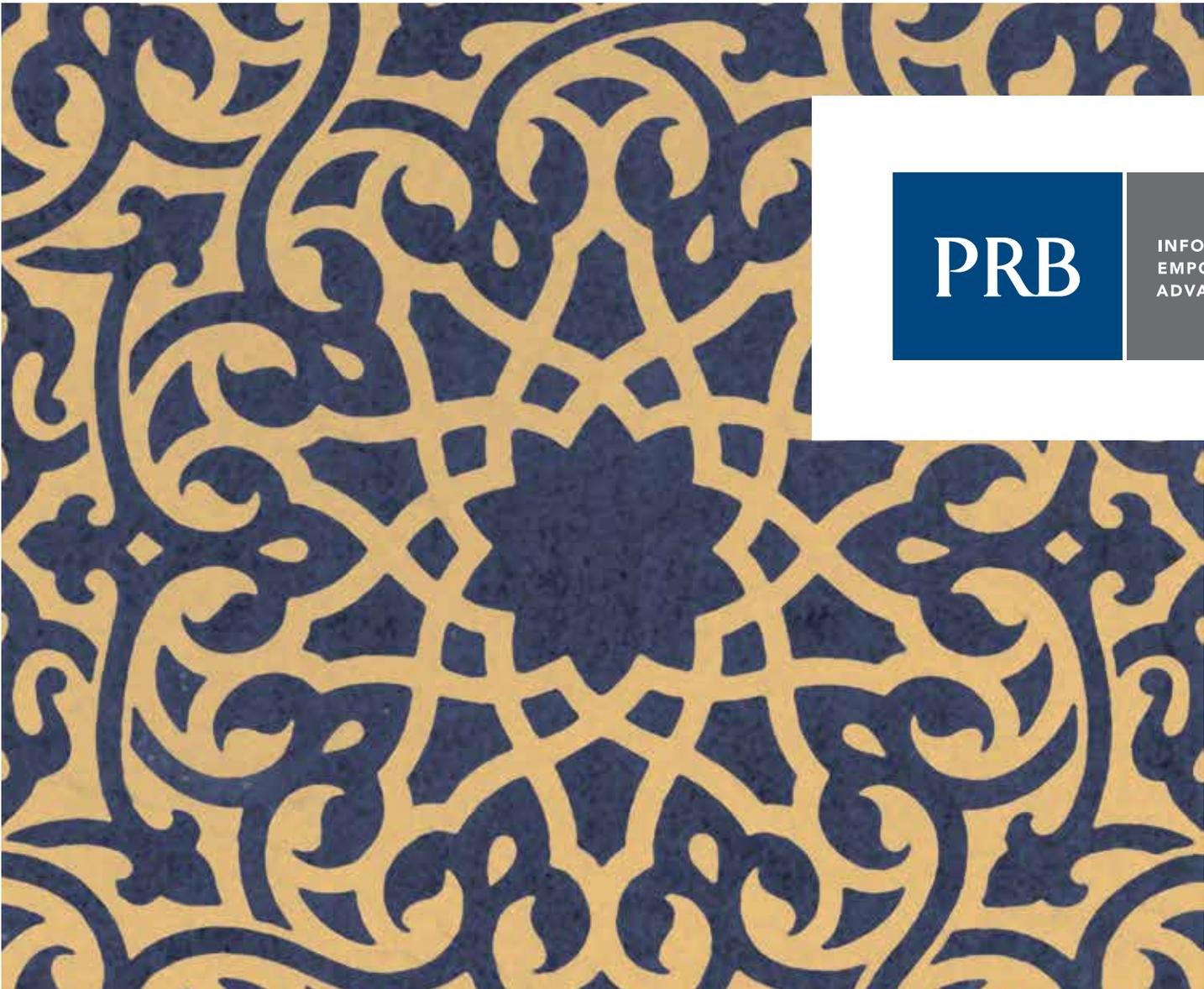




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BY **HAMIDREZA SETAYESH, FARZANEH ROUDI-FAHIMI, SHEREEN EL FEKI,  
AND LORI S. ASHFORD**

# HIV AND AIDS IN THE MIDDLE EAST AND NORTH AFRICA

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JUNE 2014

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## ACKNOWLEDGMENTS

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# HIV AND AIDS IN THE MIDDLE EAST AND NORTH AFRICA

BY HAMIDREZA SETAYESH,  
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SHEREEN EL FEKI, AND  
LORI S. ASHFORD

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The Middle East and North Africa (MENA) region defined in this report is consistent with the geographic scope of the UNAIDS' region, but differs from previous PRB reports. It includes Algeria, Bahrain, Djibouti, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Palestinian Territory, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, United Arab Emirates (UAE), and Yemen.

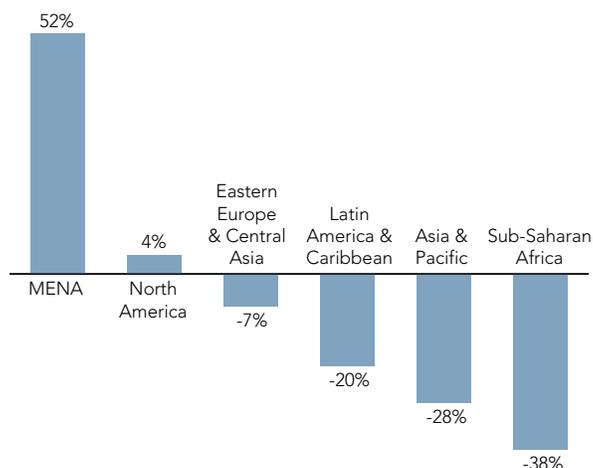
# 1. HIV IN MENA: LOW PREVALENCE, GROWING RISK

## KEY POINTS

- Rates of HIV infection in the Middle East and North Africa (MENA) are among the lowest in the world, yet MENA is one of only two world regions where HIV is still on the rise.
- Infections are spreading in every country, though the principal routes of transmission vary.
- MENA countries cannot count solely on their cultural and religious values to safeguard their populations against the HIV infection.

Around 270,000 people were living with HIV in the Middle East and North Africa (MENA) as of the end of 2012, according to the Joint United Nations Programme on AIDS (UNAIDS).<sup>1</sup> This translates to an overall HIV prevalence of 0.1 percent among adults ages 15 to 49, one of the lowest rates in the world. But other statistics tell a different story. Between 2001 and 2012, the number of new infections in MENA grew by 52 percent—the most rapid increase in HIV among world regions (see Figure 1).<sup>2</sup>

**FIGURE 1**  
Percentage Change in the Estimated Annual Number of New HIV Infections by World Region, 2001-2012



Source: UNAIDS, *Global Report: UNAIDS Report on the Global AIDS Epidemic 2013*.

AIDS-related deaths are also on the rise, more than doubling in MENA between 2001 and 2012 (see Table 1), while declining by 16 percent worldwide.<sup>3</sup> The increase is due in large part to low levels of antiretroviral therapy (ART)—a combination of medicines that extends the lives of those infected with HIV and reduces the likelihood of transmission of the virus. On average across MENA, only one in five people in need of ART is receiving it—the lowest coverage rate among world regions.<sup>4</sup> Coverage is particularly inadequate for women and children: Less than 10 percent of pregnant women living with HIV receive antiretroviral medicines to prevent HIV transmission to their newborns—also the lowest rate among world regions.<sup>5</sup>

**TABLE 1**  
HIV in MENA

270,000	Adults and children living with HIV in MENA in 2012, a 134 percent increase from 114,000 in 2001. <sup>1</sup>
16,500	AIDS-related deaths in 2012, a 176 percent increase from 6,000 in 2001. <sup>2</sup>
18%	Coverage of antiretroviral therapy among adults and children who needed the treatment at the end of 2012, with 20,000 people on treatment.
8%	Coverage of antiretroviral therapy among pregnant women who are living with HIV to prevent transmission of HIV to their babies, and keeping mothers alive, with almost 700 pregnant women receiving the treatment in 2012.

<sup>1</sup> Range: 80,000-190,000 in 2001 to 200,000-380,000 in 2012.

<sup>2</sup> Range: 3,000-11,000 in 2001 to 11,000-26,000 in 2012.

Source: UNAIDS, *2013 Regional Report for Middle East and North Africa*.

## Spread of HIV in MENA

The first AIDS cases in MENA were reported in the mid-1980s. By 1990, every country was home to people living with HIV, the vast majority of whom were infected through exposure to HIV abroad, HIV-contaminated blood products, or organ transplants. Within a few years, however, new patterns of transmission emerged. With the exception of South Sudan, parts of Somalia, and Djibouti where the virus is spreading in the general population, HIV in MENA is concentrated in certain groups whose practices put them at a higher risk of infection—namely, men who have sex with men, female sex workers, and people who inject drugs (see [Table 2](#)).

Today, the number of new infections is rising in every MENA country, although the principal routes of transmission vary from one to another:

- In Iran and Libya, for example, the majority of infections occur among people who inject drugs and their networks of sexual and injecting partners. Injecting drug use is a main contributing factor for HIV transmission in several other countries as well.
- In Djibouti, South Sudan, and parts of Somalia, HIV is primarily spreading through commercial sex networks. Concentrated epidemics (that is, an HIV prevalence of more than 5 percent) exist among subgroups of female sex workers in a number of countries.
- Concentrated HIV epidemics are emerging among men who have sex with men in parts of the region (see [Box 1](#)).

Global experience has shown that HIV can spread from these key groups to the general population, especially when the former lack access to prevention and treatment services.<sup>6</sup> In Morocco, for example, the vast majority (89 percent) of HIV

infections among men are due to high-risk behaviors such as having unprotected sex with other men or with female sex workers, or sharing contaminated needles.<sup>7</sup> About half of Morocco's new HIV infections are among women, nearly three-quarters of whom acquired the infection through sexual relations with their husbands. Also in Iran—home to the second largest number of people living with HIV in MENA (see [Table 3, page 5](#))—three-quarters of women living with HIV acquired the virus from their husbands, who were mainly injecting drugs.<sup>8</sup> As the number of women living with HIV

### BOX 1

## Men Who Have Sex With Men: A Critical Population

Men who have sex with men are stigmatized in MENA due to strong sociocultural taboos against sex between men, reflected in laws in most MENA countries. A worldwide review shows that same-sex conduct is illegal in 76 countries, 19 of which are in MENA.<sup>1</sup> The region includes five of the seven countries worldwide where consenting homosexual acts are subject to the death penalty, at least on paper: Iran, Saudi Arabia, some parts of Somalia, Sudan, and Yemen.

A recent systematic review of health service statistics and survey data related to HIV and men who have sex with men in MENA reveals that HIV epidemics appear to be emerging in several countries, with a prevalence reaching up to 28 percent among certain groups.<sup>2</sup> By 2008, the sexual transmission between men accounted for more than a quarter of the total reported HIV cases in several countries. The review highlighted a number of factors facilitating viral transmission:

- Four to 14 sexual partners on average in the last six months among different populations of men who have sex with men.
- High rates of sexually transmitted infections, such as herpes simplex virus type 2, which increase vulnerability to HIV infection.
- A low rate of consistent condom use.
- The relative frequency of male sex work.
- Substantial overlap between same-sex relations and unsafe injecting drug use.

