

# **HIV/ AIDS Epidemic in Middle East and North Africa, 2015**

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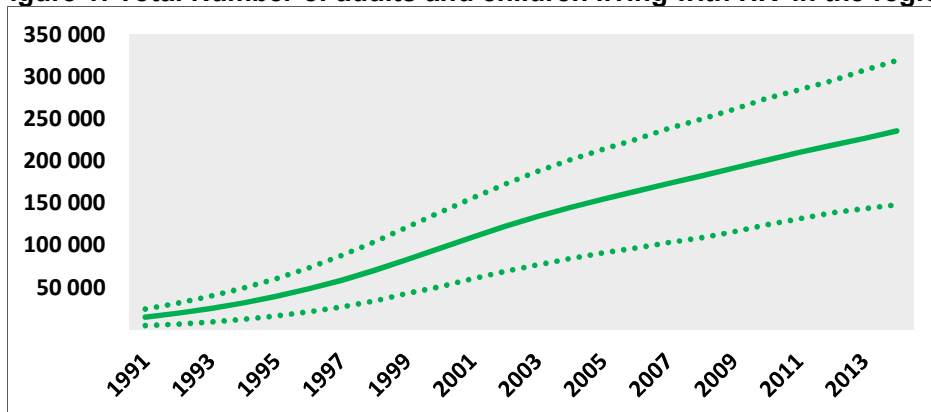
## **Introduction:**

The Middle East and North Africa region (MENA), based on the classification of the Global Fund, covers some overlapping geographical area with the World Health Organization (WHO) Eastern Mediterranean Region and UNAIDS MENA region. For reference purposes and simplicity, we will refer to countries as part of this regional application as MENA countries as per the UNAIDS specification (i.e. Algeria, Djibouti, Egypt, Jordan, Iran, Lebanon, Morocco, Oman, Somalia, Sudan, Syria, Tunisia and Yemen), in addition to Afghanistan and Pakistan (part of WHO EMR region). Further explanation and rationale for selection of countries will be provided in relevant sections.

## **Overall epidemiological situation and key populations:**

In contrast to other regions, the HIV epidemic in the Middle East and North Africa (MENA) continues to rise. By 2015, there were 336,000 People Living with HIV (PLHIV) in the region, roughly one third of this figure are female. This estimate considers combined UNAIDS MENA region (i.e. 240 000) in addition to estimates for Afghanistan and Pakistan (4,500 and 91,500 respectively). Out of this, around 257,000 (i.e. 76%) were estimated in countries included in this analysis. Moreover, between the years 2000 and 2014 there was a rapid increase in estimated number of adults and children living with HIV in the region (figure 1)<sup>1</sup>.

**Figure 1: Total Number of adults and children living with HIV in the region**



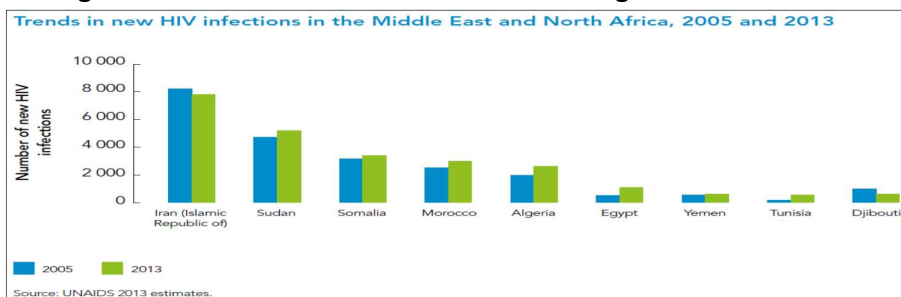
This rising burden is a reflection of a recent characteristic of the HIV epidemic in the region, which is the increasing number of new infections each year. During the period spanning between the years 2005 and 2014, the new HIV infections rose by 16%. In 2014 alone, 22,000 new HIV infections were estimated in the MENA region of UNAIDS, with more than 65% of new infections (excluding Pakistan and Afghanistan data) taking place in Iran, Sudan and Somalia<sup>2</sup>. By adding Algeria, Egypt and Morocco, this proportion exceeds 90%. In the past ten years, the number of new adult infections has declined in Morocco, and in contrast has been doubled in Egypt and Tunisia. By 2015 and across the region, only two countries, Iran and Djibouti, have managed to reverse the rates of new infections taking 2005 as baseline (figure 2)<sup>3</sup>.

<sup>1</sup> UNAIDS Report: HIV in the Middle East and North Africa 2013 – 2015

<sup>2</sup> UNAIDS Report: HIV in the Middle East and North Africa 2013 – 2015

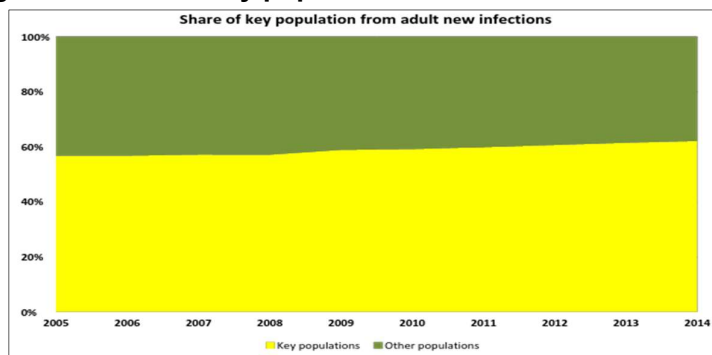
<sup>3</sup> UNAIDS Report: HIV in the Middle East and North Africa 2013 – 2015

**Figure 2: Trends in new infections in the region 2005 and 2013**



From available data, evidence consistently indicates that HIV epidemics in the region are at low-levels or concentrated, with only Djibouti and some areas of Somalia characterized by generalized HIV epidemics. The rest of the countries are characterized by epidemics that are concentrated among key populations (KPs). These are mainly men who have sex with men (MSM), people who inject drugs (PWIDs) and Female Sex Workers (FSW), as demonstrated in figure 3 below<sup>4</sup>.

