Life expectancy	69.9	Population	3 380 000

## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

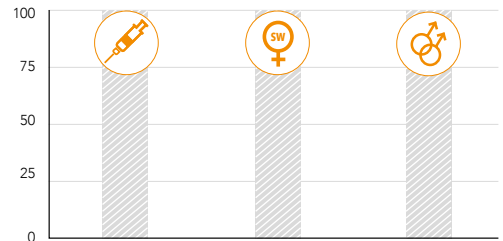
Existence of a national strategic plan  Yes  No

## EPIDEMIOLOGY FACTS

- Estimated number of new HIV infection 1990 - 2012

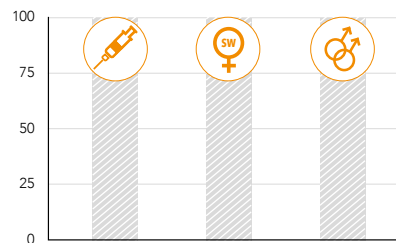
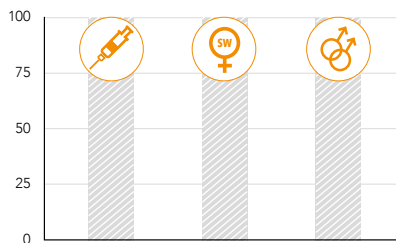


- HIV prevalence among Key Populations (%)

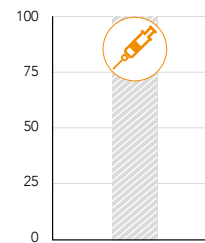


## HIV PREVENTION PROGRAMMES

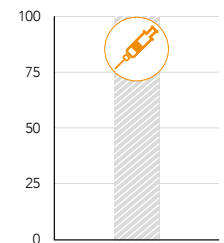
- Key population tested for in the past 12 months and received the results (%)
- Key Populations reporting the use of a condom during the last sexual intercourse\* (%)
- Use of Sterile Injecting Equipment among people who inject drugs\* (%)
- Number of syringes distributed per person



\* for sex workers is the sexual intercourse with the most recent client



\* the indicator refers to the last time injecting

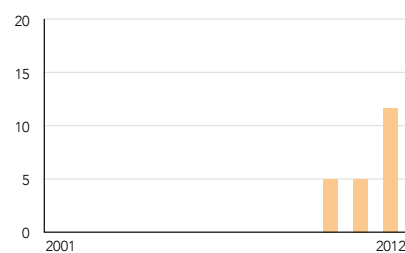


## eMTCT COVERAGE



Receiving ARV

## ADULT ART COVERAGE



Receiving ARV

(2012 data)  
ADULT ART NEED  
no data  
[LOW - HIGH ESTIMATE]  
RECEIVING ART  
**12**

(2012 data)  
PEDIATRIC ART NEED  
no data  
[LOW - HIGH ESTIMATE]  
RECEIVING ART  
no data

## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

	GOVERNMENT RESPONSE	CIVIL SOCIETY RESPONSE
Women	<input type="checkbox"/>	<input type="checkbox"/>
Young people	<input type="checkbox"/>	<input type="checkbox"/>
People who inject drugs	<input type="checkbox"/>	<input type="checkbox"/>
Men who have sex with men	<input type="checkbox"/>	<input type="checkbox"/>
Female Sex Workers	<input type="checkbox"/>	<input type="checkbox"/>
Prisoners	<input type="checkbox"/>	<input type="checkbox"/>
Migrants/Mobile populations	<input type="checkbox"/>	<input type="checkbox"/>

Legend:  Yes,  No,  No data

## HIV EXPENDITURE

Share of HIV expenditure from international sources  Share of HIV expenditure from domestic sources

## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



**NO**

# JORDAN



## COUNTRY OVERVIEW

Human Development Index	Medium	GNI (per capita - PPP)	5 272 US\$
Life expectancy	73.5	Population	7 300 000

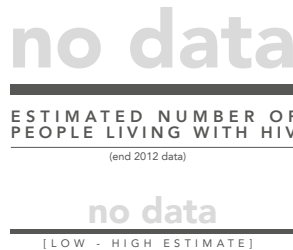
## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

Existence of a national strategic plan  Yes  No

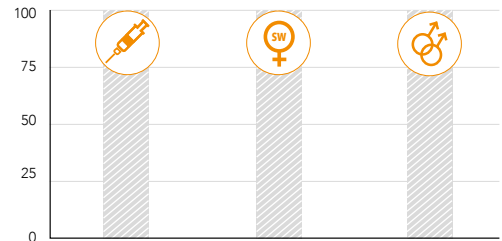
**2012** NSP DURATION **2016**

## EPIDEMIOLOGY FACTS

- Estimated number of new HIV infection 1990 - 2012

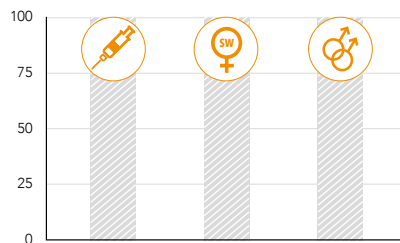


- HIV prevalence among Key Populations (%)

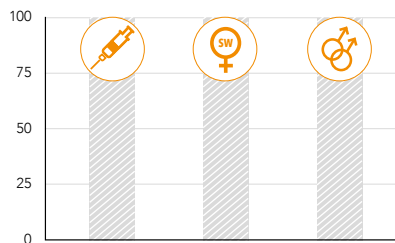


## HIV PREVENTION PROGRAMMES

- Key population tested for in the past 12 months and received the results (%)

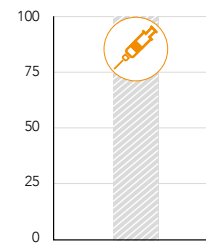


- Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



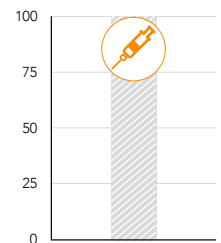
\* for sex workers is the sexual intercourse with the most recent client

- Use of Sterile Injecting Equipment among people who inject drugs\* (%)

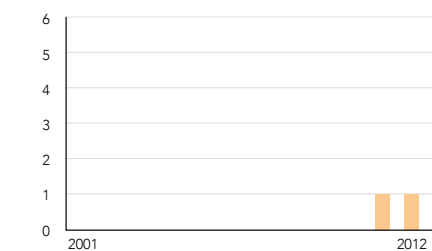


\* the indicator refers to the last time injecting

- Number of syringes distributed per person

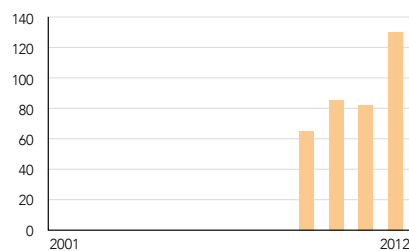


## eMTCT COVERAGE



Receiving ARV

## ADULT ART COVERAGE



Receiving ARV

(2012 data)  
ADULT ART NEED  
no data  
[LOW - HIGH ESTIMATE]  
RECEIVING ART  
**128**

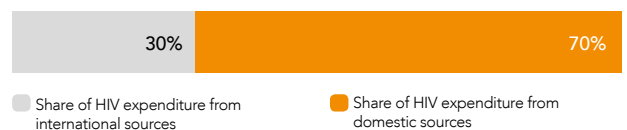
(2012 data)  
PEDIATRIC ART NEED  
no data  
[LOW - HIGH ESTIMATE]  
RECEIVING ART  
**3**

## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

	GOVERNMENT RESPONSE	CIVIL SOCIETY RESPONSE
Women	<input type="checkbox"/>	<input type="checkbox"/>
Young people	<input type="checkbox"/>	<input type="checkbox"/>
People who inject drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Men who have sex with men	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Female Sex Workers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prisoners	<input type="checkbox"/>	<input type="checkbox"/>
Migrants/Mobile populations	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Legend:  Yes,  No,  No data

## HIV EXPENDITURE



## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



**YES**

Source of information: Global AIDS Response Country Progress Reports 2012 and 2013 / The Human Development Report 2013 / Spectrum Estimation/Projection country files