These alarming data point to an urgent need to expand HIV surveillance and access to HIV testing, prevention, and treatment services for men who have sex with men, and overlapping key populations.

### References

1 UN General Assembly, *Discriminatory Laws and Practices and Acts of Violence Against Individuals Based on Their Sexual Orientation and Gender Identity. Report of the High Commissioner for Human Rights* (Geneva: United Nations, 2011); and UNAIDS, *2013 Regional Report for the Middle East and North Africa* (Cairo: UNAIDS, 2013).

2 Ghina R. Mumtaz et al., "Are HIV Epidemics Among Men Who Have Sex With Men Emerging in the Middle East and North Africa? A Systematic Review and Data Synthesis," *PLOS Medicine* 8, no. 8 (2011): 1-15.

TABLE 2

### Estimates of HIV Prevalence Among Key Populations in Selected MENA Countries

PREVALENCE RATE	MEN WHO HAVE SEX WITH MEN	PEOPLE WHO INJECT DRUGS	FEMALE SEX WORKERS
1.0% to 4.9%	Lebanon Morocco Sudan	Bahrain Oman Saudi Arabia	Algeria Iran Morocco Sudan Tunisia Yemen
5.0% to 9.9%	Egypt	Egypt Tunisia	Somalia
10.0% or higher	Tunisia	Iran Libya Morocco	Djibouti South Sudan

Sources: UNAIDS, *Middle East and North Africa Regional Report on AIDS 2011*; and UNGASS country reports for Tunisia, Sudan, and Yemen, 2012.

grows in the region, so does mother-to-child transmission, in the absence of adequate preventive measures.

Research on key populations in MENA is limited and scattered, making it difficult to form a complete picture of the spread of HIV in the region. Published studies have increased gradually over time, with much progress in recent years, although most focus on issues related to HIV surveillance rather than on high-risk behaviors or HIV programs.<sup>9</sup> Iran and Morocco are among the few countries that have conducted wide-ranging research on HIV, reflected in the greater use of their data in this and other reports.

## Help or Hindrance: MENA's Social and Cultural Norms

The low prevalence of HIV in the general population in MENA has been attributed in part to the region's religious and cultural norms, which discourage premarital sex, encourage faithfulness within marriage, and include the universal practice of male circumcision. During the 1980s and 1990s, counting on their cultural and religious values to safeguard against infection, a number of governments in the region denied that their citizens were infected with HIV, blaming any existing cases on foreigners. Belatedly, these governments now acknowledge HIV within their borders.

Growing evidence shows that people in MENA are engaging in unsafe sexual and injecting drug practices. Some cultural practices, including child marriage, polygamy, and prohibitions against condom use, may even be exacerbating the spread of HIV. Gender inequalities, stemming from the low status of girls and women in the family and society, are endemic in MENA

and hinder political, economic, and social development, including the region's response to HIV.

HIV in MENA is a double bind. Those who are at greatest risk of infection are also engaged in practices, such as sex work or same-sex relations, that are condemned by religious doctrine, social norms, and often the law. This wide-ranging stigma and discrimination further fuels the epidemic by driving those living with HIV and those most at risk of infection away from testing and disclosure, making HIV prevention and treatment increasingly difficult. This is especially true given a background of poverty, illiteracy, gender discrimination, population mobility, and conflict in many countries.

Since the beginning of this decade, political upheaval in the Arab region has put a spotlight on human rights and development. Today, human rights principles are the cornerstone of global efforts to achieve UNAIDS' goals of "zero new HIV infections, zero AIDS-related deaths, and zero discrimination." Communities across MENA now have a unique opportunity to embrace human rights principles in their direct response to HIV and in creating the broader political, economic, and social conditions that will, in the long term, turn HIV from a looming crisis to a dwindling threat.

TABLE 3

### Estimated Number of People Living With HIV in Selected MENA Countries, End of 2012

COUNTRY	ESTIMATE	LOW - HIGH
Sudan	77,000	60,000 – 105,000
Iran	71,000	53,000 – 103,000
Somalia	31,000	21,000 – 47,000
Morocco	30,000	22,000 – 40,000
Algeria	23,000	12,000 – 41,000
Yemen	19,000	9,000 – 47,000
Djibouti	8,000	6,000 – 9,000
Egypt	7,000	4,000 – 10,000
Tunisia	2,300	1,400 – 3,800

**Note:** Determining the number of people living with HIV in any community involves solid epidemiology and intelligent guesswork. The number of people living with HIV is presented as an estimate within a lower and upper range of cases.

**Source:** UNAIDS, 2013 *Regional Report for the Middle East and North Africa: Country Snapshots*.

## 2. RISING TO THE CHALLENGE: HUMAN RIGHTS AND HIV

### KEY POINTS

- Human rights are at the heart of today’s global response to HIV and AIDS, promoting nondiscriminatory approaches to prevent transmission of HIV, and care for people living with the virus.
- A rights-based approach has the greatest potential impact in terms of reaching the people who are most at risk of HIV infection and keeping those living with the virus alive and healthy.
- The UN 2011 Political Declaration on HIV/AIDS calls for “zero new HIV infections, zero discrimination, and zero AIDS-related deaths,” and new Arab agreements reinforce this declaration for the region.

In MENA, attitudes toward HIV were shaped early and have been slow to change. Even though the first diagnosed cases in MENA in the 1980s were linked to blood transfusions and blood products imported from outside the region, regional media largely portrayed AIDS as a disease of “immorality” and “western promiscuity” among homosexuals and others perceived to have strayed from “traditional values.” As a consequence, people living with HIV quickly faced stigma and discrimination.

Around the world, fear and stigma is a common reaction to HIV, especially in the early years of an epidemic. Such was the case in western Europe and America, but social movements supporting the rights of people living with HIV in the 1980s began the long process of shifting mindsets. In 1987, in its first resolution on AIDS, the World Health Organization (WHO) called for solidarity and compassion and for governments to respect the rights of people living with HIV.<sup>10</sup>

Yet these developments had little impact in MENA. HIV received little public attention in the region until the early 2000s, when the number of people living with HIV had increased and cases of school and job dismissals were publicized. Now, more than three decades into the epidemic, people living with HIV in MENA continue to face the sort of discrimination that characterized the early years of HIV in the West, including mandatory HIV testing, restrictions on international travel, barriers to employment and housing, and difficulty obtaining medical care and health insurance.<sup>11</sup>

### UN Declarations on HIV and AIDS

At the UN General Assembly Special Session on AIDS in 2001, the international community adopted a declaration making human rights a core principle of the global response to HIV, noting that “the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic.” This groundbreaking approach holds governments accountable for making sure that national efforts to respond to HIV are consistent with international human rights law. Although governments are not legally bound to implement the promises made in the declaration, they are required to submit regular progress reports to the UNAIDS Secretariat.

Five years later, in 2006, governments unanimously adopted the Political Declaration on HIV/AIDS at the close of the UN General Assembly High Level Meeting on AIDS. This declaration reaffirmed the 2001 declaration as well as the Millennium Development Goals, a set of eight goals (including one on AIDS) adopted by world leaders after the 2000 Millennium Summit to reduce poverty and promote development. The 2006 declaration also recognized the urgent need to scale up programs to reach the goal of universal access to HIV prevention, treatment, and care, and universal support for those living with HIV by 2010.

In 2011, at the 10th anniversary of the landmark UN General Assembly Special Session on HIV/AIDS, the assembly adopted a new Political Declaration on HIV/AIDS, calling for “zero new HIV infections, zero discrimination, and zero

AIDS-related deaths.” The declaration set 2015 as the deadline for achieving 10 specific targets:

- Reduce new HIV infections among adults by 50 percent.
- Reduce transmission of HIV among people who inject drugs by 50 percent.
- Eliminate new HIV infections in children.
- Enable access to HIV treatment for 15 million people.
- Reduce tuberculosis deaths among people living with HIV by 50 percent.
- Increase investments for a scaled-up response to HIV.
- Eliminate gender inequalities and gender-based abuse and violence, and increase the capacity of women and girls to protect themselves from HIV.
- Eliminate stigma and discrimination against people living with and affected by HIV through laws and policies that ensure the full realization of human rights and fundamental freedoms.
- Eliminate HIV-related restrictions on entry, stay, and residence in countries.
- Strengthen the integration of HIV with other health and development efforts.

## Arab Agreements on HIV and AIDS

To adapt the 2011 Political Declaration on HIV/AIDS to local culture and laws, Arab countries developed several policy documents, among them *The Arab Strategic Framework on HIV and AIDS (2013-2015): Working towards an AIDS-Free Generation in the Arab Countries*. In addition, the Arab Parliament adopted the *Arab Convention on the Prevention of HIV and the Protection of Rights of People Living with AIDS*. These policy documents, described below, are compatible with international agreements and treaties related to human rights and are in accordance with Islamic Shari’a.

**The Arab AIDS Strategy**, laid out in *The Arab Strategic Framework on HIV and AIDS* and endorsed by the Council of Arab Ministers of Health in 2014, is an action plan for scaling up regional and national responses to the epidemic.<sup>12</sup> It grew out of the “Arab AIDS Initiative,” a political initiative led by Saudi Arabia and launched by the Arab Ministers of Health in 2011. The strategy was developed through a consultative process with members of the League of Arab States, UNAIDS, and civil society organizations.

The main purpose of the strategy is to help countries take action, in accordance with their national situation and resources, toward achieving the goals and targets of the 2011 Political Declaration on HIV/AIDS. The strategy calls for universal access to HIV prevention and treatment, and for support for people living with HIV and the most-at-risk populations. It recommends that countries review and update their national HIV policies, strategies, and plans to ensure that they are based on human rights principles, informed by evidence,

sensitive to the needs of women and youth, and multisectoral in their approach. It also calls on governments to strengthen HIV surveillance systems and to monitor progress achieved toward the strategy’s targets.

**The Arab Convention on the Prevention of HIV and the Protection of Rights of People Living with AIDS** addresses all aspects of human rights related to HIV prevention and support for people living with HIV. It was approved in 2012 in the first regular meeting of Arab Parliament, an institution of the Arab League created to give citizens of the Arab world a voice alongside that of governments.<sup>13</sup> The Arab Convention provides a legal framework for countries to apply human rights principles in their response to HIV. Its purpose is to ensure that all people living with HIV are able to fully participate in society on equal footing with other people, with respect for their dignity, firm in the conviction that such efforts lead to an increased sense of belonging and responsibility in the prevention of HIV.

The Arab Convention emphasizes the importance of integrating the issues facing people living with HIV into national development strategies. Its 26 articles cover a wide spectrum of human rights issues, from the right to privacy and freedom of movement to the right to equality and nondiscrimination and the right to litigate. It also notes the right to health care and education, the role of media in raising awareness, and the rights of women and children living with HIV, as well as migrants, refugees, and prisoners with HIV. Moreover, it calls on governments, in their outreach programs to at-risk groups, to protect workers from legal prosecution during the exercise of their work.

