

UNAIDS

**MIDDLE EAST  
AND NORTH AFRICA**

REGIONAL REPORT ON AIDS | 2011

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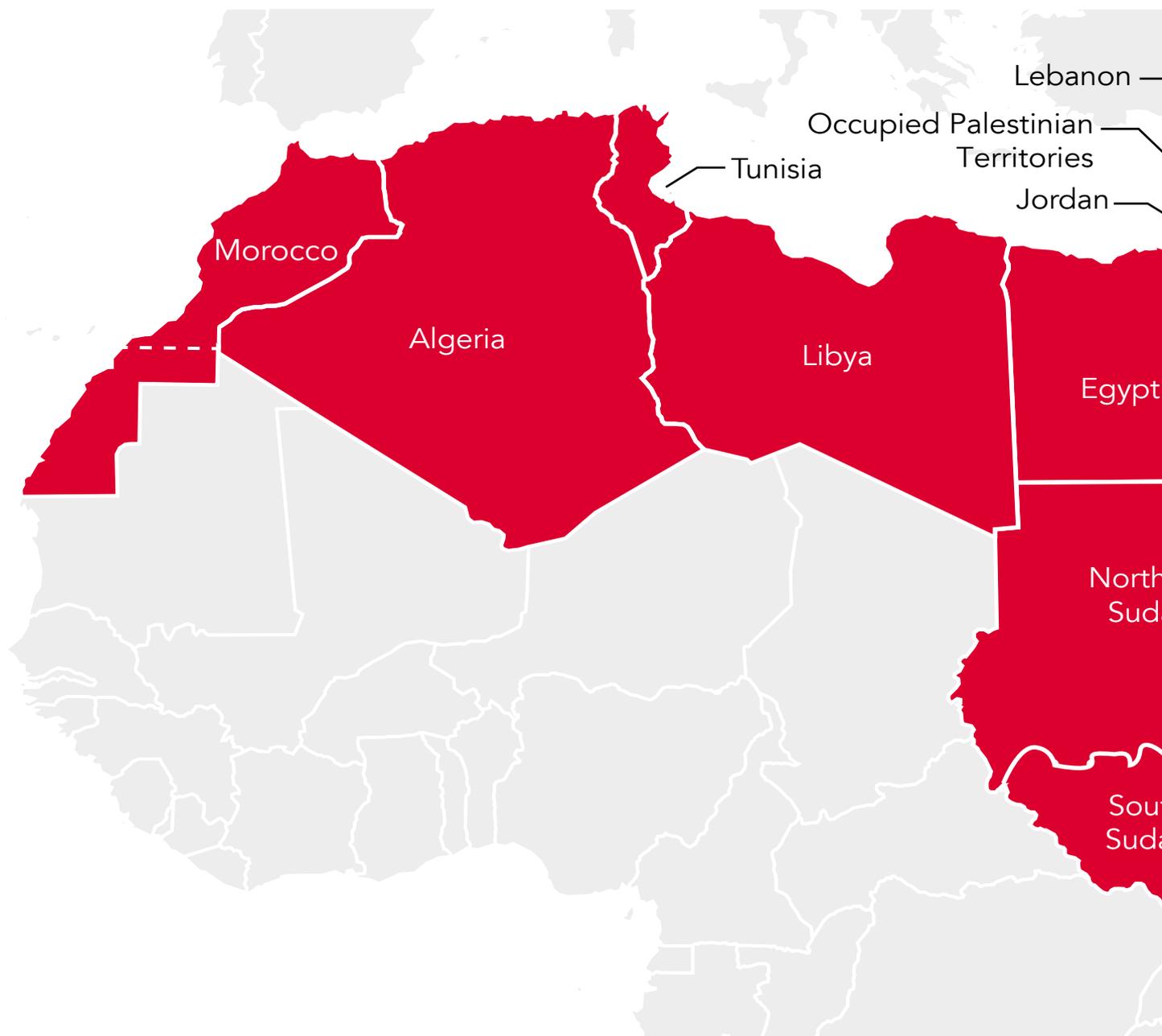
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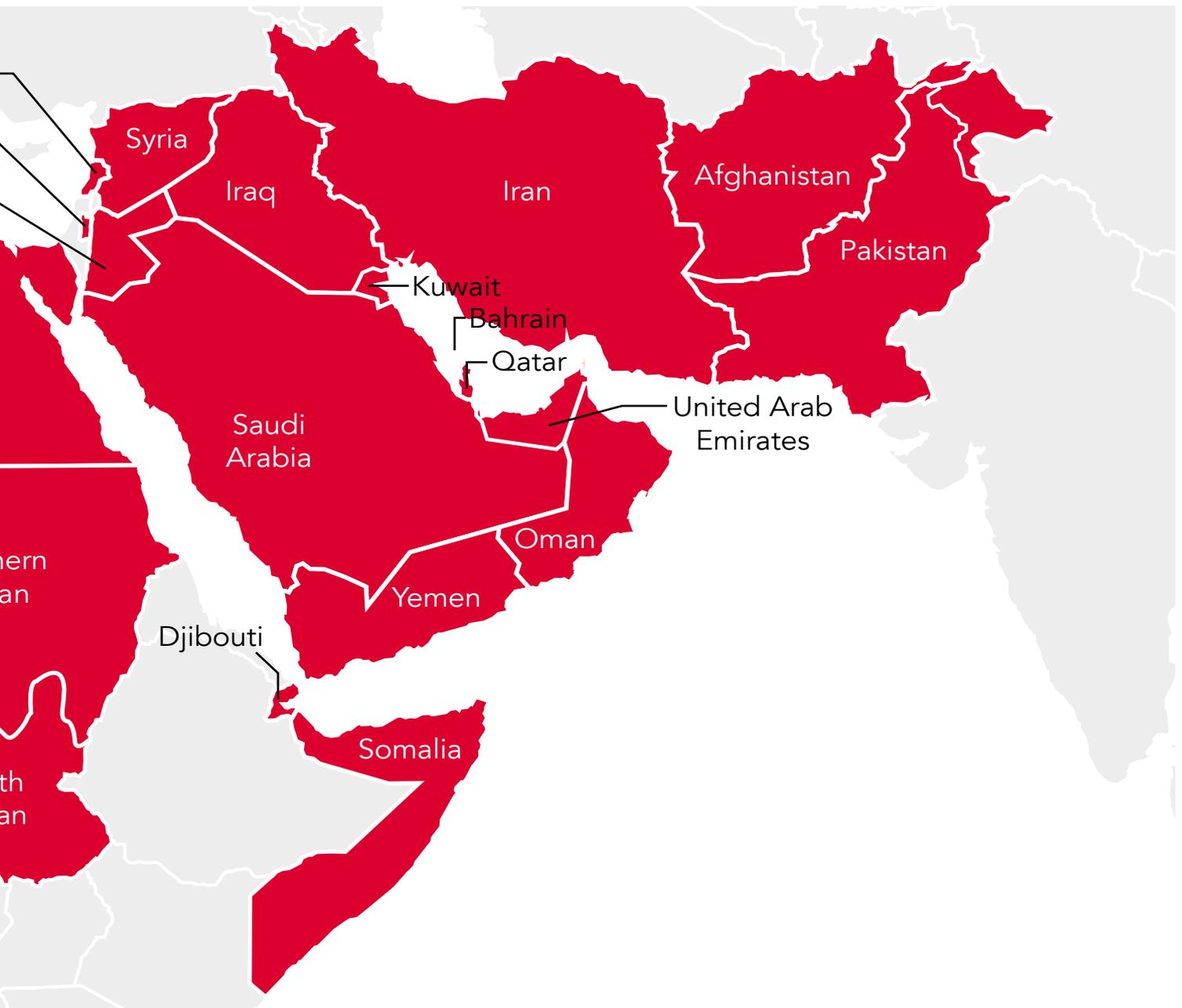
## ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
ALCS	Association de Lutte contre le sida
GCC	Gulf Cooperation Council
HIV	Human Immunodeficiency Virus
IBBS	Integrated Behavioural and Biological Surveillance/Survey
MENA	Middle East and North Africa
MENAHRA	MENA Harm Reduction Association
NGO	nongovernmental organisation
RANAA	Regional/Arab Network Against AIDS
SIDC	Soins Infirmiers Developpement Communautaire
STI	sexually transmitted infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
WHO	World Health Organization



In this report, the Middle East and North Africa (MENA) region refers to the following 24 countries or territories: Afghanistan, Algeria, Bahrain, Djibouti, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Occupied Palestinian Territories, Qatar, Saudi Arabia, Somalia, North Sudan\*, South Sudan\*, Syria, Tunisia, United Arab Emirates and Yemen.

The Region includes all the countries designated by UNAIDS and/or the World Health Organization (WHO) part of the MENA region. The UNAIDS MENA region does not include Afghanistan and Pakistan; WHO Eastern Mediterranean Region (EMR) includes 23 countries – all of those listed above except Algeria. The authors have tried their best to provide regional figures covering all 24 countries; exceptions are specified in the text.



\*Sudan is mainly referred to as one country in this document. Since most of the data available at the time of production of this report is generated before establishment of the Republic of South Sudan, UNAIDS is not able to present the data for the two states separately. Generally, data from both the Republic of South Sudan and Sudan are reported under “Sudan” in most parts of this report, and where available or applicable, with a designation of the “Southern” or “Northern” part.

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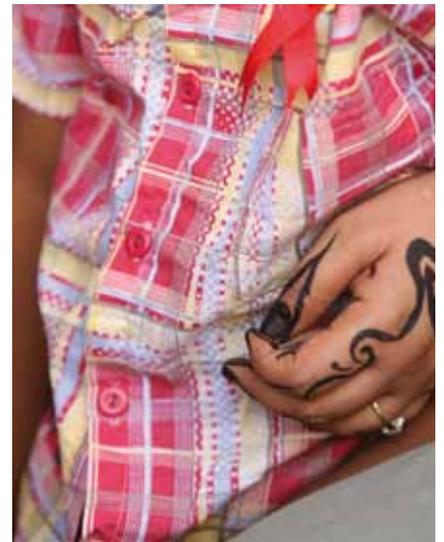
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# FOREWORD

Only two percent of the total estimated number of people living with HIV reside in the Middle East and North Africa region. This can be a relief for us. Yet, recent estimates show that it is one of the two regions with the fastest growing epidemics. Insufficient commitment, stigma, discrimination, and inappropriate laws continue to obstruct work with people living with HIV and people on the margins.

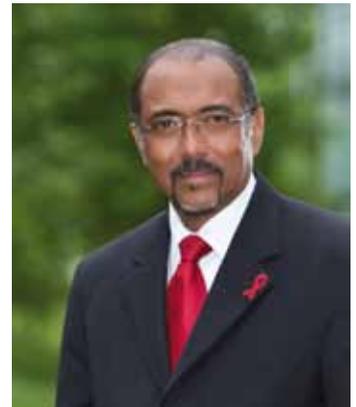
The relatively small number is our “window of opportunity”.

We need to act quickly before demand exceeds supply. We must redouble our efforts to ensure countries meet their goals towards Universal Access to HIV prevention, treatment, care and support.

Stronger political and societal determination will bring the change needed in the Middle East and North Africa region. By adopting the new Political Declaration at the 2011 United Nations General Assembly High level Meeting, leaders from the region committed to reaching bold targets by 2015.

With our joint efforts, we will move in this fourth decade of the epidemic towards focused, scaled-up and effective programmes to reach for our shared vision:

*Zero new HIV infections. Zero AIDS-related deaths. Zero discrimination.*



A handwritten signature in black ink, which appears to read "M. Sidibé". The signature is stylized and written over a horizontal line.

**Michel Sidibé**  
UNAIDS Executive Director  
Under Secretary-General of the United Nations





# EXECUTIVE SUMMARY

## The dynamics of HIV in the MENA region

In the 2001 United Nations General Assembly Special Session on HIV/AIDS declaration of commitment, member states committed to achieving a 25% decline in HIV prevalence among young people by 2010. Since then, many countries, specifically in sub-Saharan Africa, have been able to slow down the HIV epidemic. Globally, the rate of new infections is declining. In 2010, an estimated 2.7 million (2 400 000–2 900 000) people were newly infected with HIV, 13% fewer than the 3.1 million (3 000 000–3 300 000) people newly infected in 2001. HIV incidence has fallen in more than 30 countries since 2001.

In the Middle East and North Africa (MENA) region, the HIV epidemic has been on the rise since 2001. Although the overall HIV prevalence in the region is still low, the rise in new infections has put MENA among the top two regions in the world with the fastest growing HIV epidemic. The rise in the estimated number of people living with HIV in the region presumably is the result of an increased HIV prevalence among key populations at higher risk and a forward transmission of the virus to a larger number of individuals who are generally at lower risk of infection. Recent Modes of Transmission studies in Iran and Morocco and repeated rounds of bio-behavioural surveys in countries such as Egypt and Tunisia have supported this assumption. Annual estimated new infections among adults and children have substantially increased in the last decade.

Approximately 500 000 people are living with HIV in the MENA region. This number is estimated at 470 000 (350 000–570 000) without Afghanistan and Pakistan (which are not considered by UNAIDS geographic definition as part of MENA region), and reaches 580 000 (430 000–810 000) if Pakistan and Afghanistan are included<sup>1</sup>.

AIDS-related mortality has also almost doubled in the past decade among both adults and children in the MENA region. This estimated increase among children reflects three problems:

- an accelerating epidemic in the region overall
- a rise in the total number of women living with HIV
- the generally inadequate services provided to prevent new infections among children.



Annual estimated new infections have almost doubled in the past decade in the MENA region.

<sup>1</sup> Please refer to the initial pages of this report for the definition of regions used throughout this document

Again, this trend is not observed globally, where the number of AIDS related deaths has decreased due to the increased availability of antiretroviral therapy, and care and support to people living with HIV, especially in sub-Saharan Africa. Decreasing HIV incidence since the late 1990s has also contributed to the decrease of deaths worldwide.

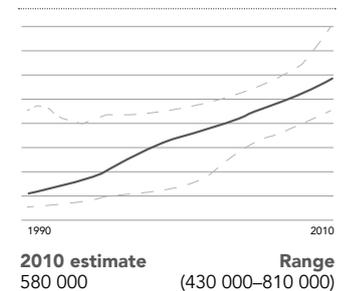
It is important to note that there is not enough evidence to suggest a firmly established HIV epidemic among the general population in any of the countries in the MENA region, except in southern Sudan<sup>2</sup>, Djibouti and Somalia, where epidemics meet the definition of a generalized epidemic<sup>3</sup>. However, even in these countries, HIV is mainly transmitted among key populations at higher risk. The remaining countries in the region have substantially lower national adult HIV prevalence and are not yet meeting the definition of having a “generalized epidemic”<sup>4</sup>. Nearly universal male circumcision in MENA could also act as an important biological factor which has potentially contributed to a reduced heterosexual transmission of HIV in the region<sup>5</sup>.

The HIV epidemic in MENA reflects the diversity of the region with different populations more heavily affected in different places. The diversity of the epidemic is further amplified by differing attitudes, policies, political commitments and the availability of and access to HIV services. In some countries, the epidemic is primarily concentrated among people who inject drugs; in other countries, it affects men who have sex with men or sex workers. Male migrant workers are also among the vulnerable populations in the MENA region and evidence of onward transmission of HIV to their spouses exists in several countries<sup>6</sup>. A large proportion of women living with HIV in the MENA region are believed to have acquired their infection from their spouses who practise high-risk behaviours. This risk of women is a phenomenon requiring further research and understanding in the region.

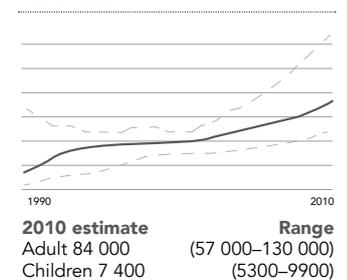
In countries that have better data, the heterogeneity and diversity of the epidemic is visible within those countries. In Morocco, for example, there is evidence of a concentrated epidemic among people who inject drugs in Nador, northern part of the country (where 17.9% of them are living with HIV<sup>7</sup>) and among men who have sex with men in Agadir, southern part (where 5.6% of them are living with HIV<sup>8</sup>).

Although the quantity of data is steadily increasing, it is still limited to build trends. There is also a shortage of data on HIV in countries across the region; specifically in United Arab Emirates, Iraq, Kuwait, Libya, Bahrain, Qatar and Saudi Arabia. This makes it difficult to get an accurate picture of the situation, both regionally and nationally. Given the gaps in HIV data, particularly related to key populations at higher risk, it is likely that the scope of the HIV epidemic and its impact in the region continues to be underestimated.

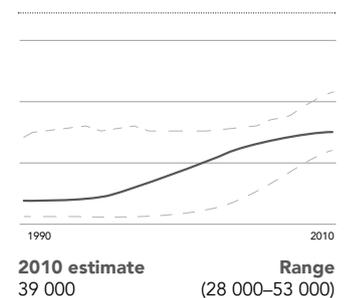
ESTIMATED HIV PREVALENCE  
(ADULTS AND CHILDREN)  
MENA REGION



ESTIMATED NEW INFECTIONS  
(ADULTS AND CHILDREN)  
MENA REGION



ESTIMATED DEATHS DUE TO AIDS  
MENA REGION



<sup>2</sup> Abu-Raddad L, Akala FA, Semini I, Riedner G, Wilson D, Tawil O, et al. Characterizing the HIV/AIDS epidemic in the Middle East and North Africa: Time for Strategic Action. Middle East and North Africa HIV/AIDS Epidemiology Synthesis Project. World Bank/UNAIDS/WHO; 2010

<sup>3</sup> HIV is more than 1% in the general population as identified through surveillance among pregnant women receiving antenatal care services

<sup>4</sup> UNAIDS. Report on the Global AIDS Epidemic 2010

<sup>5</sup> “Male circumcision: Global trends and determinants of prevalence, safety and acceptability” World Health Organization. 2007

<sup>6</sup> Summary Report. Regional Expert Group Meeting on Strategic Information and Surveillance Middle East and North Africa (MENA). 3–5 May 2011, Cairo, Egypt.

<sup>7</sup> National Sentinel Surveillance Report, Morocco. 2010

<sup>8</sup> Integrated bio-behavioural survey among men who have sex with men, Morocco, 2010–2011

## The current AIDS response in the MENA region

Overall, the current response is characterized by low coverage of prevention programmes for key populations at higher risk (i.e. people who inject drugs, men who have sex with men and sex workers). The low coverage is a contributing factor to the limited HIV knowledge and high levels of risk behaviour within these populations. However, there is a growing awareness of the importance of working with these key populations on HIV prevention in the region, and efforts are increasingly being made to understand the issues and address the shortcomings.

There are other populations in the region at heightened risk to HIV that do not have adequate access to effective prevention programmes, including prisoners, and mobile and migrant populations such as truck drivers, seafarers, uniformed services, migrant workers, and refugees and displaced persons. The settings in which these populations live give rise to behaviours strongly associated with increased HIV risk, and pose barriers to access to services. The comprehensive harm reduction programme in the Islamic Republic of Iran is an example of immediate response to outbreaks of HIV infection in prison systems, where the prevalence is eight times higher than in the general population<sup>9</sup>. Also, the UNAIDS partnership with the Intergovernmental Authority on Development, the International Organization for Migration and the United Nations Development Programme is another example of joint efforts to address HIV vulnerability of mobile populations along the Red Sea Ports and the Gulf of Aden. Through this partnership, health facilities were strengthened, intercountry collaboration promoted and protocols harmonized in Djibouti, Ethiopia, Somalia and Sudan<sup>10</sup>. However, more efforts are to be exerted to implement interventions that target the unique needs of the diverse cross-border mobile populations.

The availability, access and quality of health-specific interventions are mixed, although MENA countries have made some progress over the last few years. However, HIV testing and counselling remains a serious challenge. Nearly 60% of the diagnostic HIV tests carried out between 1995 and 2008 were for migrant workers, while only 4% of tests were for the key populations at higher risk<sup>11</sup>. Also, most of the HIV testing in the region is mandatory, and if quality voluntary counselling and testing is available, it is not always readily accessible to key populations. This is primarily due to stigma and discrimination, limited engagement and capacities of civil society organizations (CSOs) working with those populations, and existing structures not sufficiently tailored to their needs. Strengthening surveillance systems for sexually transmitted infections is another major challenge especially among key populations at higher risk.

Although individual countries have improved access to antiretroviral therapy (ART) (nearly a 25% increase, from 15 548 in 2009 to 19 483 in 2010 in one year), the estimated regional coverage remains low at 8%. Oman has the best estimated coverage in the region, with 45% of adults and children living with HIV receiving treatment at the end of 2010, followed by



Coverage of prevention programmes for key populations is low.

The estimated regional treatment coverage is

**8%**

<sup>9</sup> Shahbazi M., Farnia M., Moradi G., Ebrahimi B. Trend of HIV/AIDS prevalence among IDU's in Iranian prisoners (1376–1386). *Retrovirology* 2010, 7(Suppl 1): P101

<sup>10</sup> Martin A., Mobility, Migration and HIV Vulnerability of Populations along the Ports of the Red Sea and Gulf of Aden. 2011

<sup>11</sup> Hermez J., et al. A review of HIV testing and counselling policies and practices in the Eastern Mediterranean Region. *AIDS* 2010, 24 (suppl. 2):S25–S32

Lebanon (37%) and Morocco (30%). Most countries are falling short of the goal of universal access to treatment. Also, the number of people needing treatment has increased from 57 000 in 2001 to 210 000 in 2010, both due to a higher HIV prevalence in the region and a change in the World Health Organization (WHO) guidelines for treatment eligibility. It is worth noting that four countries in the region contribute 85% of the estimated ART eligibility: Iran (26 000), Pakistan (22 000), Somalia (25 000) and Sudan (93 000). Achieving regional targets for ART access mainly relies on these four countries scaling up their national treatment strategy, together with serious commitment to expand HIV testing and counselling, which is the most critical step to accessing treatment.

## Major challenges to reach universal access

The common threads that link all countries in the MENA region are the insufficient political leadership and stigma and discrimination.

Stigma and discrimination is one of the primary reasons that people living with HIV or key populations at higher risk do not have access to essential HIV services, as they constrain the effectiveness of the region's response to HIV. For example, stigma and discrimination limits:

- the ability of governments and civil society to provide services
- the ability of key populations to access services that are available
- the amount of data available for evidence-informed decision-making.

The civil society is playing a significantly larger role in the HIV response than it was only a few years ago. However, one of the key challenges facing CSOs that want to scale-up programmes is the need for the tools and training required to work effectively with key populations at higher risk. Work with key populations can be demanding in any setting; yet, it is significantly more difficult in settings where the levels of stigma and discrimination are high and overall support from government does not exist.

Associations for people living with HIV are typically at the frontline of care and prevention for populations affected by HIV. In the MENA region, these associations do not have the staff and financial means to sustain their work. They often face significant and persistent stigma and discrimination within their local communities, which means their outreach work can come with considerable personal risk and makes the path towards realization of positive health, dignity and prevention for all people living with HIV in the region even longer.

Finally, funding for HIV prevention is an issue across the region, regardless of a country's economic status. Based on data supplied by the countries as part of their global reporting, it is clear that the amount of funding allocated for prevention is not sufficient, particularly among countries that can afford to increase their domestic spending on HIV prevention.



**Many countries have discriminatory laws and policies, hindering an effective HIV response.**

To address these challenges, all stakeholders – policy-makers, CSOs and their networks, associations for people living with HIV, religious leaders and the United Nations (UN) – have recently renewed their commitments to reaching universal access. UNAIDS will ensure that these commitments are followed, while capitalizing on the recent political and social changes in a number of MENA countries that can provide new opportunities to work more effectively with key populations. Some of these commitments include:

- The **June 2010 Dubai Consensus Statement**, which calls for accelerated action towards universal access to HIV prevention, treatment, care and support in the MENA region; expansion and improvement of service provisions with a focus on prevention and quality treatment; strengthened strategic information; secured financial resources for a sustained HIV response; and creation of an enabling environment within individual country contexts.
- The Regional **Health Sector Strategy 2011–2015**, endorsed by all Ministers of Health at the 57<sup>th</sup> Session of the World Health Organization Regional Committee in 2010, which includes specific strategies to address the challenges related to the HIV health sector interventions, measurable regional targets, and recommendations developed by national AIDS programme managers to implement the regional strategy.
- The **September 2010 Djibouti Declaration of Commitment and Call for Action**, which calls for universal access to HIV services for mobile people, migrants and other marginalized populations residing or passing through the ports of the Red Sea and the Gulf of Aden.
- The **April 2011 Riyadh Charter** endorsed by all Gulf Cooperation Council members that reaffirmed their political commitment to respond effectively to HIV. The participants agreed on the need to combine efforts to better understand and know their countries' epidemics, and to develop strategies that are focused, results-oriented, evidence-informed and embedded in human rights. A follow-up meeting is planned in November 2011 to initiate the implementation of the charter.
- The **recent Civil Society Organizations consultation in October 2011** in Cairo, which discussed the findings of the CSO mapping in the region, concluded with detailed roadmap that will be implemented by all partners from the CSOs, associations for people living with HIV, national governments, the UN system and donors.
- The endorsement of the **Political Declaration on HIV/AIDS**<sup>12</sup>: intensifying our efforts to eliminate HIV/AIDS in June 2011 by all MENA Heads of State, which is a sign of their political will to intensified efforts in HIV prevention, treatment, care and support, and in advancing human rights to reduce stigma and discrimination.



**Leaders have demonstrated strong political will through regional and global commitments.**

<sup>12</sup> Resolution adopted by the General Assembly in June 2011

## Recommendations

Despite an increase in new HIV infections and AIDS-related deaths, there is still a window of opportunity to limit the spread of HIV as most countries have low national adult HIV prevalence. The following recommendations will guide the MENA countries in translating their recent commitment to intensified efforts to eliminate AIDS into action.

1. The single most important recommendation is for **countries in the region to learn from the experiences of their neighbours**. There are many individual success stories with lessons that can be applied more widely. For example:
  - **Djibouti** has a history of **protecting the rights of people living with HIV**. Unlike many countries, it guarantees freedom of movement for people living with HIV, including foreigners. The National Assembly has enacted legislation to address all forms of discrimination against people living with HIV and their families, and the Ministry of Justice has supported this legislation by conducting awareness campaigns to ensure that the legal protections are followed.
  - **Iran** has developed an extensive **harm reduction programme for people who inject drugs** through a long-term, high-level advocacy approach targeting policy-makers and members of the judiciary.
  - A group of **NGOs in Morocco** are working closely with **sex workers and men who have sex with men** on HIV prevention, relying on peer educators and outreach workers trained to provide commodities and essential information to participants, including condoms as well as referrals for testing and counselling and treatment of sexually transmitted infections.
2. Countries should **expand quality treatment coverage** by ensuring free and equitable access to treatment, care and support for all those in need and insurance coverage for people living with and affected by HIV.
3. Countries should **review existing laws and policies which are hindering an effective response to HIV** and whenever possible initiate reforms with the aim of protecting the rights of all individuals, including key populations at higher risk.
4. **Anti-stigma campaigns** through various means should be encouraged in all MENA countries to influence public opinion about AIDS. The recent Egyptian film, *Asmaa*, that tells the true story of a woman overcoming fear and social rejection, is an example to be followed more broadly in the region.

5. **Strong and effective political leadership** is absolutely vital for an effective HIV response, especially in countries where marginalized and vulnerable populations are at higher risk. Government officials, decision makers and opinion leaders need to demonstrate the political courage to focus the response on populations most affected by HIV.
6. **Countries across the region need more and better data** about the state of the epidemic and the response to make informed decisions. Collecting and analysing this data depends on countries having significantly more robust surveillance, monitoring and evaluation systems. Given the diversity in the MENA region – different types of epidemics, different affected populations and different cultural contexts – country responses should be based on credible evidence and delivered at sufficient scale to make an impact.
7. **Countries should invest in the right populations and the right programmes.** The UNAIDS new investment framework will enable countries to reach the 2015 targets as set out in the 2011 UN Political Declaration on HIV/AIDS provided it is fully implemented and funded. The framework is focused on high-impact, evidence-based, and high-value strategies – including interventions for key populations. It also recognises critical enablers, such as reducing stigma, respect for human rights, and capacity building for community based organizations, all relevant for the MENA region.
8. **The 2011 Political Declaration on HIV/AIDS should be more than a goal.** It should be more than an international commitment. It should be a guiding principle for national responses. It should be the foundation for political leadership.