**Figure 3: Share of key populations from adult new infections**



Data indicates that between 2005 and 2014 there were no significant changes in reducing the disease burden among key populations (KPs) considering the increasing number of new infections in the region<sup>5</sup>. This analysis highlights the need for different approaches for prevention services including HIV testing. It also indicates the urgent need to re-focus the HIV response in countries across the region and to target these KPs and other vulnerable populations with effective prevention programs. While the disease burden among these population groups varies across countries, available data indicates that injecting drug use is the driver of the epidemic spread of HIV in some of the relatively higher burden countries in the region.

***People living with HIV in the region:***

Most of the countries in the region are characterized by low prevalence epidemic. The overall adult HIV prevalence in the region is estimated to be 0.1 per cent. However, lack of adequate data has continuously hindered the ability to understand the epidemic across the region, where only 14 of 25 countries have estimations for PLHIV. All countries included as part of this regional application, with the exception of Jordan, have estimates for people living with HIV available. Data from these countries highlighted the variations in disease burden, with Iran,

4 UNAIDS Report: HIV in the Middle East and North Africa 2013 – 2015  
 5 UNAIDS Report: HIV in the Middle East and North Africa 2013 – 2015

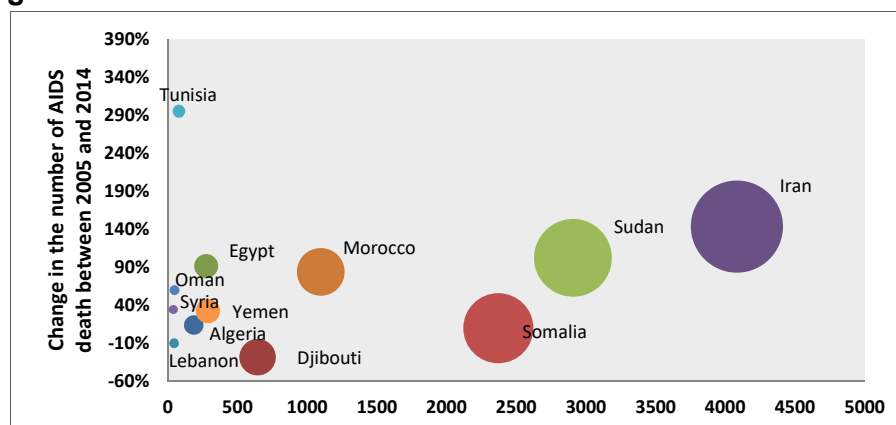
Pakistan and Sudan showing the highest burden.

**Table 1: Absolute number of people living with HIV – Selected countries** <sup>6, 7, 8</sup>

1,000 - 9,999	Afghanistan, Algeria, Egypt, Lebanon, Tunisia
10,000 - 50,000	Libya, Morocco
More than 50,000	Iran, Pakistan, Sudan
No data	Jordan

In 2014, 12,000 people died of AIDS-related causes in the MENA region, 90 per cent of these occurring in Iran, Sudan, Somalia, Morocco and Djibouti. Between 2005 and 2014, the number of AIDS-related deaths in the region rose by 60%. There is also considerable variance among countries in terms of the trend of AIDS deaths over the previous ten years. The number of estimated AIDS deaths in the past ten years has almost tripled in Tunisia and more than doubled in both Iran and Sudan. In contrast, in Djibouti and Lebanon it has decreased. The coverage by Antiretroviral Therapy (ART) and treatment and prevention of mother to child transmission (PMTCT) remains among the lowest in the world. The following graph shows where countries stand in terms of the number of AIDS deaths.

**Figure 4: AIDS death across the countries and their different trends**



### **MSM and HIV across the region:**

Among the distinct features of the epidemic in the region is HIV burden among MSM. HIV prevalence among MSM is relatively high in a majority of the countries. For example, HIV prevalence is 13% in Algeria, 10% in Tunisia, and 5% in Morocco. Still there are other countries that don't have high burden among this key population group. Please see table 2 below.

**Table 2: HIV prevalence among MSM – Selected countries** <sup>9, 10, 11</sup>

0.00 - 0.99%	Afghanistan, Jordan
1.0% to 4.9%	Egypt, Sudan
5.0% to 9.9%	Morocco
10.0% or higher	Algeria, Lebanon, Tunisia
No data	Iran, Pakistan

6 UNAIDS Country Information Brief and Country profile 2013

7 UNAIDS The Gaps Report 2014.

8 Country Progress Report 2014 to UNAIDS

9 UNAIDS Country Information Brief and Country profile 2013

10 UNAIDS The Gaps Report 2014.

11 Country Progress Report 2014 to UNAIDS

Despite this evidence, the MSM population is usually neglected as a targeted group for prevention services in most countries in the region. Only Egypt, Lebanon, Morocco, Tunisia and to a lesser extent Algeria, have introduced a package of services for MSM. In Morocco and Tunisia, coverage by testing and condom use is increasing but has yet to pass 50 per cent. Small-scale or pilot projects with limited HIV prevention services are available in some other countries, but these require extensive scale-up to achieve an impact on the epidemic. Population size estimates are not available in most of these countries (i.e. no overall estimate for the region); and most countries do not have good demographic and epidemiological profiles of this population group. Some programmes for men who have sex with men in the region have shown impact where services demonstrate respect for beneficiaries' rights and dignity and when civil society and other partners are able to provide focus and saturation. Lebanon is an example of such success<sup>12</sup>.