## Applying Human Rights Law to HIV

International human rights law makes governments publicly accountable for their actions toward people in the context of HIV and AIDS, and responsible for respecting, protecting, and fulfilling their rights.<sup>14</sup> In some cases, MENA governments have endorsed such agreements in general terms but expressed reservations that they will not implement articles that conflict with Shari’a (Islamic law) or national law. Such conflicts arise in the case of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child—two international human rights agreements that are binding. They call for, among other things, girls’ and women’s equal rights in areas such as inheritance and the legal age of marriage, and the rights of unmarried individuals to access sexual and reproductive health information and services. The Arab Charter on Human Rights, published in 1994, however, adapts some of the internationally accepted concepts of human rights to the regional context.<sup>15</sup> Its Article 5 states that everyone has the right to life, liberty, and security of person, and that these rights are protected by law.

In some limited situations, which cannot be applied to HIV, international human rights law allows governments to legitimately restrict individual rights to achieve a greater purpose,

such as protecting public health.<sup>16</sup> For example, a government might establish quarantine, limit travel, and isolate infected people during an outbreak of a serious communicable disease such as Ebola fever, typhoid, or untreated tuberculosis. But these measures should be transparent and follow established procedures. Restrictions of people's freedom and rights are serious issues under international human rights law, and should only be implemented when less-intrusive means cannot achieve the same goal.<sup>17</sup>

Evidence shows that criminalizing people living with HIV or key populations based on the assumption that they expose others to infection has had little or no impact in terms of changing behavior—which is essential to containing the HIV epidemic.<sup>18</sup> Instead, criminalization tends to drive these behaviors underground and discourage people from seeking HIV testing and other critical health services because of fear of punishment. In the MENA region, where many countries base their criminal laws on Shari'a, *fatwas* (religious edicts) can play a crucial role in Islamic courts. In some countries, such as Iran, there have been *fatwas* advising severe punishments for transmission of HIV, although they have remained on paper only. On the other hand, an Iranian judiciary decree on the noncriminal nature of activities dealing with key populations has helped nongovernmental organizations (NGOs) working on HIV in the country: In the past, such activities would have been construed as aiding and abetting criminals.

A “human-rights approach” to HIV as called for in international policy agreements means, simply stated, giving people nondiscriminatory access to information and services in a supportive environment. One challenge to putting these principles into practice is that lawmakers and lawyers in the MENA region are not well informed about the complexities of HIV and how to enable prevention programs to work legally—for example, making it easier to provide condoms. Education efforts (described in Chapter 5, p. 18) are needed to improve legal services to help people living with HIV gain access to the justice system, so that their rights can be enforced.

Countries in the MENA region have taken gradual steps toward recognizing and adopting international standards, but they still have far to go. With the MDGs set to expire in 2015, the international community is crafting a new development agenda centering on human rights, government accountability, and eliminating wide disparities in people's status and opportunities.<sup>19</sup> With “Leave No One Behind” as its motto, the emerging post-2015 agenda will provide an opportunity for governments, including MENA governments, to embrace principles of equality and nondiscrimination, and view them as a measure of societal progress and a benchmark for a just and fair society.

# 3. PREVENTION: REACHING OUT TO VULNERABLE POPULATIONS

## KEY POINTS

- Reaching out to key populations—female sex workers, men who have sex with men, and people who inject drugs—is critical because they are most at risk of acquiring HIV.
- Preventing the spread of HIV to the general population largely depends on the success of prevention measures within these three populations.
- In the absence of a vaccine, antiretroviral therapy has emerged as a powerful prevention tool because it reduces the likelihood of HIV transmission.
- Some groups, such as young people, women, migrants, refugees, prisoners, and street children, are especially vulnerable to HIV infection because of the context in which they live.

HIV can be transmitted in four ways: through unprotected sexual intercourse with a person who is living with HIV; from pregnant women living with HIV to their babies during pregnancy, delivery, or breastfeeding; by people sharing contaminated equipment for injecting drugs; or by receiving contaminated blood, blood products, or organ transplants. Efforts to prevent transmission through these routes combine biomedical, behavioral, and structural approaches:

- Biomedical interventions aim to reduce infectiousness or susceptibility. Examples include treatment of sexually transmitted infections; antiretroviral therapy as prevention; male circumcision; and preventing new HIV infections among infants and babies.
- Behavioral interventions are those that systematically encourage individuals to adopt safer attitudes and practices so they are less likely to be exposed to HIV. Examples include restricting intercourse to one sexual partner who is not living with HIV; using condoms as a barrier to sexual transmission; and using clean equipment—including cookers, water, swabs, syringes, and needles—when injecting drugs.
- Structural interventions are also necessary to address the social, cultural, economic, and legal constraints that increase the risk of HIV infection, and make living with HIV all the more difficult. Reforming punitive laws and policies are among these.

Biomedical interventions are the most readily accepted in MENA, as many are already in practice and, generally speak-

ing, pose little challenge to social and religious norms. The universal practice of male circumcision may have contributed to relatively low rates of HIV prevalence in MENA, as international studies now confirm that circumcised men are less likely than their uncircumcised peers to contract the virus from HIV-infected partners.<sup>20</sup> Across the region, blood safety systems are generally in place and antiretroviral treatment is available for those living with HIV. The medications used in antiretroviral therapy reduce levels of virus in the bloodstream to undetectable levels, and evidence shows that this reduces the likelihood that HIV will be transmitted to others. Yet, MENA has the lowest treatment coverage in the world, in part because people are reluctant to be tested due to high levels of stigma and discrimination associated with HIV and because they fear their HIV status will not remain confidential. Moreover, underfunding, poor management, inadequate health services, and ongoing political crises and conflicts often lead to intermittent drug shortages (stockouts), which put ART even further out of reach.

Biomedical and behavioral interventions are more effective when they are closely linked with measures that address the social, cultural, economic, and legal structures in the surrounding environment that affect exposure to HIV. Examples of such measures include reforming laws and their enforcement to protect people's rights—especially those of women, young people, and people living with HIV—and information and education efforts to raise awareness and reduce discrimination. The need to combine the biomedical, behavioral, and structural interventions makes HIV prevention a formidable challenge.

## Blood Safety

HIV infection through contaminated blood transfusions contributed to the first wave of infections in MENA. However, efforts at systematic surveillance of blood supplies mean that today it is safe to receive a blood donation in most parts of the region, except for the least developed countries and areas affected by conflict, including parts of Djibouti, Iraq, Somalia, South Sudan, Sudan, and Yemen.<sup>21</sup>

Although the means of securing a safe blood supply, including donor screening and quality assurance, are well-known, they are hard to implement in impoverished settings with weak health systems or fragile governments. Moreover, conflict situations increase the demand for blood while making its safety harder to secure. This situation is common in areas of chronic conflict, such as in Sudan and Somalia, and in those newly gripped by war, notably Syria and Libya, whose blood supplies were safer and more secure before the 2011 uprisings. Thus, for as long as involuntary blood donation (through force or purchase) is commonplace, and donor counseling, notification, and confidentiality are far from routine, universal blood safety will not be achieved in MENA.

## Mother-to-Child Transmission of HIV

Governments in MENA have embraced the global initiative to eliminate new HIV infections in children and keep their mothers alive: They have adopted the global targets of reducing the number of new HIV infections among children by 90 percent and the number of AIDS-related maternal deaths by 50 percent between 2011 and 2015.<sup>22</sup> But these targets will not be achieved with the current level of commitment and services in the region. In 2012, less than 10 percent of pregnant women living with HIV in MENA received antiretroviral therapy—the lowest among world regions (see Figure 2). In comparison, rates for North America, Europe, and the Caribbean are more than 95 percent.<sup>23</sup>

Some MENA countries are doing better than others on this front. In Morocco, about one-third of pregnant women living with HIV receive antiretroviral drugs, while more than 80 percent do in Tunisia.<sup>24</sup> The antiretroviral coverage among pregnant women living with HIV is exceptionally high in Oman, where antenatal care is nearly universal and all pregnant women attending antenatal care clinics are offered to be tested for HIV, with an acceptance rate of 99 percent.<sup>25</sup> Nearly 80 percent of pregnant women who tested positive in the antenatal clinics did not know they were infected.<sup>26</sup>

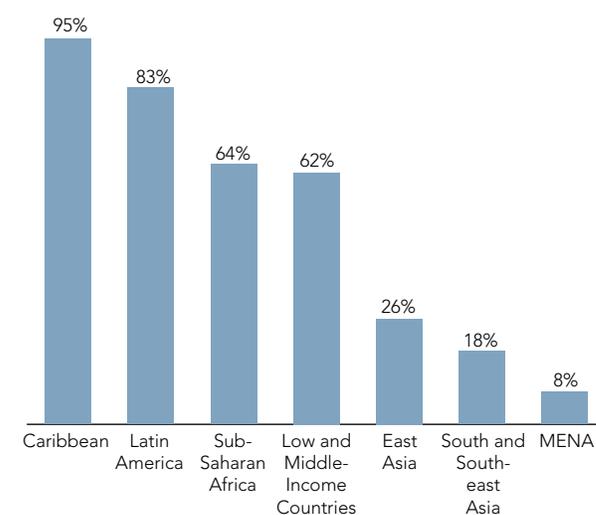
Primary prevention efforts often miss women who are infected by their husbands and are unaware of their exposure to HIV. The lack of universally available HIV testing to pregnant women on one hand, and women's reluctance to seek an HIV test on the other, has led to low ART coverage of pregnant women for the prevention of mother-to-child transmission. Scaling up HIV-prevention interventions for children in the region has been slow as well. In response,

MENA ministers of health have developed a common framework for eliminating mother-to-child transmission of HIV. Launched in 2012, the framework has made some progress in encouraging pregnant women to get tested.<sup>27</sup> In Morocco and Sudan, for example, the involvement of first ladies has helped to move the plan forward.

In general, public support has been higher for addressing mother-to-child transmission of HIV than for HIV-awareness campaigns dealing with other modes of transmission, which must grapple with powerful social and religious taboos. Media campaigns on mother-to-child transmission have increased demand for testing among pregnant women and reduced stigma for mothers who are living with HIV. However, in places where routine testing of pregnant women is not promoted, the perceived social disgrace associated with HIV testing remains a huge obstacle.

In spite of efforts now being made in the region to prevent mother-to-child-transmission of HIV, there are still missed opportunities. New infections in children could be averted more effectively (and cheaply) if services reached women earlier, along with their husbands or partners, and helped prevent HIV infection in mothers-to-be. This would entail, for example, empowering individuals to be tested for HIV (through voluntary premarital or postmarital testing, as opposed to the mandatory tests required in many countries in MENA) and educating them to use condoms if either partner is living with HIV. Using condoms along with other contraceptive methods, such as the Pill or IUD, would give women “double protection” from HIV transmission and unintended pregnancies.