Countries should invest in the right populations and the right programmes: **invest smartly, invest for results.**



# The Dynamics of HIV



In the 2001 United Nations General Assembly Special Session on HIV/AIDS declaration of commitment, member states committed to achieving a 25% decline in HIV prevalence among young people by 2010. Since then, many countries, specifically in sub-Saharan Africa, have slowed down the spread of the HIV epidemic. Globally, the rate of new infections is declining. In 2010, an estimated 2.7 million (2 400 000 – 2 900 000) people were newly infected with HIV, 13% fewer than the 3.1 million (3 000 000 – 3 300 000) people newly infected in 2001. HIV incidence has fallen in more than 30 countries since 2001.

In the Middle East and North Africa (MENA) region, the HIV epidemic has been on the rise for the past decade. Although the overall prevalence in the region is still low, the increase in new HIV infections has put MENA among the top two regions in the world with the fastest growing HIV epidemics. Annual new infections among adults and children have almost doubled in the last decade (Figure 2 and 3).

Approximately 500 000 people are living with HIV in the MENA region. This number is estimated at 470 000 (350 000–570 000) for the UNAIDS-defined MENA region and reaches 580 000 (430 000–810 000) if Pakistan and Afghanistan are included<sup>13</sup> (Figure 1).

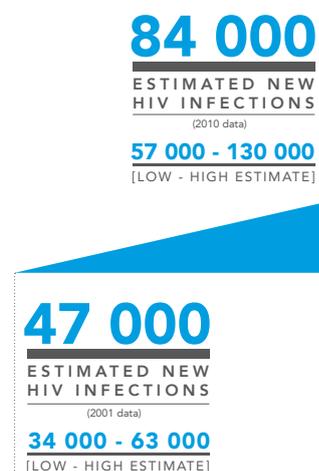
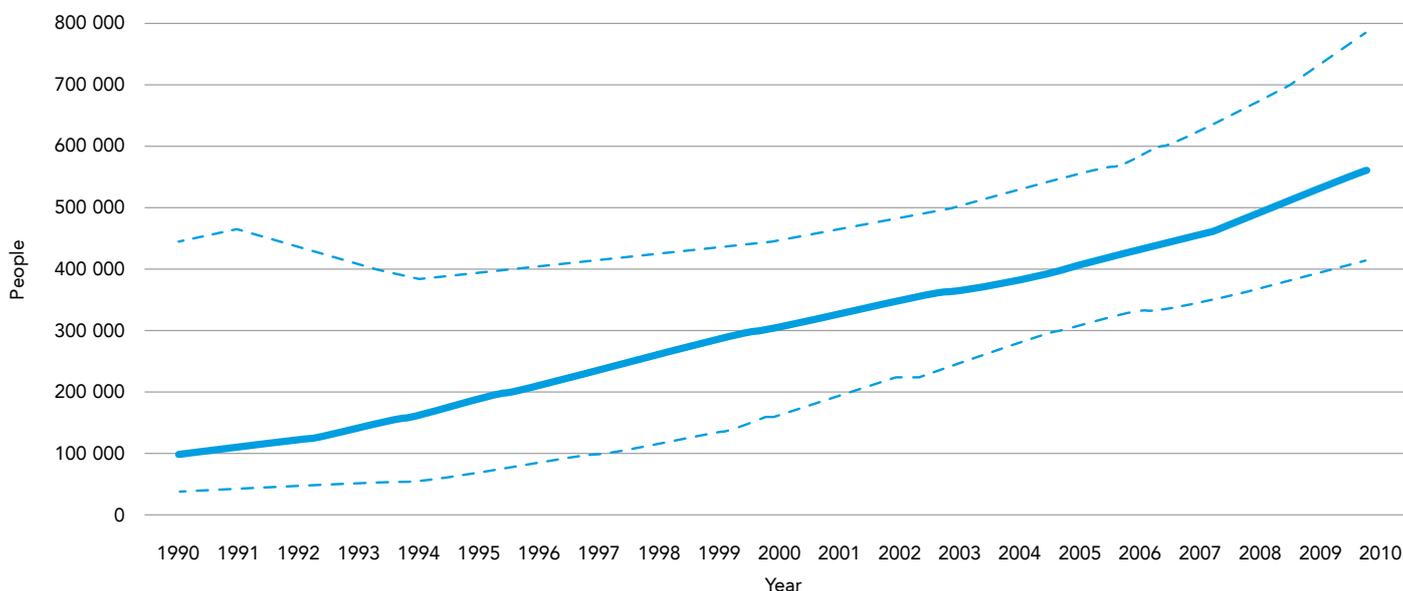


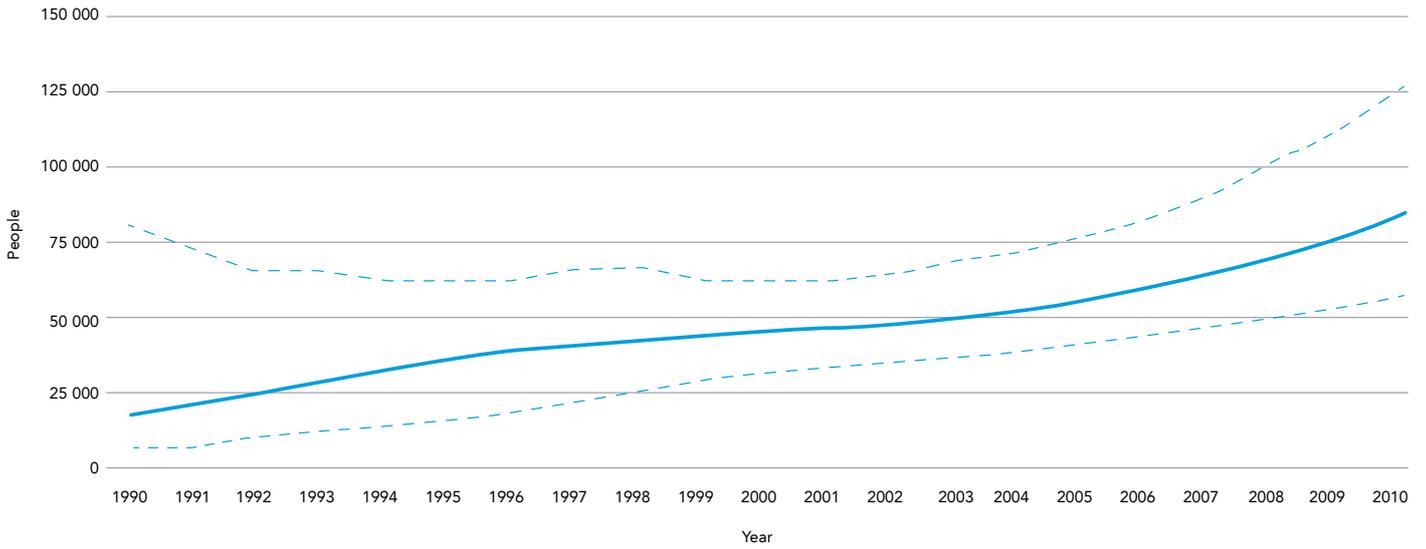
Figure 1  
**ESTIMATED HIV PREVALENCE (ADULTS AND CHILDREN)**



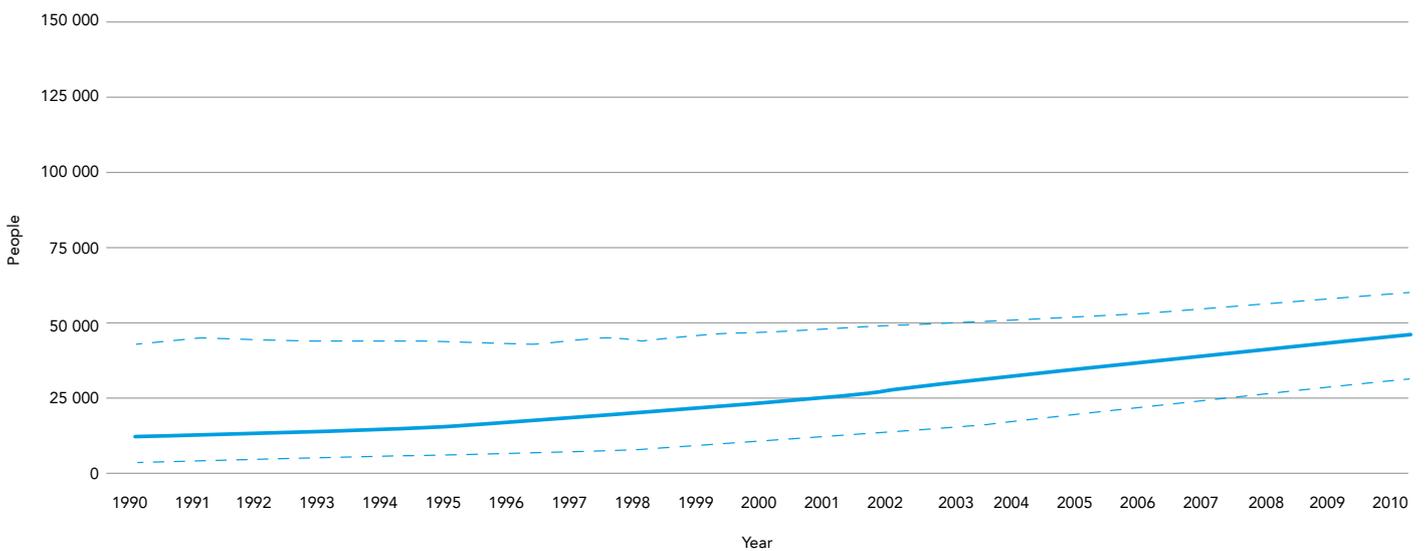
Source: UNAIDS

<sup>13</sup> Please refer to the initial pages of this report for the definition of regions used throughout this document

**Figure 2**  
**ESTIMATED NEW INFECTIONS**  
**(ADULTS AND CHILDREN)**



**Figure 3**  
**ESTIMATED PEDIATRIC**  
**INFECTIONS**



Source: UNAIDS

AIDS-related mortality has also almost doubled in the past decade among both adults and children in the MENA region (Figure 4). This estimated number among children reflects three problems:

- an accelerating epidemic in the region overall
- a rise in the total number of women living with HIV although the epidemic remains concentrated among men
- the generally inadequate services provided to prevent new infections among children

Again, this trend is not observed globally, where the number of AIDS related deaths has decreased due to the increased availability of antiretroviral therapy (ART), and care and support to people living with HIV, especially in sub-Saharan Africa. Decreasing HIV incidence since the late 1990s has also contributed to the decrease of deaths worldwide.

It is important to note that there is not enough evidence to suggest a firmly established HIV epidemic among the general population in any of the countries in the MENA region, except in the southern Sudan<sup>14,15</sup>, Djibouti and Somalia, where epidemics meet the definition of a generalized epidemic<sup>16</sup>. However, even in countries with generalized epidemics, HIV is mainly transmitted among key populations at higher risk. The remaining countries in the MENA region have substantially lower national adult HIV prevalence<sup>17</sup>.

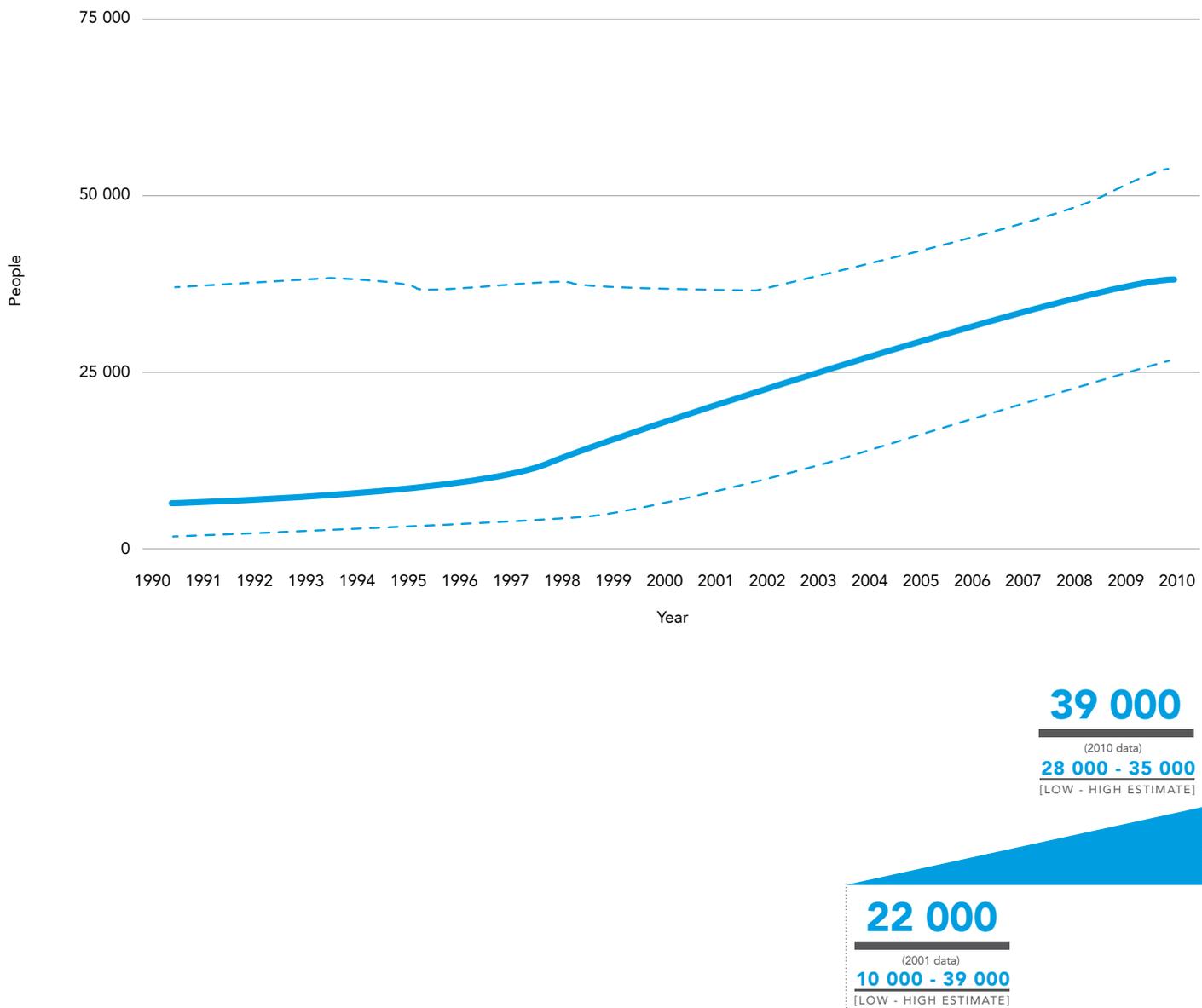
<sup>14</sup> Abu-Raddad L, Akala FA, Semini I, Riedner G, Wilson D, Tawil O, et al. Characterizing the HIV/AIDS epidemic in the Middle East and North Africa: Time for Strategic Action. Middle East and North Africa HIV/AIDS Epidemiology Synthesis Project. World Bank/UNAIDS/WHO; 2010.

<sup>15</sup> "currently Republic of South Sudan"

<sup>16</sup> HIV is more than 1% in the general population as identified through surveillance among pregnant women receiving antenatal care services

<sup>17</sup> UNAIDS. Report on the Global AIDS Epidemic 2010.

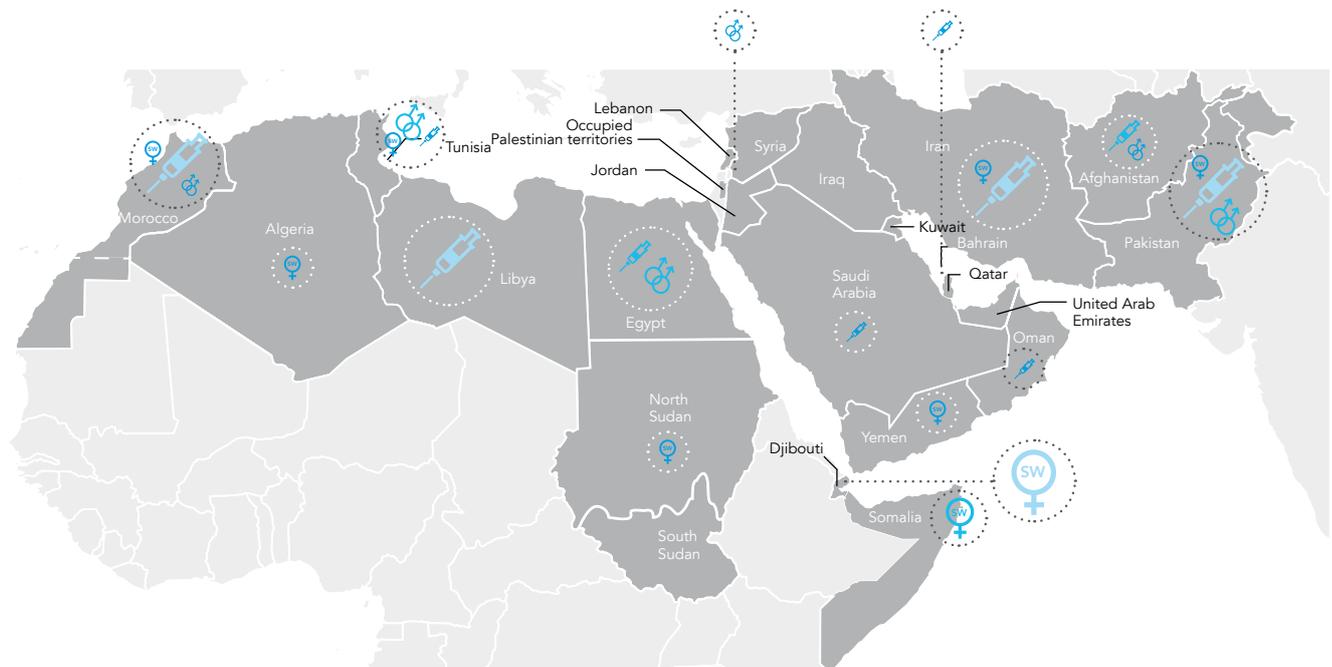
Figure 4  
**ESTIMATED DEATHS DUE TO AIDS**



Source: UNAIDS

Figure 5

HIV PREVALENCE AMONG KEY POPULATIONS IN THE MENA REGION\*



	Prevalence between 1 and 4%		Men who have sex with men
	Prevalence between 5 and 9%		People who inject drugs
	Prevalence equal and above 10%		Female sex workers

\*Data regarding HIV prevalence among key populations in several countries are not yet available

Source: Country Progress Reports 2010

The HIV epidemic in MENA reflects the diversity of the region with different populations more heavily affected in different places (Figure 5). The diversity of the epidemic is further amplified by differing attitudes, policies, political commitments and the availability of and access to HIV services. In some countries, the epidemic is primarily concentrated among people who inject drugs; in other countries, it affects men who have sex with men or sex workers<sup>18</sup>. Male migrant workers are also among the vulnerable groups in MENA and evidence of onwards transmission of HIV to their spouses exists in several countries<sup>19</sup>. A large proportion of women living with HIV in the MENA region are believed to have acquired their infection from their spouses, who practise high-risk behaviours. This risk of women is a phenomenon requiring further research and understanding in the region.

There are concentrated HIV epidemics among people who inject drugs in Pakistan (21%<sup>20</sup>), the Islamic Republic of Iran (13%<sup>21</sup>), Libya (22%<sup>22</sup>), Afghanistan (7%<sup>23</sup>) and Egypt (6.7%). The epidemic in the Islamic Republic of Iran seems to have leveled since its peak in the mid-2000s, suggesting a possible link with the comprehensive harm reduction programme introduced in 2004-2005. On the contrary, the epidemic in Egypt has increased during the past few years; HIV prevalence was only 0.6% in 2006, but it has increased to 6.7% in 2010<sup>24</sup> with a hepatitis C (HCV) prevalence of 63%<sup>25</sup> among this population. This indicates the potential for an expanded epidemic among key populations at higher risk within a short timeframe if adequate services with appropriate coverage are not in place. The brutal efficiency of HIV transmission from unsafe injecting practices – estimated to be up to ten times more transmissible than through sexual contact – is often underestimated by country responses.

The HIV epidemic among men who have sex with men has been noticed in more than half of the countries of the MENA region such as Egypt (5.7% in Cairo and 5.9% in Alexandria<sup>26</sup>) and Tunisia (5%<sup>27</sup>). Epidemic trends show an increase among this key population<sup>28</sup>, which faces a high level of stigma and discrimination, and a lack of appropriate services (Figure 6).



**The HIV epidemic is primarily concentrated among key populations at higher risk.**

<sup>18</sup> No data is yet available on clients of sex workers in the region

<sup>19</sup> Summary Report. Regional Expert Group Meeting on Strategic Information and Surveillance Middle East and North Africa (MENA). 3–5 May 2011, Cairo, Egypt.

<sup>20</sup> Universal Access report. 2011

<sup>21</sup> Integrated Bio-Behavioural Surveillance Survey, Iran. 2010

<sup>22</sup> Mathers, B. M., L. Degenhardt, B. Phillips, et al. 2008. Global Epidemiology of Injecting Drug Use and HIV among People Who Inject Drugs: A Systematic Review. *Lancet* 372: 1733–45.

<sup>23</sup> Integrated Bio-Behavioural Surveillance Survey, Afghanistan. 2009

<sup>24</sup> Ministry of Public Health and Family Health International. Integrated Bio-Behavioural Surveillance Surveys, Round two, Egypt. 2010

<sup>25</sup> Country progress report, Egypt. 2010

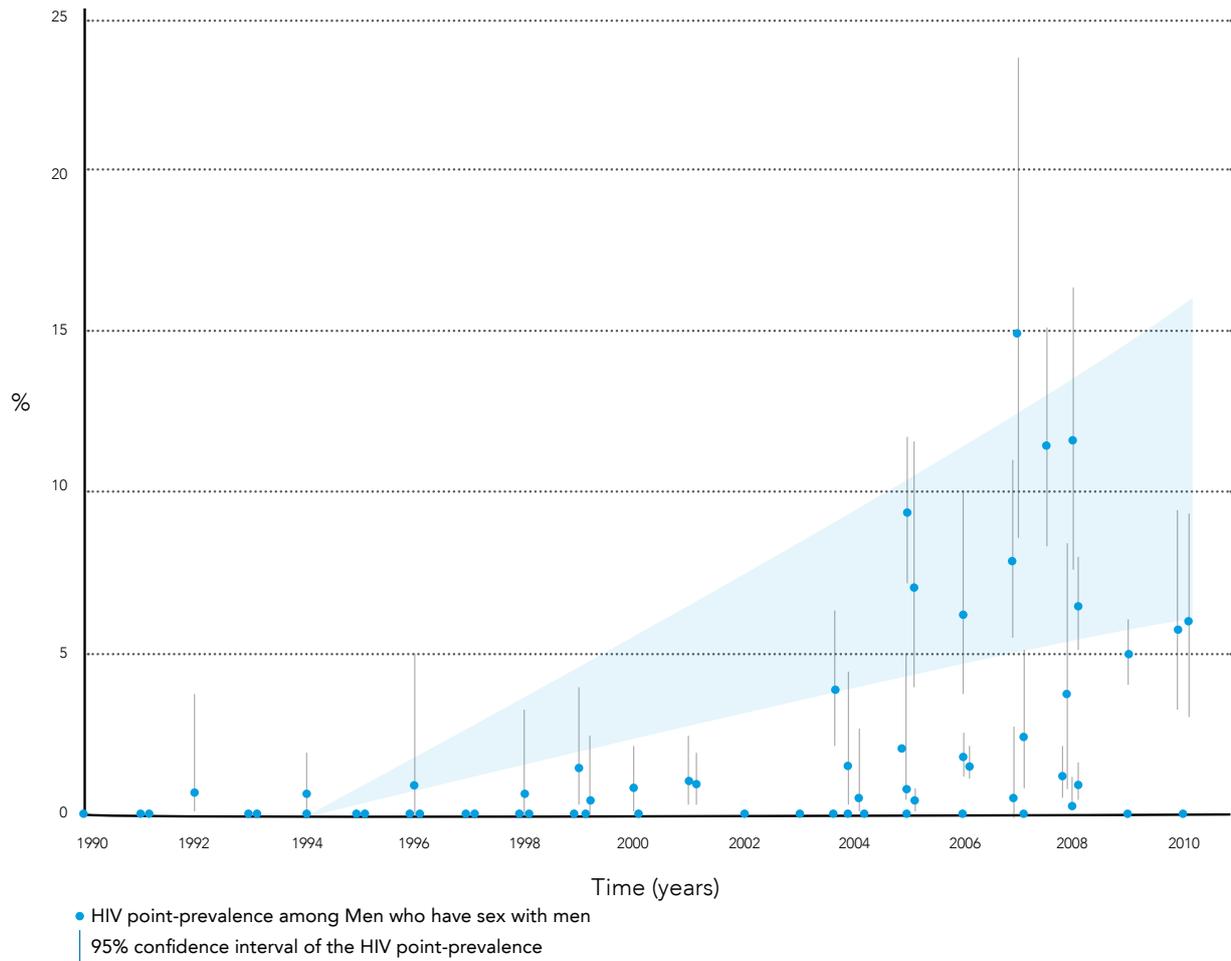
<sup>26</sup> Ministry of Public Health and Family Health International. Integrated Bio-Behavioural Surveillance Surveys among men who have sex with men, Round two, Egypt. 2010.

<sup>27</sup> Integrated Bio-Behavioural Surveillance Survey among men who have sex with men, Tunisia. 2010

<sup>28</sup> Mumtaz G, Hilmi N, McFarland W, Kaplan RL, Akala FA, et al. (2011) 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 Med* 8(8): e1000444. doi:10.1371/journal.pmed.1000444

Figure 6

HIV PREVALENCE AMONG MEN WHO HAVE SEX WITH MEN IN MENA, 1990–2010



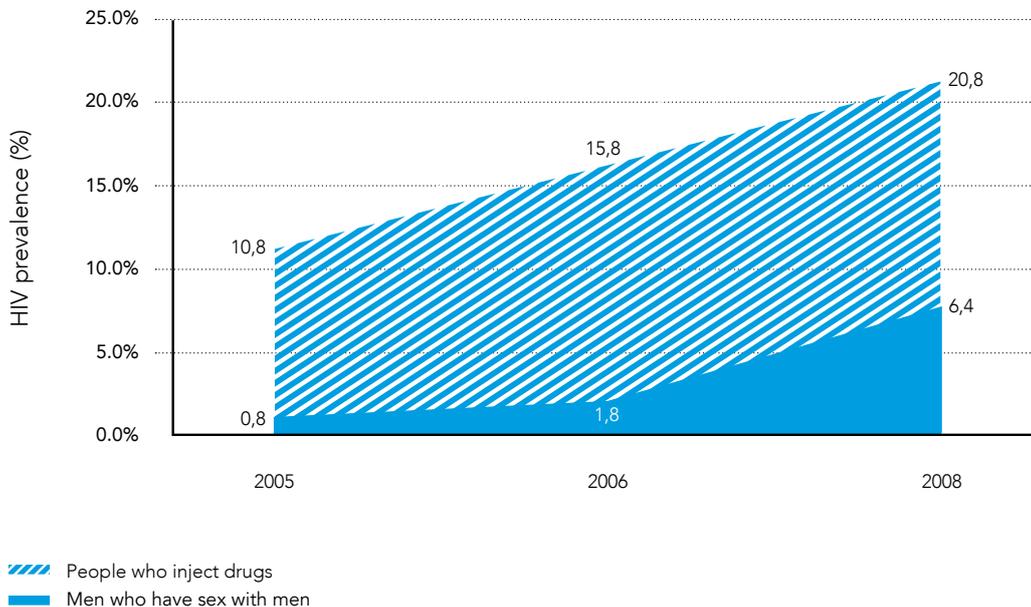
Source: Mumtaz G, et al. (2011) Are HIV Epidemics among men Who Have Sex with Men Emerging in the Middle East and North Africa?: A Systematic Review and Data Synthesis. PLoS Med 8(8)

The increasing prevalence of HIV among key populations is reinforced by data showing an increase in behaviours that actually puts these populations at higher risk of HIV exposure. Specifically, unsafe injecting practices among people who inject drugs and unsafe sexual behaviours among different key populations are increasing the overall HIV prevalence<sup>29</sup>. Unfortunately, among people who inject drugs in many countries, there is a convergence of unsafe injecting practices and unsafe sexual behaviours that puts them at a very high risk of exposure. This interrelationship of key populations has been documented in several studies, including recent modes of transmission studies in Morocco and Iran. In Pakistan, the gradual and simultaneous increase in HIV prevalence among people who inject drugs and men who have sex with men suggests an overlap of risk behaviours and a linkage between these two populations (Figure 7)<sup>29</sup>.