In 2015, the M-Coalition, a regional HIV/AIDS advocacy network specifically devoted to the needs of MSM in the Arab world, published a recent report based on a study conducted among the community members across Arab countries<sup>13</sup>. The report highlighted the main socio-demographic characteristics of the participants in the study, as well as important information regarding barriers challenging the respondents' access to mental, physical and sexual health services. Among the significant findings from this study are the gaps across the region where there is significant shortage of psycho-social services in most of the countries. The outcomes of this study, together with other unpublished reports by ATL, AMSED, the Alliance, ALCS and M-Coalition, will provide important information to help decision makers further understand the key barriers and challenges related to HIV services targeting MSM in the region, and to develop sound and effective programs that address these barriers.

***PWIDs and HIV across the region:***

People Who Inject Drugs is one of the population groups most severely affected by HIV infection in many countries. More than half of the new infections in key populations in the region are occurring among people who inject drugs<sup>14</sup>. The total number of PWIDs in 20 countries in the region is estimated to be around 570,000. The highest estimated numbers of PWIDs are in Egypt (7.2%), Iran (13.8%), and Pakistan (37.8%)<sup>15</sup>. In addition, the burden of injecting drugs is not similar across countries, with some countries reporting information gaps about this key population. Existing data shows that Pakistan has the highest HIV prevalence among PWIDs, followed by Iran and six other countries with reports of concentrated HIV epidemic (prevalence of over 5%) at least in parts of the country.

**Table 3: HIV prevalence among PWIDs – Selected countries**<sup>16</sup> <sup>17</sup> <sup>18</sup>

0.00 - 0.99%	Lebanon
1.0% to 4.9%	Afghanistan, Algeria, Tunisia
5.0% to 9.9%	Egypt, Jordan
10.0% or higher	Iran, Libya, Morocco, Pakistan
No data	Sudan

12 UNAIDS Report: HIV in the Middle East and North Africa 2013 – 2015

13 Health Assessment of Men who have Sex with Men in the Arab World

14 UNAIDS The Gaps Report 2014.

15 UNODC Report. World Drug Report 2014.

16 UNAIDS Country Information Brief and Country profile 2013

17 UNAIDS The Gaps Report 2014.

18 Country Progress Report 2014 to UNAIDS

In 2012, MENAHRA published a situational analysis report of the region. Overall, the data shows that about 20% of injections are unsafe and there is insufficient knowledge on HIV, its related risk behaviors and possible preventive measures<sup>19</sup>. Throughout the region, there is a convergence of higher-risk behaviors among PWIDs, where unsafe injecting practices are accompanied with unsafe sexual behaviors, leading to the increase in overall risk of exposure. Available reports indicate that all countries in the region, except Iran, are far from being on track in achieving the global target on reducing the number of new infections among PWIDs by 50% by 2015<sup>20</sup>. Some countries with documented epidemics among PWIDs do not currently address the needs of this population in their national AIDS strategies, and the scope and coverage of services are limited.

Pooled HIV prevalence for a limited number of women who inject drugs tested in bio-behavioral surveys (BBS) in four countries in the region was 6.7%. In 2010, 2% of identified HIV cases through injecting drug use were among women<sup>21</sup>. In 2013, MENAHRA conducted a qualitative operational research among Women Injecting Drug Users (WIDUs) in five countries. The report provided recommendations on how to improve the uptake of harm reduction services among WIDUs, and recommended developing models for women-sensitive service delivery programs in the region. The report has also recommended linking harm reduction services with mother and child health services especially in high burden countries<sup>22</sup>. Currently, no country in the region has succeeded in providing women with harm reduction services that consider the sensitivity of this dimension of HIV services.

***FSWs and HIV across the region:***

There is very little visibility around sex work in this region of the world. Consequently, there is a lack of data on the burden of HIV among FSWs and the epidemic among them is poorly understood in a majority of the countries. Many countries in the region prefer to avoid this term, instead terminologies like vulnerable women and others have been used in some contexts. With the limited data we have, we know that HIV in these countries continues to disproportionately affect FSWs. Data available from countries indicates that HIV prevalence among sex workers is significantly higher when compared with prevalence among adult females in the general population. Most of the countries do not have population size estimates, in addition to a minimal understanding of epidemiological characteristics or contextual risk behaviors of this population to developed informed prevention services.

**Table 4: HIV prevalence among Female Sex Workers – Selected countries** <sup>23</sup> <sup>24</sup> <sup>25</sup>

0.00 - 0.99%	Afghanistan, Egypt, Jordan, Tunisia
1.0% to 4.9%	Lebanon, Morocco, Pakistan, Sudan
5.0% to 9.9%	Algeria, Iran
10.0% or higher	Libya

19 MENAHRA – MENA Situational Analysis Report 2012.

20 UNODC Report. World Drug Report 2014.

21 MENAHRA – MENA Situational Analysis Report 2012.

22 MENAHRA Report: Women Injecting Drug Users in MENA 2013

23 UNAIDS Country Information Brief and Country profile 2013

24 UNAIDS The Gaps Report 2014.

25 Country Progress Report 2014 to UNAIDS

In the region, Morocco is the only country that has large-scale coverage of services for sex workers, offering a comprehensive package of HIV testing and counseling, condom distribution and case management of sexually transmitted infections (STIs). Algeria, Lebanon, and Tunisia have different forms of such programs, but with lesser coverage and without comprehensive services and with clear limitations in a rights-based programming<sup>26</sup>. Still, prevention programmes with female sex workers and women engaged in transactional sex across the region also demonstrate success, with some countries reporting high rates of condom use among sex workers. For example, Algeria and Lebanon report rates in excess of 80 per cent, while Djibouti, Iran, Jordan, Morocco and Tunisia report rates between 50 to 80 per cent.

### **Key human rights barriers, gender inequalities and other vulnerability issues:**

#### ***Legal barriers:***

Many countries in the region have included reference to HIV-related stigma and discrimination and human rights in their national strategic plans. However, only few countries have enacted specific legal protections for PLHIV and other vulnerable populations. Djibouti and Algeria are the only countries who initiated local action to enact legislation to address all forms of discrimination against PLHIV.