**FIGURE 2**  
Percentage of Pregnant Women Living With HIV Who Received Antiretroviral Therapy for Preventing Mother-to-Child Transmission, 2012



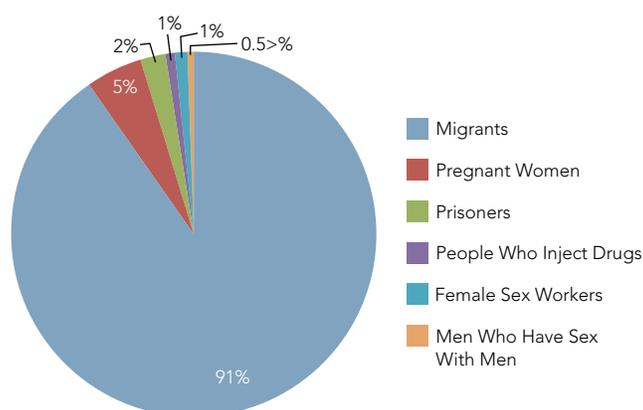
Source: UNAIDS, *Global Report: UNAIDS Report on the Global AIDS Epidemic 2013*.

## Reaching Out to Key Populations and Their Networks

Outreach to sex workers, men who have sex with men, and people who inject drugs is critical because they are most at risk of acquiring HIV and they contribute to a sizeable proportion of new infections in the region. But reaching these populations with HIV information and services is not easy, because their behaviors are viewed as illicit and very often illegal. Between 1989 and 2007, for example, less than 5 percent of HIV tests performed in the region were for these key populations. More than 90 percent of these tests involved migrants whose testing was a condition of entry and residence in countries in the region (see [Figure 3](#)).

NGOs play a critical role in reaching key populations whose practices do not conform to cultural norms or the law. [Box 2 \(page 12\)](#) presents examples of pioneering programs carried out by diverse organizations in Tunisia and Morocco. Lesbian, gay, bisexual, transgender/transsexual, and queer individuals (LGBTQ) are hard to reach because they are among the most stigmatized groups in MENA.<sup>28</sup> Helem in Lebanon was the first registered organization dealing with LGBTQ issues in the region; in recent years, other groups have emerged and are raising awareness of HIV testing and treatment and other fundamental human rights. Other key populations—especially female sex workers—lack even this nascent level of support.

**FIGURE 3**  
HIV Tests Conducted Among Selected Population Groups in the MENA Region, 1989-2007



Source: UNAIDS, *Middle East and North Africa Regional Report on AIDS, 2011*.

## Interventions to Change Behaviors Are More Challenging

Behavioral interventions are generally more challenging to implement than biomedical ones, because encouraging people to change their ways is a complex process. First, people need to be aware of the health risks they face; then, they must be motivated to change behavior, and then supported to switch to and continue safer practices. In the context of drug use, this means avoiding shared injection equipment, using less harmful types of drugs, and, if possible, getting off drugs altogether. Sexual transmission of HIV can be prevented by reducing the number of sexual partners and higher-risk sexual practices, staying faithful to only one sexual partner, and using condoms. In MENA, however, condoms are largely unpopular and rarely used.<sup>29</sup> A study of men in Egypt, for example, reveals many reasons for such low use: Many men do not believe they are at risk of STIs or HIV; others do not like the feeling of condoms or worry about their partner's reactions to suggesting condom use. Some believe they may be hazardous to use, and some are embarrassed about buying and using condoms or lack the skills to use them.<sup>30</sup>

Most of the behavioral interventions to prevent HIV in MENA focus on raising awareness about modes of transmission and promoting abstinence, but some take a stepwise approach. In the case of people who inject drugs, "harm reduction" programs use a multistage method to reduce the harmful health, social, and economic consequences associated with drug use. Such programs exist in fewer than five MENA countries, most notably in Iran whose comprehensive program includes free distribution of condoms and injecting equipment.<sup>31</sup> In the 2010 bio-behavioral survey of people who inject drugs in Iran, 92 percent reported using a clean needle and syringe on last injection.<sup>32</sup> The Iranian government distributes the equipment in pharmacies and in selected prisons (see also section on [Prisoners and Street Children, page 14](#)).

With regard to sex work, condom distribution is among the key strategies for HIV prevention. In Tunisia, some forms of commercial sex are legal, and condoms are made available within regulated establishments. Similarly, NGOs in a number of countries in the region—notably Morocco—are increasingly managing to get condoms to some of the people at risk. Around half of female sex workers in Morocco and Tunisia reported using a condom with their most recent client.<sup>33</sup> But overall, condom use is still largely taboo in the region. Sex workers caught by police in possession of condoms, for example, may face punishment because the condoms can be used as evidence of prostitution.

## Protecting Vulnerable Populations

Some groups, such as young people, women, migrants, refugees, prisoners, and street children, are more vulnerable to HIV infection than others because of the conditions in which they live.

## BOX 2

### Pioneering Programs in Tunisia and Morocco

#### RESPONDING TO THE NEEDS OF MEN WHO HAVE SEX WITH MEN IN TUNISIA

In 2004, the Tunisian Association for the Fight Against Sexually Transmitted Diseases (ATL MST/SIDA) initiated a pioneering project in Tunis to address the sexual health needs of men who have sex with men.<sup>1</sup> The project has since expanded to sites in 12 out of 24 administrative regions of Tunisia. When joining the program, men are asked to complete surveys whose results are used to define their priority needs, including HIV prevention, health and psychosocial support, and advocacy programs related to the fight against stigmatization and exclusion. Those who are HIV positive receive training on reducing the risk of transmitting HIV to others.

ATL MST/SIDA has given a voice to homosexual men and educated them on sexual health issues beyond HIV. The project uses peer educators to raise awareness about HIV among the homosexual community and to help them to deal with stigma and discrimination. It also trains medical and paramedical personnel on HIV issues such as modes of transmission and evaluating personal risk. The results of this project helped ATL MST/SIDA launch the first initiative in the field of ethics, HIV, and human rights in Tunis in 2011. Also in 2011, in a pioneering move for the region, ATL MST/SIDA conducted a national bio-behavioral survey of men who have sex with men in the country.

#### REACHING OUT TO KEY POPULATIONS IN MOROCCO

The Association for the Fight Against AIDS (ALCS) began its outreach programs in the early 1990s among female sex workers and men who have sex with men in Casablanca and Marrakech by mapping and identifying their needs.<sup>2</sup> Since then, other NGOs such as the Pan-African Organization for the Fight Against AIDS (OPALS FES), the Moroccan Association for Solidarity and Development (AMSED), and the Southern Association Against AIDS (ASCS) have joined to help scale up these interventions. Going to sites such as coffee shops, bars, and parks, their volunteers and outreach workers connect with female sex workers and men who have sex with men by listening, explaining HIV prevention, and offering information and services to them. In 2007, ALCS and other NGOs expanded their work to include harm-reduction programs for people who inject drugs. They are now active in three cities—Tangier, Tetouan, and Nador—providing a range of services, including HIV awareness and education, distribution of injection kits and condoms, and social and peer support. In addition, a pilot program offering opioid substitution therapy was launched in 2010.

Today, the NGOs in Morocco play a major role in HIV testing, using fixed centers and mobile units. ALCS organizes a national testing day every year, and also works with factory workers, prisoners, truck drivers, and migrants, among other at-risk populations. ALCS and OPALS have conducted some of the widest-ranging testing of HIV among female sex workers in MENA.

#### References

- 1 UNAIDS, *Thematic Segment: Non-Discrimination, Background Note* (Geneva: World Health Organization, 2012).
- 2 UNAIDS, *Middle East and North Africa Regional Report on AIDS 2011* (Geneva: UNAIDS, 2011).

## YOUNG PEOPLE AND WOMEN

MENA's young people and women are the largest population groups vulnerable to HIV infection because of their sheer numbers and also because they often do not perceive that they are at risk: Young people are presumed not to have sexual relationships until they are married, and married people are presumed to be faithful to their spouses. As anywhere else in the world, these are assumptions.

Surveys across the region show that young people, particularly young women, are largely left in the dark when it comes to sexually transmitted infections, including HIV.<sup>34</sup> A 2009 survey of young men and women ages 15 to 29 in Egypt revealed that only 2 percent to 3 percent knew all possible modes of HIV transmission.<sup>35</sup> More-educated youth were only slightly more likely to know of all the modes of HIV transmission, reaching 15 percent for women and 19 percent for men who had 16 years of schooling or more. Educational programs on HIV and AIDS that target youth are urgently needed throughout the region. Since most youth attend school, comprehensive sexuality education is a cost-effective way to reach out to young people with correct

information about HIV, although curricula are proving controversial and difficult to adopt across the region.<sup>36</sup> In their absence, radio shows, social media, and telephone hotlines are proving to be valuable alternatives in providing information to youth.<sup>37</sup>

In principle, married women, whose husbands are their only lifetime sexual partner, should have less reason to worry about STIs, including HIV. However, some husbands may have relations with sex workers, or they may inject drugs. Also, recent research on men who have sex with men in the region suggests that a significant proportion of these men are also married, leaving their wives vulnerable to infection.<sup>38</sup> Women often lack the power to demand fidelity or condom use within marriage. Young women are especially vulnerable to HIV because they generally marry men who are older and more sexually experienced and who may have been previously exposed to STIs, including HIV. According to one report, one in seven girls in the Arab region marries before her 18th birthday, and rates of early marriage are highest in the least developed countries and poorer segments of society.<sup>39</sup> In Somalia, Sudan, and Yemen, a third or more of girls marry

### BOX 3

## Bordering on Discrimination

Migrants living with HIV in MENA face challenges in their host countries above and beyond the usual difficulties of life away from home. From 2000 to 2013, the number of countries, territories, and areas with HIV-related travel restrictions fell by more than half, to 41, and 13 of those are in the MENA region (see [map, page 2](#)).<sup>1</sup> Algeria, Djibouti, Iran, Libya, Morocco, and Tunisia are the only countries in the region that do not impose any restrictions on foreign travelers living with HIV.<sup>2</sup> In the rest of the region, laws vary in their degree of discrimination against people living with HIV:

- Countries of the Gulf Cooperation Council (GCC)—Bahrain, Kuwait, Qatar, Oman, Saudi Arabia, and United Arab Emirates—where the great majority of migrants in the region live, generally have more restrictive laws concerning non-nationals living with HIV than other countries in the region.
- Laws in Bahrain, Egypt, Iraq, Jordan, Kuwait, Oman, Qatar, Saudi Arabia, Sudan, Syria, United Arab Emirates, and Yemen allow for the deportation of any foreign national living with HIV, without appeal, even for people legally residing in the country.
- Laws in Egypt, Iraq, and Qatar impose mandatory HIV testing on foreign nationals, even for short-term stays (10 to 90 days).
- Four out of five countries in the world that have a complete ban on the entry and stay of people living with HIV are in MENA: Oman, Sudan, United Arab Emirates, and Yemen.
- Four MENA countries—Egypt, Lebanon, Jordan, and Sudan—report that they are on track to meet the global goal of removing all travel bans on people living with HIV by 2015.