# KUWAIT



## COUNTRY OVERVIEW

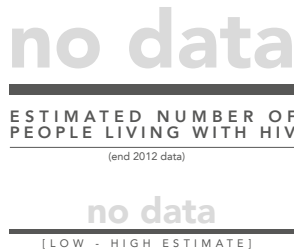
Human Development Index	High	GNI (per capita - PPP)	52 793 US\$
Life expectancy	74.7	Population	3 400 000

## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

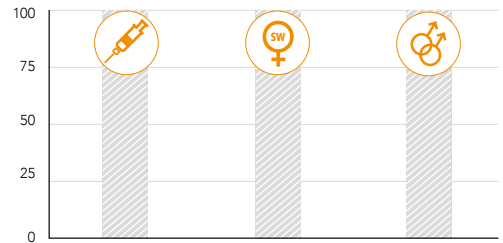
	Yes	No
Existence of a national strategic plan	<input checked="" type="checkbox"/>	<input type="checkbox"/>

## EPIDEMIOLOGY FACTS

### • Estimated number of new HIV infection 1990 - 2012

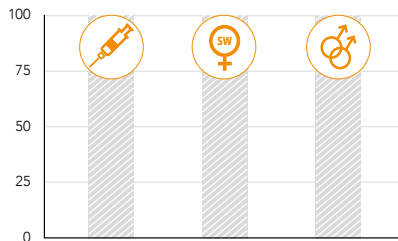


### • HIV prevalence among Key Populations (%)

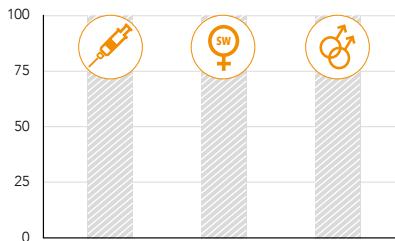


## HIV PREVENTION PROGRAMMES

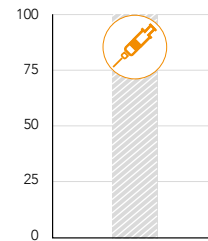
### • Key population tested for in the past 12 months and received the results (%)



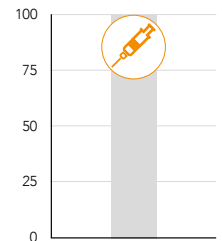
### • Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



### • Use of Sterile Injecting Equipment among people who inject drugs\* (%)



### • Number of syringes distributed per person



\* for sex workers is the sexual intercourse with the most recent client

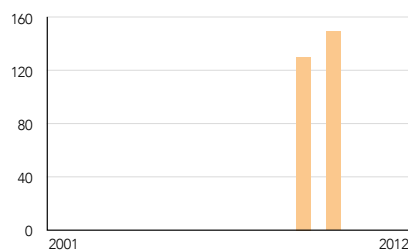
\* the indicator refers to the last time injecting

## eMTCT COVERAGE



Receiving ARV

## ADULT ART COVERAGE



Receiving ARV

(2012 data)  
ADULT ART NEED  
no data  
[LOW - HIGH ESTIMATE]  
RECEIVING ART  
no data

(2012 data)  
PEDIATRIC ART NEED  
no data  
[LOW - HIGH ESTIMATE]  
RECEIVING ART  
no data

## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

	GOVERNMENT RESPONSE	CIVIL SOCIETY RESPONSE
Women	<input type="checkbox"/>	<input type="checkbox"/>
Young people	<input type="checkbox"/>	<input type="checkbox"/>
People who inject drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Men who have sex with men	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Female Sex Workers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prisoners	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Migrants/Mobile populations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Yes  
 No  
 No data

## HIV EXPENDITURE



Share of HIV expenditure from international sources

Share of HIV expenditure from domestic sources

## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



# NO

# LEBANON



## COUNTRY OVERVIEW

Human Development Index	High	GNI (per capita - PPP)	12 364 US\$
Life expectancy	72.8	Population	4 800 000

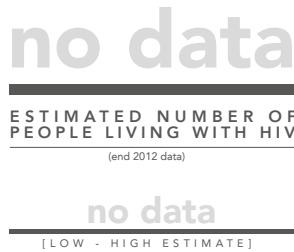
## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

Existence of a national strategic plan  Yes  No

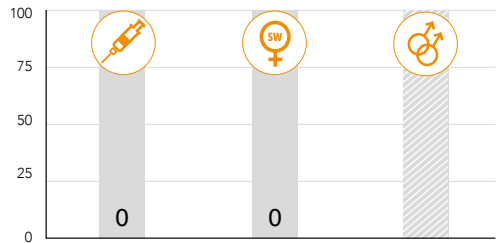
**2012** NSP DURATION **2015**

## EPIDEMIOLOGY FACTS

• Estimated number of new HIV infection 1990 - 2012

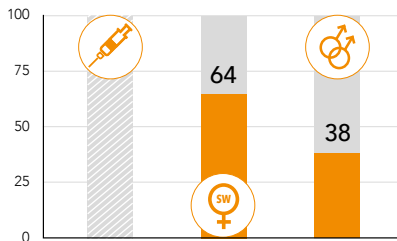


• HIV prevalence among Key Populations (%)

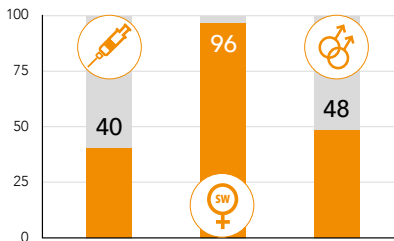


## HIV PREVENTION PROGRAMMES

• Key population tested for in the past 12 months and received the results (%)

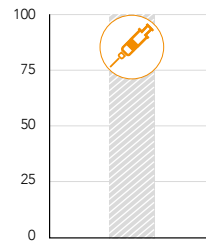


• Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



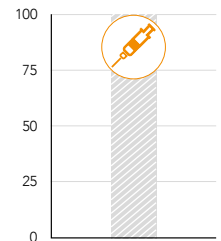
\* for sex workers is the sexual intercourse with the most recent client

• Use of Sterile Injecting Equipment among people who inject drugs\* (%)

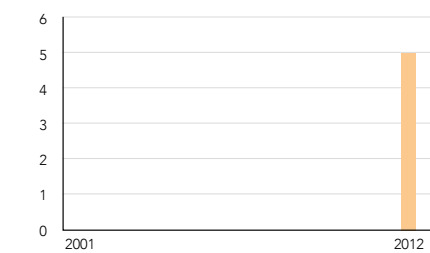


\* the indicator refers to the last time injecting

• Number of syringes distributed per person

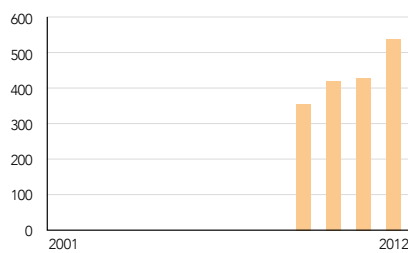


## eMTCT COVERAGE



Receiving ARV

## ADULT ART COVERAGE



Receiving ARV

(2012 data)  
ADULT ART NEED  
**no data**  
[LOW - HIGH ESTIMATE]  
RECEIVING ART  
**536**

(2012 data)  
PEDIATRIC ART NEED  
**no data**  
[LOW - HIGH ESTIMATE]  
RECEIVING ART  
**4**

## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

	GOVERNMENT RESPONSE	CIVIL SOCIETY RESPONSE
Women	No	Yes
Young people	No	No
People who inject drugs	Yes	Yes
Men who have sex with men	Yes	Yes
Female Sex Workers	Yes	Yes
Prisoners	Yes	No
Migrants/Mobile populations	Yes	No data

## HIV EXPENDITURE



## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



**YES**

Source of information: Global AIDS Response Country Progress Reports 2012 and 2013 / The Human Development Report 2013 / Spectrum Estimation/Projection country files

# LIBYA



## COUNTRY OVERVIEW

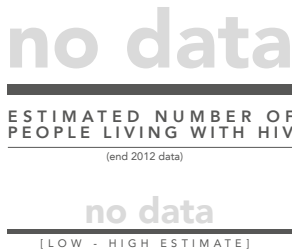
Human Development Index	High	GNI (per capita - PPP)	13 765 US\$
Life expectancy	75	Population	6 200 000

## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

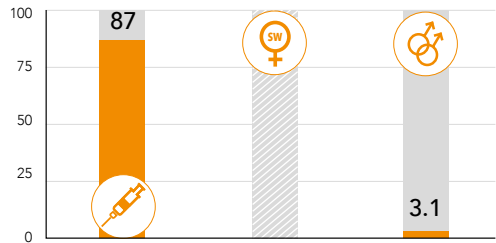
Existence of a national strategic plan  Yes  No

## EPIDEMIOLOGY FACTS

- Estimated number of new HIV infection 1990 - 2012

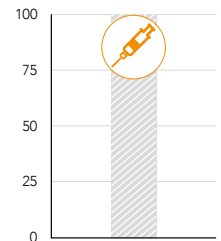
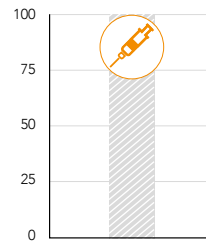
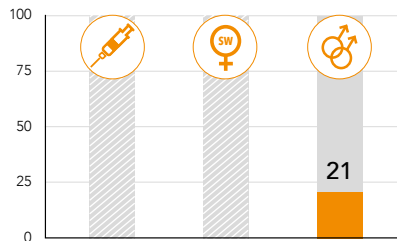
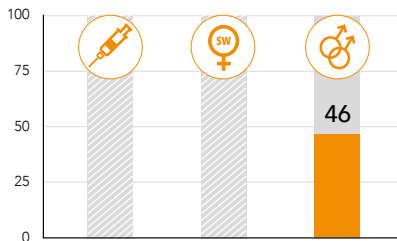


- HIV prevalence among Key Populations (%)

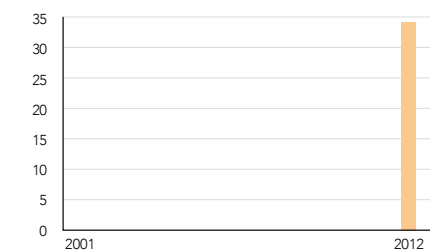


## HIV PREVENTION PROGRAMMES

- Key population tested for in the past 12 months and received the results (%)
- Key Populations reporting the use of a condom during the last sexual intercourse\* (%)
- Use of Sterile Injecting Equipment among people who inject drugs\* (%)
- Number of syringes distributed per person



## eMTCT COVERAGE



## ADULT ART COVERAGE



Receiving ARV

Receiving ARV

## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

	GOVERNMENT RESPONSE	CIVIL SOCIETY RESPONSE
Women	No	No
Young people	No	No
People who inject drugs	No	No
Men who have sex with men	No	No
Female Sex Workers	No	No
Prisoners	No	No
Migrants/Mobile populations	No	No

## HIV EXPENDITURE

Share of HIV expenditure from international sources (grey) and domestic sources (orange)

## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



**YES**

Source of information: Global AIDS Response Country Progress Reports 2012 and 2013 / The Human Development Report 2013 / Spectrum Estimation/Projection country files

# MOROCCO



## COUNTRY OVERVIEW

Human Development Index	Medium	GNI (per capita - PPP)	4 384 US\$
Life expectancy	72.4	Population	33 000 000

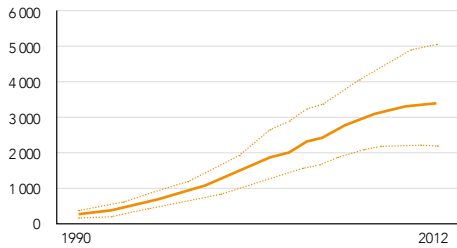
## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

Existence of a national strategic plan  Yes  No

**2012** NSP DURATION **2016**

## EPIDEMIOLOGY FACTS

### • Estimated number of new HIV infection 1990 - 2012



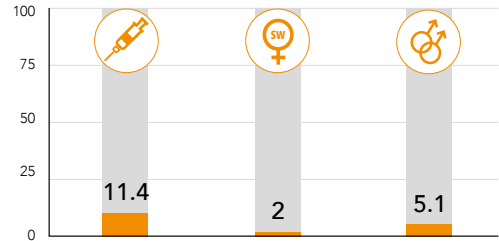
**30 000**

ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2012 data)

**22 000 - 40 000**

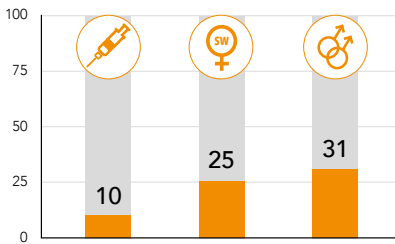
[LOW - HIGH ESTIMATE]

### • HIV prevalence among Key Populations (%)

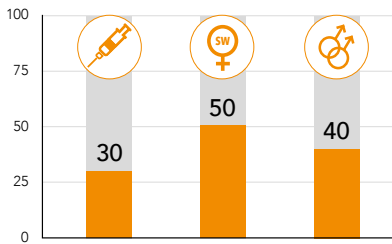


## HIV PREVENTION PROGRAMMES

### • Key population tested for in the past 12 months and received the results (%)

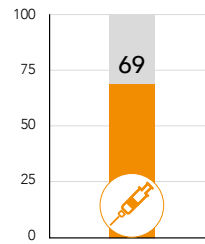


### • Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



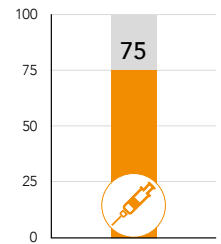
\* for sex workers is the sexual intercourse with the most recent client

### • Use of Sterile Injecting Equipment among people who inject drugs\* (%)

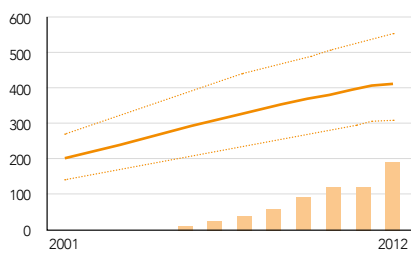


\* the indicator refers to the last time injecting

### • Number of syringes distributed per person

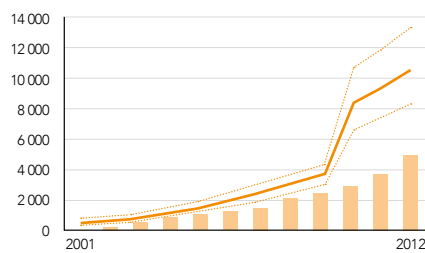


## eMTCT COVERAGE



Receiving ARV

## ADULT ART COVERAGE



Receiving ARV

(2012 data)  
ADULT ART NEED

**10 500**

8 420 - 13 201  
[LOW - HIGH ESTIMATE]

RECEIVING ART

**5 059**

(2012 data)  
PEDIATRIC ART NEED

**440**

328 - 590  
[LOW - HIGH ESTIMATE]

RECEIVING ART

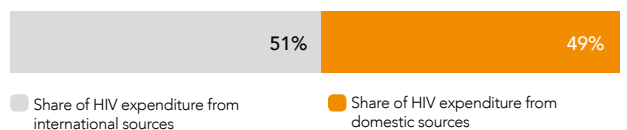
**244**

## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

	GOVERNMENT RESPONSE	CIVIL SOCIETY RESPONSE
Women	<input type="checkbox"/>	<input type="checkbox"/>
Young people	<input type="checkbox"/>	<input type="checkbox"/>
People who inject drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Men who have sex with men	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Female Sex Workers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prisoners	<input type="checkbox"/>	<input type="checkbox"/>
Migrants/Mobile populations	<input type="checkbox"/>	<input type="checkbox"/>

Yes  
 No  
 No data

## HIV EXPENDITURE



## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



**YES**



# OMAN



## COUNTRY OVERVIEW

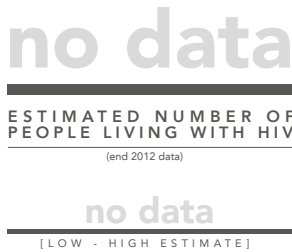
Human Development Index	High	GNI (per capita - PPP)	24 092 US\$
Life expectancy	73.2	Population	3 600 000

## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

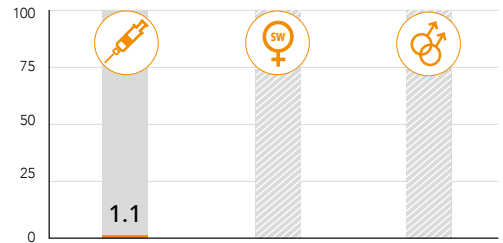
	Yes	No
Existence of a national strategic plan	<input checked="" type="checkbox"/>	<input type="checkbox"/>