In their response to 'National Commitments and Policies Instrument (NCPI)' moderated by UNAIDS in 2013, many countries in the region highlighted the existence of some laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for KPs.

The existing legal provisions in the region create situations of vulnerability and lead to high-risk behaviors, preventing individuals from accessing prevention and treatment services. In turn, this increases stigmatization and social inequality, and ultimately increases vulnerability of individuals to HIV infection.

As noted from the above analysis, all targeted populations request were faced with either (a) some sort of legal provisions that were considered barriers for them to access the services, or (b) their rights to access the services are not protected by legal frameworks. The situation in the rest of the countries in the region is not different, as another ten countries still report having laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for vulnerable populations. Moreover, at least 14 countries in the region deport or ban entry and cross-border movement of people living with HIV, who also continued to suffer from many challenges related to workplaces and lack of protective laws. While the challenging policy environment in many countries in the region might be considered difficult to change, past experience has shown potential and highlighted the important role of information, evidence and advocacy in influencing policy changes that enable increased accessibility to services and support for PLHIV.

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<sup>26</sup> Country Progress Report 2014 to UNAIDS

### **Human rights:**

While countries across the region are diverse, still the overall outlook of the HIV response is characterized by similar human rights barriers and violations. Similar to other parts of the world, persistent stigma associated of HIV status with controversial occupation, sexual orientation, and drug use make it extremely difficult to reach them with services in many countries in the region. Criminalized by their behavior and marginalized by stigma, these populations maintain very low profiles in their communities and may deliberately avoid available services. While the constitutions of countries in the region usually provide an overall protection against discrimination, the majority of countries that are part of this regional application do not have specific non-discrimination laws or regulations to protect the rights of vulnerable populations. This prevalent social stigma also undermines efforts to mobilize the political leadership and financial support which are vital to the development of prevention programming targeting these population groups. This level of stigma blocks progress by limiting the ability of governments and civil society to provide wider services; limiting the ability of KPs to access services that are available. Table 6 below provides an overview of the situation with regard to existence of non-discrimination laws or regulations that specify protection for KPs in the countries which are part of this regional application<sup>27</sup>.

**Table 6: Existence of non-discrimination laws or regulations in selected countries**

<b>Key populations</b>	<b>Yes</b>	<b>No</b>
People living with HIV	Sudan, Iran	Rest of countries (9)
Men who have sex with men	Pakistan	Rest of countries (10)
People who inject drugs	Afghanistan, Jordan, Pakistan, Lebanon, Iran	Rest of countries (6)
Sex workers	Pakistan	Rest of countries (10)

Important note: data in this table was extracted from National Commitments and Policies Instrument 2013 of selected countries.

These situations influenced by stigma and discrimination highlight the need to integrate the AIDS response in a wider framework of human rights. Building on experience from some countries in the region, e.g. Sudan, it was considered important to support development of such laws not only in the context of HIV, but other communicable diseases as well including Tuberculosis (TB), viral hepatitis and other health problems resulting from communicable diseases. This approach will support the wider policy environment in targeted countries, by avoiding further sources of discrimination and stigma generation when focusing on rights related to people living and affected by HIV in isolation from other health rights. It is also considered highly important in the regional context to address the issue of accessibility of health services as a key human rights agenda. It is important that governments in all countries take steps to better understand and address factors that contribute to vulnerability to HIV and impede access to services. In addition, there is a need to measure and reduce stigma and discrimination, initiate legal reform, enforce existing protective laws and work to ensure a safe and dignified space to permit people living with and affected by HIV to lead the work against stigma and discrimination. This cannot be achieved through isolated efforts and requires partnerships between affected populations, civil society, governments and other stakeholders.

<sup>27</sup> National Commitments and Policies Instruments 2013 of selected countries <http://www.unaids.org/en/regionscountries/countries>

### ***Gender inequalities and Gender-based violence***

Women members of the communities are usually faced with many barriers that make them more vulnerable to risk factors, behaviors and situations. Included among these groups are women living with HIV, female sex workers, female sex partners of MSM and men who inject drugs, as well as women who inject drugs. Only few countries in the region have demonstrated a gender sensitive approach in their national response. In their national strategic plans, a number of MENA countries report that gender inequality and the lower social status of women are key challenges for national responses to HIV. About half the countries report that gender equality is addressed in their national strategic plans and/or report national policy on equal access to HIV prevention programs. In most of the countries, women living with HIV have less chances to access treatment and adhere to it. Coverage of PMTCT services is very low, only a small proportion of FSWs are actually reached with prevention packages, and huge information gaps exist with regard to other women groups at higher risk<sup>28</sup>. There have been some recent initiatives in this area among CSOs as well as advocacy groups such as MENAROSA; which is a network of women living with HIV aiming to address the broader structural problems that make women vulnerable to infection and to support women living with HIV through daily challenges. These initiatives aim at empowering women living with HIV to play an active role in prevention services targeting vulnerable women as well supporting PLHIV in general to know their rights in accessing medical services, through awareness creation activities and support groups<sup>29</sup>.

Closer analysis of the situation in some countries in the region underlines the fact that women engaged in high-risk behavior such as commercial sex or the injection of drugs, with inadequate protection, are very generally liable to be infected by HIV. Some women are infected by their husbands and others are victims of damaging traditional practice such as early marriage. Gender-based violence is commonplace in the MENA region, as indicated by a number of national surveys. Few MENA countries have legislation that specifically and explicitly criminalizes violence against women, intimate-partner abuse or sexual harassment. Attitudes towards gender-based violence pose a tremendous challenge. In many countries in the region, studies show that women and men accept violence against women as a fact of life and even find it justifiable in cases of disobedience or sexual transgression<sup>30</sup>. Some governments and CSOs are attempting to help women on the receiving end of gender-based violence with support groups, hotlines, shelters and other assistance. These initiatives are still small in scale, and most of targeted women are not yet aware or have access to such services.