Countries generally justify their travel bans on the basis of protecting public health or reducing the economic burden to their health services—justifications that WHO dismisses as unfounded. Without safeguards in place for informed consent and of confidentiality of test results, foreign nationals living with HIV can be dismissed from work on the spot and forcibly returned to their home country. Deporting HIV-positive immigrants raises the issue of whether the sending or receiving country should be responsible for their HIV treatment and care when they were infected while living in the host country.

MENA countries' travel restrictions, along with the absence of comprehensive anti-discrimination laws and deportation policies, make it virtually impossible for migrants living with HIV to seek treatment or legal services. As a result, most instances of discrimination against migrants are undisclosed or poorly documented and only rarely brought to court. There have been a few exceptions in which cases have been publicized in the media: For instance, in 2011, a South African journalist was deported from Qatar after being diagnosed with HIV and sacked by the satellite network Al-Jazeera.<sup>3</sup> Despite increasing political pressure, many countries in the region remain resistant to changing their restrictive policies on migrants living with HIV, in blatant violation of human rights.

### References

- 1 UNAIDS, *Global Report: UNAIDS Report on the Global AIDS Epidemic 2013* (Geneva: UNAIDS, 2013).
- 2 UNAIDS, *2013 Regional Report for the Middle East and North Africa* (Geneva: UNAIDS, 2013); 53; *UNAIDS Middle East and North Africa Regional Report on AIDS 2011* (Geneva: UNAIDS, 2011); and UNAIDS, "HIV-Related Restrictions on Entry, Stay, and Residence," accessed at [www.gbchealth.org/system/documents/category\\_13/274/UN%20TravelRestrictions\\_FactSheet.pdf](http://www.gbchealth.org/system/documents/category_13/274/UN%20TravelRestrictions_FactSheet.pdf), on April 24, 2014.
- 3 Agence France-Presse, "HIV+ Journalist Says Deported From Qatar, Sacked by Al-Jazeera" (Dec. 3, 2011), accessed at [www.ndtv.com/article/world/hiv-journalist-says-deported-from-qatar-sacked-by-al-jazeera-154911](http://www.ndtv.com/article/world/hiv-journalist-says-deported-from-qatar-sacked-by-al-jazeera-154911), on April 24, 2011.

before age 18. On average, the younger the bride, the wider the age difference between spouses. In Morocco, for example, 13 percent of girls marry before age 18, and these girls are twice as likely to have a husband who is at least 10 years older than women who marry in their 20s.<sup>40</sup>

The average age at marriage, however, has increased in MENA countries—for men and women—and an increasing number of young people today remain unmarried throughout their 20s and well into their 30s. Because of social disapproval of sexual relations outside of marriage, survey data on their sexual activity are limited. But in the few MENA countries where surveys have been conducted on this issue, a majority of young men and a minority of women report having sexual relations before marriage.<sup>41</sup> Meeting the needs of this growing group of young people for sexual and reproductive health information and services has been largely overlooked.

## MIGRANTS AND REFUGEES

Globally, HIV is more prevalent among mobile populations such as truck drivers and labor migrants, whose living conditions and lack of access to HIV prevention services can put them at a higher level of vulnerability to HIV infection. MENA has large movements of people, including from North Africa to Europe and from Egypt, Sudan, Jordan, and Yemen to the Gulf Cooperation Council (GCC) countries—Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and United Arab Emirates—where demand for foreign labor is high, attracting large numbers of laborers from Asia as well. In Qatar and the United Arab Emirates, migrants make up more than 90 percent of the total labor force.<sup>42</sup> The majority of countries in the region—GCC countries in particular—have laws requiring migrant workers to be tested for HIV and allow governments to deny visas and deport migrants solely on the grounds of their positive HIV status (see [Box 3](#)).

Recent conflicts in the region have added millions to MENA's already large internally displaced and refugee population. Forced displacement, whether inside a country or across borders, heightens the risk of exposure to HIV infection because social norms and networks are disrupted; there is increased sexual and gender-based violence; people may adopt riskier behaviors to cope with their situations; and condoms may be inaccessible. The most vulnerable people of all are those who become victims of sex trafficking (usually young women), whose numbers are rising in the MENA region, including in Sudan, South Sudan, Syria, and Yemen.<sup>43</sup>

Protecting health should be among the basic rights of refugees and internally displaced populations. But HIV has not been high on the agenda of humanitarian agencies working in the MENA region, because HIV prevalence is low and immediate priorities generally prevail in refugee and conflict settings. While data are scarce, reports of rape, increased sexual violence, disruption of health and social services, and other factors are increasing people's vulnerability to HIV in these settings.<sup>44</sup>

### **PRISONERS AND STREET CHILDREN**

Prisoners and street children are more vulnerable to HIV because they are more likely to have unprotected sex and use nonsterile injecting equipment. But prevention programs involving these groups in the region have been limited and remain small in scale. Iran has had some success in addressing HIV transmission in prison settings, by having inmates participate in harm reduction programs that include testing and counseling and providing injecting drug users with clean needles and syringes and opioid substitution therapy.<sup>45</sup> These pioneering programs complement those already underway

that make condoms available during "private conjugal meetings," in which married inmates can spend time privately with their spouses. All prisoners and their families are required to attend education sessions on HIV prevention.

A 2009 bio-behavioral survey of prisoners in Iran showed that 2 percent of inmates (both female and male) were living with HIV—down from around 4 percent in 2002.<sup>46</sup> The 2009 survey, however, showed that the rate of HIV infection was still as high as 8 percent among inmates who had a history of injecting drugs. Today, an increasing number of MENA countries, such as Egypt, Lebanon, Morocco, and Tunisia, are also trying to address HIV transmission among their prisoners.

Helping street children protect themselves from HIV is a huge challenge, and falls under broader efforts to protect them from the abuse that they routinely experience in their daily lives. A recent study of street children ages 12 to 17 living in Egypt's two largest urban centers, Cairo and Alexandria, revealed that the vast majority (93 percent) have encountered harassment or abuse.<sup>47</sup> The majority of 15-to-17-year-olds reported being sexually active (67 percent); more than half of these said that they had multiple partners (54 percent) and that they never used condoms (52 percent). The study also revealed that these street children had substantially overlapping encounters with men who have sex with men, sex workers, and people who inject drugs, all of which exposed them to a higher risk of HIV. A 2010 survey of street children ages 10 to 18 in Tehran, Iran, showed that 4 percent to 5 percent were living with HIV, and as many as 9 percent of those who have used drugs were living with the virus—a rate similar to that found in a 2007 study of Iranian youth under age 25 who inject drugs.<sup>48</sup>

## 4. TREATMENT AND SUPPORT: LIVING WITH HIV

### KEY POINTS

- The MENA region has the lowest coverage rate of HIV treatment in the world.
- Early diagnosis and treatment help prevent AIDS-related disability and death and reduce the risk of HIV transmission.
- Effective national responses to HIV link the social, legal, and health needs and rights of people living with HIV, thereby increasing their dignity and security in society and improving their health.

The great majority of people living with HIV in MENA are not aware of their infection. Individuals and health authorities typically come to learn about infections through mandatory testing (for example, when applying for a job or travel visa) or when people are sick and seek hospitalization. Unfortunately, the majority of people with HIV reach the health system too late to take full advantage of treatment.

Due to advances in antiretroviral drugs and clinical practice, people living with HIV today can lead normal and productive lives if their infection is diagnosed and treated early. Optimal care involves identifying infected individuals, linking them to initial HIV care, and ensuring long-term adherence to treatment and health care—the so-called cascade of care. As noted in previous chapters, antiretroviral therapy (ART) increases the life expectancy of people living with HIV and helps prevent the spread of HIV by reducing levels of the virus in the bloodstream. The therapy consists of a combination of three or more antiretroviral drugs to prevent HIV from replicating, and is given under medical supervision.

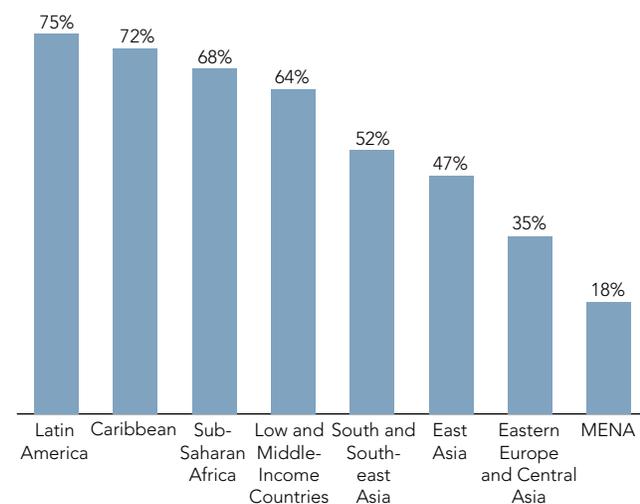
At the end of 2012, one in five people in need of ART in MENA was receiving the medicines, compared with a coverage rate almost three times higher in other low- and middle-income countries (see [Figure 4](#)).<sup>49</sup> Although the number of people receiving ART in MENA has more than doubled in recent years—from 8,700 people treated in 2009 to 19,400 in 2012, it is far from adequate.<sup>50</sup> Children born with HIV are particularly ill-served, as pediatric formulations of ART and specialized care are not available in many parts of the region.

### HIV Testing and Treatment

A number of factors hinder people from seeking HIV testing, which in turn leads to low rates of diagnosis and treatment. From a medical and public health perspective, the earlier an infection is identified, and the person enrolled in care and treatment, the better the prognosis of the disease, and the lower the risk of transmission to others. But many people at

FIGURE 4

Percentage of Adults Needing Antiretroviral Therapy Who Receive It, 2012



Sources: UNAIDS, *Global Report: UNAIDS Report on the Global AIDS Epidemic 2013*; and UNAIDS, *2013 Regional Report for the Middle East and North Africa*.

risk of HIV infection, as well as health care providers, are unaware of the benefits of early diagnosis and treatment. Many people still consider HIV a death sentence, unaware that treatment is indeed available and that early quality care can significantly prolong life expectancy. Fear of social disgrace, for themselves and their families, can outweigh the perceived advantages of treatment.

As discussed previously, the high levels of stigma and discrimination associated with HIV are the greatest barriers to people coming forward for testing. Members of key populations may avoid testing because of their fear of poor treatment by health providers and the possibility of being subjected to criminal charges. Confidentiality is a major concern for people considering HIV testing. Unauthorized disclosure of HIV status to family members, employers, and other health workers is a frequent abuse that can lead to severe consequences, including physical violence, for people living with HIV.<sup>51</sup>

Studies of people living with HIV in the region have revealed that stigma and discrimination in health care settings are common.<sup>52</sup> These studies found that denial of care, breach of confidentiality, testing without informed consent, poor quality of care, and gossip and blame were all frequent. Cases have been reported in Egypt, for example, of women living with HIV being denied treatment because health care providers wanted to know the source of their infection.<sup>53</sup> Sexual transmission is commonly (and mistakenly) seen as the result of illicit relations, despite evidence to the contrary that the majority of women living with HIV are infected through their husbands.<sup>54</sup>

Voluntary counseling and testing (VCT) centers are operating in most MENA countries, through government-sponsored clinics or NGOs. For example, Sudan has more than 200 VCT centers; Iran has more than 100; Morocco has more than 50; and Egypt has at least 20, including mobile units.<sup>55</sup> How frequently people use the centers varies across countries. In 2011, Morocco performed HIV tests in its VCT centers at a rate of one test for almost 500 inhabitants, compared to one test per 13,300 inhabitants in Egypt. The reluctance of key populations to seek testing is the main reason for underutilization of VCT centers in Egypt and elsewhere.