Figure 7

### HIV PREVALENCE TRENDS IN PAKISTAN, 2005 - 2008

MEN WHO HAVE SEX WITH MEN AND PEOPLE WHO INJECT DRUGS



Source: Pakistan, Country Progress Reports 2010

<sup>29</sup> Abu-Raddad L, Ayodeji Akala F, Semini I, et al. Characterizing the HIV/AIDS epidemic in the Middle East and North Africa: Evidence on levels, distribution and trends. Time for Strategic Action, Middle East and North Africa HIV/AIDS Epidemiology Synthesis Project, World Bank/UNAIDS/WHO, (2010).

The heterogeneity and diversity are also visible within the MENA countries. Geographic variation is observed in epidemics across the region and among certain key subpopulations. There are specific locations (e.g. densely populated suburban centers, port cities, junction towns and prison settings) where a convergence of factors – ranging from limited knowledge of HIV, false perceptions of low risk activities, lack of availability of prevention commodities such as clean injecting equipment and condoms, and a concentration of populations engaged in high-risk behaviors – have contributed to the rapid spread of HIV in those areas. This has been documented in various countries of the region, including Morocco, Southern Sudan, Somalia, and Algeria<sup>30</sup>. In Morocco, for example, there is evidence of a concentrated epidemic among people who inject drugs in Nador, northern part of the country (where 17.9% of them are living with HIV<sup>31</sup>) and among men who have sex with men in Agadir, southern part (where 5.6% of them are living with HIV<sup>32</sup>).

Countries in the region have clearly recognized the importance of more and better data. For example, in 2010, nearly all countries (95%) in the region submitted Country Progress Reports 2010 to UNAIDS. This is a significant increase from the 50% that reported in 2008 and the 20% that reported in 2006. There are also more studies and surveys directly linked to the dynamics of their local epidemics. For example, in 2010–11, Egypt, Tunisia and Sudan (five provinces in East Sudan) completed Integrated Biobehavioural Surveillance surveys, which included people who inject drugs, men who have sex with men and sex workers; Morocco conducted an IBBS among men who have sex with men and people who inject drugs; Iran conducted an IBBS among sex workers and people who inject drugs; and Yemen conducted an IBBS among men who have sex with men. Clearly, an increasing number of countries in the region understand the importance of the long-standing advice from HIV experts to ‘know your epidemic’.

Although the amount of available data is steadily increasing, the shortage of data on HIV across the region, and specifically in some countries such as United Arab Emirates, Iraq, Kuwait, Libya, Bahrain, Qatar and Saudi Arabia, makes it difficult to get an accurate picture of the situation, both regionally and nationally. Given the gaps in their HIV data, particularly related to key populations at higher risk, it is likely that the scope of the HIV epidemic and its impact in the region continues to be underestimated, and countries in the MENA region should be concerned about emerging epidemics among key populations at higher risk.



There are specific geographical areas in countries where a convergence of factors has contributed to rapid spread of HIV.

<sup>30</sup> UNAIDS Regional Support Team for Middle East and North Africa

<sup>31</sup> National Sentinel Surveillance Report, Morocco, 2010

<sup>32</sup> Integrated Behavioral and Biological Surveillance Survey among Men who have Sex with Men (MSM) in Agadir and Marrakech, Morocco, 2010–2011



The UNAIDS strategy for 2011–2015 aims to advance global progress in achieving country-set targets for universal access to HIV prevention, treatment, care and support; halt and reverse the spread of HIV; and contribute to the achievement of the Millennium Development goals by 2015. The HIV response is a long-term investment, and the intent of the strategy is to revolutionize HIV prevention, catalyze the next phase of treatment, care and support, and advance human rights and gender equality.

**The vision of having “zero new HIV infections, zero AIDS-related deaths and zero discrimination” included in the strategy is relevant for to the MENA region.**

**Zero  
new HIV infections**



The 2011 United Nations General Assembly Political Declaration on HIV/AIDS has defined targets and elimination commitments.

The overall goal of the political declaration is to achieve universal access to HIV prevention, treatment, care and support by 2015.

The targets related to universal access to prevention or “zero new HIV infections” set in the Political Declaration are:

- Reduce sexual transmission of HIV by 50% by 2015
- Reduce transmission of HIV among people who inject drugs by 50% by 2015
- Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths

In general, these targets and commitments are highly relevant in the MENA region, given the increasing number of new infections. Sexual transmission is a major driver of the epidemic in the region and reducing it by 50% would have a significant impact on new HIV infections, particularly among the populations at the greatest risk of HIV exposure, including men who have sex with men and sex workers. Preventing infections among people who use drugs is another challenge in the region, given the scale of the problem in few populous countries such as Pakistan and Iran. In comparison, new HIV infections among children and AIDS-related maternal deaths do not affect as many people in the region; however, it is feasible and responsible to take the necessary steps to achieve the stated goals by 2015.

## HIV prevention among key populations

The epidemiology of HIV in the region clearly and strongly supports focusing on prevention among the key populations at higher risk specifically, people who inject drugs, men who have sex with men and sex workers.

The key populations at higher risk do vary by individual country. However, the concentrated nature of the epidemic in nearly all countries in the region presents an opportunity for national governments and civil society to move quickly and decisively to prevent the spread of HIV. The concentrated nature of the epidemic in the region – combined with the different populations at risk in different locations – also suggests that countries need good data on their local epidemics, supported by a strong understanding of the regional situation in order to tailor their prevention programmes for the populations at the highest risk.



National governments and civil society have a significant opportunity to move decisively to prevent the spread of HIV.



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## HIV prevention among key populations Morocco

From the beginning of the HIV epidemic, Morocco has adopted a multisectoral approach, with clear recognition by the policy-makers of the fundamental role of Civil Society Organizations (CSOs). The early mobilisation of CSOs in prevention among key populations at higher risk of HIV exposure has been guided by principles such as freedom of action and speech, and human rights.

The Association de Lutte Contre le Sida (ALCS) has initiated outreach prevention programmes among female sex workers in 1991 and men who have sex with men in 1993 in Casablanca and Marrakech, including with mapping and needs identification of these populations. Since then, other nongovernmental organizations (NGOs) such as OPALS FES, Association Marocaine de Solidarité et de Développement (AMSED) and Association Sud contre le sida (ASCS) have joined to help scale-up such interventions.

Over the years, the programmes have been expanded to cover the 18 sections of ALCS with more than 350 volunteers and 50 outreach workers in different sites such as coffees, bars, parks – all listening, explaining, informing and orienting key population to services. The programmes offer a large range of behaviour change, medical and social services, including awareness raising, condom distribution, HIV counselling and testing, STI treatment, psychosocial support and income-generating activities. An education programme using the Internet for men who have sex with men has been started. Outreach programmes among men who have sex with men and sex workers implemented by thematic NGOs in several sites across the country have reached 15 000 men who have sex with men and 30 000 female sex workers in 2009.

A harm reduction programme for people who inject drugs was initiated in 2007 in Tangier, and has been extended to Tetouan and Nador with NGOs playing an active role in advocacy and implementation (ASCMFH, RDR and ALCS). The range of services includes awareness and education, distribution of injection kits and condoms, needle exchange, and social and peer support. The harm reduction network includes several NGOs working in this field, and nearly 1500 people who inject drugs were reached in 2009. An opioid substitution therapy pilot programme was launched in June 2010 for 120 people who inject drugs in four sites.

ALCS has also been working with vulnerable populations, mainly factory workers, prisoners, truck drivers and migrants. Interventions are focused in priority regions selected based on a number of criteria such as epidemiological, economic and social.

In Morocco, NGOs also play a major role in the implementation of HIV testing activities, using fixed centres and mobile units. A national testing day is organized annually by ALCS. The testing centres completed 45 076 tests in 2009 (52% for men and 48% for women) with 54% of tests handled by the mobile centres. Key populations at higher risk made up approximately 23% of the tests administered. The Ministry of Health has started a process of integrating voluntary HIV testing in health centres in priority areas and a screening strategy initiated by the provider. To ensure service quality, the Ministry is implementing a certification process for testing centres. All persons found to be HIV-positive are referred to treatment centres with the assistance of mediators (“mediateurs thérapeutiques et sociaux”) from NGOs.

## Inclusion of key populations in national strategic planning

In recent years, more countries in the region have moved to include references to key populations at higher risk in their national strategic plans (Figure 8). Currently, 13 countries in the region include references to people who inject drugs in their plans, 14 countries reference men who have sex with men, 14 reference sex workers and 15 reference prisoners. Including the key populations at higher risk in these plans is an important step in acknowledging the need to engage with these populations to address HIV in the country. However, it is only one step in a much larger process of ensuring that individual members of these key populations are fully involved in the national planning process, have ready access to the services required to reduce their risk of infection and, if necessary, to provide them with treatment, care and support if they are living with HIV.



Figure 8

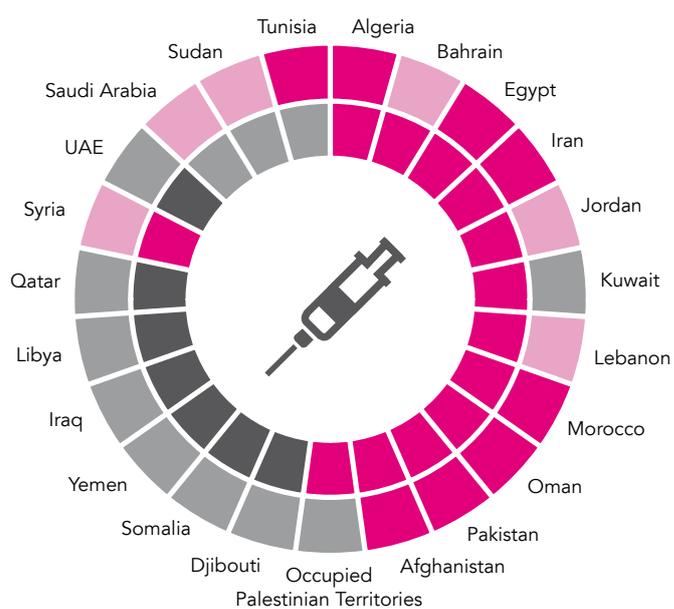
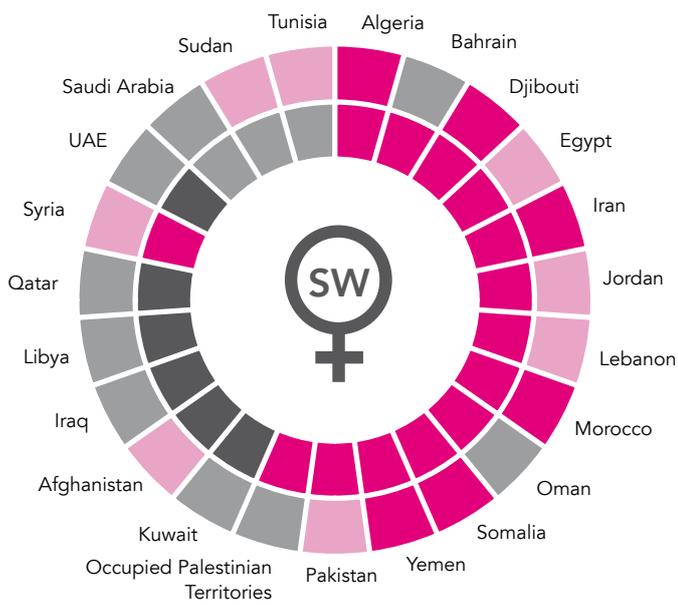
**CORRESPONDENCE BETWEEN THE LEVEL OF HIV EPIDEMIC AMONG EACH KEY POPULATION AND THEIR INCLUSION IN THE COUNTRIES NATIONAL STRATEGIC PLANS**

NATIONAL STRATEGIC PLAN:

- NATIONAL STRATEGIC PLAN ADDRESSING THE KEY POPULATION
- NATIONAL STRATEGIC PLAN NOT ADDRESSING THE KEY POPULATION OR NATIONAL STRATEGIC PLAN NOT EXISTING
- NO DATA

HIV EPIDEMIC:

- HIV PREVALENCE AMONG THE KEY POPULATION  $\geq 1\%$
- HIV PREVALENCE AMONG THE KEY POPULATION  $< 1\%$
- NO DATA



Source: Country Progress Reports 2010. Universal Access Reports 2011.



NATIONAL STRATEGIC PLAN addressing the KEY POPULATION



FEMALE SEX WORKERS



MEN WHO HAVE SEX WITH MEN



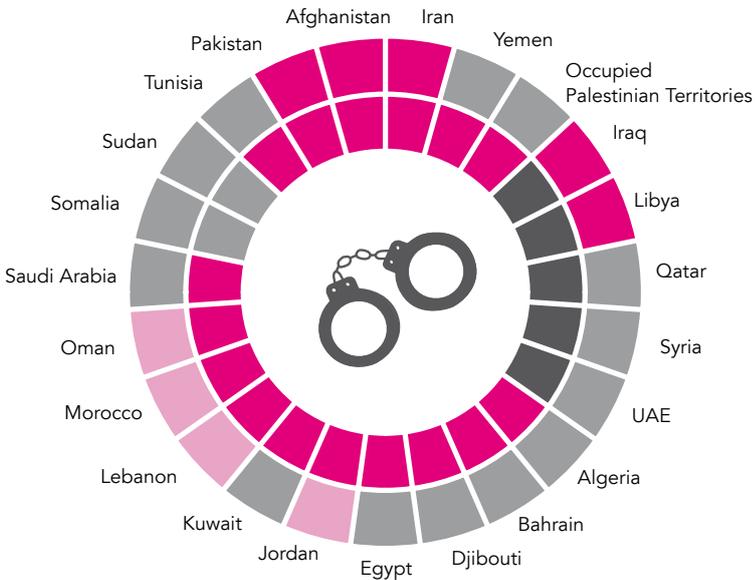
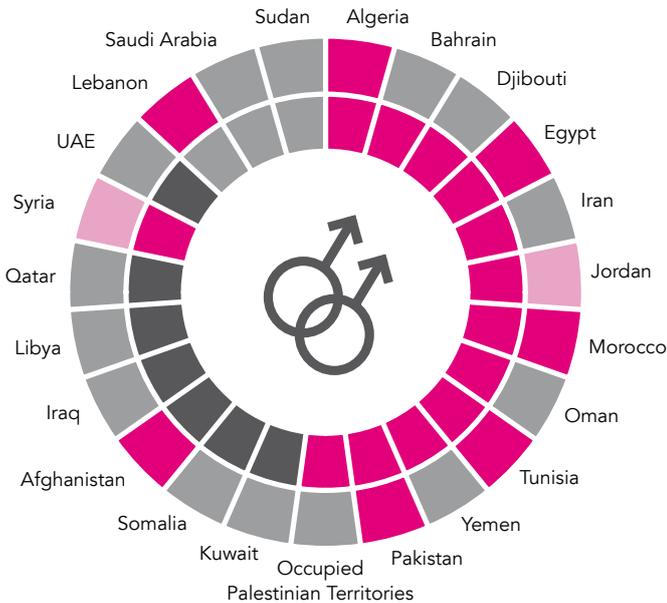
HIV prevalence of the KEY POPULATION



PEOPLE WHO INJECT DRUGS



PRISONERS



## Programmes addressing key populations

In general, the available data on prevention for key populations at higher risk shows the limitations of the current response in the region. Comprehensive knowledge about HIV prevention among the key populations is generally weak. Among countries that do have data on this issue, the percentage of key populations with HIV prevention knowledge varies from 6.9%<sup>33</sup> among sex workers in Somalia, to 29%<sup>34</sup> among people who inject drugs in Afghanistan and 35.6%<sup>35</sup> among men who have sex in Morocco. Condom use is also alarmingly low across the region. In general, condom use is higher among sex workers (Figure 10) than among people who inject drugs (Figure 11) and men (Figure 9) who have sex with men. The reported use of sterile injecting equipment is high in a number of countries of the region. Of the nine countries that have conducted a survey among people who inject drugs, seven have reported a percentage higher than 60% (Figure 11).

Although some countries have gradually increased the coverage of prevention programmes for these populations as shown in the case studies presented in this section, it is clear that the scale of the interventions remains low. This makes it difficult to have the necessary impact on the behaviour change and ultimately the reduction in the spread of HIV among these populations. The exception is the widely acknowledged effectiveness of Iran's programmes for people who inject drugs, demonstrating that a commitment can yield results. The programme is supported by the fact that the country reports that there are 679 sites for needle/syringe programmes<sup>36</sup>. As a point of comparison, the next highest number reported is 21 sites in Afghanistan<sup>37</sup>.

There is a concern that [key populations] are not seeking health services within the health institutions for fear of stigma and that in the absence of programmes offering needed health services, these populations remain unknown in their numbers and largely unreached by the necessary prevention and treatment options made available in Oman.

Country Progress Report 2010, Oman

<sup>33</sup> Integrated bio-behavioral surveillance survey, Somalia. 2008

<sup>34</sup> Integrated bio-behavioral surveillance survey, Afghanistan. 2009

<sup>35</sup> Integrated bio-behavioral surveillance survey, Morocco. 2010

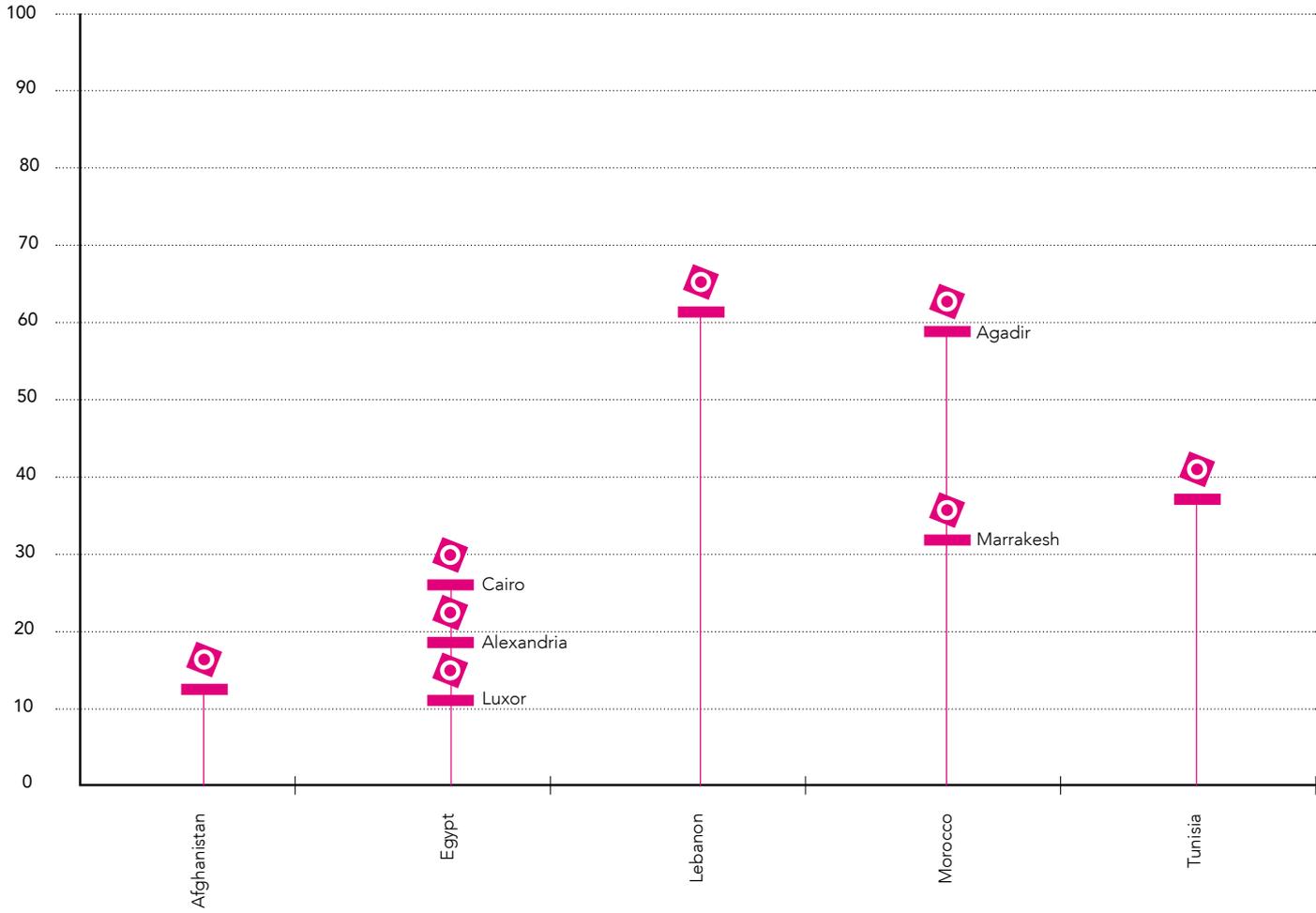
<sup>36</sup> Universal Access report 2011, Iran

<sup>37</sup> Universal Access report 2011, Afghanistan

Figure 9

**CONDOM USE - MEN WHO HAVE SEX WITH MEN.**

Percentage of men reporting the use of a condom the last time they had a sexual intercourse with a male partner



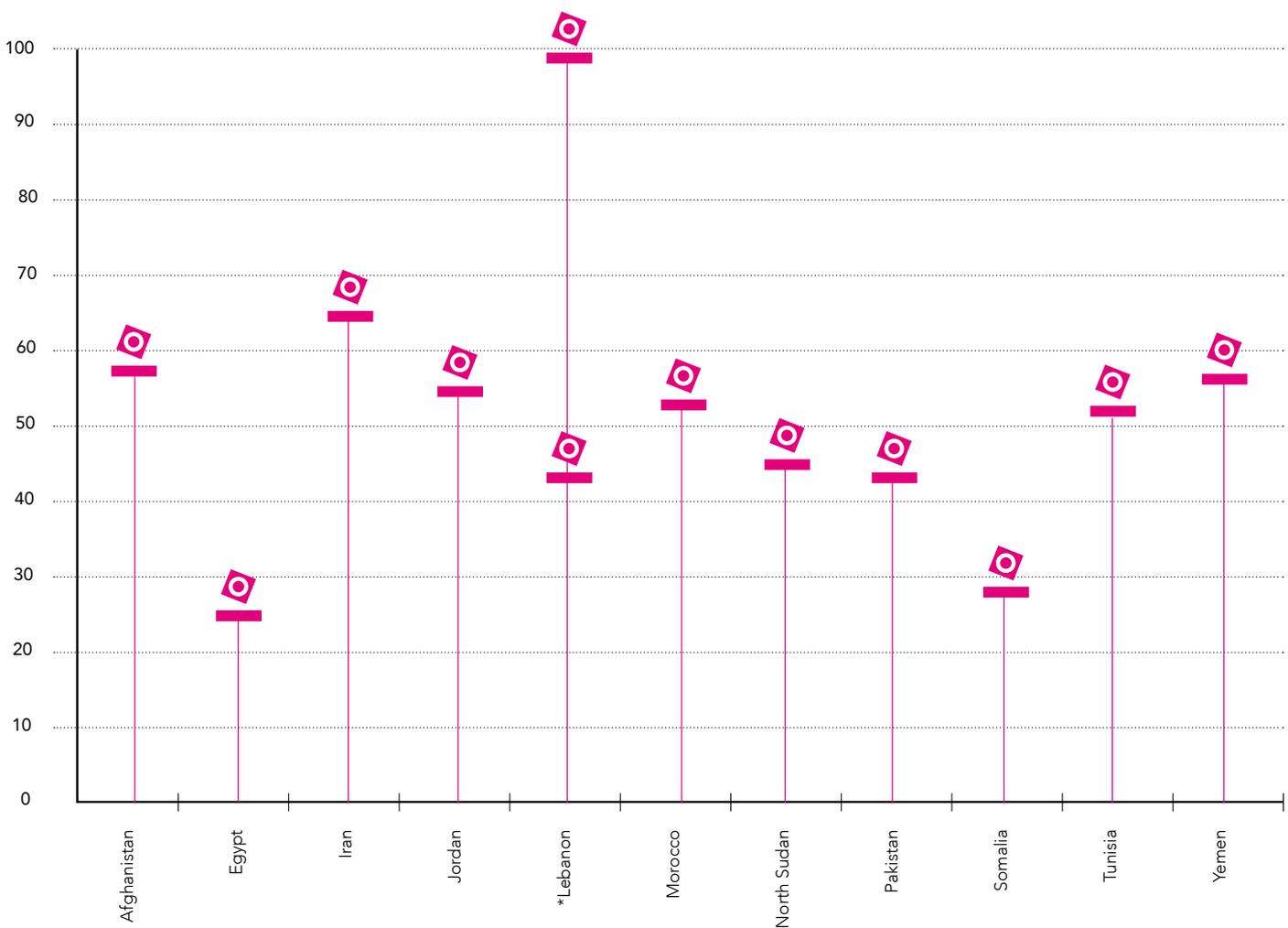
 Condom use

Source: Country Progress Reports 2010.  
Universal Access Reports 2011.

Figure 10

**CONDOM USE - FEMALE SEX WORKERS**

Percentage of Female Sex Workers reporting the use of condom with their most recent client



 Condom use

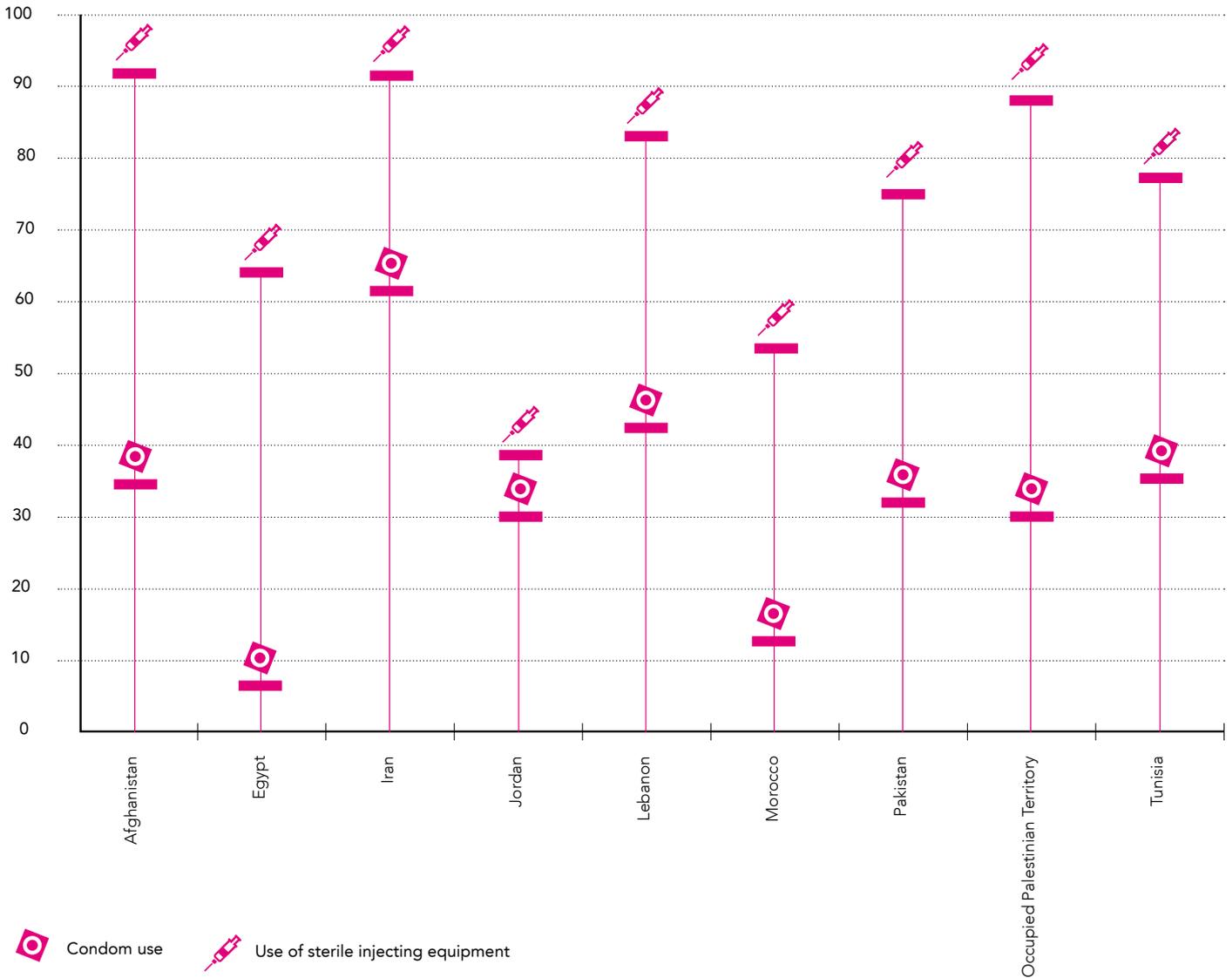
\* The percentage is 43% for regular client and 98% for non regular client

Source: Country Progress Reports 2010.  
Universal Access Reports 2011.