### ***Lack of involvement of key affected populations***

Based on data analysis, and looking at shared issues across the region, it is important to highlight not only the fact that KPs continue to be challenged by stigma, discrimination and sometimes denial of their rights to access services, but also by the lack of engagement in service planning and monitoring. Key populations are less likely to organize and participate meaningfully in the design of HIV services, including community-level initiatives, thus limiting the public health outcomes of these services.

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28 UNAIDS The Gaps Report 2014.

29 UNAIDS report: Women and HIV in the Middle East and North Africa 2012

30 MENAHRA Report: Women Injecting Drug Users in MENA 2013

For a long time, the role of the key population communities and PLHIV was underestimated and they were considered beneficiaries and not key partners of the HIV response. Additionally, the KPs and CSOs working with them are not usually engaged as part of monitoring quality of services provided, including documenting rights violation cases. One of the factors contributing to this situation is the capacity of these communities, their representative organizations and/or organizations working with these communities. This includes capacity to organize engagement as well as technical capacities such as management and service related-knowledge and skills. Further information will be provided about the available capacities and gaps of community systems in the region.

While these are shared issues, there are considerable variations across the region in terms of major inequality and vulnerability factors related to human rights, gender and other issues.

### **Health systems across the region:**

Despite some progress in recent years, health systems in most of countries of the MENA region continue to struggle due to lack of harmonization of services and extremely limited capacity to mobilize an effective response not only to HIV epidemics but to other health priorities as well. Looking at the region in general, we can notice that countries with the highest burden of HIV also struggle with the greatest challenges within their health systems<sup>31</sup>. A major challenge and gap across the region is related to low level of responsiveness of these systems to the needs of vulnerable populations. But in the majority of the countries, the systems are not ready to accommodate the needs of key and vulnerable populations as far as the HIV epidemic is concerned. Public health programs in general are a low priority in many national spending and HIV programs are not an exception. The epidemiological transition of overall diseases burden in MENA countries is also important to consider, with a rising burden of non-communicable diseases while burden of communicable diseases is still high, resulting in a 'double burden' on under-funded health systems.

As part of the analysis in this section the focus will revolve around three major functions of health systems in the selected countries. These functions are governance, information systems and service delivery.

### **Governance:**

In this region, the overall policy environment continues to challenge the HIV response due to ongoing or escalating conflicts, as well as other factors, in many countries. Policy formulation on HIV-related aspects continues to be challenged by (a) difficult environments influenced by the deeply rooted stigma and discriminatory laws against KPs; (b) lack of strong participation of communities and their organizations in policy change; and (c) gaps in strategic data that can be used to initiate meaningful policy change. Despite these challenges Key stakeholders in the region continue to share the same vision and spirit of partnership in mutually targeted policy changes to enable the environment for better HIV response and services. Governments - through National AIDS Programs (NAPs), CSOs, UN technical partners and other longstanding technical partners of the HIV response in MENA, such as the Alliance - have all demonstrated strong leadership and engagement to ensure HIV and AIDS policies continue to be responsive enough to current epidemiological challenges and to accommodate the right package of services. As a demonstrative example of these efforts; the Council of Arab Ministers of Health - under the umbrella of the League of Arab States, and with a strong partnership with RANAA,

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31 UNAIDS The Gaps Report 2014.

UNAIDS, WHO and other stakeholders - have endorsed the Arab Strategic Framework for the Response to HIV and AIDS (2014–2020). The strategy came as a result of collective efforts and partnership to achieve informed policy guidance that will support member countries to address priority issues in the HIV response as part of their national plans. However, a remaining challenge is to ensure that policy environments within countries and part of the wider health systems are ready to take appropriate actions as part of their strategic plans. It is important to mention in this context that the Arab Strategy is not funded as it is meant to be an implementation strategy, or rather a guiding document for countries in the region. In many countries, lack of an sufficient levels of advocacy from communities affected by HIV makes it less likely to achieve responsive and adequate policies, regulations or strategic frameworks.

Linked to issues on policy formulation, with only few exceptions, most of the health systems in the selected countries lack strong mechanisms for coordination and partnership among key players around the HIV response. While all countries request have reported the existence of officially recognized national multi-sectoral HIV coordination bodies (i.e., a National HIV Council or equivalent), members of civil society across the region still report a minimum level of access to policy forums and are not usually engaged or consulted in policy formulation. Even in countries receiving support from the Global Fund, where the Country Coordinating Mechanisms (CCMs) should be active in managing the grant, it is not uncommon for civil society and KPs to have a non-visible role in these coordination bodies. There is a clear need in the region to establish a coordination mechanism or platform at the regional level that brings together the representatives of KP communities and other CSOs in the region.

Another important gap in most of the health systems in the region is the lack of accountability mechanisms related to wider health system issues, including services. While accountability as a concept might be present in one form or another, and at different levels in each country, accountability related to HIV programs are usually overlooked. At the head of this issue, is the accountability related to accessibility to HIV services such as treatment and prevention, including the right to access information and prevention tools. Health, as a human right, continues to be a guiding principle for all health systems in the region and the concept is highlighted very strongly in some national strategic plans including HIV plans. What is currently missing is to ensure that this principle is enforced and observed by those who manage the programs and those who deliver the services. In many countries there is clear lack of mechanisms and tools that help in gathering information, documenting undesirable trends and distortions, and understanding the right level of response to these challenges. Civil society organizations and communities of KPs are in better positions to play a major role in this important dimension of health systems if equipped with the right skills and tools.