In reporting on implementation of the 2011 Political Declaration on HIV/AIDS to UNAIDS (see [Chapter 2](#)), about two-thirds of countries in the region acknowledged stigma and discrimination within the health care system.<sup>56</sup> A recent study in Egypt points to several factors that contribute to physicians and nurses' reluctance to provide services to HIV-positive patients.<sup>57</sup> These include limited knowledge about HIV and how to prevent it, doubts about the effectiveness of prevention measures, moral opposition to sex outside of marriage, fears among health providers of being stigmatized themselves by family members and co-workers, and misconceptions about care and treatment of people living with HIV. Studies in Egypt and elsewhere, however, have shown that proper training and education on how to treat people living with HIV have the po-

#### BOX 4

### Positive Clubs in Iran

Iran has successfully introduced Positive Clubs, with 14 centers across the country, reaching 10 percent of people diagnosed with HIV. The clubs' main activities include group therapy and psychosocial counseling for people living with and affected by HIV; workshops and education sessions on topics related to living with HIV; vocational training; booklets, posters, and public installations to raise awareness about living with HIV; conferences to advocate for engaging religious figures in psychosocial and spiritual support program for people living with HIV and their family members; dental care and vision aids; and collection of information on topics such as condom use and antiretroviral treatments.

Evidence shows that the Positive Clubs in Iran have helped improve the national response to HIV by encouraging members to adhere to treatment and empowering them to reach out to their communities to promote voluntary testing. In addition, the clubs' relationships with civil society organizations has helped increase the profile of people living with HIV in their wider community and in the eyes of decisionmakers. As a result, they have developed constructive and balanced working relationships among various stakeholders working on the HIV response, and have attracted support from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

**Source:** UNAIDS, *Thematic Segment: Non-Discrimination, Background Note* (Geneva: World Health Organization, 2012).

tential to change the attitudes of health care workers toward patients and to improve the quality of care.<sup>58</sup>

All MENA countries provide HIV treatment free of charge, but services are often centralized in few sites and are far from accessible to all who need them. Adherence to treatment can also be undermined by the side-effects of antiretroviral drugs, insufficient counseling, and a lack of choice of drugs due to financial constraints. More problematic, however, are the intermittent shortages of antiretroviral drugs. According to the International Preparedness Treatment Coalition, all MENA countries have been experiencing stockouts of these drugs.<sup>59</sup> Shortages of drugs and commodities may be due to poor planning, delivery, or other administrative factors; or external forces such as political uprisings, conflicts, and economic sanctions. Tunisia and Libya experienced stockouts during their recent uprisings, and international economic sanctions have limited Iran's access to new antiretroviral drugs.

In addition, during times of political and economic instability, people on antiretroviral therapy may drop out of treatment programs and develop drug resistance as a consequence, not only jeopardizing their own health but potentially facilitating the spread of the virus to their sexual or injecting partner(s). Moreover, many countries in the region lack pediatric formula-

## BOX 5

### MENA-Rosa: Portraits of Women Living With HIV

**MENA-Rosa** is the first regional group in the Middle East and North Africa dedicated to women living with HIV. Launched in 2010, its founding members were the first women in the region to speak extensively in public about their personal and family life with HIV. The name of the network originates from MENA (Middle East and North Africa), and Rosa, a woman's name, reminding the group of Rosa Parks, a black woman in the United States who famously refused to give up her seat on a bus to a white man, thereby helping to catalyze the civil rights movement for black Americans. MENA-Rosa offers women living with HIV a much-needed opportunity to talk about their many trials and occasional triumphs in dealing with HIV, from medical matters to family affairs.

In 2011, MENA-Rosa solicited the views of 200 women living with HIV in 10 countries across MENA: Algeria, Djibouti, Egypt, Iran, Jordan, Lebanon, Morocco, Sudan, Tunisia, and Yemen. Parts of their stories and voices are narrated in a UNAIDS report, *Standing Up, Speaking Out: Women and HIV in the Middle East and North Africa*.

The interviews revealed that:

- The majority of women received HIV tests late in the course of infection.
- Two-thirds (65 percent) were tested because of their husbands' positive test, his illness, or death, or were

referred for testing due to suspected HIV-related symptoms such as tuberculosis.

- Half of the women were tested under pressure or without their knowledge.
- One-third never received counseling when they had the test.
- Three-quarters of the women had children and one in four children was diagnosed HIV positive.

One in three of the women (35 percent) was advised by a health professional not to have a child; 17 percent were coerced by health care professionals into being sterilized; and 8 percent were coerced by a health professional to have an abortion in the year before the study. One in five women had been forced to change her place of residence or was unable to rent an accommodation in the previous year because of her HIV status. In the same period, 36 percent of the working women lost their jobs or sources of income. Half of them had to stop work due to poor health.

In the year preceding the study, 10 percent of the women's school-age children were dismissed, suspended, or prevented from attending school because of their mothers' HIV status; 30 percent of the women were denied medical or dental services; and 15 percent were denied family planning and reproductive health services because of their HIV status.

**Source:** UNAIDS, *Standing Up, Speaking Out: Women and HIV in the Middle East and North Africa* (Cairo: UNAIDS, 2012).

tions of the drugs outside of specialized centers in the capital. As a result, children are often treated with "adjusted" dosages of adult formulations, far from best clinical practice.

### Supporting People Living With HIV

Linking the social, legal, and health needs and rights of people living with HIV can have reinforcing effects that improve their health, dignity, and security in the society. Community-based approaches such as "Positive Clubs" are used around the world, including in the MENA region, to bring together people living with HIV and their families to create a social support network and build their self-esteem while receiving professional help. An important aspect of the positive health, dignity, and prevention approach is to involve people living with HIV in formulating policies and programs as much as possible (see [Box 4](#), page 16).

The concept of positive prevention does not preclude the right of people living with HIV to have a safe sexual life and have children. In reality, however, no programmatic guidance

exists in the region on the sexual and reproductive health needs of people living with HIV. Lacking such guidance, health providers may arbitrarily violate patients' rights. In Sudan, for example, there have been reported cases of health care workers denying sex workers living with HIV access to hospitals or summarily discharging them from care unless they consent to sterilization, an abuse experienced by women living with HIV in some other parts of the region as well.<sup>60</sup>

The situation is especially challenging for women living with HIV because women in MENA societies are generally disadvantaged economically, socially, and culturally, and routinely experience gender-based discrimination in their daily lives, in addition to living with HIV. While men are likely to be forgiven for behaviors that lead to infection, women are often blamed for their condition, despite the fact that most reported cases of HIV among women stem from their husbands.<sup>61</sup> Nearly half of people living with HIV in the region (44 percent) are women. Slowly, and against considerable odds, women living with HIV in MENA are finding their voice and speaking publicly about their experiences (see [Box 5](#)).

## 5. KEY PARTNERS: CIVIL SOCIETY, MEDIA, AND FAITH-BASED INITIATIVES

### KEY POINTS

- Involving civil society organizations is crucial to every aspect of the HIV response: advocacy, funding, prevention, and treatment.
- NGOs play a critical role in reaching key populations at risk of HIV, particularly when their practices are prohibited by law or cultural norms.
- The media has the power to break the silence on taboo subjects such as HIV and AIDS, and shed light on stigma and discrimination.
- Religious leaders and institutions can help countries' HIV response by providing support and spiritual counseling to people living with HIV and their families, reaching out to the most vulnerable groups in society, and dispelling fear and discrimination.

Involving civil society organizations is key to an effective HIV response, from advocacy to funding, prevention, and treatment. Gaining the support of religious leaders and establishments, nongovernmental organizations (NGOs), and the media helps change attitudes and break the silence on taboo subjects such as HIV and AIDS. It encourages key populations to go for testing and empowers people living with HIV to voluntarily disclose their status in safety, to protect themselves and others from sexually transmitted infections, and to delay the progression of AIDS. While the role of civil society in the HIV response in MENA has grown significantly in recent years, it remains limited and is largely driven by donors.

### NGOs

NGOs are instrumental in their willingness to reach out to key populations at higher risk and people living with HIV and work with them for prevention and treatment (see [chapters 3 and 4](#)). NGOs' work can complement governmental efforts, working where governments cannot because of limited public resources or laws that they must enforce. Moreover, because of their work in communities, NGOs are better positioned and trusted to involve members of key population groups in their outreach activities, and they can collect data on these populations to inform programs and policies.

In addition to enhancing prevention, a robust NGO sector can help address MENA's treatment crisis by:

- Mobilizing communities and vulnerable groups for HIV testing to create demand for treatment.
- Raising awareness in communities about the rights of people who are most at risk.
- Providing counseling and support to people living with HIV.
- Supporting health services by linking people living with HIV to treatment and care centers.
- Advocating for and providing legal services and support to people living with HIV to claim their rights.

Many NGOs in the region are involved in raising awareness among health professionals and people living with HIV alike, helping reduce stigma and discrimination within health care settings. The representatives of MENA Rosa in Yemen (see [Box 5, page 17](#)), for example, have showcased their efforts in a campaign, "The doctor is a friend," to educate physicians on the rights of people living with HIV.<sup>62</sup>

NGO work is also critical to help key populations and people living with HIV access legal services (see section on [Legal Services, page 19](#)). In the MENA region, Morocco stands out for its ability to support and engage NGOs to work with key populations on the principles of human rights and freedom of action and speech.

## Engaging Religious Leaders and Institutions

Religious leaders and institutions have the capacity to help countries' HIV response in a number of ways: providing support and spiritual counseling to people living with HIV and their families; reaching out to the most vulnerable groups in society; dispelling stigma and discrimination; and promoting healthy behaviors among men and women in their congregations. Teachings can be found in every religion to encourage spiritual leaders to be involved and play a positive role in the lives of people who are marginalized. In the case of Islam and HIV, for example, *fatwas* (religious edicts) related to the necessity of protecting human life—which is *wajib* (required) in Islam—can apply to people living with HIV, making it a religious obligation for them to adhere to medication, or for vulnerable groups to seek information and services that can safeguard them against HIV. Another example is the use of *zakat*—obligatory alms—to support AIDS orphans and women-headed households, such as female sex workers and widows who lost their husbands to AIDS.