## EPIDEMIOLOGY FACTS

### • Estimated number of new HIV infection 1990 - 2012

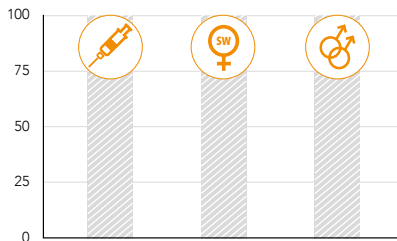


### • HIV prevalence among Key Populations (%)

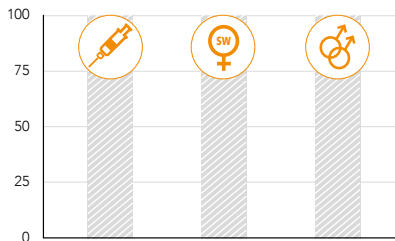


## HIV PREVENTION PROGRAMMES

### • Key population tested for in the past 12 months and received the results (%)

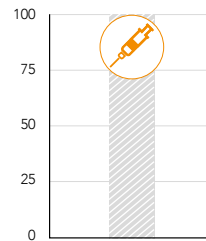


### • Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



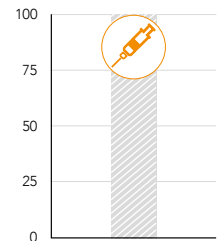
\* for sex workers is the sexual intercourse with the most recent client

### • Use of Sterile Injecting Equipment among people who inject drugs\* (%)



\* the indicator refers to the last time injecting

### • Number of syringes distributed per person

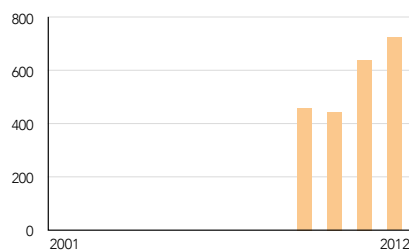


## eMTCT COVERAGE



Receiving ARV

## ADULT ART COVERAGE



Receiving ARV

(2012 data)  
ADULT ART NEED  
no data [LOW - HIGH ESTIMATE]  
RECEIVING ART  
**731**

(2012 data)  
PEDIATRIC ART NEED  
no data [LOW - HIGH ESTIMATE]  
RECEIVING ART  
**19**

## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

	GOVERNMENT RESPONSE	CIVIL SOCIETY RESPONSE
Women	<input type="checkbox"/>	<input type="checkbox"/>
Young people	<input type="checkbox"/>	<input type="checkbox"/>
People who inject drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Men who have sex with men	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Female Sex Workers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prisoners	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Migrants/Mobile populations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Legend:  Yes,  No,  No data

## HIV EXPENDITURE

2%



Share of HIV expenditure from international sources

Share of HIV expenditure from domestic sources

## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



**YES**

Source of information: Global AIDS Response Country Progress Reports 2012 and 2013 / The Human Development Report 2013 / Spectrum Estimation/Projection country files

# OCCUPIED PALESTINIAN TERRITORY



## COUNTRY OVERVIEW

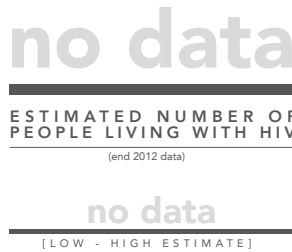
Human Development Index	Medium	GNI (per capita - PPP)	3 359 US\$
Life expectancy	73	Population	4 300 000

## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

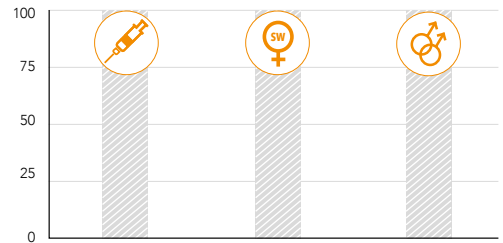
Existence of a national strategic plan  Yes  No

## EPIDEMIOLOGY FACTS

- Estimated number of new HIV infection 1990 - 2012

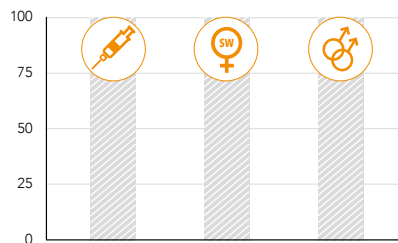
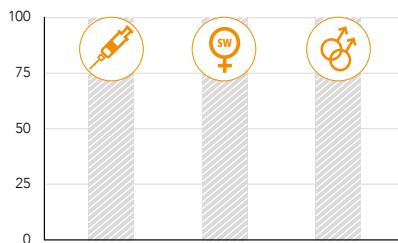


- HIV prevalence among Key Populations (%)

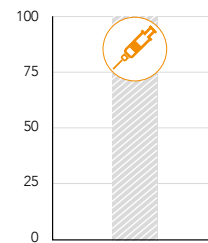


## HIV PREVENTION PROGRAMMES

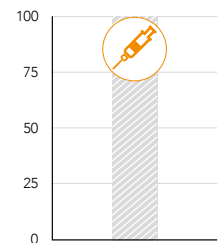
- Key population tested for in the past 12 months and received the results (%)
- Key Populations reporting the use of a condom during the last sexual intercourse\* (%)
- Use of Sterile Injecting Equipment among people who inject drugs\* (%)
- Number of syringes distributed per person



\* for sex workers is the sexual intercourse with the most recent client



\* the indicator refers to the last time injecting

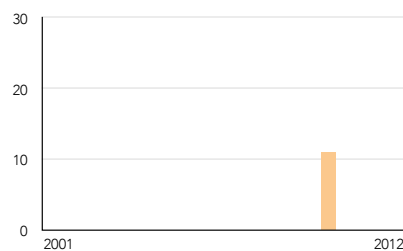


## eMTCT COVERAGE



Receiving ARV

## ADULT ART COVERAGE



Receiving ARV



## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

	GOVERNMENT RESPONSE	CIVIL SOCIETY RESPONSE
Women	<input type="checkbox"/>	<input type="checkbox"/>
Young people	<input type="checkbox"/>	<input type="checkbox"/>
People who inject drugs	<input type="checkbox"/>	<input type="checkbox"/>
Men who have sex with men	<input type="checkbox"/>	<input type="checkbox"/>
Female Sex Workers	<input type="checkbox"/>	<input type="checkbox"/>
Prisoners	<input type="checkbox"/>	<input type="checkbox"/>
Migrants/Mobile populations	<input type="checkbox"/>	<input type="checkbox"/>

Yes  
 No  
 No data

## HIV EXPENDITURE



## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



# YES

Source of information: Global AIDS Response Country Progress Reports 2012 and 2013 / The Human Development Report 2013 / Spectrum Estimation/Projection country files

# QATAR



## COUNTRY OVERVIEW

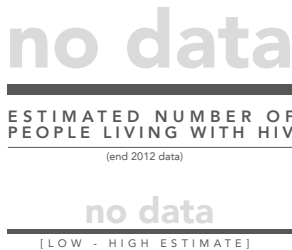
Human Development Index	Very High	GNI (per capita - PPP)	87 478 US\$
Life expectancy	78.5	Population	2 200 000

## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

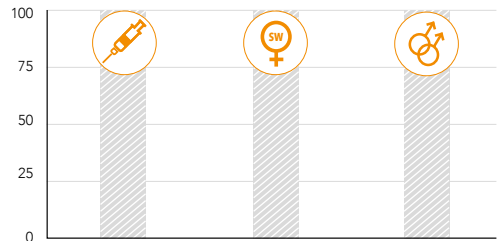
	Yes	No
Existence of a national strategic plan	<input type="checkbox"/>	<input checked="" type="checkbox"/>