#### **Information system and HIV Surveillance:**

There are still large gaps in HIV-related strategic information, and basic data and scientific evidence in the region, with remarkable variations across countries. Despite the fact that limited data is available on some aspects in some of the countries, there is currently a better understanding of HIV epidemiology in the region in general and some adequate data is available for a reasonable analysis in a number of countries. However, the region is still perceived to have limited HIV data. In some countries the systems are not appropriately designed to ensure that the right and complete level of data and information are made available to inform future programs and activities. Linked to weaknesses of routine information systems, HIV surveillance in its different forms, is usually neither strongly designed nor fully implemented with adequate coverage.

Part of our analysis of the region highlighted clear and major gaps in HIV-related research. While there are increasing numbers of studies emerging, including bio-behavioral studies, key population mappings and others, some countries such as Afghanistan, Egypt, Iran, Morocco, Pakistan and Tunisia have now implemented several rounds of surveillance among high-risk populations providing longitudinal data to track the evolution of the epidemic. Other countries have conducted their first round of surveillance; and in most of these, subsequent rounds are either planned or being implemented. However the gap remains significantly present. There is limited research among key populations in Jordan and Lebanon. While few countries have reached strong capacity, other countries continue to be far behind in terms of their will and capacity to conduct HIV research.

A recent study was conducted to quantitatively characterize the progress in HIV research in this region. The study found, in proportion to global HIV records, that evidence related to the MENA region is only 1.2% of the total. The number of records shows large heterogeneity across countries in the region. The existence of a considerable amount of potentially unpublished data could be used as a proxy indicator for the situation in this area. Taking a closer look, considerable gaps can be identified in operational research related to KPs linked to HIV services. Other related research areas are lacking as well, such as size estimations, mapping and ethnographic studies as well as data on sexual and injecting networks. Operational research on the experience of people living with HIV related to case management and quality of care is also needed, including test-treat-retain cascade studies<sup>32</sup>.

Another study conducted in the region in 2012 aimed at assessing the quality of HIV surveillance systems in the period 2007-2011. The study concluded that: *“The performance of HIV surveillance systems in several of the MENA countries has improved in recent years. The extent of HIV epidemics in the populations most at risk of HIV is still largely unknown in 10 countries. Multiple data sources that most of the countries still lack would enable indirectly estimation not only of the patterns of HIV epidemics but also the effectiveness of HIV responses”*<sup>33</sup>.

Reinforcement and capacity building will enable the implementation of an effective system for producing information which will form the root of evidence-based policy changes and programming. Strategic data will also be used for advocacy purposes at both the regional and national levels. During the last few years, some countries in the region have started to invest in strengthening their information systems including areas related to HIV and AIDS from domestic resources. Still in other countries, the external support such as the Global Fund, continues to be the only source of funds to build the capacity of information systems. However only a few countries have managed to increase and commit their domestic funds to support research activities related to HIV, including surveillance-based research.

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32 Hanan E, et al. Characterizing the progress in HIV/AIDS research in the Middle East and North Africa. Sex Transm Infect. 2013 Nov; 89 (Suppl 3): iii5–iii9. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3841727/>

33 Bozicevic L, et al. HIV surveillance in MENA: recent developments and results. Sex Transm Infect. 2013 Nov;89 Suppl 3:iii11-16. <http://www.ncbi.nlm.nih.gov/pubmed/23434789>

## Service delivery:

Many health systems in the region are facing challenges that are considered key barriers to HIV services. Challenges around the limited availability of services, distance to acquire them, the administrative management of the services, and lack of integration of services, are all challenges experienced in some countries in the region.

The limited availability of, and accessibility to, HIV voluntary counseling and testing (VCT) are main challenges and in-turn are major barriers to increasing ART coverage in the MENA region. While the rate of HIV testing has increased steadily since 2006, the overall percentage of people tested remains much low when compared with national targets. The vast majority of HIV tests carried out in most of the countries is mandatory and not voluntary. Where voluntary testing is available, services are limited and rarely accessible to key populations. By targeting low-risk groups and only minimally reaching key populations, HIV cases among these populations remain hidden, unidentified within the health system, and impossible to reach with treatment and care. The contexts in which people are tested undermine progression to treatment and other services. There are some good experiences in expanding the services in some countries. For example, the number of people tested in Morocco in 2014 was ten times more than in 2011. Similar expansion of services has been observed in other countries, such as Algeria, Egypt, Iran and Sudan<sup>34</sup>. On the other hand, a study reviewing HIV testing and counseling policies and practices in the Eastern Mediterranean Region of WHO found that between 1995 and 2008, 59% of reported diagnostic HIV tests were carried out on migrant workers, 8% were carried out on patients accessing STI, TB or antenatal care services, and only 4% were carried out on key populations. However, the largest proportion of HIV-positive cases were identified among these lesser tested groups, with 23% HIV prevalence among key populations and 18% HIV prevalence among STI, TB or antenatal care patients<sup>35</sup>.

As indicated before, treatment and PMTCT services are witnessing an emergency situation in the MENA region. The low coverage in the region is a result of long standing bottlenecks in health systems in most of the countries. This is also linked to challenges related to stigma and discrimination that hinder the integration of HIV services into the wider spectrum of health services. In addition to the widespread stigma within health systems, ART coverage remains so low not only because so few HIV positive cases have been formally identified within the health system, but also due to weak capacities for dealing with PLHIV in this sector, among other reasons. There is a wide disparity between the number of known HIV positive cases and the number of estimated HIV positive cases in the region. While in some countries, for example, 80% of identified HIV positive patients receive ART, this is only a 10% coverage of the estimated number of PLHIV in these countries<sup>36</sup>. Though some countries are making impressive gains, ART coverage and efficacy are undermined by poor treatment retention, lack of treatment follow-up, and tenuous connections between treatment, care and support. This overall picture also masks variations among countries. Over the course of only two years (2013-2014), the number of people on ART has increased by almost 15,000, a 60 per cent increase region-wide, and a 70 per cent increase in Algeria, Egypt and Yemen. In Libya, despite continuing crises, the number of people on ART has more than doubled in this period. At this rate, MENA can reach its treatment coverage target by 2020<sup>37</sup>. Overall, MENA countries are