Religious leaders working closely with communities have a role in promoting health and healthy behaviors and advocating for the right to health. Their influence in communities could be better utilized to convey faith-based messages that treatment is a personal responsibility; that staying healthy is a religious obligation; and that people should not judge and condemn individuals. Religious leaders can also disseminate positive messages through the media to mobilize people for testing and treatment. Religious leaders can be particularly effective in dispelling stigma and discrimination when they act as role models. In Djibouti, for example, a number of clerics and religious leaders have been tested for HIV on live television, to encourage people and reduce the fear of testing.<sup>63</sup> And in Algeria, the instance of a religious leader hugging a person living with HIV in public was seen as a significant step toward reducing HIV-related stigma in that country.<sup>64</sup>

Other successful examples of engaging religious leaders in the HIV response come from Iran, where *ayatollahs* (Shiite religious authorities) have supported harm reduction programs for people who inject drugs.<sup>65</sup> Iranian religious leaders have also been involved in a project providing psychosocial support to people living with HIV. The majority of Iranian religious leaders participating in a survey (83 percent) believed that religious leaders have a role to play providing psychosocial support to people living with HIV.

Religious leaders have made a number of public declarations specifically on HIV and AIDS. These include the 2004 Tripoli Declaration of Women Religious Leaders on AIDS that calls for protecting the rights of women and children to prevent HIV; the 2004 Cairo Declaration signed by 80 religious leaders from 19 Arab countries that calls for breaking the silence about HIV, promoting abstinence and faithfulness, reaching out to vulnerable groups, and providing care and support to people who live with HIV and their families; and the 2007

Djibouti Declaration endorsing the use of condoms for birth spacing and preventing HIV transmission.

## Media and Attitudes Toward HIV and AIDS

The media has the power to reach society at large and to break the silence on taboo subjects, such as HIV and AIDS, while raising awareness about the modes of transmission and availability of treatment, and shedding light on stigma and discrimination. Entertainment media in particular have a powerful role in shaping people's attitudes toward HIV and those living with it across MENA. This is especially true of movies and soap operas, the mainstay of satellite television watched in roughly 70 percent of households in the region.<sup>66</sup> But HIV on screen is usually an unhappy sight, generally depicting AIDS as a deadly disease and people living with HIV as those who have defied social norms. Such misinformation hampers HIV testing and prevention by creating a false sense of safety among groups not engaged in risky practices, and taints the lives of people living with HIV. Efforts are needed to portray the lives of people living with HIV more realistically (see [Box 6, page 20](#)).

Social media—including blogs, Facebook, and Twitter—is an increasingly important means of communication and mobilization, as the events of the Arab Spring have clearly demonstrated. MENA is among the regions with the fastest growth in social media use in the world, with most users under age 30.<sup>67</sup> Beyond politics, however, social media is proving to be an important set of tools for information and connection among certain key populations, especially men who have sex with men. ALCS (Association for the Fight Against AIDS), one of Morocco's leading NGOs working on HIV, uses social websites for gay men to provide information on HIV prevention and treatment. There are blogs in Arabic by people living with HIV in which people share their experiences, often anonymously. SIDABloggingDay in Morocco, for example, attracted more than 4,500 participants in 2011.<sup>68</sup> Internet listservs, such as the Global Network of Researchers on HIV/AIDS in the Middle East and North Africa (GMR-MENA) and Iran HIV/AIDS are also proving useful for information-sharing among academics and activists working in the field. And Youtube is a vital channel for broadcasting documentaries on the realities of living with HIV.

## Legal Services

Legal services for people living with HIV are especially important to help them gain access to the justice system and redress in cases of HIV-related discrimination, among other legal matters. In the context of HIV treatment, these might include breaches of privacy and confidentiality, illegal action by the police, discrimination in access to health and social services, or denial of treatment and care.

People living with HIV are often unable to access the justice system because they are unaware of their rights or of how to address violations; because of the costs of legal services

## BOX 6

### The Movie, 'Asmaa'

"Asmaa," an Egyptian film released in 2011, tells the story of a woman who has been living with HIV for more than a decade, having been infected by her husband.<sup>1</sup> The plot centers on her efforts to secure lifesaving surgery, effectively out of reach because doctors either refuse to touch her or demand to know how she was infected, implying a distinction between "good" and "bad" HIV. The film shows the hard knocks of Asmaa's life: the tragic circumstances that led to her infection; her fear of disclosure, leading to conflict with her father and daughter; her precarious living, which is taken away when her employer learns of her condition; and the difficult choice she faces in order to secure the operation she so desperately needs. But the film is also full of touching moments of humanity: the support Asmaa receives from other men and women living with HIV; her dream of seeing her daughter happily married and her own chance at romance; her unshakeable faith in God; and her quiet dignity in the face of so much hardship and injustice.

The director, Amr Salama, based his film on the lives of people living with HIV whom he had the chance to work with under the auspices of UNAIDS Egypt. While *Asmaa* is a composite of many of their life stories, sadly, the central element of the plot

is all too true: The film is dedicated to an Egyptian woman who, in fact, died from medical neglect, unable to find treatment because of her HIV status. Almost half a million Egyptians saw the film during its theatrical release, and "Asmaa" has reached international audiences through film festivals worldwide. The movie triggered an avalanche of media coverage: hundreds of print articles and scores of TV shows covering the film's key issues—confidentiality and other rights of people living with HIV, women's empowerment, and medical ethics among them. "Asmaa" is clearly making a difference: One online survey found that three-fifths of respondents took a more positive view of people living with HIV after watching the film.<sup>2</sup> Such positive attitudes have translated into concrete action, including a recent move by Cairo University Medical School and UNAIDS to promote better treatment of people living with HIV and initiatives to change health care provider attitudes.

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or shortage of lawyers trained on human rights and HIV; or because they are unable to report or provide evidence of violations. Reporting of violations that take place in health care settings and those related to police actions is particularly challenging for people living with HIV because they could be subject to further harassment when they try to file a complaint.

Documenting and monitoring human rights violations are crucial steps towards empowering people living with HIV to claim their rights. The lack of sufficient evidence makes it challenging for civil society and people with HIV to hold governments accountable for inadequate health services and other problems. Since 2009, the International Development Law Organization (IDLO, based in Rome, Italy) has helped build capacities in selected MENA countries, beginning in Egypt with organizations such as the Egyptian Initiative for Personal Rights (EIPR) and the Egyptian Justice and Freedom Association. The initiative aims to assess the need for legal services among people living with or at high risk of HIV and to strengthen and expand HIV-related legal services.

The program has since expanded across MENA. In 2010, EIPR held the first regional meeting on HIV and the law, with representatives from six Arab countries—Algeria, Egypt, Jordan, Lebanon, Morocco, and Tunisia—to share experiences in using the law to address discrimination and other HIV-related issues. The following year, IDLO started working

with the Al Shehab Foundation for Comprehensive Development on a project to strengthen and expand the scope of HIV-related legal services, focusing on women at higher risk of HIV in Egypt.

Also, in 2011, IDLO and UNAIDS conducted a study of HIV-related legal services in those six countries to identify best practices.<sup>69</sup> The study report supplements the Arabic version of the *Toolkit: Scaling up HIV-related Legal Services*.<sup>70</sup> Both are useful tools for governments and civil society organizations to strengthen and expand these services. [Box 7 \(page 21\)](#) presents examples of organizations in the region offering such services.

One of the first, prominent legal cases occurred in the mid-1990s, when the Iranian Hemophiliac Society sued the government of Iran for importing contaminated blood products in the preceding decade, resulting in the first wave of HIV infections in the country (among hemophiliac patients).<sup>70</sup> After several years of legal battles, judges ordered the Iranian Ministry to provide free, lifelong, quality treatment and care to all patients who acquired HIV through contaminated blood; and to compensate those still living and the survivors of those who had died of AIDS. The court found the head of the IBTO (an affiliate of the Ministry of Health) guilty due to ignorance, sentencing him and other government officials to prison terms, and asking the health ministry for a formal apology. In a more recent case on blood contamination in Saudi

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BOX 7

## Examples of Organizations Providing Legal Services in the MENA Region

**Algeria's Association for the Fight against STI/AIDS and for Health Promotion (AnisS)** trains leaders from most-at-risk populations to reach out to their networks. AnisS' lawyers provide education on human rights concepts and legal issues, and the association then hires its trainees as outreach workers to give legal information to members of their communities and help link them with AnisS' lawyers. As a result, demand for legal aid has increased among members of these communities.

**Egypt's Justice and Freedom** program provides legal information to people living with HIV through printed materials and legal advice. Its lawyers represent cases involving people living with HIV in courts and informal dispute resolution. The program has undertaken lawsuits on issues such as expulsion from employment of people living with HIV and depriving HIV-positive mothers of custody of their children. It has also taken on the cases of men who have sex with men. To address the lack of sufficient awareness among the police and judges with regard to the HIV epidemic, the program has distributed manuals to lawyers, judges, and public prosecution officers, providing information on the nature of HIV, modes

of transmission, and consequences. It has also produced an Arabic version of the AIDSLEX website on HIV and the law around the world.

**Egypt's Al-Shehab Foundation for Comprehensive Development** also provides HIV-related legal services to key populations and people living with HIV, focusing mainly on outreach to and legal services for female sex workers. The foundation works with women to alleviate the impact of the discrimination and harassment they face and to improve their conditions. In addition to legal representation of sex workers in court or at the police station, Al-Shehab provides legal training to other lawyers and legal information to sex workers on their rights, what to do in cases of arbitrary arrest, and how to acquire legal identity documents for those who lack them.

**Morocco's Association for the Fight Against AIDS (ALCS)**, the first NGO in the region to respond to HIV and AIDS in 1988, provides a wide range of services to people living with HIV, including legal assistance and advocating and mobilizing journalists, lawyers, and judges to defend the rights of people living with HIV and other key populations—men who have sex with men, female sex workers, and people who inject drugs. To confront stigma and discrimination, the association has been conducting research on human rights, labor rights, and the violations affecting people living with and those at higher risk of HIV.

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Arabia, the government immediately accepted responsibility, dismissed some officials, and apologized after a young girl received HIV-infected blood.<sup>72</sup>

Some people living with HIV have won significant legal cases in recent years. In 2010, the city of Oran, Algeria, experienced a stockout of antiretroviral drugs for more than three months, which resulted in a formal legal complaint by people living with HIV and the Association de Protection Contre le Sida (APCS), citing “non-assistance to vulnerable individuals.”<sup>73</sup> The APCS director submitted the complaint on behalf of seven people with HIV, followed by a story on the stockout and its handling by government officials in an Algerian newspaper. Their efforts resulted in a public response by the Minister of Health, promising to improve the availability of antiretroviral drugs.

## 6. MOVING FORWARD: FROM POLICY TO ACTION

### KEY POINTS

- Political commitment, backed by financial and human resources, is needed to close existing gaps between well-intentioned policy documents and actions on the ground.
- To inform policies and programs, governments should promote research on key populations and HIV-related issues.
- Applying human rights principles to the HIV response helps build stronger societies, marked by less discrimination and inequality and more accountability on the part of governments and health services.