## EPIDEMIOLOGY FACTS

### • Estimated number of new HIV infection 1990 - 2012

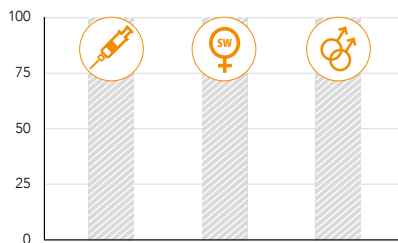


### • HIV prevalence among Key Populations (%)

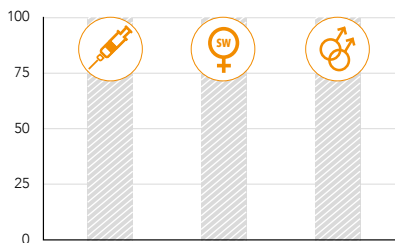


## HIV PREVENTION PROGRAMMES

### • Key population tested for in the past 12 months and received the results (%)

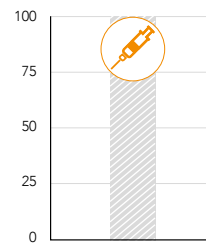


### • Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



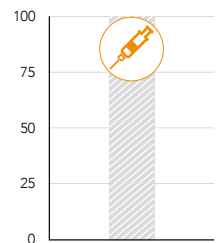
\* for sex workers is the sexual intercourse with the most recent client

### • Use of Sterile Injecting Equipment among people who inject drugs\* (%)

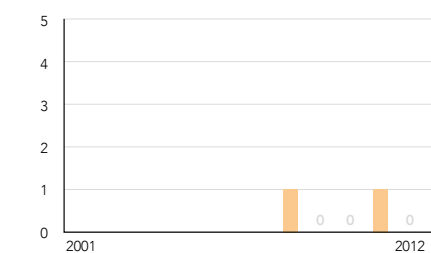


\* the indicator refers to the last time injecting

### • Number of syringes distributed per person

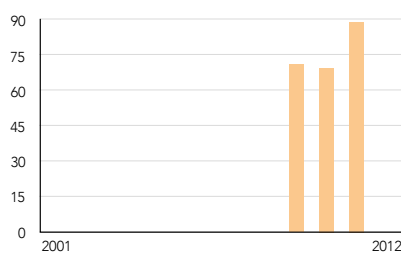


## eMTCT COVERAGE



Receiving ARV

## ADULT ART COVERAGE



Receiving ARV

(2012 data)  
ADULT ART NEED  
no data  
[LOW - HIGH ESTIMATE]  
RECEIVING ART  
no data

(2012 data)  
PEDIATRIC ART NEED  
no data  
[LOW - HIGH ESTIMATE]  
RECEIVING ART  
no data

## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

	GOVERNMENT RESPONSE	CIVIL SOCIETY RESPONSE
Women	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Young people	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
People who inject drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Men who have sex with men	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Female Sex Workers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prisoners	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Migrants/Mobile populations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Yes  
No  
No data

## HIV EXPENDITURE



Share of HIV expenditure from international sources

Share of HIV expenditure from domestic sources

## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



NO

# SAUDI ARABIA



## COUNTRY OVERVIEW

Human Development Index	High	GNI (per capita - PPP)	22 616 US\$
Life expectancy	74.1	Population	28 800 000

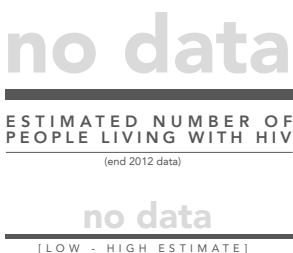
## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

Existence of a national strategic plan  Yes  No

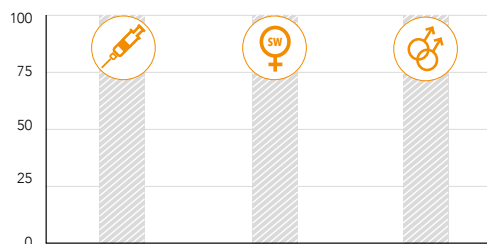
**2013** NSP DURATION **2017**

## EPIDEMIOLOGY FACTS

- Estimated number of new HIV infection 1990 - 2012

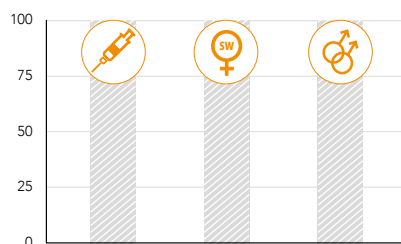


- HIV prevalence among Key Populations (%)

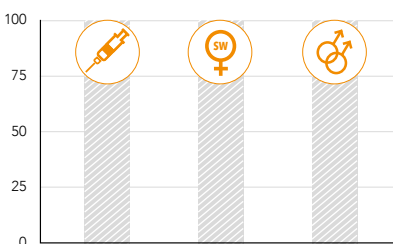


## HIV PREVENTION PROGRAMMES

- Key population tested for in the past 12 months and received the results (%)

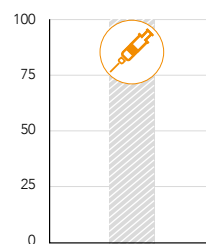


- Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



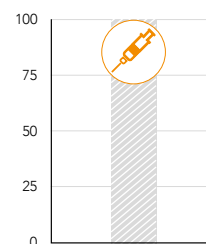
\* for sex workers is the sexual intercourse with the most recent client

- Use of Sterile Injecting Equipment among people who inject drugs\* (%)



\* the indicator refers to the last time injecting

- Number of syringes distributed per person

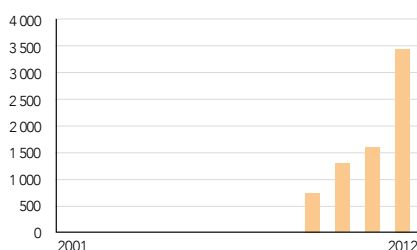


## eMTCT COVERAGE



Receiving ARV

## ADULT ART COVERAGE



Receiving ARV

(2012 data)  
ADULT ART NEED  
**no data**  
[LOW - HIGH ESTIMATE]  
RECEIVING ART  
**3 866**

(2012 data)  
PEDIATRIC ART NEED  
**no data**  
[LOW - HIGH ESTIMATE]  
RECEIVING ART  
**113**

## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

	GOVERNMENT RESPONSE	CIVIL SOCIETY RESPONSE
Women	No	No
Young people	No	No
People who inject drugs	No	No
Men who have sex with men	No	No
Female Sex Workers	No	No
Prisoners	No	No
Migrants/Mobile populations	No	No

Yes No No data

## HIV EXPENDITURE



Share of HIV expenditure from international sources

Share of HIV expenditure from domestic sources

## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



**YES**

Source of information: Global AIDS Response Country Progress Reports 2012 and 2013 / The Human Development Report 2013 / Spectrum Estimation/Projection country files

# SOMALIA



## COUNTRY OVERVIEW

Human Development Index	Low	GNI (per capita - PPP)	
Life expectancy	55	Population	10 500 000

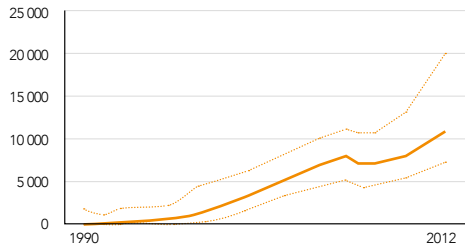
## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

Existence of a national strategic plan  Yes  No

**2009** NSP DURATION **2013**

## EPIDEMIOLOGY FACTS

• Estimated number of new HIV infection 1990 - 2012



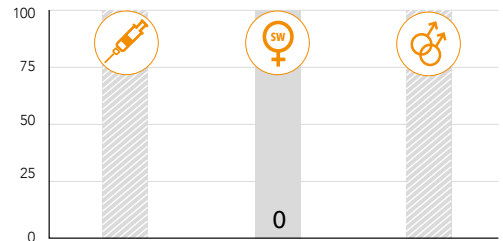
**31 000**

ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2012 data)

**21 000 - 47 000**

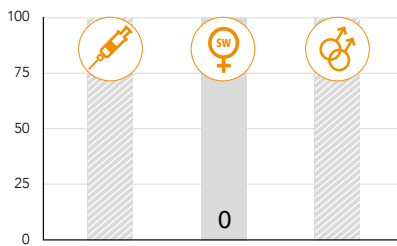
[LOW - HIGH ESTIMATE]

• HIV prevalence among Key Populations (%)

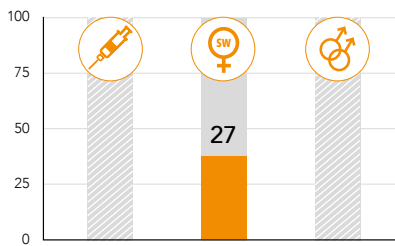


## HIV PREVENTION PROGRAMMES

• Key population tested for in the past 12 months and received the results (%)