34 UNAIDS Report: HIV in the Middle East and North Africa 2013 – 2015

35 Hemez J, et al. A review of HIV testing and counseling policies and practices in the Eastern Mediterranean Region. AIDS. 2010 Jul;24

Suppl 2. <http://www.ncbi.nlm.nih.gov/pubmed/20610945>

36 UNAIDS The Gaps Report 2014.

37 UNAIDS Report: HIV in the Middle East and North Africa 2013 – 2015

behind global averages for 12-month treatment among PLHIV receiving ART. Only few countries were able to maintain a percentage above the global average of 82% retention and a number of countries have very low rates of retention. Many countries also struggle to link PLHIV to treatment and care services because of poor referral systems, which can affect retention and follow-up. This is exemplified in poor follow-up for patients co-infected with TB<sup>38</sup>. Most countries report that less than 50% of these patients receive treatment for both infections.

In October 2013, WHO and UNAIDS launched a regional initiative on accelerating HIV treatment in the WHO Eastern Mediterranean and UNAIDS Middle East and North Africa regions. This promising initiative aims to achieve universal coverage of HIV treatment by 2020 by mobilizing urgent remedial actions to accelerate treatment scale-up in order to end the treatment crisis in the region. While medical services are much centralized and managed by public health systems, still non-governmental sectors can play important roles to address some of the challenges mentioned before.

Nearly all countries in the region report limited HIV prevention programming, particularly in relation to KPs. Often this challenge is related to lack of information about PWID, MSM and SW, difficulty accessing these populations in high-stigma contexts, and weak capacity of local systems to target and deliver services to these populations. The limited scope of prevention efforts targeting KPs is evidenced by lack of knowledge of HIV risk factors and extremely low condom use among these groups. Key gaps in this area include: (1) inconsistent availability of expertise; (2) limited access to effective and evidence-based comprehensive HIV prevention and care packages for KPs, (3) lack of gender sensitive programming to increase women's access to treatment facilities; and (4) severe lack of resources hampering the scale-up of HIV interventions.

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38 UNAIDS The Gaps Report 2014.

### **Availability of funds for each program area:**

With many wealthy countries in the Middle East and North Africa, the region is full of potential financial resources for the HIV response, at least in principle. However, these potentials have been hardly materialized into strong financial support for HIV programs except in few countries. While high-income and some upper-middle-income countries (Algeria, Gulf Cooperation Council countries and Iran) domestically fund more than 90% of their responses, some lower-income countries fund less than 20% of their responses. These variations may reflect the difference between countries in terms of their income, but also reflect the commitments of the governments towards HIV as a priority public health issue. On the other hand, the region is currently witnessing emerging concentrated epidemics among key populations in many countries. However, even when countries invested in HIV programs, not all of them succeeded in directing their financial resources towards comprehensive prevention programs targeting the affected populations. As a result of these financing policies, none of the countries in the region have managed to fully finance a wider program that covers all key population groups.

These gaps were clear when assessing the funding landscape in selected countries under this regional. Funding of programs for key populations remains a major challenge in the selected countries of this regional program. For instance, Jordan, Lebanon and Libya are not eligible for the Global Fund, with only few external donor in these countries supporting HIV programs (USAID has been supporting MSM prevention program in Lebanon for 10 years). For these countries, there are considerable gaps in targeted program areas requested in this regional application. All of the other countries are currently recipients of Global Fund support, and at different stages of accessing their allocations for the period 2014 – 2016. In these countries, the decision was to assess and understand the nature of the Global Fund programs in each country, and to evaluate how this regional grant could complement the existing programs through selected interventions that do not duplicate the national activities. The process was very data demanding due to different information from different sources, with the starting point of understanding the country needs and the financing of the NASP in each country. Due to some limitations of the NASPs, costing of these plans was not available for all countries. Assessing the funding gaps for the period 2015 – 2017 in these countries will highlight the considerable gaps in these countries. Table 12 below provides overall figures for these countries.

**Table 12: Estimates of financial gaps in HIV response – Selected countries**

Figures in USD

Country	Demand forecast <sup>39</sup> (2015 – 2017)	Government Investment <sup>40</sup> (2015 – 2017)	Global Fund Allocation <sup>41</sup> (2015 – 2017)	Non-GF Donors <sup>42</sup> (2015 – 2017)	Estimated gaps
Afghanistan	21,948,000	16,659,082	13,077,396	ND	7.9 Million
Algeria	ND	ND	ND	ND	ND
Egypt	25,755,824	16,659,082	7,040,468	ND	2.1 Million
Iran	361,553,530	249,234,938	20,238,295	4,270,272	87.9 Million
Jordan	ND	ND	Zero	ND	ND
Lebanon	ND	ND	Zero	ND	ND
Libya	ND	16,636,236	Zero	ND	ND
Morocco	244,545,039	34,788,316	24,605,906	800,000	184.1 Million
Pakistan	62,364,600	6,516,854	28,468,596	2,095,321	25.3 Million
Sudan	73,329,566	25,311,154	38,005,683	1,500,000	8.5 Million
Tunisia	42,871,119	16,659,082	12,305,077	2,576,500	11.3 Million

ND=No Data

According to the UNAIDS Gap report of 2011, eighteen countries in the region submitted data on their HIV spending as part of the Country Progress Reports 2010. The percentage of the total budget funded from domestic public resources ranges from 1% (Afghanistan) to 100% (Kuwait), although the majority of countries (including some that have not submitted data for this indicator) rely on international funding. As for the share of HIV spending on prevention, the percentages range from 3% (Syria and United Arab Emirates) to 78% (Pakistan) with a large number of countries under 50%<sup>43</sup>.