Figure 11

**CONDOM USE AND USE OF STERILE INJECTING EQUIPMENT - PEOPLE WHO INJECT DRUGS**

Percentage of People who Inject Drugs reporting the use of a condom the last time they had sexual intercours and percentage of People who Inject Drugs reporting the use of sterile injecting equipment the last time they injected



Source: Country Progress Reports 2010.  
Universal Access Reports 2011.

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## Double stigmatisation: Outreach work with men who have sex with men Tunisia

Association Tunisienne de Lutte contre les MST et le Sida (ATL MST/SIDA) Tunis has worked several years with two goals:

- design interventions to most effectively support men who have sex with men at risk of acquiring HIV
- endeavour to further understand how to improve their outreach work among these communities through qualitative community-based research.

In 2005, ATL MST/SIDA-Tunis initiated a qualitative study to better understand the specific needs of men who have sex with men in relation to HIV prevention, treatment, care and support. It also sought to more specifically distinguish the different categories of men who have sex with men in order to design different interventions more effectively. From this research, ATL MST/SIDA Tunis made four different distinctions of this population: 1) adolescents and young people who have difficulty accepting their attraction towards men due to social stigma and hostility against their sexual orientation; 2) men who have sex with men who are mainly young and define themselves as “gay”, and who publicly disclose their sexual orientation; 3) men who have sex with men who lead a double life with respect to social norms, in particular those who are also married; and 4) male sex workers who do not necessarily define themselves as homosexual.

After the full results of the qualitative study, ATL MST/SIDA-Tunis was able to develop a more holistic and participative approach to reaching this key population at higher risk in Tunisia. The research showed that it was clear that their needs are not simply health related, but also concern respect for human rights. Therefore, the approach comprised elements to comprehensively address health and psychosocial needs of men who have sex with men, but also integrated a strong advocacy component to advocate against stigma and discrimination at certain levels of the population. A significant component of this work has been to advocate to uphold human rights and to ensure more effective access to vital services.

ATL MST/SIDA-Tunis has trained peer educators to do outreach work with key populations at higher risk to promote, in particular, sexual relations that are responsible and protected. The choice to work with peer educators was driven by the expressed need of the community for confidentiality, and by the fear of stigma and discrimination in formal health entities by health workers and medical professionals. In addition, ATL MST/SIDA-Tunis designed a “meeting space” in Tunis for men who have sex with men to have an informal space for exchange, listening, support, information, orientation and education in dialogue with their peers. ATL MST/SIDA-Tunis has also initiated a telephone hotline for those individuals who do not have the opportunity to come to the association, so that they can also receive support and advice about sexual health, in particular sexually transmitted infections and HIV.

Finally, recognizing the need for a holistic response, ATL MST/SIDA-Tunis worked with an on-site psychologist to support the mental health needs of its clients. This comprehensive approach, driven by evidence-informed research, has permitted ATL MST/SIDA-Tunis to more effectively reach this key population in Tunisia. While simultaneously meeting the physical and mental health needs of the community, it is also working to tackle stigma and discrimination against men who have sex with men, and to advocate against laws that hamper access to HIV prevention, treatment, care and support.

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de Lutte



الشيخا  
SIDA  
مركز الوقاية من الأمراض المعدية  
والسرطان  
والتهنئة  
والوقاية  
والوقاية  
والوقاية

## Soeur-à-Soeur project Djibouti

In Djibouti, the Community Intervention Support Unit (CISU), or Unité d'Appui aux Interventions Communautaires, is part of the national AIDS control programme. CISU is widely recognized as having done remarkable work in reducing the stigma of HIV and mobilizing community support for the HIV response. One of its most impressive initiatives is the Soeur-à-Soeur, or Sister-to-Sister, project. The goal of the project was to reduce the vulnerability of women working in the sex work to HIV and other sexually transmitted infections (STIs).

The project has helped women better understand these issues; it enhanced their knowledge on how to reduce their own risk and got them directly involved in helping other sex workers reduce their risk of HIV infection. It also included a number of focused activities around condoms, including increased availability and education on proper use. Women participating in the project were engaged in advocacy and focus group sessions to better understand the dynamics of their work and how to reduce their risk. Even the name of the project served a specific purpose: Soeur-à-Soeur was selected to eliminate the stigma associated with the term “sex worker”.

The project has also helped establish a network through which distribution of condoms for sex workers and their clients, referral for voluntary counselling and testing, STI and treatment, care and support all became easier. The ongoing mapping and size estimation of sex workers and men who have sex with men is using this network to generate strategic information for interventions that engage key populations.



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## MENA Harm Reduction Association

MENA Harm Reduction Association (MENAHR) has been working to prolong and improve the quality of life for people who inject drugs in the region. Launched in 2007 through an initiative by the World Health Organization and the International Harm Reduction Association, and with financial support from the Drosos Foundation, MENAHR covers 19 countries in the MENA region. The organisation has three objectives that all are helping to reshape the agenda for harm reduction in the region: 1) to establish sustainable structures that can deliver capacity building activities, undertake advocacy and provide information resources on harm reduction in the region; 2) to establish sustainable structures that can foster and facilitate information sharing and mutual support among stakeholders in the region; and 3) to provide direct support to civil society organizations (CSOs) to initiate and/or expand harm reduction activities, and to identify and support emerging model programmes that are capable of demonstrating the feasibility and effectiveness of harm reduction activities in the region.

Through MENAHR, 28 training workshops on harm reduction trained 542 people from different CSO and governmental structures (health, law enforcement, media, etc.). There is evidence to suggest that the knowledge hubs' training and advocacy workshops have contributed to changes that favour harm reduction in both policies and practices. MENAHR has successfully trained eight CSOs in six different countries: Pakistan, Egypt, Iran, Afghanistan, Algeria and Tunisia. As a result, six CSOs provide needle/syringe services to 2292 people who inject drugs (distributing 222 078 needles and syringes); three CSOs (in Iran, Afghanistan, and Egypt) provide voluntary counselling and testing either on-site or via referral (1088 clients have used this service). CSOs report that their harm reduction services have engendered a growth in harm reduction service provision beyond their individual projects<sup>38</sup>.

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<sup>38</sup> Burns K., *Strengthening Civil Society's role in delivering harm reduction services in the Middle East and North Africa*. 2010.

Overall, stigma and discrimination are powerful limiting factors for prevention programmes in the region. On the supply side, it limits the development and availability of programmes; on the demand side, it inhibits people from accessing these vital services. The issue is pervasive, negatively affecting every sector and population, even those with clear interests in preventing HIV infection. The greatest impact is on those populations with the highest risk of HIV exposure. For them, stigma and discrimination translate directly to an increased vulnerability.

Increased commitment and involvement of governments and civil society are signs that some progress is being made in this area, and more countries are improving the collection of epidemiological evidence on HIV and on risk behaviour among key populations in the MENA region<sup>39</sup>. There is also a growing awareness of the importance of working with the key populations on HIV prevention in the region, and efforts are increasingly being made to understand the issues and address the shortcomings in HIV prevention.

## HIV prevention among vulnerable populations

It is important that HIV prevention strategies mirror the epidemiology of the HIV situation in a country. Prisoners, clients of sex workers<sup>40</sup>, mobile and migrant populations, and young people should have access to effective prevention programmes.

### Prisoners

There is a greater risk to HIV transmission among prisoners because of use of non sterile injecting equipment and unprotected sex in prisons. In many countries, these risks are downplayed because of beliefs that these activities do not occur in prison settings. Unfortunately, these beliefs generally translate to a lack of relevant prevention programmes in prisons (e.g. testing and counselling, needle/syringe exchange, substitution therapy, condom distribution), which further increases the risk of infection among this population. Fortunately, countries have gradually recognized the importance of addressing the issue, with progressive work accomplished in Iran. Other countries such as Tunisia, Egypt, Lebanon and Morocco have learnt from the Iran experience and have made progress towards providing a comprehensive package of services for prisoners.

Although studies are underway to better understand the impact of the harm reduction programme on the reduction of the HIV epidemic among people who inject drugs in Iran, it is reasonable to state that the comprehensive approach adopted – including the expanded opioid substitution therapy coverage – has contribution to such reduction (Figure 12).



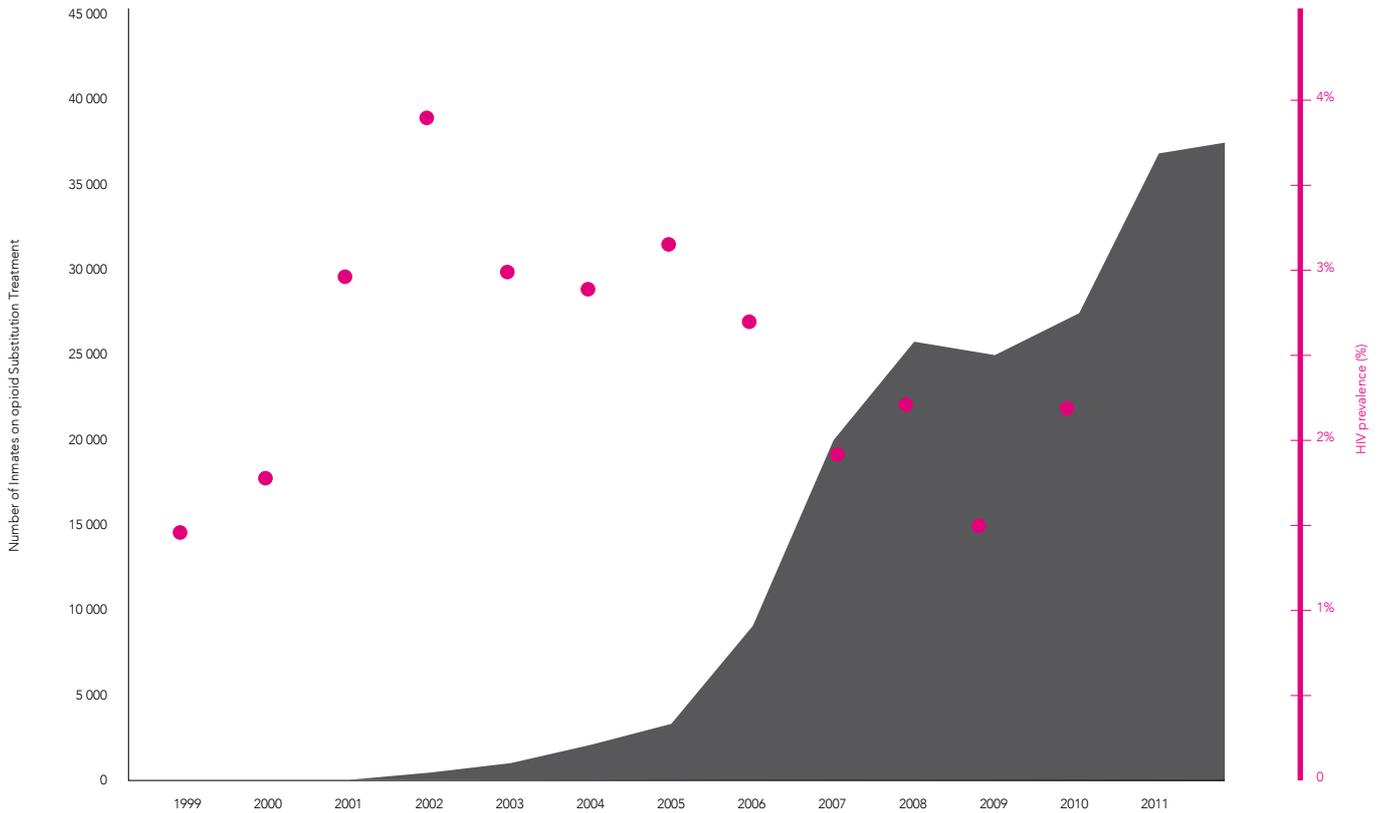
There is growing awareness of the importance of working with the key populations on HIV prevention in the region.

<sup>39</sup> Mumtaz G, Hilmi N, McFarland W, Kaplan RL, Akala FA, et al. (2011) 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 Med 8(8): e1000444. doi:10.1371/journal.pmed.1000444

<sup>40</sup> This group is not covered in the report as no data is yet available in the MENA region

Figure 12

**TREND IN HIV PREVALENCE AND PROVISION OF OPIOID SUBSTITUTION THERAPY IN PRISONS: IRAN**  
 As part of a comprehensive Harm Reduction Programme (1999 - 2011)



- HIV prevalence in prisons
- Number of prisoners receiving methadone

This graph does not demonstrate a decrease in the new HIV infections (incidence). The data points are result of HIV sero-surveillance and show point prevalence. It is important to consider limitations in interpretation of this data as it can be confounded by high turnover rates and possible increase in mortality

Source: National HIV Surveillance - Ministry of Health and Medical Education, Iran.  
 Programme Monitoring data, Prison Health Department, Iran's Prison Organization.

## Triangular Clinics<sup>41</sup>

### Iran

The concept of the triangular clinic is innovative and pragmatic. It deals with three frequently overlapping issues: injecting drug use through harm reduction; the treatment of sexually transmitted infections; and care and support for people living with HIV. Triangular clinics utilize the services of medical doctors as well as paramedical staff and counsellors. Some clinics have visiting specialists, such as infectious diseases specialists and psychiatrists. Prevention efforts directed at key populations include provision of harm reduction packages where clients are usually provided with up to one week's supply of injecting equipment at a time, as well as condoms. The clinics have been organized in such a way that other agencies can refer clients to the clinics for counselling and testing as well as for care and support.

The first triangular clinic was established in Kermanshah's central prison in October 2000. The Kermanshah clinic demonstrated that by grouping the three service areas together, it was possible to deliver a responsive, comprehensive and integrated service to drug users, their local community and people living with HIV, including drug users and their families.

Following the experience of the Kermanshah clinic, the triangular clinic model has been expanded throughout the country. At present, there are 102 such clinics in 32 provinces, together with 180 pure VCT facilities. As at the end of 2010, the Iranian Prisons Organization supported an additional 133 such facilities within its own system. In all the clinics the focus is on the provision of care and support for people living with HIV. The clinics avoid stigmatization by not making direct, specific public references to HIV. The triangular clinics are also sometimes referred to as the "counselling and treatment centres for behavioural diseases", or VCT centres.

After formal registration and documentation of relevant details, which are kept confidential in files that can be accessed only by counselling or treatment staff, patients are offered the services of a counsellor for pre- and post-test counselling. Blood is usually drawn at the triangular clinic and sent to the Blood Transfusion Organization for HIV and hepatitis B virus testing, and hepatitis C virus testing is included for those with a history of injecting. Blood samples are coded to maintain confidentiality. The results are sent back to the triangular clinic, where they are given to clients with post-test counselling.

The clinics have the potential to diagnose and effectively treat HIV as well as offer prophylactic treatment for opportunistic infections. Suspected tuberculosis cases are screened and, after establishing a diagnosis, are usually referred to a DOTS (directly observed treatment, short-course) programme—which is already operational in the Iranian health system. Similarly, clients with various medical and psychiatric problems are referred to respective clinics.

Opioid substitution therapy (OST) is offered free of charge for opiate-dependent people living with HIV in some triangular clinics. Staff at clinics offering OST reported that this has helped more people injecting opiates to access their services. Methadone treatment is attractive to opiate-dependent clients, and since many clinics do not have strong linkages with people who inject drugs' communities, the clinics emphasize the significance of OST in promoting themselves to drug users. In some areas, the prime reason for clients registering with the clinic is the desire to access methadone treatment.

<sup>41</sup> HIV prevention and care among injecting drug users in the Islamic Republic of Iran: a review of best practice / World Health Organization. Regional Office for the Eastern Mediterranean (2008) updated from information provided by Dr. Farnia, DG Health, IPO and Dr. Kamali, senior technical expert at the HIV/AIDS Bureau, CDC, MOHME

Triangular clinics are not all the same. Their capacity to provide treatment and care for people living with HIV varies with only some of them providing ART to a limited number of patients. Clinics also differ in their ability to organize other support services for people living with HIV. The formation of self-help groups that can provide support and advocacy is an important step in an effective response to AIDS. Some triangular clinics, such as in Khoram Abad (Lorestan) and Shiraz (Fars), have facilitated the organization of such groups among their clients. These “Positive Clubs”, which now number twelve nationwide, have been funded through successive rounds of Global Fund grants and are being scaled up further. They are also expanding the range of services they provide to include capacity development and vocational training.

## Mobile and migrant populations

The relationship between acquiring an HIV infection among individuals and their mobility status is widely recognized. Although mobility and migration are not risk factors for HIV transmission by themselves, the often harsh, unsafe and isolated conditions surrounding the mobility process can give rise to behaviours strongly associated with increased risk of HIV transmission, and pose barriers to access to services. These populations include truck drivers and their assistants, seafarers, uniformed service people, migrant workers, and refugees and displaced persons.

Recent research has explored these dynamics in ports of the Red Sea and adjacent transport corridors, and found that cross-border mobile populations interact in places that are generally prone to a higher risk of HIV transmission throughout the Horn of Africa and Arab Peninsula<sup>42</sup>. These areas are where certain goods and services – such as fuel, lodging, vehicle repair, loading/unloading, immigrations or customs clearance, meals, alcohol, drugs and entertainment – are available more readily than in other areas. This not only impacts mobile populations, but also people who live or work near highways and ports. These areas are frequented by large numbers of mobile people throughout the Red Sea and Gulf of Aden region, including female sex workers, truck drivers and their assistants, seafarers, uniformed service men, pastoralists and refugees. Mobile men are often young, sexually active, and spend long periods of time away from their families and regular partners. These groups self-report engaging in multiple concurrent sexual partnerships with casual or regular partners, including sex workers.



The unsafe conditions surrounding the mobility process can give rise to behaviours strongly associated with increased risk of HIV transmission.

<sup>42</sup> Martin A., *Mobility, Migration and HIV Vulnerability of Populations along the Ports of the Red Sea and Gulf of Aden*. 2011

The female sex workers report that truck drivers are their most common clients, followed by uniformed service men, nomads and other mobile men. In nearly every context, respondents reported low or irregular condom use and demonstrate limited HIV knowledge and risk perception. This combination of factors, including the high HIV prevalence observed among female sex workers in many places, such as in Djibouti (20.3%<sup>43</sup>), indicates that the risk of HIV transmission is extremely high in these settings.

The loneliness that truckers experience as a result of being far from home, the proliferation of alcohol and khat<sup>44</sup> in areas, and their need for entertainment and companionship leads them to engage in casual sex, transactional sex or regular sexual relationships in one or more of the stopover towns along the major highways. A study in Yemen found that truck drivers spending long hours away from their homes and their partners, and travelling long distances engage in high-risk behaviours such as unprotected sexual relations while on the road<sup>45</sup>. Also, research conducted around the Port of Suez found that this behaviour is repeated in multiple stopping points along transport routes<sup>46</sup>.

People who migrate for work, including those coming to the region and those moving from one country in the region to another, routinely encounter levels of stigma and discrimination that make it difficult to reach them with important health messages and programmes. Although they are not a homogeneous group, many of these migrant workers tend to be a 'hidden' population without legal status or protections. Consequently, there are serious issues related to the availability and accessibility of prevention services for these people, particularly if they are also part of another key population at higher risk, such as people who inject drugs or men who have sex with men.

Returning migrant workers, who live in the region and may have been infected with HIV outside of their home country, need access to services to protect their partners from infection. However, their HIV status subjects them to the deep-seated stigma and discrimination towards people living with HIV that is prevalent in the region. This, in turn, limits their willingness and ability to disclose their status and access HIV prevention, treatment, care and support services.

Conflicts in the region have also created large populations of refugees and displaced persons in various countries around the region. The status as a refugee or displaced person is not a de facto risk factor for HIV infection. However, the uncertainties and instabilities faced by many refugees can create situations of increased risk among individual members of these groups. For example, precarious conditions in refugee camps – often characterized by poor sanitation, overcrowding, abuse and violence – can increase risk; again, most commonly through injecting drugs or unsafe sexual practices, including unprotected sex work.

<sup>43</sup> Mork N., HIV Vulnerability and Cross Border Mobility in the Horn of Africa: A report on risk and vulnerability to HIV among mobile population groups and the communities they interact with in the Horn of Africa

<sup>44</sup> Khat is a plant containing an alkaloid which is an amphetamine-like stimulant. Khat is very popular in many countries of Horn of Africa, specifically Yemen.

<sup>45</sup> Gharama et al., *Rapid Assessment: Vulnerability to HIV among key population groups in Aden, Yemen*, 2010 15.

<sup>46</sup> IOM. *Rapid Assessment: Vulnerability to HIV among Key Population Groups in Hotspot Areas in the Port of Suez, Egypt*. 2010.



Given that forced sex is often subject to underreporting, it is notable that 9% of women and 3% of men reported experiences of forced sex. While it was most commonly reported to have happened before or during displacement, it was also reported after displacement, and from a wide variety of perpetrators, including military officers, family members and regular partners.

HIV Behavioural Surveillance Survey in Dadaab Refugee Camps, Kenya  
(camp for Somali refugees)  
August 2010

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## Mobility, migration and HIV vulnerability of populations along the ports of the Red Sea and Gulf of Aden

UNAIDS has worked in partnership with the Intergovernmental Authority on Development (IGAD), International Organization for Migration and the United Nations Development Programme since 2004 to advance an initiative entitled Mobility, Migration and HIV Vulnerability of Populations along the Ports of the Red Sea and Gulf of Aden. The overall objective of the initiative is to help provide universal access to HIV services for mobile groups, migrants and other marginalized populations in or passing through the ports of the Red Sea and the Gulf of Aden. The initiative has recently reported that social and economic marginalization and isolation – including marginalization related to gender inequality – are key issues driving vulnerability to HIV among cross-border mobile populations. It found that cross-border mobile populations in the countries bordering the Red Sea and Gulf of Aden, including sex workers, transport workers, uniformed services, pastoralists and refugees, interact with each other in contexts that lead to increased risk for exposure to HIV.

To date, the IGAD's Regional HIV/AIDS Partnership Programme has advanced a response to this situation in Djibouti, Ethiopia, Somalia and Sudan through strengthening health facilities, promoting intercountry collaboration and supporting the harmonization of protocols. Since programme inception in 2009, more than 20 000 people have been reached through community based prevention programming, 185 000 people have received HIV counselling and testing in project sites, and the number of people receiving ART has increased from 379 in 2009 to 2134 in 2011. Training has been provided to 8786 people, including health care providers, peer educators, youth, people with HIV, sex workers and community leaders, and new associations of people with HIV have been established to support community outreach<sup>47</sup>.

However, there is still a great deal of work to be done to form and implement interventions that target the unique needs and situations experienced by diverse cross-border mobile populations. Lessons from beyond the Red Sea and Gulf of Aden confirm that targeted approaches to programming that use existing infrastructure and partner with allies in the private sector have made great strides in supporting these groups with services. Concrete recommendations in the area of planning, programming, partnership and research have been made to improve the response and will be discussed with all stakeholders in early 2012<sup>48</sup>.

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<sup>47</sup> Intergovernmental Authority on Development (IGAD), *IRAPP Third Quarter Progress Report for 2011* (IGAD Regional HIV and AIDS Partnership Programme, 2011).

<sup>48</sup> Martin A., *Mobility, Migration and HIV Vulnerability of Populations along the Ports of the Red Sea and Gulf of Aden*. 2011



## Young people

The MENA region has a rapidly growing population of young people between the ages of 15 and 30 (Figure 13). In many countries in the region, more than 20% of the population falls into this age bracket. As a population, young people in the region – and the circumstances they face – are extremely diverse. They speak many different languages, belong to different religions, have different levels of education, and have very different job prospects.

High levels of unemployment and the disaffection that comes with sustained unemployment are a pervasive problem in the region. In 2008, the MENA region had the highest percentage of young people who were looking for a job as well as the lowest percentage of young people who were participating in the labour force, compared to the rest of the world. Chronic unemployment is also disrupting traditional social patterns in the region; for example, young people are living with the parents longer and delaying marriage.

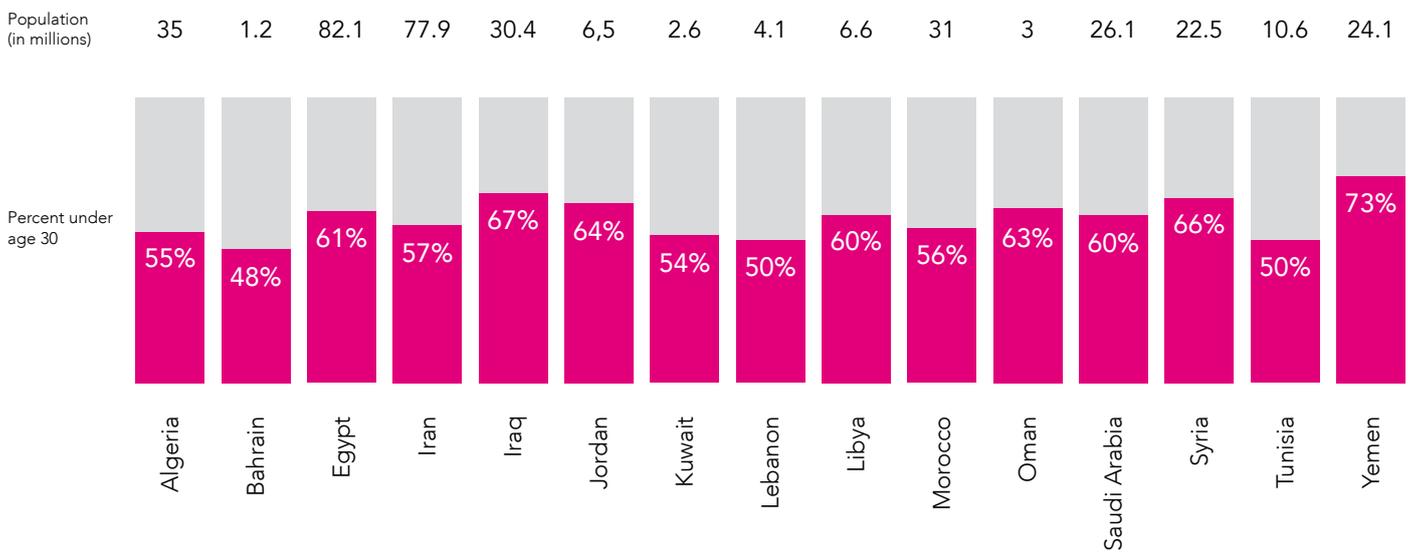
Historically, the region has also been slow to adopt international approaches to education on sexual and reproductive health issues. As a result, policies, strategies and programmes related to these important issues are not well developed, which translates to low levels of accurate knowledge and limited use of contraceptives, including condoms, among young people. The situation is further complicated by the fact that premarital sex is highly stigmatized, which means that young people are reluctant to seek reliable information or take steps to protect themselves.

In addition, gender roles have traditionally been very rigid in the region. Consequently, there is a significant disparity between the social roles assigned to men and women, which leads directly to inequities for young women – one that limits their choices and opportunities. In the context of sexual and reproductive health, the levels of stigma associated with premarital sex are even higher for young women. As a recent report found, “Girls and young women across the region generally have less information than young men about sex, less ability to speak about it, less negotiating power to protect themselves in the event of unplanned sexual relations, and less chance of remedying the consequences”<sup>49</sup>.

<sup>49</sup> Roudi-Fahimi F. and El Feki S; *Facts of Life: Youth Sexuality and Reproductive Health in the Middle East and North Africa*; Population Reference Bureau. 2011

Figure 13

### YOUNG POPULATION UNDER 30: SHARE OF UNDER AGE 30 OVER TOTAL POPULATION



Source: UN Population database.