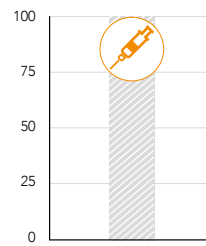


• Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



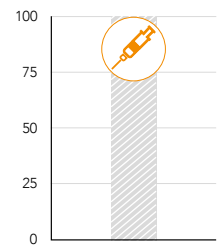
\* for sex workers is the sexual intercourse with the most recent client

• Use of Sterile Injecting Equipment among people who inject drugs\* (%)

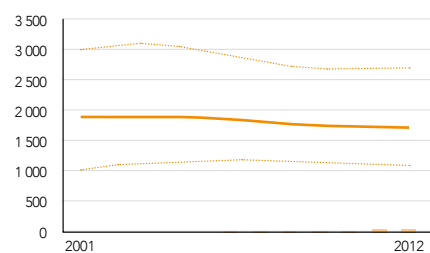


\* the indicator refers to the last time injecting

• Number of syringes distributed per person

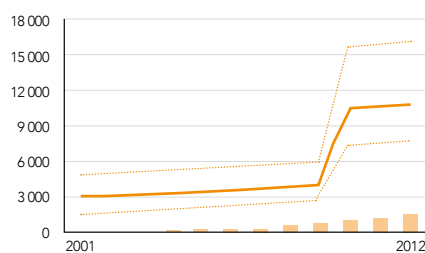


## eMTCT COVERAGE



Receiving ARV

## ADULT ART COVERAGE



Receiving ARV

(2012 data)  
ADULT ART NEED

**10 735**

[7 561 - 16 035]  
[LOW - HIGH ESTIMATE]

RECEIVING ART

**1 407**

(2012 data)  
PEDIATRIC ART NEED

**3 000**

[2 014 - 4 532]  
[LOW - HIGH ESTIMATE]

RECEIVING ART

**43**

## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

Women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People who inject drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Men who have sex with men	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Female Sex Workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prisoners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migrants/Mobile populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Yes  
 No  
 No data

## HIV EXPENDITURE



## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



**YES**

Source of information: Global AIDS Response Country Progress Reports 2012 and 2013 / The Human Development Report 2013 / Spectrum Estimation/Projection country files

# SUDAN



## COUNTRY OVERVIEW

Human Development Index	Low	GNI (per capita - PPP)	1 848 US\$
Life expectancy	61.8	Population	38 000 000

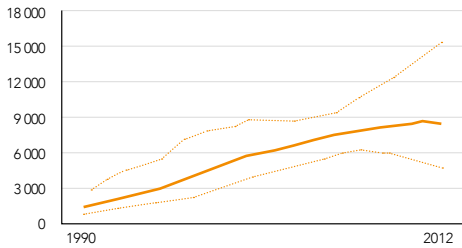
## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

Existence of a national strategic plan  Yes  No

**2011** NSP DURATION **2015**

## EPIDEMIOLOGY FACTS

### • Estimated number of new HIV infection 1990 - 2012

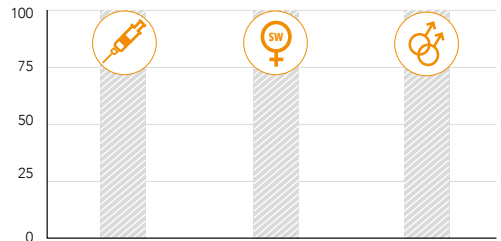


**77 000**

ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2012 data)

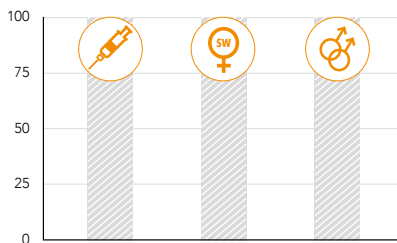
**60 000 - 105 000**  
[LOW - HIGH ESTIMATE]

### • HIV prevalence among Key Populations (%)

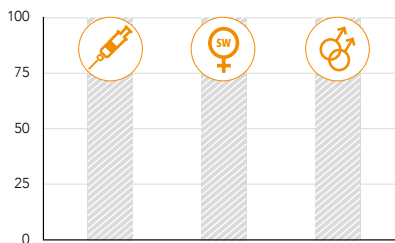


## HIV PREVENTION PROGRAMMES

### • Key population tested for in the past 12 months and received the results (%)

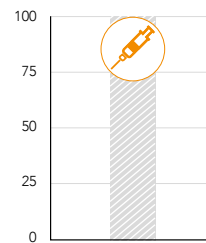


### • Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



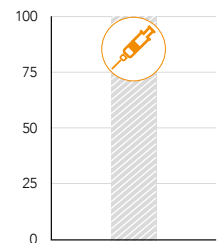
\* for sex workers is the sexual intercourse with the most recent client

### • Use of Sterile Injecting Equipment among people who inject drugs\* (%)

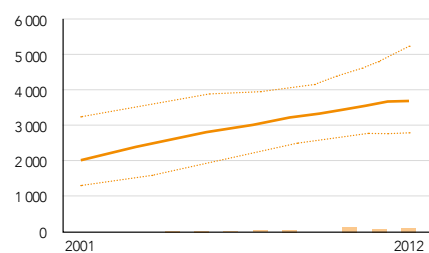


\* the indicator refers to the last time injecting

### • Number of syringes distributed per person

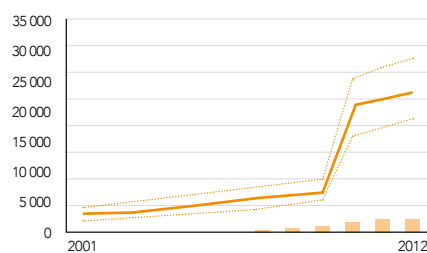


## eMTCT COVERAGE



Receiving ARV

## ADULT ART COVERAGE



Receiving ARV

(2012 data)  
**ADULT ART NEED**  
**23 097**  
[18 432 - 28 697]  
[LOW - HIGH ESTIMATE]

**RECEIVING ART**  
**2 405**

(2012 data)  
**PEDIATRIC ART NEED**  
**4 433**  
[3 446 - 5 635]  
[LOW - HIGH ESTIMATE]

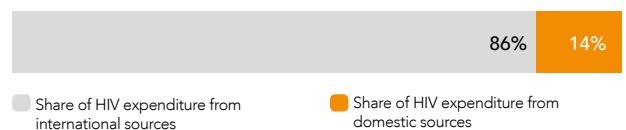
**RECEIVING ART**  
**170**

## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

	GOVERNMENT RESPONSE	CIVIL SOCIETY RESPONSE
Women	<input type="checkbox"/>	<input type="checkbox"/>
Young people	<input type="checkbox"/>	<input type="checkbox"/>
People who inject drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Men who have sex with men	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Female Sex Workers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prisoners	<input type="checkbox"/>	<input type="checkbox"/>
Migrants/Mobile populations	<input type="checkbox"/>	<input type="checkbox"/>

Legend:  Yes,  No,  No data

## HIV EXPENDITURE



## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



**YES**

Source of information: Global AIDS Response Country Progress Reports 2012 and 2013 / The Human Development Report 2013 / Spectrum Estimation/Projection country files

# SYRIA



## COUNTRY OVERVIEW

Human Development Index	Medium	GNI (per capita - PPP)	4 674 US\$
Life expectancy	76	Population	21 900 000

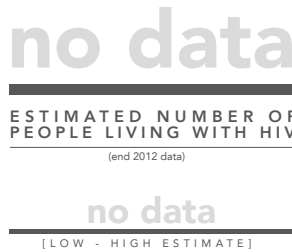
## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