Adequately funded areas may vary from one country to another depending on the situation of the epidemic in each country, targeted beneficiaries of the program and willingness of the governments to invest in certain programs. From the high level analysis conducted for this request, it is justifiably understood that the majority of NASPs are focusing the available recourse towards securing the key commodities that are essential to run the key and essential services. This includes, ARVs especially for adult patients, HIV testing kits, lab materials and reagents, and condoms. These supplies usually consume the major proportion of available funding, however the coverage of these technologies, and their relevant interventions, is still far from the acceptable levels. Other than these areas, there is no area that usually receives adequate long-term financing.

Looking at the region in general, the majority of low-income countries have successfully mobilized external funding for their HIV programs in recent years, primarily through the Global Fund. Since its inception in 2002 and until the end of 2010, The Global Fund had approved proposals valuing approximately US \$1.2 billion for the region. It is important to note that three countries in the region are also donors to the Global Fund. However, it is clear that governments need to increase their domestic investments in the HIV response, diversifying sources of funding and reallocate funding to more effective interventions within their response.

<sup>39</sup> UNAIDS figures from demand forecast for replenishment 2013, NASP submitted to the Global Fund

<sup>40</sup> Reported to the GF, UNAIDS GARPR

<sup>41</sup> Global Fund GMP platform

<sup>42</sup> OECD CRS, GF reported

<sup>43</sup> UNAIDS Gap report of 2011

Many countries in the region, including those with the sufficient financial capacity to support their HIV response, are facing difficult choices to convince decision makers to increase their health spending including HIV financing. But the governments' willingness to provide funding has not been demonstrated yet. It is clear that governments should ensure that their HIV investment is addressing the key challenges revolving around the epidemics, and ensuring that investments are made on most effective interventions towards populations at higher risks.

Contributions from CSOs in the region to the national and regional responses could not be overlooked in the regional context, and a lot of gains were achieved through these contributions, but with the majority of these programs supported through external funding. Despite these gains, the MENA countries and especially CSOs still face a shortage of financial resources for the HIV response, particularly in prevention programmes. In addition, they are primarily dependent on a single donor such as the Global Fund with no or limited presence of other global financing mechanisms such as PEPFAR. The limited abilities of some CSOs to mobilize resources, and to write successful funding proposals, have implications on the current HIV financing. Only few CSOs in some countries have managed to demonstrate their capacities and ability to build trust with donors - including the government - and to mobilize additional funding for prevention programs. There is a growing need for the key players in the region to seek new funding sources and explore additional support from domestic and regional sources and the private sector. Part of the strategic thinking is to equip member organizations and partner networks of key populations with the required tools and skills that will enable them to increase their potential to mobilize funding, especially from the private sectors. With some successful models and previous experiences in some countries of building strong public-private partnerships, the aim is to expand this experience to other countries in the region through this request.

### **Under-funded areas:**

The high level analysis indicates some of the potentially underfunded areas relevant to the scope of this regional program:

1. Comprehensive combination prevention programs targeting key populations is one of the main gaps. Based on data provided by countries as a part of their biennial reporting to UNGASS, it is clear that the amount of funding allocated to prevention among KPs is insufficient, particularly among countries that can afford to increase their domestic spending in this area. The percentage of HIV spending that goes to prevention programming is as low as 3% in some countries in the MENA region, with a large number of countries under 50%<sup>44</sup>. From our analysis we have noticed that treatment adherence programs, counseling and psychosocial support for PLHIV and their sexual partners are hardly receiving the needed attention in terms of priorities.
2. Removal of legal barriers to access services is a typical example of underfunded areas in concept notes submitted to the Global Fund from countries. Even when included, these issues were partially addressed and few investments were made to achieve strong outcomes. Since most of the funding requests are influenced by the voice of the governments, it is hard to receive funding requests that strongly address the human rights approach in programming. Advocacy programs are usually neglected especially with the absence of key populations and their representatives during country dialogues

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<sup>44</sup> UNAIDS Gap report of 2011

and concept note development.

3. Investing in community systems strengthening is another typical example for underfunded areas. It is not unique only to HIV programs, as Malaria and TB communities have also been affected by these gaps. When included, the activities are usually focusing on short term activities, typically trainings, and ignore investing in strengthening the systems and development of sustainable processes and mechanisms.

To address these gaps and challenges, CSOs still have their own challenges to face in this regard. The UNAIDS mapping of CSOs response in 2011 (excluding Morocco), shows that funding from the Global Fund only covered 10% of the funding for CSOs, which is very limited compared to the amount of funding that goes to the country to cover all aspects of the response. With the limited funding from other donors, the need to cover this financial gap is more pertinent than ever. As policy makers call on CSOs to prioritize work with key populations to prevent the emergence of generalized HIV epidemics in the region, many organizations find themselves unable to sustain this work financially. Many donors may decide to fund organizations and interventions on a limited project-by-project basis. While traditional funding mechanisms may continue to be appropriate for HIV/AIDS education and prevention initiatives directed at the general population, these mechanisms of funding render working with key populations untenable.

Another important challenge relates to the link between financial and technical resources. Without sufficient financial resources allocated to capacity development as well as operational costs, PLHIV, KP networks and HIV CSOs in the region will continue to struggle to develop and/or acquire the necessary technical expertise to improve their responses to HIV and to ensure sustainability for their interventions. The challenge facing program implementers in civil society is to demonstrate the many benefits of direct investment in improving technical capacity, including the ability to implement an evidence-informed response, the ability to deploy financial resources more efficiently, and the ability to leverage technical skills in all areas of the HIV response. Once all of the above is achieved, the commitment of the country to continue the successful evidence-based interventions will be engaged and programs can be sustained through national ownership.

**End of the analysis.**