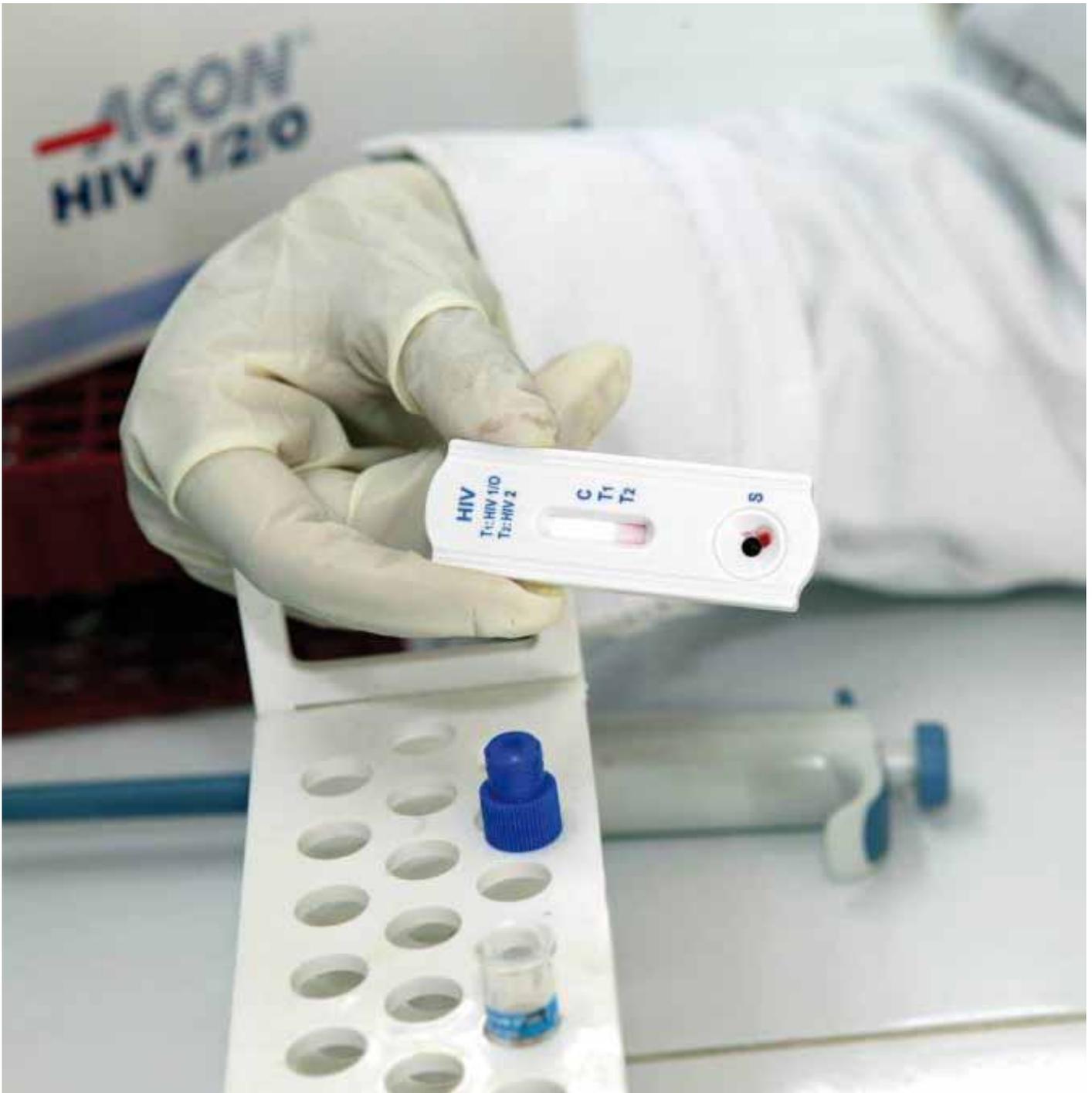
The social dynamics facing young people in the region does create some increased levels of risk of HIV transmission. For example, there is data showing that a percentage of young men and women have experimented with illegal drugs, have risky, unprotected sex, and engage in transactional sex (e.g. in exchange for money or gifts). The increased vulnerability of young people to HIV is due primarily to their risk behaviours, not their age. However, the sheer and growing size of the young population in the MENA region, combined with shifting social dynamics, will certainly increase the percentage of young men and women who are willing to take risks that may lead to HIV infection. The challenge is to find appropriate measures to mitigate this risk – for example, accessible and accurate sexual and reproductive health education – that do not divert much-needed resources from prevention programmes for populations at far greater risk of infection.



**The increased vulnerability of young people to HIV is due primarily to their risk behaviours, not their age.**

## Health-specific HIV prevention programmes

The success of every HIV prevention programme in the world hinges on its ability to provide the right services in the right way to the right people. For national programmes, it also includes providing the right mix of services, including the right health-specific interventions. In the MENA region, the availability, uptake and quality of these interventions is mixed at best.



## HIV testing

In the MENA region, most countries have policies in place on HIV testing and counselling. Since 2006, the rate of HIV testing in these countries has steadily increased. However, the overall percentage of people tested remains much lower than the global percentage, and most of the testing is focused on migrant workers, not on the key populations who are at higher risk of HIV exposure (Figure 14).

According to a 2010 report on HIV testing in the region<sup>50</sup>, nearly 60% of the tests completed between 1995 and 2008 were for migrant workers, while only 4% of tests were for key populations at higher risk. It also appears that most of these tests were mandatory; mandatory testing is widely used by countries in the region, particularly for migrant and foreign workers. Only Morocco and Djibouti have explicit national policies prohibiting mandatory testing.

Immigration requirements in the region are a key reason for the sustained, large-scale testing of migrant workers, and individuals from this population who test positive for HIV are typically deported to their home country. Unfortunately, there are reports that people who do test positive are not informed of their HIV status before being deported, which means these people do not know they need to seek treatment, nor they are aware that they need to modify their behaviour to prevent further transmission of HIV. In general, the widespread use of mandatory testing of migrants in the region has serious human rights implications that undermine the global commitment to dramatically reduce discrimination related to HIV.

Another significant proportion of mandatory HIV testing targets low-risk populations, such as couples before they are married. The practice of mandatory testing has no public health grounds, does not conform to universal guidelines on ethical practice, and it raises serious questions about human rights, stigma and discrimination. By principle, HIV testing should be carried out under conditions respecting the three Cs: Confidentiality, informed Consent and Counselling.

Mandatory testing is also used extensively with key populations at higher risk, often in conjunction with arrest or detention. From a prevention perspective, this use of mandatory testing has little or no value because it is typically delivered without counselling, and it is the combination of both activities that contributes most significantly to effective prevention and behaviour change.

There are limited data on HIV testing among people who inject drugs, men who have sex with men and sex workers. In the Country Progress Reports 2010, only two countries – Iran and Tunisia – provided data on all three populations. Slightly more countries reported on the individual groups: five reported on people who inject drugs; three reported on men who have sex with men; and seven reported on sex workers. In general, data show that the rates of testing among these populations is extremely low. Also, the size of key populations is not estimated in most of the MENA countries, making it difficult to determine the exact coverage of HIV testing (Figure 15).



Migrant workers were subject to

**60%**  
of the HIV tests



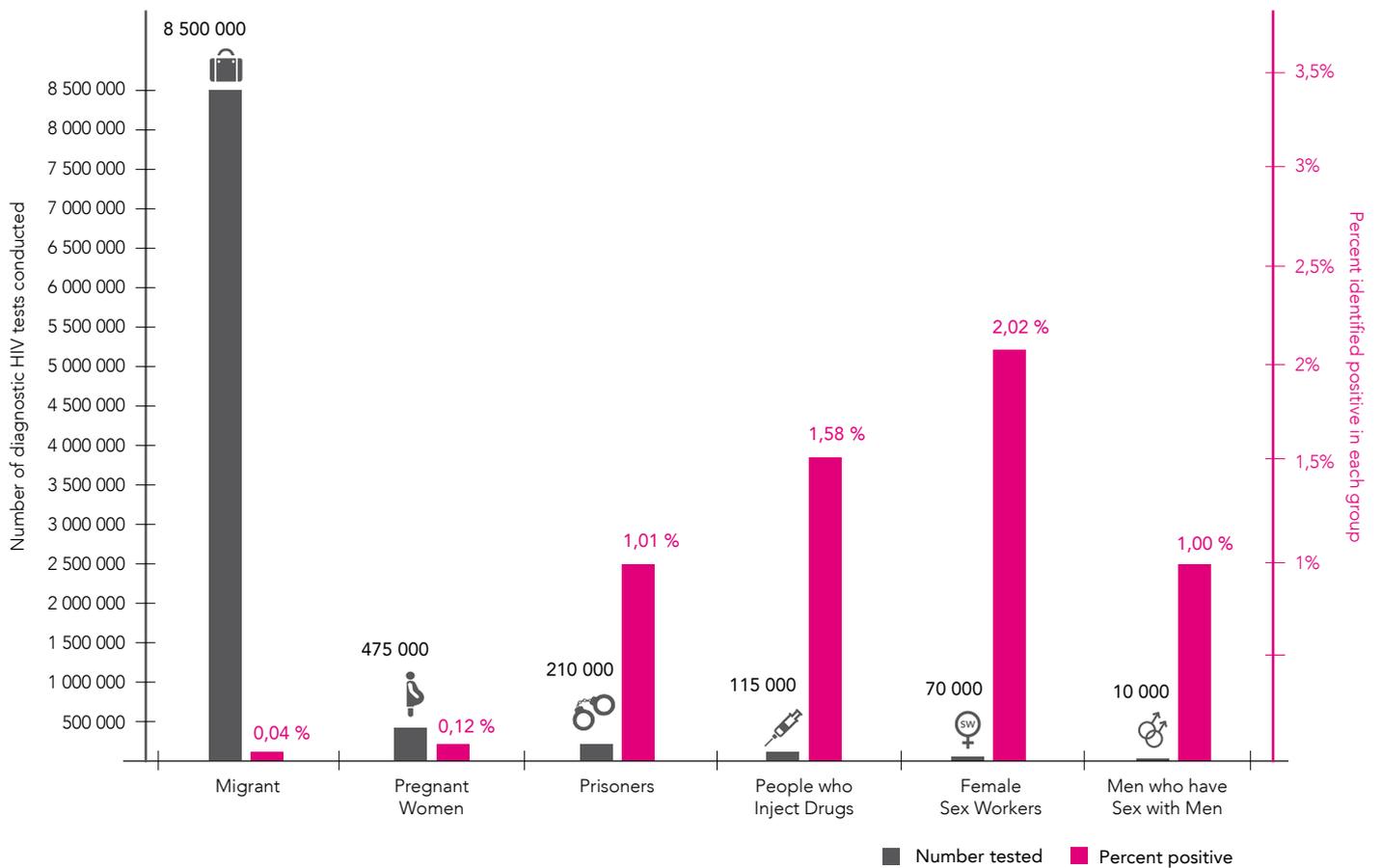
Uptake of HIV testing among key populations was only

**4%**

<sup>50</sup> Hermez J, Petrak J, Karkouri M., et al. *A review of HIV testing and counselling policies and practices in the Eastern Mediterranean Region*. AIDS 2010, 24 (suppl. 2):S25–S32

Figure 14

**HIV TESTING IN DIFFERENT POPULATION GROUPS IN MENA**  
 Number tested vs. percent positive (1989 - 2007)

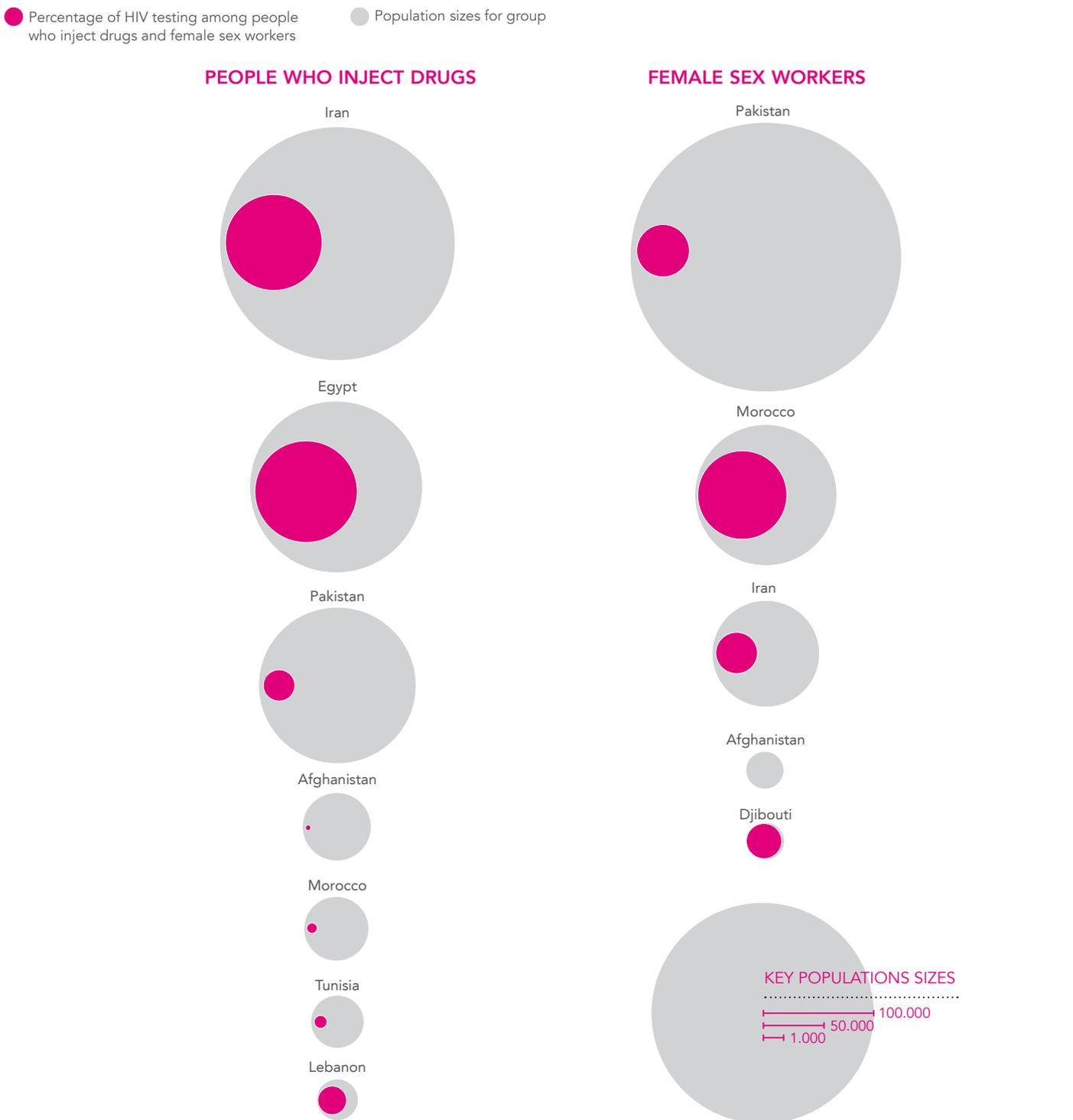


Reported diagnostic HIV tests conducted in the WHO Eastern Mediterranean Region from 1995 to 2008. The percentages are the total HIV cases detected divided by the cumulative total HIV tests performed on each of the different population groups.

Source: Hermez J, Petrak J, Karkouri M., et al. A review of HIV testing and counselling policies and practices in the Eastern Mediterranean Region. AIDS 2010, 24 (suppl. 2):S25–S32

Figure 15

**PERCENTAGE OF HIV TESTING AMONG SEX WORKERS AND PEOPLE WHO INJECT DRUGS AND POPULATIONS SIZES FOR EACH GROUP**



Many countries are not present in this graph as they did not report on the population sizes or coverage of HIV testing among female sex workers or people who inject drugs. The data for men who have sex men (population size estimate and coverage of HIV testing), reported by the countries, was not sufficient for generation of a similar graph.

Source: Country Progress Reports 2010.  
 Universal Access Reports 2011.

It is also important to note that the availability of high-quality voluntary counselling and testing is limited in the region. If it is available, it is not always readily accessible to key populations, primarily due to stigma and discrimination, limited engagement and capacities among CSOs working with these populations and existing structures that are not sufficiently tailored to the population's needs. Moreover, testing strategies in most MENA countries rely on complicated laboratory tests rather than on rapid tests. Rapid tests improve the rate of key populations receiving their test results and become engaged with prevention programmes. Even where rapid tests are used, testing strategies use labour-intensive laboratory techniques such as ELISA and western blotting to confirm positive HIV results. This subsequently incurs cumbersome processes and longer waiting times to obtain HIV test results, and thus poses additional barriers for key populations to access HIV testing or to return for the result.

Scaling-up provider-initiated HIV testing and counselling (PITC) can further identify people living with HIV, as well as to provide them with better access to HIV prevention services. PITC is gaining ground in the region, albeit it is still at the nascent stages and has low coverage. Recent experiences in Morocco, Oman and Somalia show high rates of HIV testing when pregnant women are offered the test in antenatal care clinics. PITC in tuberculosis services in Sudan and Djibouti are also scaling-up, reaching a coverage of 60% and 55%, respectively, of tuberculosis patients who know their HIV status. Of the tuberculosis patients tested in Djibouti and Sudan, 10% and 4% respectively were HIV positive<sup>51</sup>.

Consequently, for most countries, it is imperative to significantly increase the availability, accessibility and uptake of voluntary HIV testing among the key populations, including both client and provider-initiated testing, and accompany it with counselling and necessary referral services. Otherwise, these countries will struggle to strengthen their overall prevention programmes. The WHO regional strategy for the health sector response to HIV (2011–15), endorsed by all Ministers of Health from the region, includes a set of priorities agreed upon to scale-up HIV testing. Concrete steps and a timeline for implementation were discussed with the national AIDS programme managers at the 2011 meeting, where country-specific steps and milestones were identified depending on the level of advancement of the response in each country.



For most countries, it is imperative to significantly increase the availability, accessibility and uptake of HIV testing among key populations.

<sup>51</sup> Hermez J, Petrak J, Karkouri M., et al. *A review of HIV testing and counselling policies and practices in the Eastern Mediterranean Region*. AIDS 2010, 24 (suppl. 2):S25–S32

## Sexually transmitted infections

Recent data on STIs in the MENA region are generally limited because of the lack of adequate surveillance systems. Data on STIs among key populations at high risk in the region are even scarcer. In the 2011 round of reporting on Universal Access, only six MENA countries reported on the two indicators relevant to STIs. These indicators relate to the percentage of active syphilis infections among men who have sex with men and sex workers. Available data from Universal Access and other sources show that rates of STIs among men who have sex with men vary widely, from 7% in Morocco (Agadir) to 36% among hijras in Pakistan. The rates among sex workers were equally varied, from 9% (Agadir) in Morocco to more than 40% in Djibouti. The high rates of STIs in some countries are a serious concern, given that STIs amplify the risk of HIV transmission. The scarcity of current data makes it difficult to draw many conclusions, but it is likely that the STI problem is even more serious among populations at high risk of HIV infection than what is currently known.

The degree to which MENA countries have already established STI control programmes and their ability to implement them, in terms of available political support, resources and systems, varies widely. STI interventions that are currently being implemented in several countries often do not build on evidence-informed public health approaches, as recommended in the WHO regional strategy for the prevention and control of STIs. Thirteen MENA countries have implemented the syndromic approach for STI case management, but only six (Djibouti, Egypt, Jordan, Morocco, Pakistan and Somalia) have carried out etiological studies to validate the WHO flowcharts relating to the syndromic approach. Also, most countries in the region do not provide any special STI services for key populations at higher risk. Only three countries provide special consultation and treatment services for sex workers and men who have sex with men. Any STI response that does not address key populations at higher risk will fall short of having a significant impact on the spread of STIs and HIV in the region.

MENA countries should be taking steps to introduce, expand and/or strengthen surveillance systems for STIs. These systems are important for the general population as well as key populations at higher risk. In addition, steps should be taken to ensure the availability and accessibility of prevention and treatments services, particularly as an integral component of HIV prevention programmes for the key populations.

The WHO regional strategy for the prevention and control of STIs 2009–2015, endorsed by Ministers of Health, provides a framework to guide accelerated efforts for the prevention and control of STIs at a regional and national level. Objectives of the strategy are to:

- ensure reliable data to guide the response
- improve case finding and management
- promote safe sexual behavior
- interrupt transmission in high-transmission networks through engaging interventions.

## Blood safety

Knowing that a safe supply of blood is available for transfusions is an important health issue for the general population in every country. A safe blood supply also eliminates a possible mode of HIV transmission in a country. In recent years, there have been strong national commitments in MENA countries to improve the safety of blood supplies. Nearly every country now has a national policy on the screening of blood for transfusions. More importantly, the ability of countries in the region to ensure that safe blood is available is steadily improving. For example, 13 countries reported in 2010 that 100% of donated blood units are screened for HIV in a quality-assured manner. Although there is room for further improvement – especially in Yemen, Pakistan and Afghanistan – the trend in the region is clearly moving in the right direction.

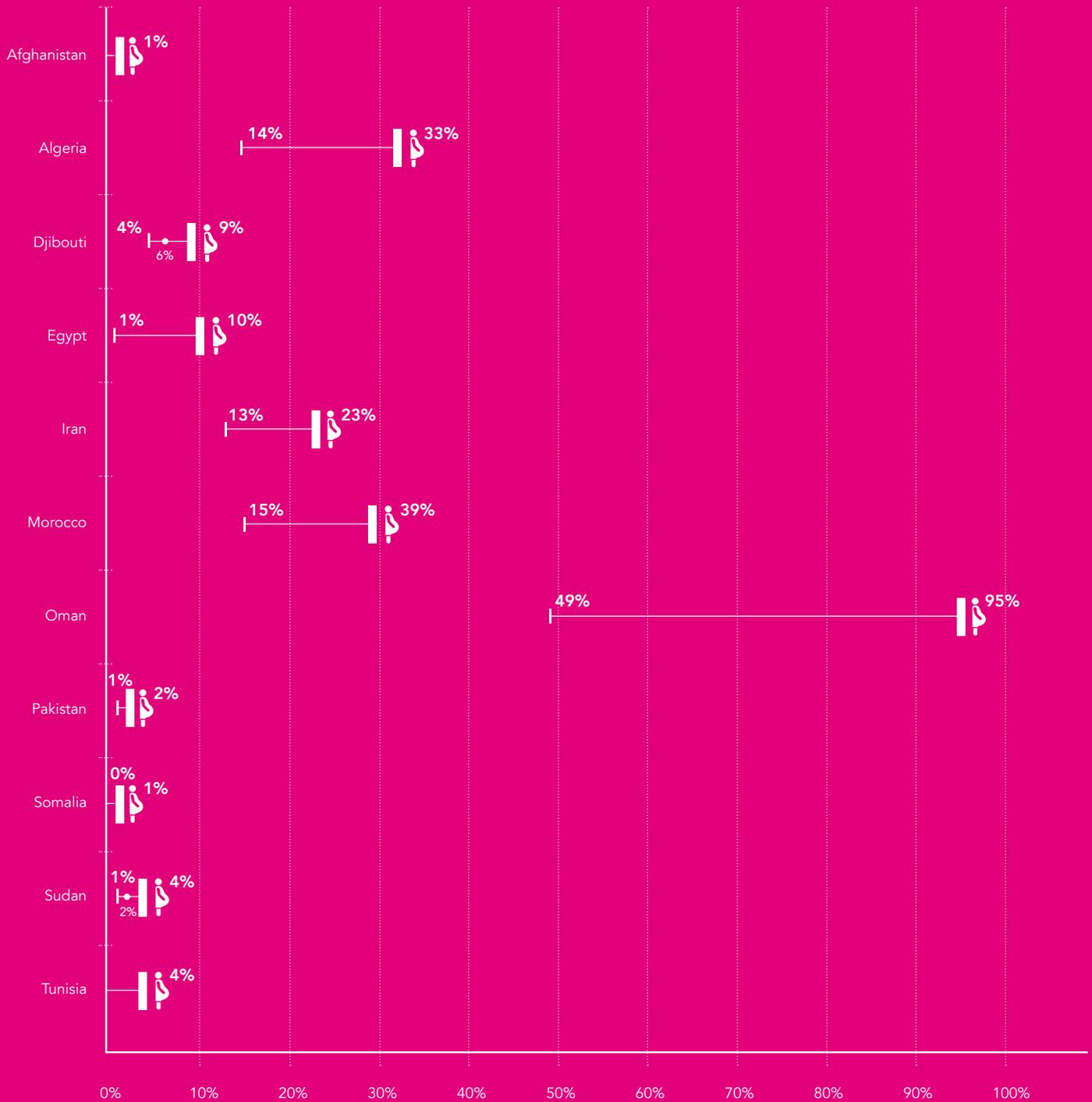
## Prevention of new infections among children

In the 2011 Universal Access Report, 12 countries in the region have reported data on HIV-positive pregnant women who receive antiretroviral therapy to prevent mother-to-child transmission of HIV.

Although the total number of women living with HIV who received antiretroviral therapy to prevent new infections among children in the MENA region doubled in one year (from 550 in 2009 to 1100 in 2010), the estimated regional coverage remains very low at 5% and well short of the UNAIDS goal of eliminating vertical transmission. Oman reports the highest coverage with more than 49% of pregnant women living with HIV receiving antiretroviral therapy; Morocco has the next highest percentage at 26% (Figure 16). Also, the estimated number of mothers needing treatment to prevent mother-to-child transmission has increased from 15 000 in 2001 to 20 000 in 2010.

Figure 16

### ESTIMATED PERCENTAGE OF PREGNANT WOMEN LIVING WITH HIV WHO RECEIVED ARV FOR PREVENTING NEW INFECTIONS AMONG CHILDREN, SELECTED COUNTRIES



With a window of opportunity to limit the spread of HIV, MENA countries should take up the challenge from UNAIDS to revolutionize prevention in the region. For example, national governments have an opportunity to prioritize their prevention funding to focus on the populations at the highest risk of infection. Political, religious and civil society leaders should affirm their commitment to place people living with HIV at the centre of planning, implementing, monitoring and evaluating national responses, and to reduce the stigma and discrimination that limits the availability and accessibility of prevention programmes. Lessons from successful prevention programmes in the region could be shared more broadly and used more effectively to advocate for improvements in prevention efforts in countries that are currently underperforming. Countries could strengthen their monitoring and evaluation systems so they can improve their ability to make evidence-informed decisions.

Available, accessible and appropriate prevention programmes for populations at higher risk should be a priority for every country in the region. Although it may be challenging to address these populations in many countries, this work has the ability to have the greatest impact on the course of the epidemic. In addition, in an era of limited resources, interventions that are focused and use combination HIV prevention strategies (i.e. combining behavioral, biomedical, and structural strategies) is unquestionably the most cost-effective course of action.

UNAIDS has mapped a new investment framework for AIDS investments which are focused on high-impact, evidence-based, high-value strategies. The framework is based on six essential programme activities:

- focused interventions for key populations at higher risk (particularly sex workers and their clients, men who have sex with men, and people who inject drugs);
- prevention of new HIV infections in children;
- behaviour change programmes;
- condom promotion and distribution;
- treatment, care and support for people living with HIV;
- and voluntary male circumcision in countries with high HIV prevalence and low rates of circumcision.

These programme activities recognise critical enablers, such as reducing stigma, respect for human rights, and capacity building for community based organizations, which are crucial to overcome the barriers to effective programming. If fully implemented and funded, the framework would enable countries to reach the 2015 targets as set out in the 2011 UN Political Declaration on HIV/AIDS.



**Prevention programmes for key populations at higher risk should be a priority for every country in the region.**



**Zero  
AIDS-related deaths**



The 2011 United Nations General Assembly Political Declaration on HIV/AIDS has defined targets and elimination commitments.

The overall goal of the political declaration is to achieve universal access to HIV prevention, treatment, care and support by 2015.

The targets related to universal access to care and treatment or “zero new AIDS-related deaths” set in the Political Declaration are:

- Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015
- Reduce tuberculosis deaths in people living with HIV by 50 percent by 2015.

These goals are relevant in every country of the world, regardless of the size and scope of their HIV situation. More importantly, they are also inextricably linked to every person living with HIV, regardless of their race, religion, gender, national origin, sexual preference, economic status, disability or any other factor.

In the MENA region, access to treatment, care and support is improving. However, with more than 500 000 people living with HIV across the MENA region, countries need to scale-up the availability and improve the accessibility of these services for those who need them. Unfortunately, the ability of people living with HIV as well as those affected by HIV to access these services is undermined by the high levels of stigma and discrimination that they face as people living with HIV and/or as members of a marginalized population, including people who inject drugs, men who have sex with men: and sex workers.

### Antiretroviral treatment for people living with HIV

Although individual MENA countries have improved access to antiretroviral therapy - nearly a 20% increase, from 15 548 in 2009 to 19 483 in 2010 in one year - (Figure 17), the estimated regional coverage remains low at 8%. Oman has the best estimated coverage in the region, with 45% of adults and children living with HIV receiving treatment by the end of 2010, followed by Lebanon (37%) and Morocco (30%). Most countries are falling short of the goal of universal access to treatment. Also, the number of people needing treatment has increased from 57 000 in 2001 to 210 000 in 2010, both due to a higher HIV prevalence in the region and a change in the treatment protocols by WHO.