Existence of a national strategic plan  Yes  No

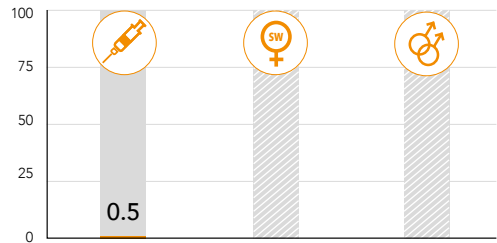
**2011** NSP DURATION **2015**

## EPIDEMIOLOGY FACTS

• Estimated number of new HIV infection 1990 - 2012

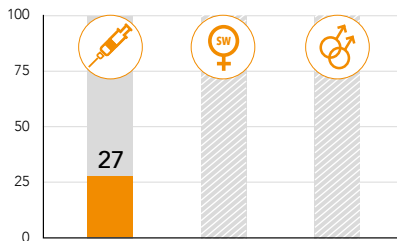


• HIV prevalence among Key Populations (%)

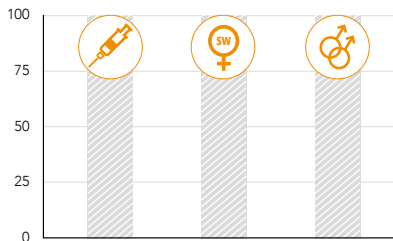


## HIV PREVENTION PROGRAMMES

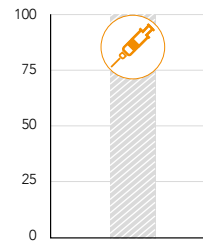
• Key population tested for in the past 12 months and received the results (%)



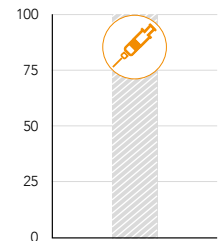
• Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



• Use of Sterile Injecting Equipment among people who inject drugs\* (%)



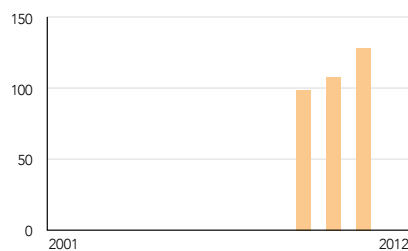
• Number of syringes distributed per person



## eMTCT COVERAGE



## ADULT ART COVERAGE



(2012 data)  
ADULT ART NEED  
no data  
[LOW - HIGH ESTIMATE]  
RECEIVING ART  
no data

(2012 data)  
PEDIATRIC ART NEED  
no data  
[LOW - HIGH ESTIMATE]  
RECEIVING ART  
no data

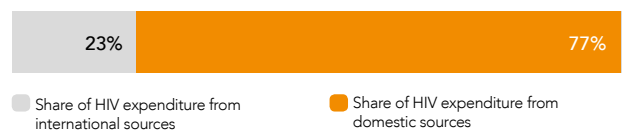
Receiving ARV

Receiving ARV

## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

	GOVERNMENT RESPONSE	CIVIL SOCIETY RESPONSE
Women	No	No
Young people	No	No
People who inject drugs	No	No
Men who have sex with men	No	No
Female Sex Workers	No	No
Prisoners	No	No
Migrants/Mobile populations	No	No

## HIV EXPENDITURE



## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



**YES**

Source of information: Global AIDS Response Country Progress Reports 2012 and 2013 / The Human Development Report 2013 / Spectrum Estimation/Projection country files

# TUNISIA



## COUNTRY OVERVIEW

Human Development Index	High	GNI (per capita - PPP)	8 103 US\$
Life expectancy	74.7	Population	11 000 000

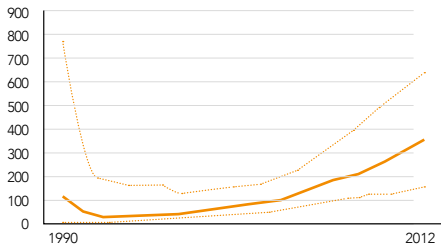
## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

Existence of a national strategic plan  Yes  No

**2012** NSP DURATION **2016**

## EPIDEMIOLOGY FACTS

### • Estimated number of new HIV infection 1990 - 2012



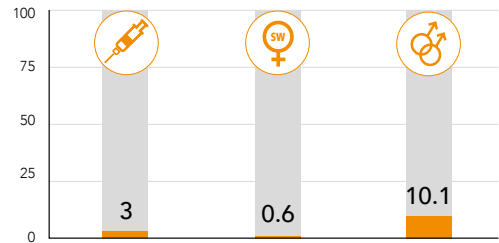
**2 300**

ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2012 data)

**1 400 - 3 800**

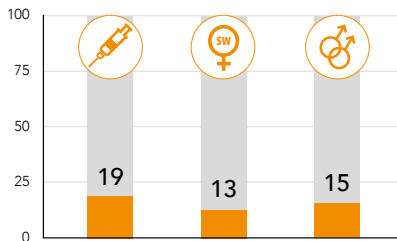
[LOW - HIGH ESTIMATE]

### • HIV prevalence among Key Populations (%)

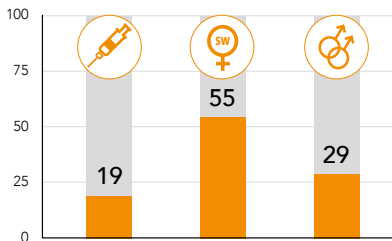


## HIV PREVENTION PROGRAMMES

### • Key population tested for in the past 12 months and received the results (%)

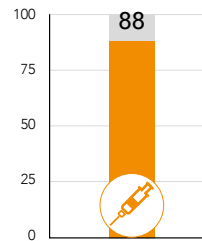


### • Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



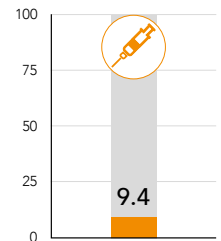
\* for sex workers is the sexual intercourse with the most recent client

### • Use of Sterile Injecting Equipment among people who inject drugs\* (%)

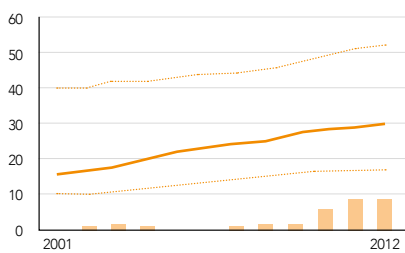


\* the indicator refers to the last time injecting

### • Number of syringes distributed per person

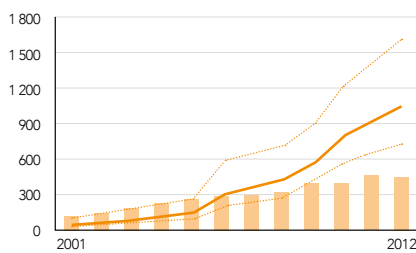


## eMTCT COVERAGE



Receiving ARV

## ADULT ART COVERAGE



Receiving ARV

(2012 data)  
**ADULT ART NEED**  
**1 054**  
[727 - 1 591]  
[LOW - HIGH ESTIMATE]

**RECEIVING ART**  
**443**

(2012 data)  
**PEDIATRIC ART NEED**  
**35**  
[24 - 58]  
[LOW - HIGH ESTIMATE]

**RECEIVING ART**  
**12**

## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

	GOVERNMENT RESPONSE	CIVIL SOCIETY RESPONSE
Women	<input type="checkbox"/>	<input type="checkbox"/>
Young people	<input type="checkbox"/>	<input type="checkbox"/>
People who inject drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Men who have sex with men	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Female Sex Workers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prisoners	<input type="checkbox"/>	<input type="checkbox"/>
Migrants/Mobile populations	<input type="checkbox"/>	<input type="checkbox"/>

Legend:  Yes,  No,  No data

## HIV EXPENDITURE

Share of HIV expenditure from international sources

Share of HIV expenditure from domestic sources

## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



**YES**

Source of information: Global AIDS Response Country Progress Reports 2012 and 2013 / The Human Development Report 2013 / Spectrum Estimation/Projection country files



# UNITED ARAB EMIRATES



## COUNTRY OVERVIEW

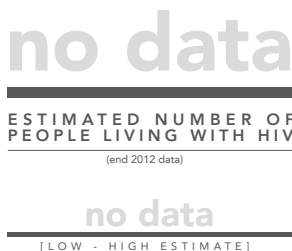
Human Development Index	Very High	GNI (per capita - PPP)	42 716 US\$
Life expectancy	76.7	Population	9 300 000

## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

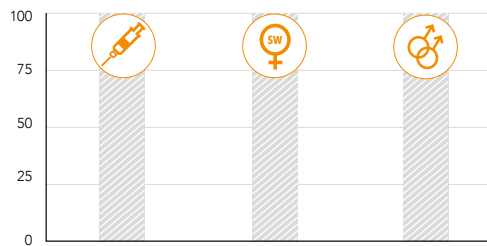
	Yes	No
Existence of a national strategic plan	<input checked="" type="checkbox"/>	<input type="checkbox"/>