MENA governments are increasingly taking a human rights approach to address HIV and AIDS. Applying human rights principles to the HIV response benefits not only people living with HIV and those who are most at risk, but also their families and communities at large, by:

- Reducing stigma and discrimination.
- Strengthening health systems and civil society institutions.
- Bringing accountability to government action.
- Taking into account the interconnections between the legal and policy environment and the right to health.

The challenge facing MENA governments is how to close the wide gap that exists between well-intentioned policy documents—international, regional, or national—and practices on the ground. Governments’ policies and programs should be based on evidence, grounded in human rights principles, and backed by financial commitment.

### Gaining Political Commitment

Recent political agreements on HIV and AIDS in MENA (discussed in [Chapter 2](#)) reflect a move in the right direction, although governments’ willingness and ability to make changes on the ground have been uneven at best, and countries affected by the Arab Spring have regressed. As of mid-2014, all MENA governments have endorsed the 2011 Political Declaration on HIV/AIDS, which provides a roadmap toward achieving the vision of “zero new HIV infections, zero discrimination, and zero AIDS-related deaths.” Some changes can be seen in the country progress reports submitted to UNAIDS as

part of reporting on HIV to the UN. In 2010, many countries in the Arab region—particularly members of the Gulf Cooperation Council—submitted no data on HIV prevalence or on risks among female sex workers, men who have sex with men, or youth, claiming that such behaviors were contrary to their “culture and religion.” In the 2012 and 2013 reports, however, a number of these governments acknowledged the existence of such populations and their potential risk for infection. It is small progress, but a welcome step on the long road to understanding and addressing the region’s emerging HIV epidemic.

Governments indeed have a long way to go. To implement the 2011 declaration’s recommendations and incorporate human rights principles into national HIV policies and programs, MENA governments need to expand their HIV response beyond one or two implementing agencies. They need to engage a wide range of organizations and constituencies from both government and civil society, such as ministries of justice, labor, education, women’s affairs, and interior; parliaments; human rights organizations; labor unions; and faith communities. By doing so, programs can better address stigma and discrimination that increase people’s vulnerability to HIV and AIDS.

In sum, governments should help create an enabling environment for:

- Removing punitive laws and reducing stigma.
- Training health care workers on nondiscrimination, informed consent, confidentiality, duty to treat, and infection control.

- Collaborating with police and law enforcement agencies on HIV and human rights to facilitate access of key populations to HIV services and eliminate discriminatory policing practices.
- Providing legal services and legal literacy for people living with HIV, women, and key populations.
- Educating young people, especially young women, about HIV and their rights to stay free from the virus and empowering them to take actions to protect their health.
- Realizing gender equality.

As of 2011, seven MENA countries—Djibouti, Iran, Jordan, Kuwait, Syria, Sudan, and Yemen—reported having anti-discrimination laws that provide specific protection to people living with HIV.<sup>74</sup> Two of these countries—Yemen and Djibouti—have passed specific laws to protect people living with HIV. But, experts recommend using existing laws to protect the rights of people living with HIV for the moment, and discourage passing new HIV-related legislation because it may fall short of international human rights standards.<sup>75</sup>

## Increasing Knowledge Through Research

To inform policies and programs, governments must support research on key populations and HIV-related issues. Countries can use research results to better tailor their HIV response toward those who are most at risk of and affected by HIV. Research can also help identify which programs work, which do not, and why—essential information for governmental and civil society organizations aiming to scale up their prevention and treatment programs.

Compared with other world regions, research on HIV and AIDS in the MENA region is scarce: Less than 2 percent of all published and unpublished literature on HIV worldwide relates to MENA.<sup>76</sup> The reports that exist are scattered across the region—with some countries, such as Morocco and Iran, generating the majority of studies, while others, such as the United Arab Emirates, having little or no published research on the epidemic. Research is often hidden from public view, as public authorities may not disseminate studies for purposes beyond their own planning and policies, or they may be reluctant to publicly acknowledge the existence of populations on the margins of society or the extent of HIV in their societies.

These gaps are also evident in HIV surveillance, which is underdeveloped in most MENA countries. Only a handful of countries have systems in place that allow for tracking of the epidemic among key populations and in locations over time. Only Iran and Morocco, for example, systematically monitor HIV in pregnant women, while Djibouti and Morocco also track infections among female sex workers. Elsewhere, surveillance is incomplete and facility-based testing and case reporting fail to capture the full extent of the problem, often missing hard-to-reach populations. Also absent in most countries are robust estimates of the size of populations at risk,

which would aid in the planning and delivery of prevention and treatment services. Nor is there systematic evaluation and monitoring of many programs already in place.<sup>77</sup>

The field is changing, however. Thanks to international support from donors such as the Global Fund and partnerships with foreign research centers such as the U.S. National Institutes of Health, there is a growing interest in HIV research in MENA and an emerging cadre of researchers. Mirroring the epidemic itself, MENA is experiencing a faster rate of growth in HIV-related research reports than other world regions. Moreover, the quality of research is also improving, with a slow but steady shift away from largely anecdotal descriptions to more scientific methods, such as integrated bio-behavioral surveys. These include assessments of hard-to-reach key populations, with multiple rounds of studies of female sex workers, men who have sex with men, and injecting drug users, in countries such as Egypt, Iran, Morocco, and Tunisia.<sup>78</sup> Libya recently conducted its first bio-behavioral survey in Tripoli among people who inject drugs, with the hope of using the findings in its national HIV strategy.<sup>79</sup> A recent review of available HIV-related data concerning people who inject drugs points to a large volume of biological and behavioral studies, but how these studies and other data are used to inform policies and programs is yet another topic for research.<sup>80</sup>

## Funding Matters

The MENA region varies greatly in wealth, but one thing that rich and poor countries in the region have in common is their low investment in HIV and AIDS. In 2010, per capita domestic spending by governments on HIV ranged from less than 5 cents in the poorest countries of the region, to just over \$1 in the richest, putting MENA near the bottom of world regions in public spending on HIV.<sup>81</sup>

Many countries in the region are highly dependent on foreign assistance to support HIV prevention and treatment (see [Table 4, page 24](#)).<sup>82</sup> Given recent global economic turbulence, declines in international assistance have meant a drop in spending on HIV and AIDS in many parts of MENA. Domestic public and private investment has also been hit by economic downturns, and further affected by declines in countries like Egypt, Tunisia, and Syria, swept up in the Arab Spring and related political and economic crises.

Because of their middle-income status, many countries in the region are ineligible for international funds, such as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), or for bilateral assistance from other donor nations. The Global Fund to Fight AIDS, Tuberculosis and Malaria has been the principal source of finance for the HIV response in MENA, with over 15 grants to countries in the region, representing more than 70 percent of the total support for HIV and AIDS in MENA. However, recent changes to financing criteria at the Global Fund have led to concerns that this support may be curtailed, jeopardizing the HIV response in several countries, including Tunisia and Morocco.<sup>83</sup>

TABLE 4

## HIV Spending in Selected MENA Countries, 2009 and 2011

COUNTRY	2009		2011	
	TOTAL SPENT (US\$)	PERCENT FROM INTERNATIONAL SOURCES	TOTAL SPENT (US\$)	PERCENT FROM INTERNATIONAL SOURCES
Algeria	\$2,708,000	6%	\$8,921,000	10%
Djibouti	2,007,000	100%	4,294,000	86%
Iran	40,761,000	11%	—	—
Jordan	3,099,000	60%	1,434,000	30%
Kuwait	4,578,000	0%	—	—
Lebanon	4,450,000	28%	2,420,000	35%
Mauritania	87,000	0%	3,721,000	0%
Morocco	13,453,000	57%	13,118,000	49%
Oman	812,000	23%	4,704,000	4%
Saudi Arabia	19,389,000	0%	—	—
Somalia	5,982,000	100%	—	—
Syria	1,977,000	9%	810,000	23%
Tunisia	—	—	2,743,000	96%
UAE	17,584,000	0%	—	—
Yemen	4,956,000	97%	1,614,000	71%

— No data available.

**Note:** Numbers are rounded to the nearest US\$1,000.

**Source:** UNAIDS, *Global Report: UNAIDS Report on the Global AIDS Epidemic 2013*.

Financial and political crises since 2011 are bad news for a region already struggling to provide prevention and treatment to all those in need. A few countries in MENA are rising to the challenge by increasing their domestic spending: Oman is a notable example, where national spending has increased almost sixfold since 2009. Other countries are trying to spend what money they do have more effectively. Morocco, for example, revised its spending plans according to new information on modes of transmission that shows that the main drivers of the country's epidemic are unprotected paid sex, sex between men, and the sharing of contaminated drug-injecting equipment. In the past, the Moroccan government did not direct most of its funding toward key populations engaging in such high-risk practices, but its 2012-2016 National Strategic Plan redistributes the resources, with almost two-thirds now allocated to these groups.

With myriad political, economic, and social problems competing for their attention, governments rarely focus on HIV spending as a priority, especially given the marginal, and in many cases, illegal status of many of those at greatest risk of infection. Many countries in the region—particularly those in the wealthier GCC countries—have the capacity to spend more on HIV, both at home and within the region. Indeed, re-

gional philanthropy, such as the OPEC Fund for International Development (OFID), has made a welcome contribution to the response to HIV; and some countries, such as Kuwait, have made substantial contributions to the Global Fund. But countries in the region will need to do more, both at home and regionally, to prevent HIV from derailing political, economic, and social development in MENA in the decades to come.

## The Way Forward

To eliminate HIV in their countries, MENA governments now have the opportunity to:

- Learn from successful experiences within the region.
- Expand the coverage of HIV treatment and improve the quality of care to ensure patients' adherence to treatment.
- Review existing laws and policies that deter people living with HIV from using public health services.
- Promote anti-stigma campaigns to influence public opinion through the media and by engaging the religious community.
- Include sexuality and reproductive health education in school curricula.

- Demonstrate the political courage to focus the national response on the populations most affected by HIV.
- Invest in collecting information that helps make smarter investments, directing resources toward the right programs for the right populations.

For the HIV response to be effective, MENA governments will need to involve many sectors, from ministries of interior, justice, labor, and education to the parliament, law enforcement agencies, and prisons. NGO partners should include human rights and social justice groups, women's groups, migrant groups, justice reform groups, and labor unions to protect the rights of people living with or most at risk of HIV. The HIV response should include helping individuals and institutions gain legal literacy, because they need to be fully aware of rights, able to demand them, and seek redress when they are violated. The participation of people living with HIV and civil society organizations is crucial to the legitimacy and acceptability of HIV policies and programs, and thus to their effectiveness.

Justice, human rights, and gender equality are the hallmarks of an effective global response to the HIV pandemic and the catalyst for progress in countries. Taking a rights-based approach can ensure that national and international resources support programs that have the biggest impact in terms of caring for people living with HIV and reaching those who are most at risk. The programs with the greatest potential effect are those that recognize and respect human rights. The MENA region has an opportunity that millions around the world are literally dying for: to stop HIV in its tracks. MENA is at a turning point in history; in public health as in politics, the coming years are critical.

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