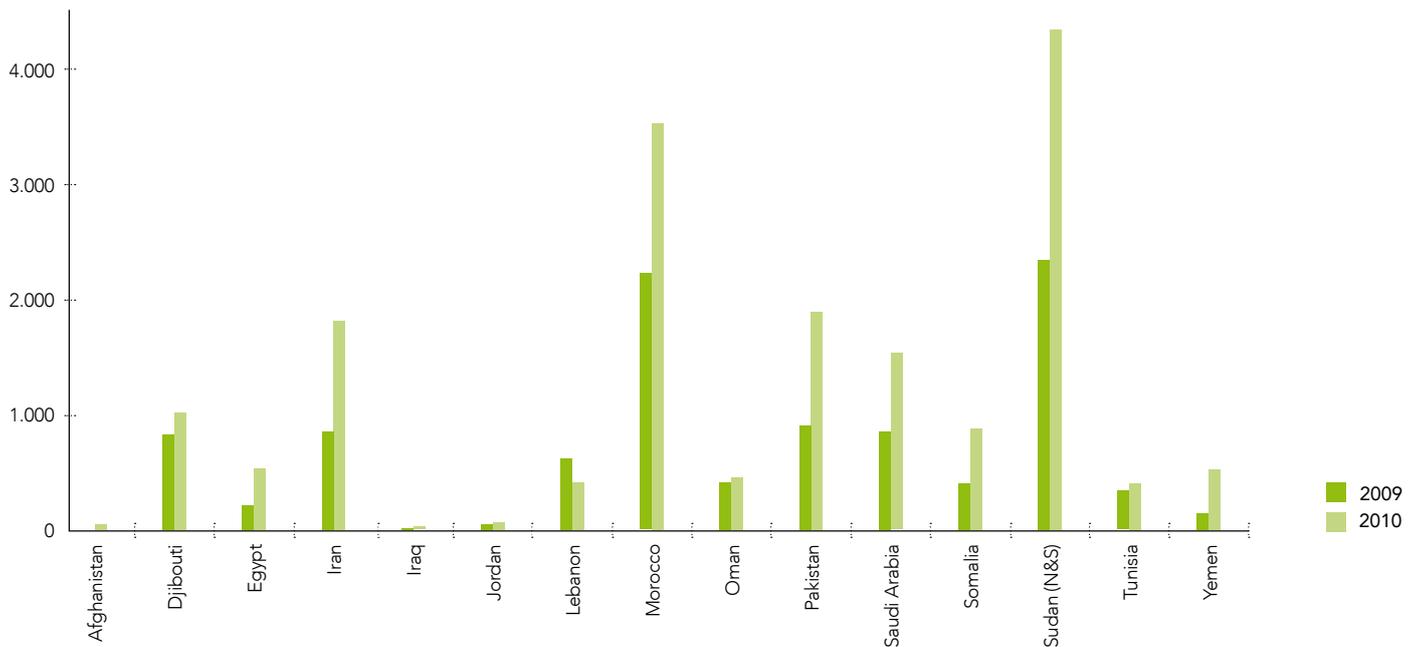


The estimated regional treatment coverage remains low at

**8%**

Figure 17

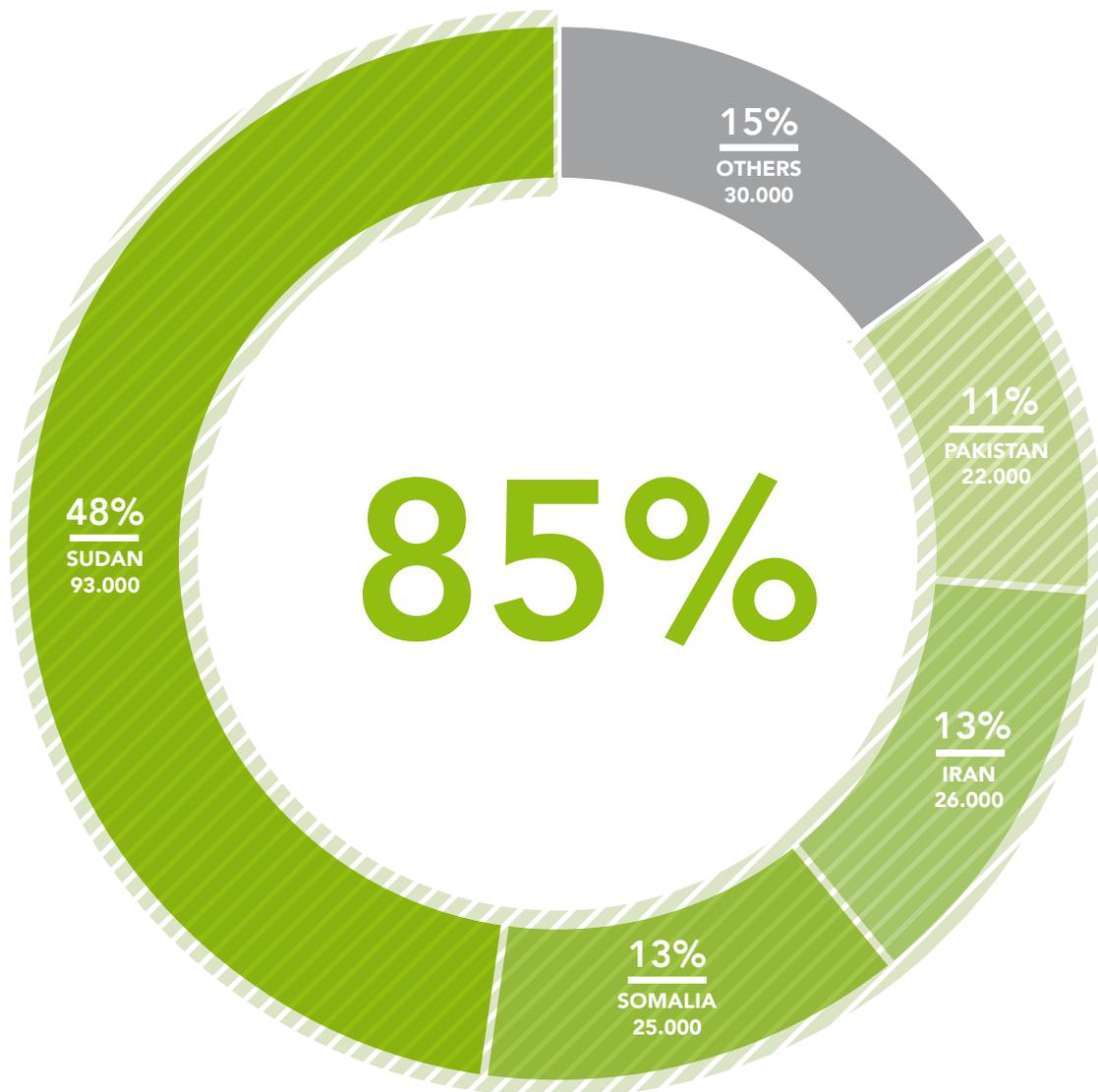
### NUMBER OF ELIGIBLE ADULTS AND CHILDREN RECEIVING ART IN 2009 AND 2010 SELECTED COUNTRIES



Plans for improving availability and access to treatment vary widely across the region, and tend to mirror the financial and human capacity of a country – in addition to the issue of stigma and discrimination and its impact on treatment-seeking behaviour in all countries. However, it is worth noting that four countries in the region contribute 85% of the number of people eligible for antiretroviral therapy: Iran (26 000), Pakistan (22 000), Somalia (25 000), and Sudan (93 000) (Figure 18). Achieving regional targets for antiretroviral therapy access is dependent on those four countries' scaling-up strategy, together with serious commitment to expand HIV testing and counselling as the most critical step to providing access to treatment.

Figure 18

**ESTIMATED NUMBER OF PEOPLE ELIGIBLE FOR ANTIRETROVIRAL THERAPY**



 The estimated number of people eligible for antiretroviral therapy in Iran, Pakistan, Somalia and Sudan represent nearly 85% of the total across the region

Source: Universal Access Reports 2011.

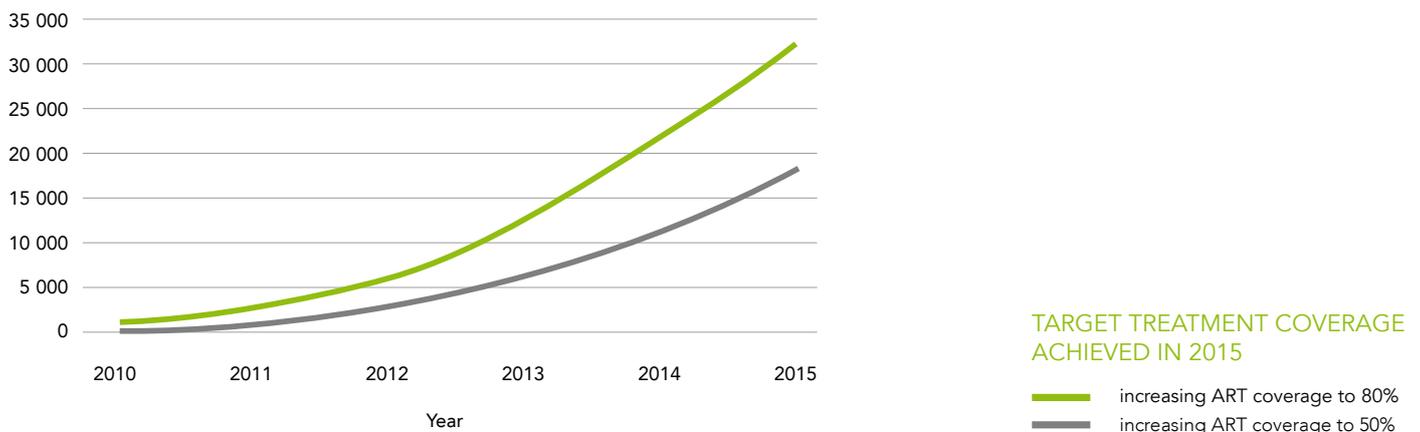
For health professionals, the spectre of drug shortages is a real and serious threat to the health of their patients receiving antiretroviral therapy. It should be noted that countries reporting on an indicator in the 2011 Universal Access survey did not find stock-outs of antiretroviral drugs in health facilities to be a significant problem in the region except for southern Sudan and Djibouti. However, to help deal with concerns about possible shortages, there have been calls within the region to establish a regional framework for negotiating drug prices with suppliers to reduce the cost of drugs. There have been parallel calls for a regional initiative to help countries forecast demand for antiretroviral drugs and other essential products, in order to determine the optimal size and timing of regional and/or national procurements.

AIDS-related mortality has almost doubled in the past decade among both adults and children. The estimated number of deaths due to AIDS has increased from 22 000 (10 000 - 39 000) in 2001 to 39 000 (28 000 - 53 000) in 2010.

Projections for the next five years show that, with a rapid increase in treatment coverage to 80% across the region, 62% of expected deaths due to AIDS by 2015 could be averted, saving the lives of more than 32 000 individuals. Even if the antiretroviral therapy provision increases from its current level to 50% of those eligible for treatment, 25 000 deaths can be averted in 2015 (Figure 19).

Figure 19

### PROJECTED ANNUAL NUMBER OF DEATHS AVERTED BY INCREASING ART COVERAGE FROM THE CURRENT LEVEL



## Retention in care

Seventeen countries of the region reported data on retention in care or survival for people receiving antiretroviral therapy after 12 months, an important indicator of programme effectiveness. Not surprisingly, the data clearly show the extraordinary impact that antiretroviral therapy can have on the lives of people who are eligible for antiretroviral therapy. Their life expectancy can increase dramatically and it can have transformational impact on the overall quality of their life. In addition, for the marginalized populations heavily affected by HIV in the MENA region, the health benefits of antiretroviral therapy help reduce the stigma for people living with HIV.

The global average for retention at 12 months in low and middle-income countries is 82%. Based on the 2011 Universal Access reporting, only six MENA countries reported a percentage above this average and a number of them have very low rate, such as Djibouti, Yemen and Sudan.

It is important to note that many countries have problems linking people who are living with HIV to treatment and care because of poor referral systems. Also, as is the case in other regions of the world, there are also problems with retention and loss for follow-up. As a result, the connection between HIV testing, treatment and care is tenuous and problematic.

The extensive use of mandatory HIV testing in the region is not an effective gateway to treatment. For many people at increased risk (e.g. people who inject drugs, men who have sex with men and sex workers), this testing occurs when they are arrested, admitted to hospital or incarcerated. In these situations, the results are rarely followed by counselling or access to treatment. The fact that the three Cs of HIV testing are not widely used in the region has a negative impact on country efforts to provide universal access to treatment.



The fact that the three Cs - Confidentiality, informed Consent and Counselling - of HIV testing are not widely used in the region has a negative impact on country efforts to provide universal access to treatment.

## Associations for people living with HIV take the lead

### Djibouti

Oui à la Vie was established in Djibouti in 2001 by six people living with HIV and who had the aim of advocating for the availability of antiretroviral therapy in Djibouti. Three years later, five of the six original founders had died as a result of HIV-related illness; however, other individuals living with HIV rose to meet the challenge of carrying the work of the organization forward. Since 2003, the association now has a formal office space as a result of financial support from the Sidaction project “Vivre avec le sida”.

The main mission of Oui à la Vie is to demonstrate that solidarity is the best response to HIV. This is demonstrated through the core interventions of the organization, which include:

- prevention and education, including promoting voluntary HIV testing;
- accompanying individuals on medical visits;
- home visits to people living with HIV;
- care and support to orphaned children affected by HIV;
- creation of a space for people living with HIV to come together as a mutual support group, to share experiences and to understand together how to defend their rights, and act in the face of stigma and discrimination.

In addition, as an outcome of long and sustained advocacy towards national-level decision-makers and decision-makers and the World Bank. Oui à la Vie was given the authorisation to import tax-free generic antiretroviral drugs from India to sell back to people living with HIV at the base price. This action permitted individuals on a lower income to finally have access to life-saving treatments before they were made officially available only a few years ago.

The success Oui à la Vie can be attributed to many factors, including the commitment of its members, the key partnerships formed over time and the diversified funding base from a range of organizations and donors. Oui à la Vie currently works with the World Food Programme (WFP), Sidaction, the Global Fund to Fight AIDS, Tuberculosis and Malaria, United Nations Population Fund, United Nations Development Programme and Save the Children US on a range of interventions and projects.

Associations for people living with HIV are vital in providing support to local communities and individuals living with HIV, combating both political and societal stigma and discrimination, advocating greater rights for people living with HIV – including access to treatment – and demonstrating a greater solidarity in the response to HIV.

## HIV-associated tuberculosis

Tuberculosis is the leading HIV-associated opportunistic infection in low and middle-income countries, and is a leading cause of death among people living with HIV globally. Although antiretroviral therapy is shown to reduce incidence of tuberculosis at the individual and population level, and mortality, the percentage of co-infected patients that are receiving treatment is low in most countries of the region. Few countries in the region have framework for tuberculosis/HIV collaborative activities. This means that countries are unlikely to see a significant reduction in tuberculosis deaths among people living with HIV. In addition, limited data, particularly related to populations at higher risk, makes it difficult for countries to fully understand the scope of the problem and accurately assess the effectiveness of their response.

Of the 11 countries that provided data on the percentage of estimated HIV-positive incident TB cases that received treatment for both infections in the 2011 Universal Access reporting, two countries performed extremely well: Oman (100%) and Algeria (99%). The remaining nine countries did less well, with five countries reporting less than 10% and four countries reporting between 22% and 55%. Again, the challenge for most countries to improve the coverage of tuberculosis and HIV co-treatment is directly related to the marginalized populations most in need of the services.

## Social protection

In the MENA region, social protection is defined by a different set of issues than in regions with generalized HIV epidemics. In Sub-Saharan Africa, there are pressing issues about orphans and vulnerable children, and in MENA countries, these issues are replaced with concerns such as social security and health insurance for people living with HIV, employment prospects for vulnerable and/or marginalized populations, and the social safety net for migrant and mobile populations. For example, the economic challenges faced by people living with HIV in the region are primarily a result of limited economic opportunity, lack of skills required to engage in income-generating activities, and an individual sense of vulnerability as a result of the stigma and discrimination associated with living with HIV. The challenge is to identify mechanisms in government, civil society and the private sector that can help address the issues related to social protection.

To create business opportunities for people living with HIV, CARITAS Egypt – a registered NGO working in relief, development and social services – is exploring an innovative loan scheme that funds small-scale enterprises and projects. It is designed to empower people living with HIV to gradually assume complete ownership of a project they develop and manage, including assuming the risk and profit associated with the project.

The ability of migrant and mobile populations to ask for services linked to social protection is of specific concern, particularly given the large number of people on the move. For example, the Population Division of the United Nations Department of Economic and Social Affairs estimated that from 2000 to 2010, Saudi Arabia gained 2.2 million immigrants, the Syrian gained 1.3 million, and Jordan and the United Arab Emirates each gained 1.0 million. In addition, the four countries with the highest proportion of “non-national residents” in 2010 (among those with at least 1.0 million inhabitants) were Qatar (87%), the United Arab Emirates (70%) and Kuwait (69%). Even though HIV only affects a small percentage of these mobile populations, countries do not currently have in place the policy and legal frameworks or the capacity to provide the services linked to social protection.

It is promising that almost all<sup>52</sup> countries in the region have adopted the International Labour Organization’s recommendation concerning HIV and AIDS in the World of Work, 2010 (Recommendation 200). This recommendation addresses a wide range of issues relevant to social protection in MENA countries, including reducing stigma and discrimination, and access to prevention and employment protections.



**Almost all countries have adopted the 2010 International Labour Organization’s recommendation concerning HIV and AIDS in the World of Work.**

<sup>52</sup> Except for Iraq and Lebanon, where for the latter government abstained, while employers and workers representatives adopted the ILO recommendation



## Empowerment of women living with HIV Algeria

In Algeria, the HIV epidemic has increased significantly among women. In 2010, and for the first time in history, there were more women living with HIV than there were men living with HIV. El Hayet, a nongovernmental organization, was launched to emancipate women so that they can acquire social and financial autonomy – leading to a decrease in risky behaviours. The NGO was designed to provide a way for women living with HIV to make a positive contribution to society by joining the workforce. El Hayet was the first NGO for people living with HIV in the MENA region, and remains the only one in Algeria. It has a unique, crucial and noteworthy role in improving the psychosocial support of people living with HIV, and sets out previously unimagined actions for the women's HIV response.

*“HIV is not an obstacle, women are the pillar of society, they do not support themselves only, but they do also provide care for everyone around them, starting with their families and [children]. Women should be productive and run their own lives”.*  
– Ms Nawel Lahouel, El Hayet, President

A recent initiative, launched under the theme of “Help to create a training center and accompanying microprojects for women living with HIV”, engage a total of 150 women. The programme includes six-month workshops for dressmaking, handicrafts and pastries. During their education, the trainees receive specific training sessions from a team of teachers qualified in vocational training, and the women obtain important skills and become qualified (with a diploma) in line with the agreement established between the National Agency for Administration of Micro-credit and El Hayet. The workshops are in Tamanrasset, a region situated in the extreme south of Algeria, and is highly characterized by its remoteness, instability and vulnerability due to its proximity to the African Sahara. Tamanrasset is also distanced from the biggest Algerian cities, which probably provide better access to HIV information, prevention and care. The training is a real example of removing barriers and strengthening the initiative against stigma and discrimination towards people living with HIV. The initiative is led mainly by UNAIDS, and supported by different departments of the Algerian Government (Ministry of Gender, Ministry of Vocational Training, Ministry of Health and the National Micro Credit Agency).

This project highlights the achievements that can be gained by women living with HIV, especially when they are provided with the sufficient and necessary atmosphere for their empowerment.

*“The Ministry of Vocational Training will continue to support access to vulnerable populations particularly women infected and affected by HIV in its structures and different mechanisms to reduce precariousness and stigma. There is an absolute commitment from the Algerian government”.* – Ms Akila Chergou, Director of Continuing Education Cross-Industry Relations

**Zero  
discrimination**



The 2011 United Nations General Assembly Political Declaration on HIV/AIDS has defined targets and elimination commitments.

The overall goal of the political declaration is to achieve universal access to HIV prevention, treatment, care and support by 2015.

The targets related to “zero discrimination” set in the Political Declaration are:

- Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms
- Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV
- Eliminate HIV-related restrictions on entry, stay and residence.

Discrimination based on actual or perceived HIV status remains a serious problem around the world. It continues to deprive individuals and communities of the opportunities and incentives to protect themselves from infection, and to create healthy and secure futures for themselves and their children. A focus on protecting human rights, and creating supportive social and legal environments can have a major impact on the overall availability, accessibility and effectiveness of HIV programmes. In addition, a reduction in stigma and discrimination can ensure equitable access to essential services for those most affected by HIV.

In MENA countries, stigma and discrimination has limited the effectiveness of the region’s response to HIV. For example, it limits:

- the ability of governments and civil society to provide services;
- the ability of key populations to access services that are available;
- the amount of data available for evidence-informed decision-making.

Due to stigma and discrimination, few people, especially [most-at-risk populations], will go for voluntary counselling and HIV testing (VCT) to avoid the negative societal consequences of being diagnosed with HIV.

Ministry of Health  
Directorate of Chronic and Communicable Diseases  
National AIDS Programme  
Syria

## Laws and legal frameworks

A national strategic plan can be used to lay the foundation for a country's human-rights approach in their HIV responses. For example, to help improve the legal environment, a national strategic plan should address:

- any legal reforms needed to remove obstacles to HIV services;
- access to legal services for people living with HIV and people vulnerable to infection;
- expanded legal literacy among HIV-affected people;
- harmful gender norms and cultural practices that contribute to HIV vulnerability;
- the capacity of judges and police to understand the legal issues related to HIV, including stigma, discrimination and the right to access services.

Currently, 15 countries in the region address the core issue of protecting human rights in their national strategic plans.

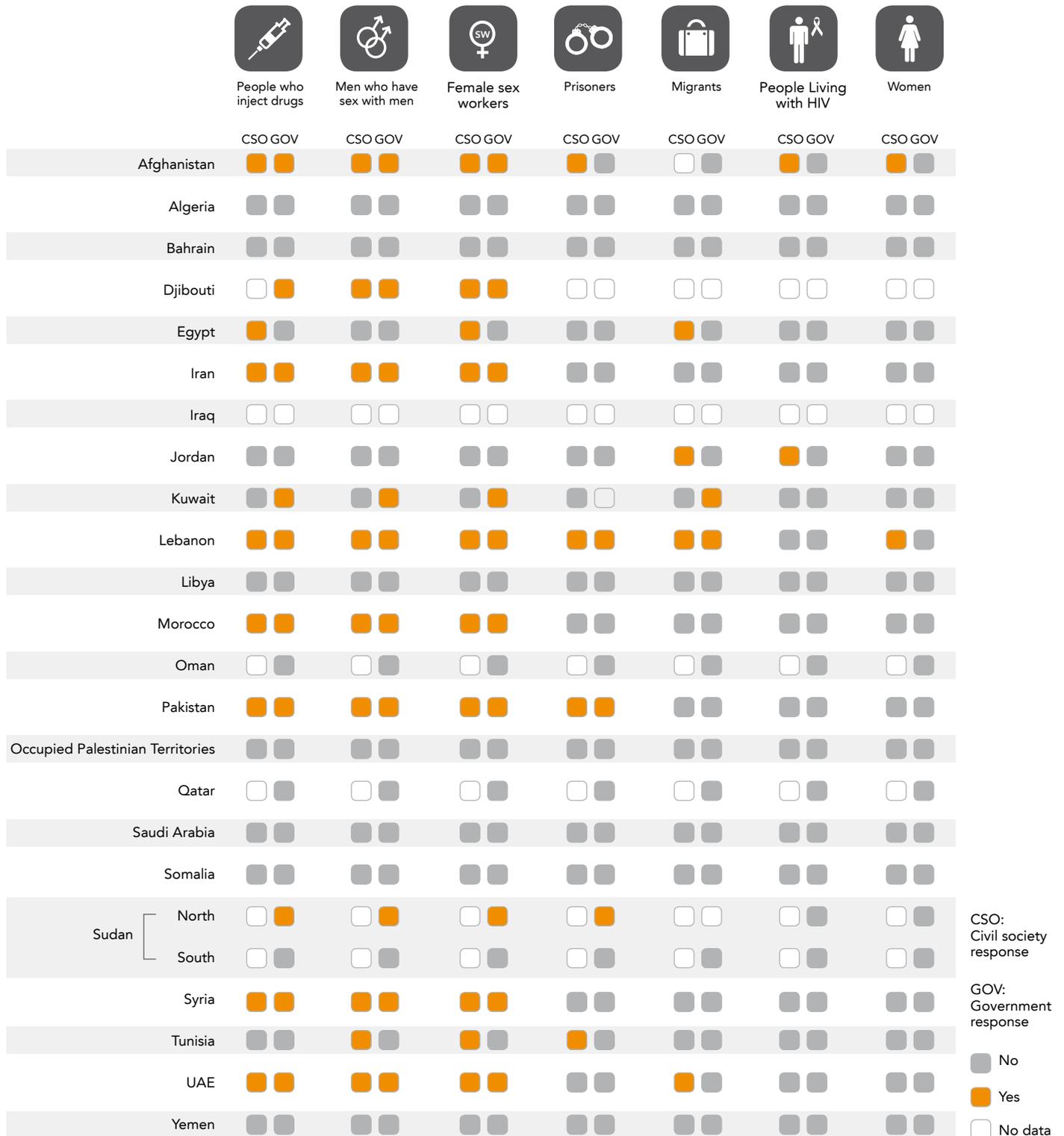
A broad commitment to protecting human rights should also include specific protections for vulnerable or marginalized populations. According to data provided by countries in the last round of Country Progress Reports 2010 only four countries report having these protections for one or more vulnerable or marginalized populations (i.e. people who inject drugs, men who have sex with men, migrants and prisoners). Eleven MENA countries report having laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for vulnerable or marginalized populations (Figure 20). However, 15 countries report having laws and regulations in place that protect people living with HIV from discrimination; an additional two countries report having drafted these laws and regulations.



Half of MENA countries report having laws, regulations or policies that **present obstacles to effective HIV prevention, treatment, care and support for key populations.**

Figure 20

**LAWS PRESENTING OBSTACLES TO EFFECTIVE HIV PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATIONS AND VULNERABLE GROUPS**



Source: Country Progress Reports 2010.

“A 2009 needs assessment on HIV-related legal services in Egypt found the most significant legal problems were faced by people living with HIV, people who inject drugs, men who have sex with men and sex workers. The problems were particularly acute for people living with HIV, including violations of their right to health care and treatment; violations of their right to work; discriminatory practices against women, especially those whose husbands have died of AIDS (and whose own positive sero-status is then also automatically presumed); and disputes related to their personal status, such as in marriage, divorce and inheritance”.

Needs Assessment to Strengthen and Expand HIV-Related Legal Services in Egypt,  
The Egyptian Initiative for Personal Rights,  
October 2009

In many countries, denial about HIV remains high although substantial progress has been made over the past 10 years in countries such as Algeria and Djibouti. The failure to acknowledge the existence of HIV contributes to an underlying fear of the disease, which leads to stigmatizing and discriminatory behaviour, particularly for people living with HIV. In addition, this denial limits the ability of governments and civil society to mount an effective response to HIV.

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## Defending the rights of people living with and affected by HIV Algeria

People living with HIV are often susceptible to abuses of human rights as a result of stigma and discrimination, either at the community or political level. Rights can be abused by denying access to treatment and health services, employment, or guardianship or inheritance. The rights of migrants to health and education can also be denied. For these reasons, several organizations working on HIV awareness are increasingly targeting their activities to address the legal rights of people living with HIV. Some are partnering with human rights organizations to develop their capacities to effectively address legal injustices, and others are benefiting from the volunteer support of legal professionals who regularly collaborate with the organisation to put forward legal complaints against rights abuses. The Association de Protection Contre le sida (APCS) in Algeria, through its partnership with Le Fond de Droit Humain Mondial (FDHM), is working to legally challenge stigma and discrimination against people living with HIV. Through the support of FDHM, APCS is able to bring and follow up legal complaints to court. This partnership has allowed APCS to fight discrimination against men having sex with men, women affected by HIV and migrants living in Algeria.

In May 2010, the city of Oran experienced a stock-out of antiretroviral therapy that lasted more than three months. This resulted in a formal legal complaint by people living with HIV and APCS to the Oran Tribunal, citing “non-assistance to vulnerable individuals”. The APCS director submitted the legal complaint on behalf of seven individuals living with HIV. This complaint was followed by advocating the local media of the treatment stock-out in the newspaper article “People living with HIV seek justice”. The article underscored the sentiments of people living with HIV, citing that “this rupture in treatment is not only scandalous but unacceptable and takes hostage of individuals who are fragile and vulnerable, who do not even have the right to fully express their anger”. The advocacy efforts and the article resulted in the public response by the Minister of Health to ameliorate the rupture in treatment.