## EPIDEMIOLOGY FACTS

- Estimated number of new HIV infection 1990 - 2012

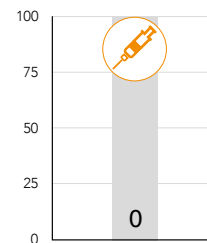
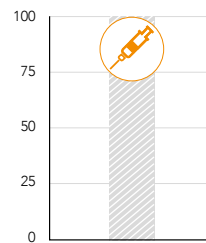
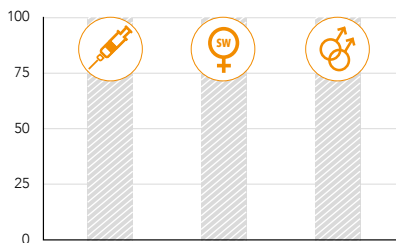
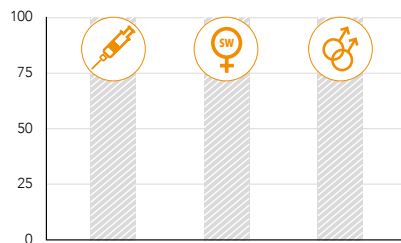


- HIV prevalence among Key Populations (%)



## HIV PREVENTION PROGRAMMES

- Key population tested for in the past 12 months and received the results (%)
- Key Populations reporting the use of a condom during the last sexual intercourse\* (%)
- Use of Sterile Injecting Equipment among people who inject drugs\* (%)
- Number of syringes distributed per person



\* for sex workers is the sexual intercourse with the most recent client

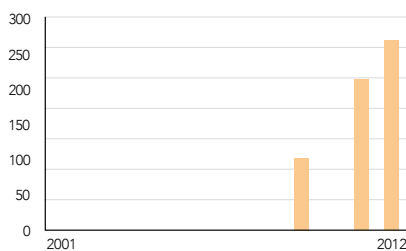
\* the indicator refers to the last time injecting

## eMTCT COVERAGE



Receiving ARV

## ADULT ART COVERAGE



Receiving ARV

(2012 data)  
ADULT ART NEED  
no data  
[LOW - HIGH ESTIMATE]  
RECEIVING ART  
264

(2012 data)  
PEDIATRIC ART NEED  
no data  
[LOW - HIGH ESTIMATE]  
RECEIVING ART  
3

## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

	GOVERNMENT RESPONSE	CIVIL SOCIETY RESPONSE
Women	<input type="checkbox"/>	<input type="checkbox"/>
Young people	<input type="checkbox"/>	<input checked="" type="checkbox"/>
People who inject drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Men who have sex with men	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Female Sex Workers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prisoners	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Migrants/Mobile populations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Yes  
 No  
 No data

## HIV EXPENDITURE



## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



NO

Source of information: Global AIDS Response Country Progress Reports 2012 and 2013 / The Human Development Report 2013 / Spectrum Estimation/Projection country files

# YEMEN



## COUNTRY OVERVIEW

Human Development Index	Low	GNI (per capita - PPP)	1 820 US\$
Life expectancy	65.9	Population	24 400 000

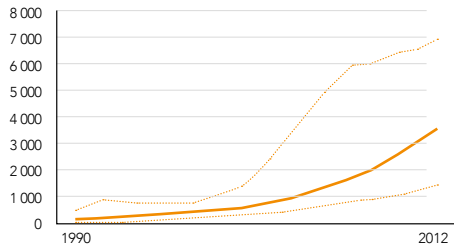
## NATIONAL STRATEGIC PLAN ON HIV AND AIDS

Existence of a national strategic plan  Yes  No

**2009** NSP DURATION **2015**

## EPIDEMIOLOGY FACTS

### Estimated number of new HIV infection 1990 - 2012



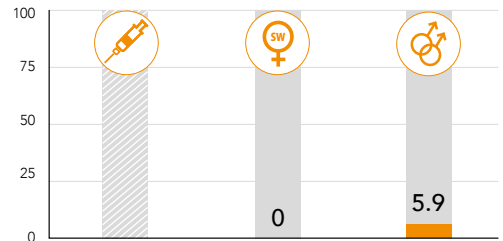
**19 000**

ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2012 data)

**9 000 - 47 000**

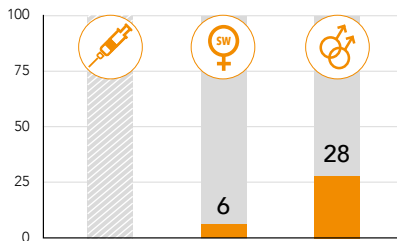
[LOW - HIGH ESTIMATE]

### HIV prevalence among Key Populations (%)

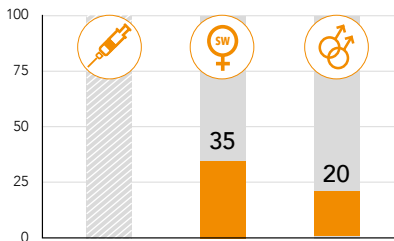


## HIV PREVENTION PROGRAMMES

### Key population tested for in the past 12 months and received the results (%)

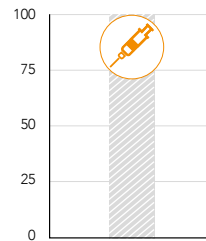


### Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



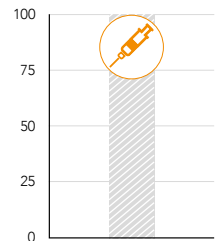
\* for sex workers is the sexual intercourse with the most recent client

### Use of Sterile Injecting Equipment among people who inject drugs\* (%)

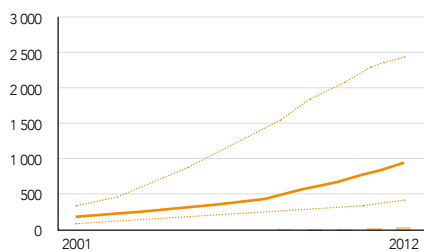


\* the indicator refers to the last time injecting

### Number of syringes distributed per person

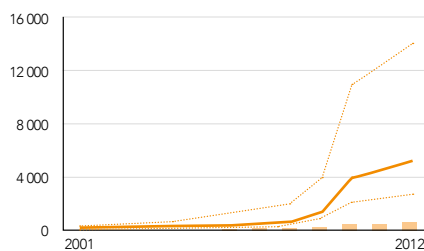


## eMTCT COVERAGE



Receiving ARV

## ADULT ART COVERAGE



Receiving ARV

(2012 data)  
**ADULT ART NEED**  
**5 249**  
[2 806 - 13 944]  
[LOW - HIGH ESTIMATE]

**RECEIVING ART**  
**703**

(2012 data)  
**PEDIATRIC ART NEED**  
**843**  
[432 - 2 165]  
[LOW - HIGH ESTIMATE]

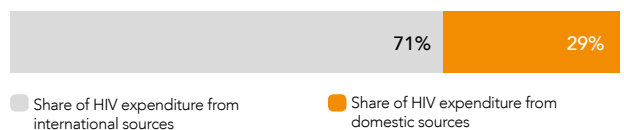
**RECEIVING ART**  
**53**

## LAWS, REGULATIONS OR POLICIES THAT PRESENT OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATION AT HIGHER RISK AND VULNERABLE GROUPS

	GOVERNMENT RESPONSE	CIVIL SOCIETY RESPONSE
Women	<input type="checkbox"/>	<input type="checkbox"/>
Young people	<input type="checkbox"/>	<input type="checkbox"/>
People who inject drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Men who have sex with men	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Female Sex Workers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prisoners	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Migrants/Mobile populations	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Legend:  Yes,  No,  No data

## HIV EXPENDITURE



## PRESENCE OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV



**YES**

Source of information: Global AIDS Response Country Progress Reports 2012 and 2013 / The Human Development Report 2013 / Spectrum Estimation/Projection country files





**UNAIDS** Regional Support Team for the Middle  
East & North Africa

Abdoul Razzak El-Sanhouri Street, 20

Nasr City  
Cairo, Egypt

Tel: (+20) 222765257