APCS has also been able to legally pursue cases in which people living with HIV have been evicted from their residence as soon as their HIV status was known, cases in which medical professionals have illegally disclosed a person living with HIV to an employer, and in which people living with HIV experienced stigma and discrimination by health workers. Furthermore, APCS has been working simultaneously to develop the advocacy capacities of people living with HIV to address these rights abuses themselves. For example, recently groups of people living with HIV who are involved in community support groups known as “Groupes des Paroles” have mobilized themselves to take their complaints on stigma and discrimination to the higher local authorities. Therefore, the benefit of the partnership with FDHM has not only been to support the legal rights of people living with HIV at the organizational level, but to also develop these capacities in individuals over time.

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# Appel au leadership!

Stop SIDA, tenez la promesse. Rendez-vous sur [www.worldaidscongress.org](http://www.worldaidscongress.org)

4.3 millions  
contracté  
en 2006 : le  
jamais enre  
année. Les  
affectées t  
cette tend  
exemple -



## Restrictions on entry, stay or residence of People Living with HIV

Algeria, Djibouti, Morocco and Pakistan are the only MENA countries that do not impose any restrictions on entry, stay or residence of people living with HIV. In addition, in Lebanon and Tunisia, there are no restrictions on entry or stay for people living with HIV; however, practices are not always consistent. At least nine countries in the region deport people living with HIV, and six countries ban the entry of people living with HIV (Figure 21). It is important to note that HIV is not the only health condition for which entry, residence and stay restrictions are applied. Most of the countries group HIV, and hepatitis B and C together, some impose restrictions on individuals with syphilis and tuberculosis, whereas other countries apply restrictions on malaria and other – sometimes easily treatable – communicable diseases.

Usually, these restrictions are justified with public health reasons or to avoid economic burden on health sectors, as those people may “become a public charge”. This issue is mainly relevant in the Gulf Cooperation Council Countries where the population structure is unique in terms of the high percentage of non-national residents. Although the data on the population is not publicly available, various sources show that the total population in the Gulf Cooperation Council has increased by 10-fold in the past 50 years (from 4 to 40 million). The percentage of foreigners living in some countries has reached 80% in the United Arab Emirates, and between 65% and 75% in Kuwait and Qatar.

From a public health perspective, with the unavailability of community-level comprehensive HIV services and an increased level of stigma and discrimination against people living with HIV, the restrictions lead to an escalating number of HIV infections in both receiving and sending countries. Also, there are several instances that by such discriminatory policies, the human rights of people living with HIV have been violated (see box on page 77), and these policies have posed a negative image of the deporting countries to the world, picturing them as conservative, non-liberal countries with outdated migration policies.

With improved access and the sharp reduction in the cost of antiretroviral medications, and considering the number of productive years of work that most individuals have before showing any symptoms of AIDS, the economic justification for HIV-specific restrictions is unreasonable and unnecessary.

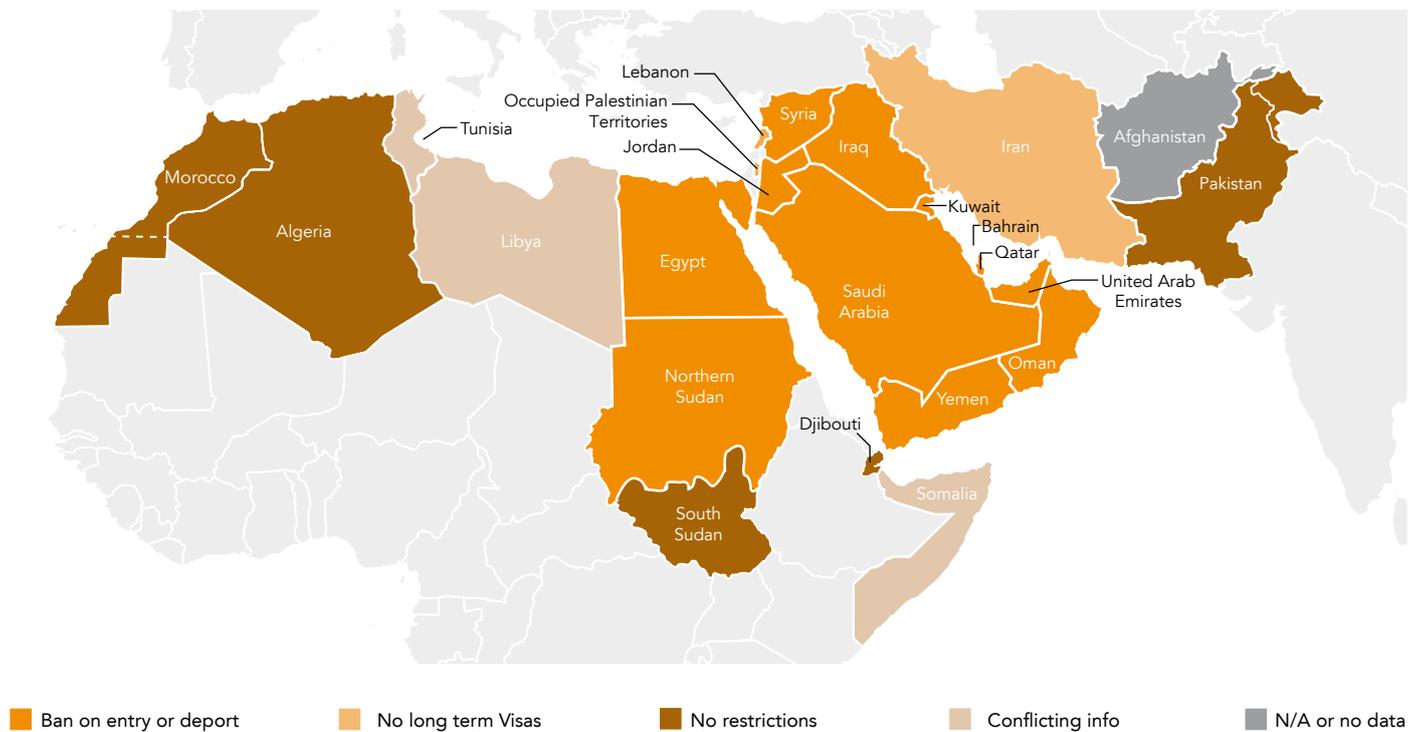


**The Republic of South Sudan removed any types of restriction on entry, stay or residence of people living with HIV when it became an independent state.**

Quality data on the number and characteristics of the deported individuals based on their HIV status are not available from the Gulf Cooperation Council (or not systematically shared with United Nations agencies). Anecdotal information from Asian and other Middle Eastern countries that are sending migrant workers to Gulf Cooperation Council countries shows a significant increase in HIV prevalence among returning migrant workers. While this data needs to be supported by stronger evidence, yet, it is quite alarming<sup>53</sup>.

Figure 21

**COUNTRIES IN MENA WHICH IMPOSE HIV RELATED RESTRICTION ON ENTRY, STAY AND RESIDENCE OF PLHIV**



<sup>53</sup> Setayesh H., *HIV Specific Restrictions on Entry, Stay and Residence of People Living with HIV in Middle East and North Africa*. Presented at the Symposium on Family, the Millennium Development Goals and AIDS in the Middle East and North Africa region: linkages, challenges and opportunities. Doha, Qatar. November 2011

### Human rights principles that are regularly violated by imposing restrictions on entry, stay or residence of People Living with HIV<sup>54</sup>

The implementation of HIV-specific restrictions on entry, stay and residence of people living with HIV has regularly violated the human rights principles of:

- non-refoulement of refugees (which prohibits return to a place where life or freedom is threatened);
- obligations to protect the family;
- protection of the best interests of the child;
- right to privacy;
- right to freedom of association;
- right to information;
- right of migrant workers;
- right to seek asylum and to work;
- right to education;
- right to highest attainable standard of health, dignity and life.



<sup>54</sup> Human Rights Watch. *Discrimination, Denial and Deportation, Human Rights Abuses Affecting Migrants Living with HIV*, 2009

## Gender equality

Gender issues are a complex interplay of societal beliefs, norms, customs and practices that collectively define what is considered acceptable behaviour for women and men. In the context of HIV, the combination of women's lower social status, including access to education and information, and their limited ability to control decisions about their lives has made them increasingly vulnerable to infection in many countries and cultures<sup>55</sup>. This is certainly the case in MENA countries.

A 2010 report on women and HIV programmes and services in Yemen, Jordan, and Egypt<sup>56</sup> identified 10 key issues that are relevant across the region:

- Fears of harm to social reputation of unmarried women and girls may inhibit their access to health care services and limit necessary exposure to information about HIV, and subsequent protective and preventive measures.
- Social barriers to discussions about sexuality and HIV may reduce awareness about HIV in women and young people.
- Unprotected sexual practices may increase vulnerability of infection in female youth.
- Women and girls who are survivors of sexual violence are untreated or underdiagnosed for STIs and HIV.
- Women who are survivors of domestic violence may be at increased vulnerability to infection and lack of awareness about HIV.
- Wives of clients of sex workers and of men who have sex with men are vulnerable to HIV infection due to a lack of awareness of HIV, and insufficient negotiating skills and power to protect themselves.
- Young, newly recruited female sex workers and home-based sex workers may be underserved by HIV campaigns and have a lack of awareness about HIV.
- Women who inject drugs may be at increased risk to HIV through unprotected transactional sex and exposure to sexual violence.
- Sufficient and quality access to reproductive health care services for women living with HIV presents a challenge.
- Limited understanding of the sexual networks of men who have sex with men, and the distinction among the different types of men who have sex with men, may limit the access and exposure to HIV campaigns of all men who have sex with men<sup>57</sup>.

<sup>55</sup> UNDP, *HIV Vulnerabilities of Migrant Women: from Asia to the Arab States. Shifting from silence, stigma and shame to safe mobility with dignity, equity and justice*. Colombo, Sri Lanka, 2008

<sup>56</sup> Anguera de Sojo, M. & Vogel, J., *Gender analysis of women's access to and quality experience of HIV/AIDS programmes and services in Yemen, Jordan, and Egypt*, 2010

<sup>57</sup> "Respondents, particularly in Yemen, appeared to classify men who have sex with men as those who perform the "female" or receiving role in sexual encounters. The designation of men who have sex with men also seemed constricted to male sex workers. For example, married men who have sex with men, or men who perform the so called "male" role in sexual encounters, were not classified as men who have sex with men among respondents in Yemen. This is in alignment with gender norms that depict women as the passive recipient and men as the active provider. Inconsistent classification may limit outreach and exposure of HIV prevention and services to all men who have sex with men."

In the Country Progress Reports 2010, 10 Countries indicate that gender equality is addressed in their National Strategic Plans; and 13 countries report having a policy on equal access to HIV prevention programmes with one additional country having a draft policy. The findings demonstrate that the region is moving to address the critical issues connecting gender and HIV. However, it is the next task – developing, supporting and sustaining the actual programmes that provide equal access to gender-appropriate services – that will be more difficult for countries.

## Stigma and discrimination

Stigma devaluates the dignity and worth of a person based on some characteristics or association. HIV stigma is largely related to ignorance and fear of transmission, as well as moral condemnation. Stigma is widespread in the MENA region, both among professionals and ordinary people. Stigmatising attitudes by doctors, nurses, teachers, police and even by other people living with HIV has been widely documented. The level of stigma is sometimes unbelievably high; as an example, in a study in Saudi Arabia, 76% of surveyed participants believed that people living with HIV should be isolated from the public and 60% said people living with HIV should be fired from their jobs<sup>58</sup>. In a multicountry study on young people in Yemen, Jordan, Kuwait and Qatar, more than 60% (61–78%) of respondents believed that having a relative with HIV would tarnish their own reputation<sup>59</sup>. In the same study, more than 80% of respondents believed that women living with HIV should not be allowed to get married; between 67% and 80% thought that women living with HIV should be sterilized so they cannot have children; and around 67% said that they would want a pregnant woman living with HIV to have an abortion.



Stigma is widespread in the MENA region, both among professionals and ordinary people.

<sup>58</sup> Badahdah AM. *Stigmatization of Persons With HIV/AIDS in Saudi Arabia*, J Transcult Nurs. 2010 Oct;21(4):386–92

<sup>59</sup> Badahdah AM., Presentation at The 2011 Qatar Symposium on Family, the Millennium Development Goals and AIDS in the Middle East and North Africa region: linkages, challenges and opportunities, 2011

There is no question that the stigma associated with HIV is a powerful and pervasive force in MENA countries. It makes it difficult – and in many cases, impossible – for people needing essential HIV services to access them. It interferes with the ability of governments to put programmes in place to protect public health. It restricts the ability of CSOs to work with people living with HIV.

One of the main obstacles to more effective prevention for key populations at higher risk is the level of stigma and discrimination associated with HIV, including denial, and specific risk behaviours by the populations themselves. This stigma is related to social and religious norms and traditions prevalent in the MENA region. It is difficult for national governments to mobilize and sustain the political leadership and financial support that is vital for effective prevention programmes for the most vulnerable – and highly stigmatized – populations. However, without such leadership, it is challenging for civil society to work with these populations.

Some specific examples of stigma and discrimination include:

- Men who have sex with men face widespread stigma and discrimination in the region because of their sexual practices. Consequently, the community maintains an extremely low profile in countries around the region, which makes it very difficult for them to access services and engage meaningfully in national responses.
- As is the case in most countries around the world, people who inject drugs in the region are highly stigmatized, due largely to the fact that it is a criminalized behaviour. Given the role that injecting drug use has on the spread of HIV, the stigma and discrimination faced by people who inject drugs undermines efforts to work with them to reduce their risk of HIV infection.
- Female sex workers face a similar problem. They also engage in a criminalized behaviour that is coupled with strong sociocultural disapproval of their actions. When combined with other gender issues in the region that limit women's rights, female sex workers are confronted with an environment that places little value on their protection and access to HIV prevention programmes.

### **ASMAA (اسماء), a feature film tells the true story of a woman overcoming fear and social rejection**

UNAIDS has called on and collaborated with media to help address stigma and discrimination. The sense of isolation and low self esteem is all too common for many people living with HIV in Egypt and the region. For the majority of Egyptians and citizens of MENA countries, AIDS remains without a personal face which contributes to misconceptions and fear about the disease.

In this feature movie, Tunisian celebrity actress Hind Sabry, plays the leading role in the film of the character Asmaa. This is the story of a woman living with HIV who bravely overcomes her own fears as well as social rejection to claim her rights. Asmaa has already received several recognition and awards in international and regional festivals and it is expected to make a significant contribution by positively influencing public opinion about AIDS and people living with the virus.



Fifteen countries in the region have taken the important step of including the issue of stigma and discrimination in their national strategic plans. The challenge for these countries is to ensure that the strategies are translated into concrete actions that have a measurable impact. It is important to further understand whether laws that present obstacles to effective HIV prevention, treatment, care and support for vulnerable or marginalized populations are being repealed and whether laws and regulations that protect people living with HIV from discrimination are adequately enforced.

Across the region, other influential actors from the civil society, people living with HIV, key populations and religious leaders are working to reduce the levels of stigma and discrimination. It is not an easy task but there are important activities that can make a difference. For example, supporting regional and country networks for people affected by HIV-related stigma and discrimination to better understand and address the legal and social issues; and using tools such as the People Living with HIV Stigma Index to conduct much needed research on the situation in order to influence policy and funding decisions. The tool has been implemented in a number of MENA countries and findings should be available in early 2012.

Religion has proven to be a powerful force in reducing all types of stigma and discrimination. Key religious messages of tolerance and compassion are invaluable in the region's response to HIV. In fact, when religious leaders actively engage with the HIV response, they can multiply the effectiveness of programmes. One of the best known examples in the region is the support of the ayatollahs in Iran for harm reduction programmes for people who inject drugs. With their support, the country's harm reduction programme has become the most extensive and effective in the MENA region. Another excellent example is the Djibouti Declaration, which was adopted in 2007. In this declaration, Djiboutian religious leaders endorsed the use of condoms as one of the ways to prevent HIV and for birth spacing.

Religious leaders can also play a vital role in improving the quality of life for people living with HIV. In Iran, religious leaders are active participants in a project on psychosocial support to people living with HIV. This project, which is funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria, is working with Islamic leaders on understanding the psychological and social aspects of HIV and providing them with the necessary knowledge and communication skills to support people living with HIV. As part of an initial needs assessment with participants, this project found that 83% of religious leaders believed in the participation of religious leaders and figures in psychosocial support for people living with HIV.



Religious leaders can play a vital role in improving the quality of life for people living with HIV.



# Enabling environment



## Policy environment

In the 2011 Universal Access Reports, countries have reported on four policy areas that can make an important difference in the availability and accessibility of essential HIV services: 1) the provision of free services for prevention; 2) the provision of free services for treatment; 3) the provision of free services for care and support; and 4) equal access for men and women to prevention, treatment, care and support services.

In the MENA region, 12 countries reported that free services for prevention, treatment, care and support are available, and 14 countries reported equal access for men and women to HIV services.

The number of countries reporting the existence of policies in each of these areas is a positive sign for the region. The challenge for countries is ensuring that policies translate into programmes that are available and accessible to all who need them, including marginalized populations.

It is also important for countries to have a costed national strategic plan for HIV and a functioning national coordinating body if the policy environment is going to support an appropriate and effective response. Based on the Country Progress Reports 2010, only three MENA countries reported having a costed strategic plan, and only eight countries report the active participation of civil society in the development and implementation of the strategic plan. However, 15 countries in the region report having a functional national coordinating body.

Leadership is another essential measure of the policy environment in a country. Strong and sensible leadership is absolutely vital for an effective HIV response. Leadership is particularly important in countries where marginalized and vulnerable populations are at a higher risk. Although it is undeniably true that political leadership can be extremely challenging in this context, government officials, decision-makers and opinion leaders need to demonstrate the political courage to focus the response on the populations most affected by HIV.

Strong leadership is also needed to successfully address many of the critical HIV-related policy issues in the region: reducing stigma and discrimination, decriminalizing specific behaviours, universal access to essential HIV services, engaged civil society, and adequate financial and technical resources. Without strong leadership, it is unlikely that these issues will be fully or properly addressed.



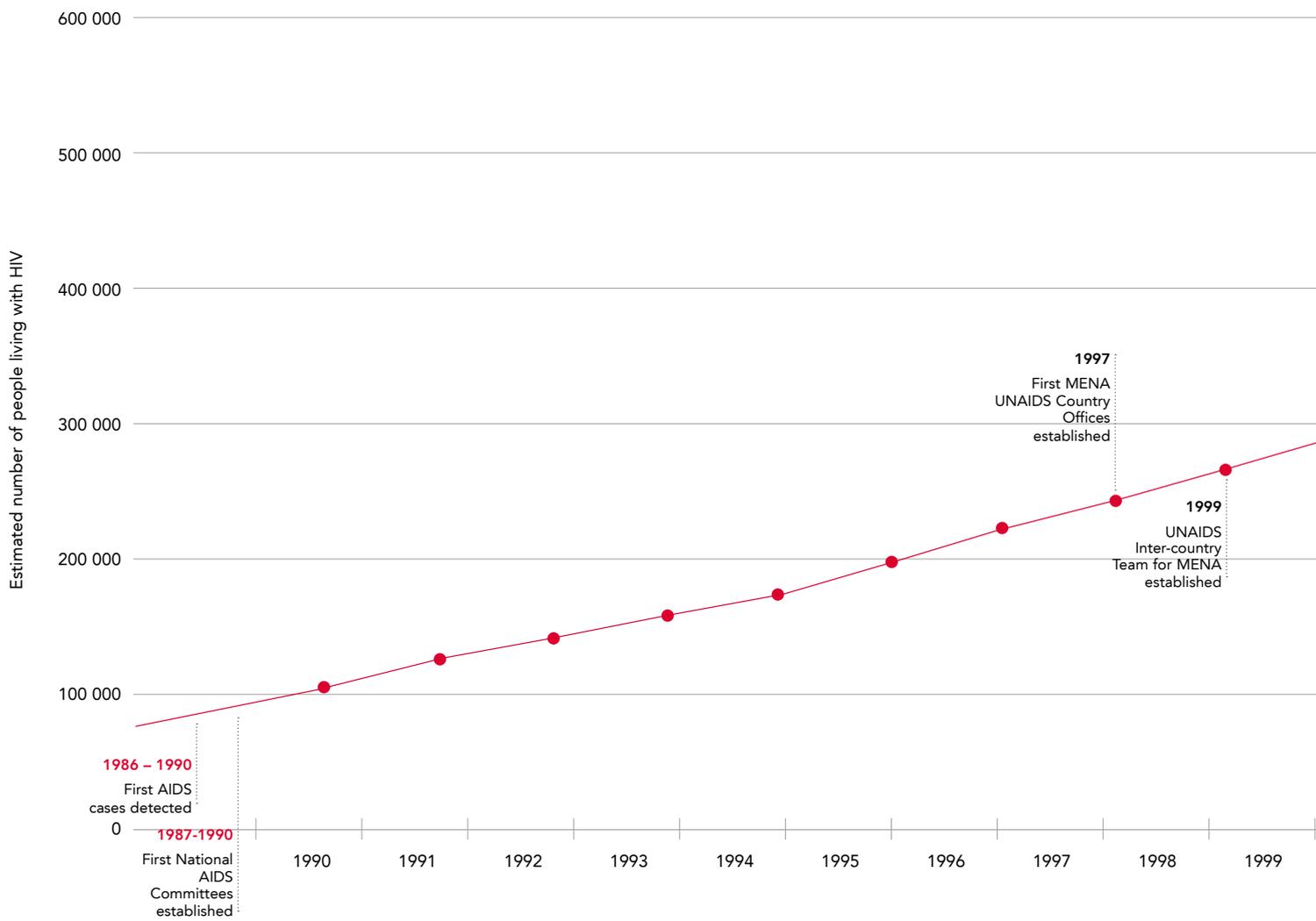
**Government officials, decision-makers and opinion leaders need to demonstrate the political courage to focus the response on the populations most affected by HIV.**

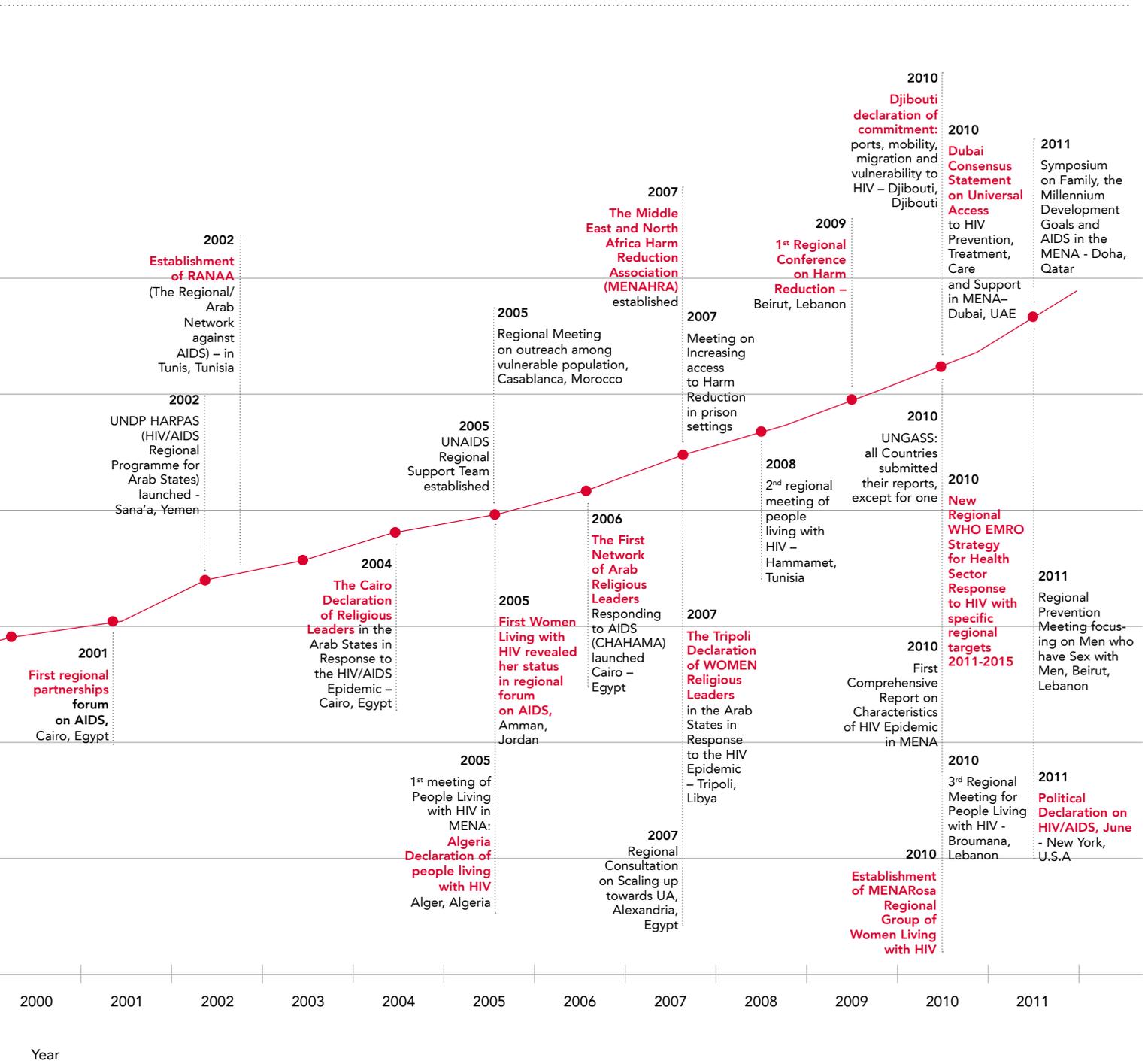
Policy-makers from the MENA region have recently acknowledged the importance of HIV issues, and have reiterated their commitment to universal access to HIV prevention, treatment, care and support, contained in four key documents:

- The **June 2010 Dubai Consensus Statement**, which calls for accelerated action towards universal access in MENA countries; expansion and improvement of service provisions with a focus on prevention and quality treatment; strengthening of strategic information; securing financial resources for a sustained HIV response; and creating an enabling environment within individual country contexts.
- The **Regional Health Sector Strategy 2011–2015**, endorsed by all Ministers of Health at the 57<sup>th</sup> Session of the World Health Organization Regional Committee, which includes specific strategies to address the challenges related to the HIV health sector interventions, measurable regional targets, and specific recommendations developed by national AIDS programme managers to implement the regional strategy.
- The **September 2010 Declaration of Commitment and Call for Action**, which calls for universal access for the mobile people, migrants and other marginalized groups residing or passing through the ports of the Red Sea and the Gulf of Aden.
- The **April 2011 Riyadh Charter**, endorsed by all Gulf Cooperation Council members, that reaffirmed their political commitment to respond effectively to HIV. The participants agreed on the need to join efforts to better understand and know their countries' epidemics, and to develop strategies that are focused, results-oriented, evidence-informed and embedded in human rights. A follow-up meeting is planned in November 2011 to implement the charter.

Figure 22

**KEY MILESTONES IN THE HIV RESPONSE IN THE MENA REGION**





## The role of civil society

Since the earliest days of the global HIV epidemic, civil society has played an essential role in the response. Its involvement has made a critical difference in literally every aspect of the response, ranging from advocacy to funding, and from prevention to treatment. However, it is widely acknowledged that the most important role played by civil society has been to work with the key populations at higher risk and people living with HIV. The willingness and ability of civil society to work with populations as diverse as people who inject drugs, men who have sex with men, sex workers, prisoners and migrants has made the global response to HIV immeasurably more effective.

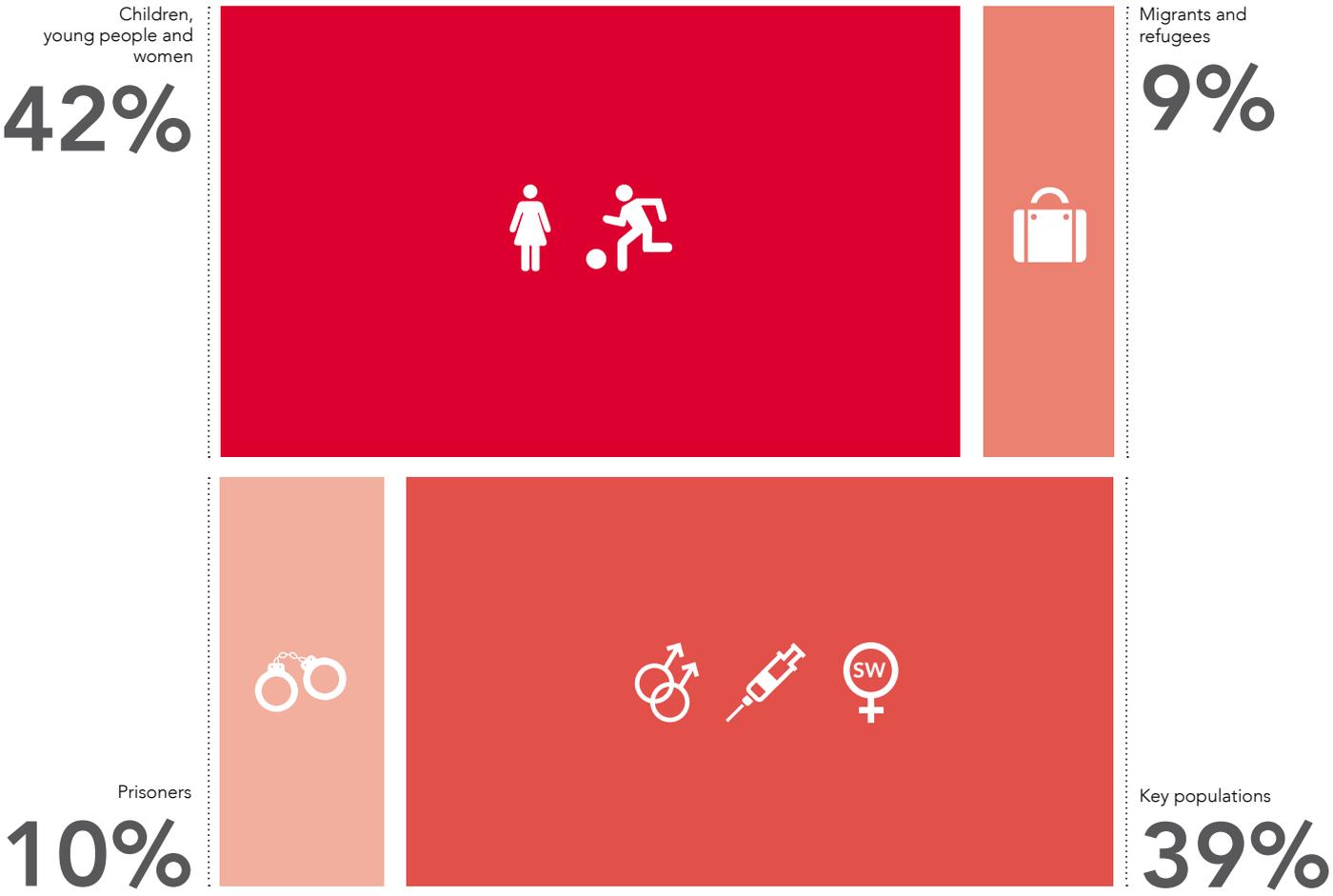
In MENA countries, civil society is playing a significantly larger role in the HIV response than it was only a few years ago. When compared to other parts of the world, the role of civil society is relatively small, but it continues to grow. As is the case in many aspects of the regional response, stigma and discrimination is a major concern, making it difficult for CSOs to engage with the key populations at higher risk and vulnerable groups that would benefit most from their work. This limited engagement is confirmed by the results of the 2011 CSO Mapping Regional Survey, which shows that only one third of NGOs spent equal or more than half of their time working with key populations over the past year (Figure 23). Also, many of the CSOs do not have the requisite knowledge, skills or financial support needed to make an effective contribution to the response.

However, the state of affairs in the region is changing. For example, at the High Level Meeting on AIDS that took place at the UN General Assembly (New York, June 2011), the Civil Society Group organized and implemented a series of activities to ensure that the issues in the region and the voice of people living with HIV and civil society were part of the discussions. The Civil Society Group was able to influence the Arab policy makers in the endorsement of the Political Declaration on HIV/AIDS. It was the first time that the concerns of the region were so visible at such an important forum. Also, the case studies presented in this document show the gradual expansion of CSO and their pivotal role in the HIV response.

“[The country] has an effective network of civil society including NGOs that executes most of the interventions/programmes such as VCT, Outreach, Referral, Hotline, distribution of condoms and lubricants, raising awareness and reaching youth and key populations. They work in collaboration with NAP, Ministries, UN Agencies and they have a meaningful involvement for PLHIV and target groups in all their interventions and activities”. Country progress report 2010, Lebanon

Figure 23

**CIVIL SOCIETY WORK WITH PRIORITY GROUPS IN MENA**



Source: UNAIDS CSO Mapping Survey 2011.

## Working to strengthen partnerships across the MENA region: RANAA

Partnership and coordination are essential features to ensure an effective HIV response at global, regional, national and local levels. As the MENA region works to scale-up the response through increased coordination at the regional level (e.g. through national networks and support mechanisms), it becomes increasingly necessary to also provide for this coordination at a regional level. Furthermore, increased coordination brings a greater profile for HIV to respond to stigma, and the opportunity to augment the greater involvement of people living with HIV. Consequently, the MENA region is witnessing a growing response in the form of regional networks such as RANAA.

The civil society organizations undertook an initiative in Tunis, Tunisia, in December 2002, to establish RANAA. The network is composed of national networks of different CSOs, associations and people living with HIV. The main mission of RANAA is to reduce HIV expansion and improve the quality of life of people living with HIV through networking, advocacy, and building the technical and organizational capabilities of the civil society at all levels and globally. The main objectives of RANAA are to:

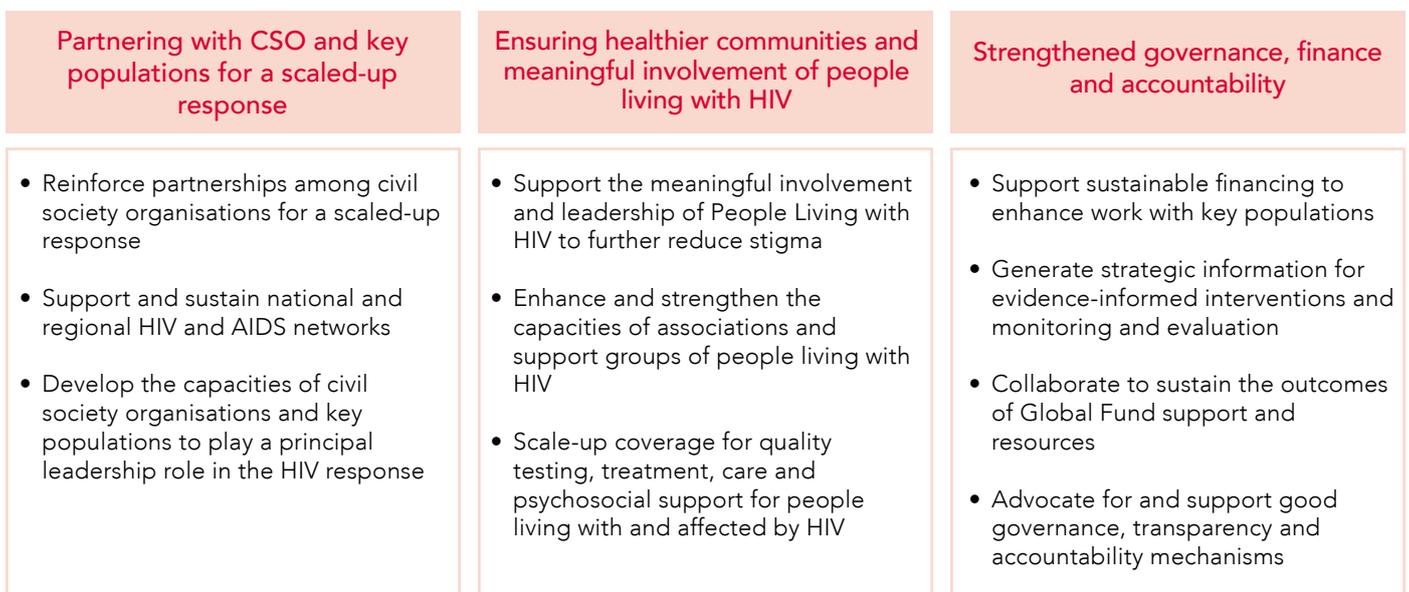
- strengthen the technical and organizational capacities of CSOs working on HIV and association for people living with HIV in the MENA region;
- support the national HIV networks for better coordination, consolidation and exchange among CSOs;
- support greater advocacy for HIV in the MENA region.

Since its establishment, the missions and key objectives for RANAA have been expanding to become more of a regional technical support facility for CSOs especially on management, strategic planning, and monitoring and evaluation. During the last two years through the technical and financial support of UNAIDS, AIDS Alliance, USAID and others, RANAA was able to give a stronger voice to civil society and scale-up its presence and response to a large extent. Its main achievements, with the collaboration of key actors and civil societies in the region, are 1) strengthening secretariat, network governance and communication; 2) coordinating and building capacity of NGOs in partnership development; 3) providing technical support targeting national and subregional networks, and programming for key populations; and 4) improving advocacy efforts and resource mobilization.

RANAA is currently working to ensure the integration of CSOs working with people living with HIV in decision-making; the representation of CSOs and people living with HIV on international level; a better coordination and exchange at the regional level and support on national level; and regional commitment and sustainability of financial resources. Since the establishment and consolidation of RANAA, several other regional initiatives for addressing HIV have emerged, including MENARosa (for women living with HIV), MENAHRA (for people who inject drugs) and CHAHAMA (for religious leaders), each of which will provide the opportunity for improved coordination and partnership in the ongoing response to HIV.

The 2011 UNAIDS CSO mapping exercise identified a set of pivotal issues and challenges facing these organizations. The findings provide a useful roadmap for UNAIDS, as it strengthens its partnership with civil society and key populations for an improved HIV response in the region. Three strategic directions and concrete recommendations and actions were identified and agreed upon during a recent consultation in Cairo:

### Partnership with Civil Society for an enhanced response to HIV epidemic



As the HIV epidemic and the response in the region continues to evolve, the role of civil society will be increasingly important. UNAIDS is working to support national governments to actively engage with civil society by including representatives in planning, implementation, and monitoring and evaluation, as well as recognizing their comparative advantages that make them excellent partners in the HIV response.

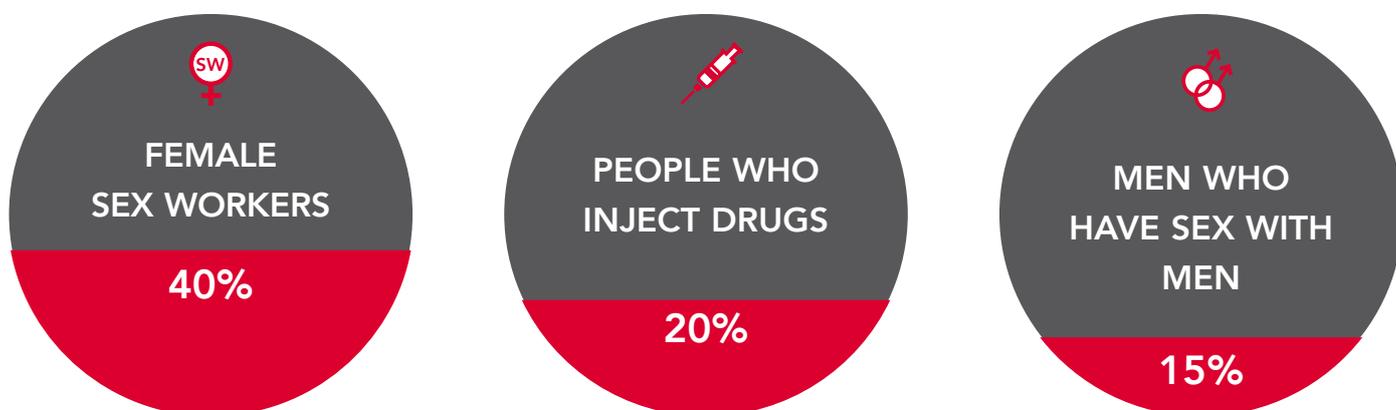
## Strategic information

Although the availability of accurate and comprehensive information on the state of the HIV epidemic and the response continues to improve, HIV surveillance, monitoring and evaluation systems including population size estimation remain weak in many MENA countries. This makes it difficult to estimate epidemic trends and service coverage.

The limited data on key populations at higher risk is the overriding concern. The majority of countries had no data to report on four specific indicators in the UNGASS set on risk behaviours among people who inject drugs, men who have sex with men and sex workers (Figure 24). A number of countries note in their UNGASS responses that some or all of these indicators are irrelevant and/or inappropriate in their countries. However, the dynamics of the epidemic in the region makes a strong case for tracking this data in all countries. Consequently, insufficient or inadequate data on these indicators limits countries' ability to develop and deploy effective responses to HIV. In a broader context, it is likely that the shortage of epidemiological, biomedical and behaviour data is masking higher prevalence in multiple populations in multiple countries in the region.

Figure 24

### PERCENTAGE OF COUNTRIES THAT REPORTED DATA IN THEIR COUNTRY PROGRESS REPORTS 2010 ON KEY POPULATIONS



Source: Country Progress Reports 2010

About half of the countries that submitted a 2010 Country Progress Report, reported having a national monitoring and evaluation plan, with two additional countries reporting that the development of their plan was in progress. However, few of them reported having been able to fund the plans and many countries also acknowledged deficiencies in national monitoring and evaluation systems, and the urgent need to improve these systems. A lack of political leadership, as well as stigma and discrimination, tend to restrain the ability of technical experts to make substantive improvements in data systems.

“The quality and quantity of data gathered on HIV/AIDS and associated conditions need to be improved, strengthened and harmonised. Systems of collection, collation, analysis, reporting, and evaluation of clinical, programmatic and community-based data need to be established in order to better monitor the epidemic and develop evidence-based and targeted responses”.

“Efforts should be made to invest in a better more efficient surveillance system”.

“Representatives from the Department of Public Health stated that there is a systematic lack of information of critical groups such as female sex workers and men who have sex with men”.

“...there hasn't been substantial effort in strengthening behavioural and sentinel surveillance at the zonal level”.

“An additional challenge remains with regards to undertaking special studies and surveys in a contextually appropriate manner and using the information generated by such studies to develop programmes that specifically target key populations at higher risk”.

Comments from Country Progress Reports 2010

There are also serious questions about how well the data are being used; in other words, what conclusions are being drawn from the data and what are their influences on the direction of the responses? A primary area of concern is the overall lack of emphasis given to prevention, particularly among populations at higher risk. However, some progress in linking data to planning has been observed in few countries such as Morocco.

## Comprehensive data analysis for planning Morocco<sup>60</sup>

In 2011, Morocco undertook a comprehensive review and analysis of its HIV data. The goal of the exercise was to provide input into the updated national strategic plan for 2012–2016. The work involved a wide range of stakeholders and data sources, including the recent mode of transmission study. Most importantly, estimates of HIV incidence were calculated for different risk populations, using the modes of transmission model. The calculations were based on a review of the available epidemiological, biological, behaviour and contextual HIV data.

The modes of transmission analysis indicated that the core drivers of the HIV epidemic in Morocco are networks of heterosexual sex workers, of men who have sex with men and of people who inject drugs. Together they contribute about two-thirds of the total number of new HIV infections and should therefore be prioritized for HIV programming. In more detail, the analysis showed that:

- HIV incidence in paid sex networks contributed an estimated 43% (uncertainty range 26–64%) of new HIV infections in 2009. HIV transmission among female sex workers occurs across most of the country, but is most intense in the south (especially in Agadir) where HIV prevalence exceeds 5%.
- Together, networks of men who have sex with men and people who inject drugs are estimated to have contributed just over 20% of the HIV incidence in 2009. The analysis pointed to a potential for a substantial HIV epidemic among people who inject drugs. Data about risk behaviour among men who have sex with men were limited, but with availability of the results of a recent study in 2011, there will be a better picture about the risks and vulnerability in this group.
- Although the HIV incidence rate in the general heterosexual population is small, the actual number of new infections in this population group is considerable since this group comprises most of the sexually active population.

Recommendations for the national strategic plan included:

- reinforce and expand combination prevention programmes for key populations at higher risk and ensure adequate allocation of resources;
- focus condom distribution and STI treatment on key and vulnerable populations;

<sup>60</sup> Mumtaz G., Hilmi N., Zidouh A., et al. *HIV Modes of Transmission Analysis in Morocco. 2010*. Ministry of Health of Morocco, UNAIDS, and Weill Cornell Medical College in Qatar

- develop specific and innovative approaches for prevention among clients of sex workers;
- develop and implement a condom social marketing programme to improve access to condoms in risk-behaviour networks;
- review the priority regions to insure optimal coverage according to the local dynamics and characteristics of the epidemic;
- ensure and harmonize quality of the prevention interventions among key populations to maximize results and impacts of the programmes;
- ensure more visibility for human rights in the national strategic plan and promote collaboration with human right actors.

The UNAIDS Regional Support Team has just finalized the monitoring and evaluation training modules tailored to the MENA region context, which will be gradually rolled-out in all countries in 2012 with the aim of strengthening all elements of national monitoring and evaluation systems. Also, an increasing number of countries in the region have been able to make incremental improvements in their surveillance systems since the last round of UNGASS reporting. For example, Egypt, Iran, Morocco, Sudan, Tunisia and Yemen completed Integrated Biological and Behavioural Surveillance (IBBS) among key populations at higher risk in 2010 and 2011. In addition, Iran and Morocco completed modes of transmission studies during this time, and similar studies are currently underway in Egypt, Sudan and Tunisia.

Where data are available in the region, it supports the expansion of prevention programmes as an efficient and cost-effective way to control the spread of HIV. Although countries in the region should be recognized for their commitment to expanding and maintaining treatment for people living with HIV, this commitment must not come at the expense of preventing new infections. Strategic information can be a very powerful advocacy tool for demonstrating to decision-makers and opinion leaders that focused prevention activities among key populations is a sensible and responsible cornerstone of the response from both a public health perspective and a financial perspective.



Strategic information has proven to be a strong advocacy tool in the region.

## Investment in the HIV response

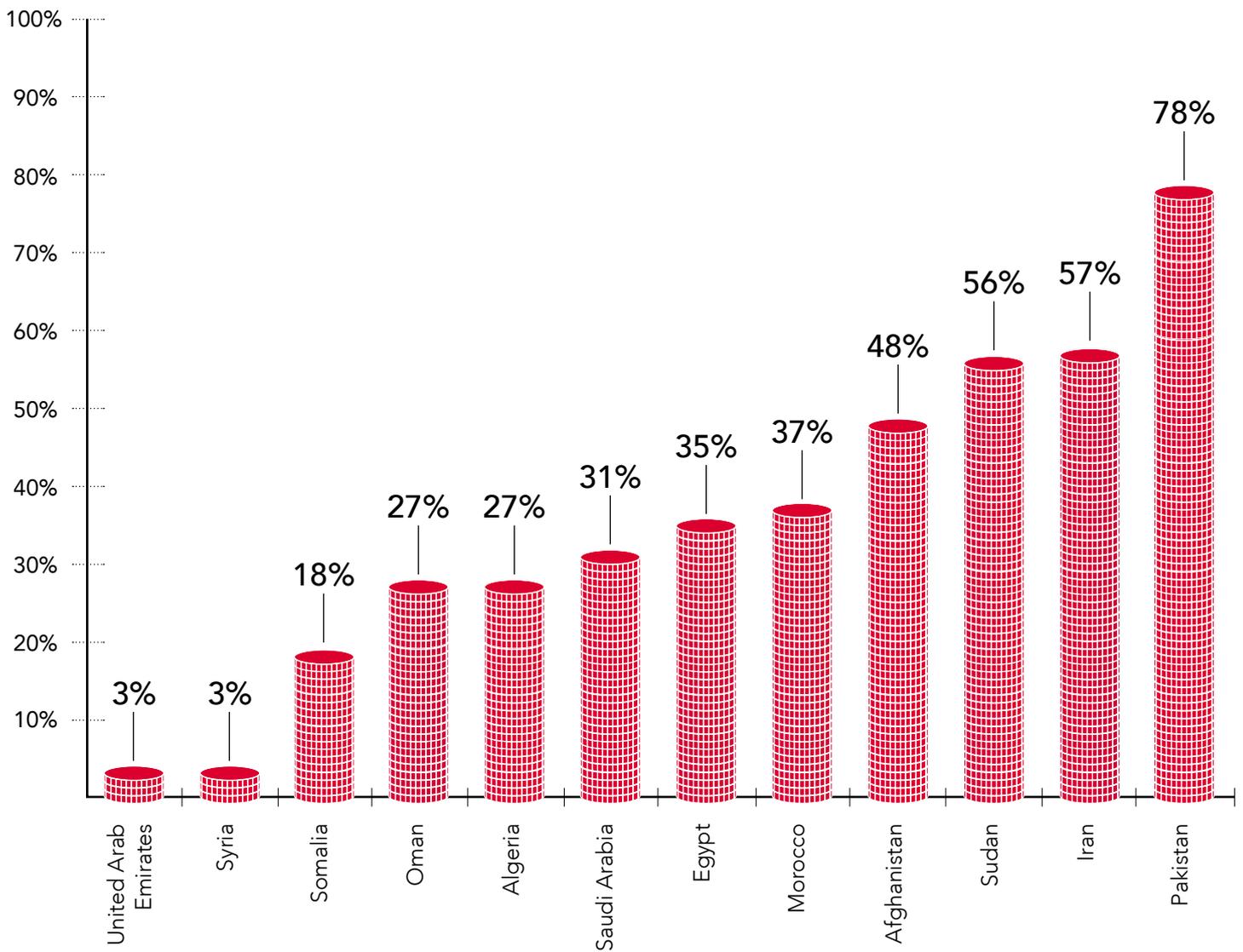
A common challenge facing countries across the MENA region is a shortage of financial resources to implement the AIDS response fully. Funding is an issue across the region, regardless of a country's economic status.

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% (Figure 25).

Based on available data, it is clear that countries should be increasing their spending on HIV and/or reallocating it to more effective initiatives within their response. For many countries, including those with the financial capacity to support an expanded response to HIV, the problem appears to be one of resource allocation, both in terms of governments' willingness to provide funding and to allow public health experts to use those funds where they would be most effective. Without the necessary political leadership and political will, it is likely that critical programmes in these countries will not receive sufficient funding to make a significant impact on the spread of HIV.

Figure 25

**SHARE OF HIV SPENDING IN PREVENTION OVER TOTAL DOMESTIC SPENDING, 2008-2009, SELECTED COUNTRIES**



Source: Country Progress Reports 2010.

For some countries – particularly the lower income countries with higher prevalence rates – the challenge is to source sufficient funds to cover the full range of needed programmes. In most cases, these are the same countries that receive significant financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria, the largest source of external funding in the region<sup>61</sup>.

It is important to note that three countries in the region are also donors to the Global Fund. Since 2003, Kuwait has donated \$3 million; Saudi Arabia donated \$28 million. In 2011, Tunisia donated \$2 million.

There is an inextricable link between financial and technical resources. Without sufficient financial resources, it is difficult for countries to develop and/or acquire the necessary technical expertise to improve their response to HIV. Although donor organizations and agencies have some interest in capacity development, the responsibility is increasingly falling to the countries directly. The challenge facing programme implementers in government and civil society is to demonstrate to decision-makers the many benefits of direct investment in improving technical capacity, including, for example, the ability to develop and implement an evidence-informed response; the ability to deploy financial resources more efficiently and cost-effectively; and the ability to leverage technical skills (e.g. surveillance) in all areas related to the HIV response.



Countries should invest more in improving technical capacities for cost-effective HIV responses.

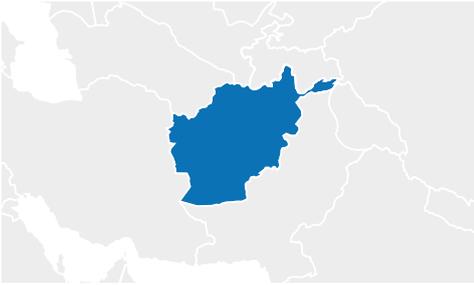
<sup>61</sup> Through Round 10, Global Fund grant portfolios in the region total \$397 367 504



# Country snapshots



# AFGHANISTAN



## Country Overview

Human Development Index	low	GDP (per capita)	466 US\$
Life expectancy	42 years	Population	29.1 million

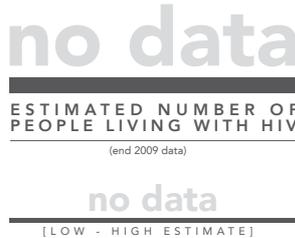
## National Strategic plan on HIV and AIDS

Existence of a national strategic plan  Yes  No

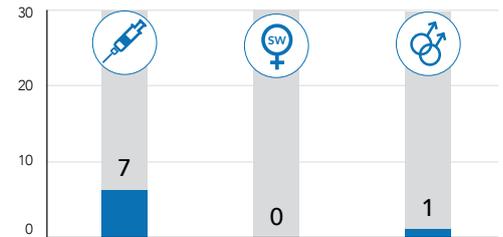
**2006** NSP DURATION **2010**

## Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009

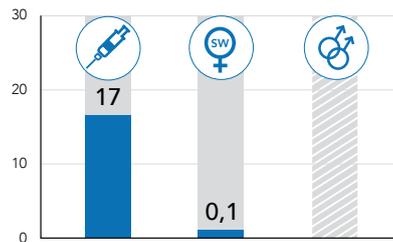


• HIV prevalence among Key Populations (%)

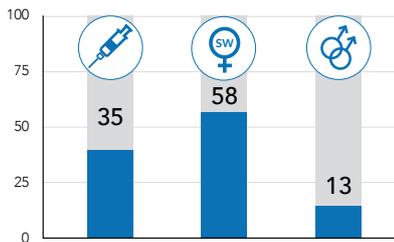


## HIV Prevention Programmes

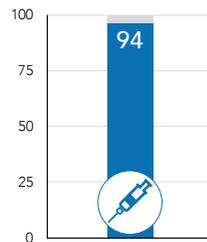
• Key Populations reached with HIV Prevention Programmes (%)



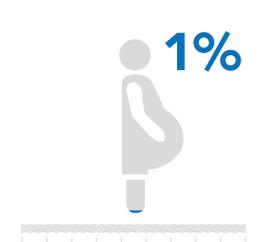
• Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



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

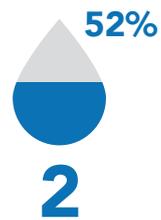


• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)

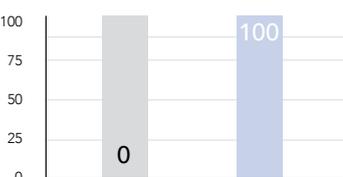


## Health System Interventions

• Blood safety

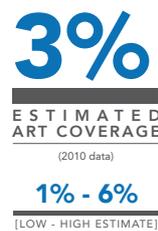
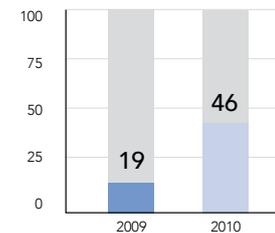


NUMBER OF HEALTH FACILITIES THAT OFFER ART

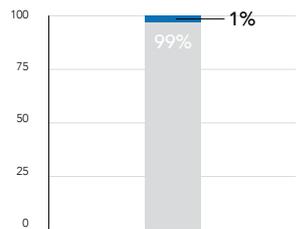


## Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



## HIV expenditure



## Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

## Global Fund HIV Grants

Global Fund Grant for HIV/AIDS in progress  Yes  No

**5,1 M**  
GLOBAL FUND GRANT AMOUNTS (PLEGGED) IN US\$

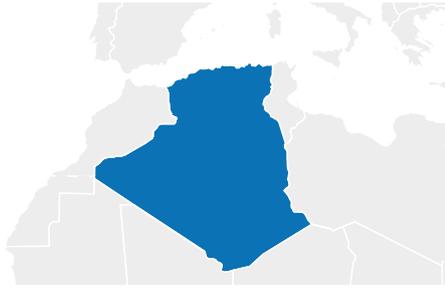
## Presence of associations of People living with HIV



**NO**

Country Progress Report 2010, Universal Access Reports 2011, HIV surveillance, programme monitoring and bio-behavioural/behavioural surveys conducted in the country that may not necessarily be nationally representative

# ALGERIA



## Country Overview

Human Development Index	medium	GDP (per capita)	4,959 US\$
Life expectancy	71 years	Population	35.4 million

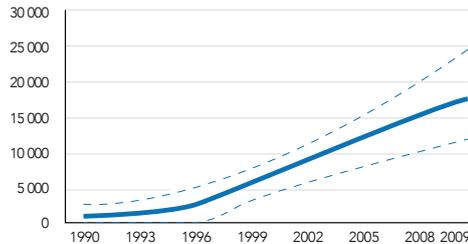
## National Strategic plan on HIV and AIDS

Existence of a national strategic plan  Yes  No

**2008** NSP DURATION **2012**

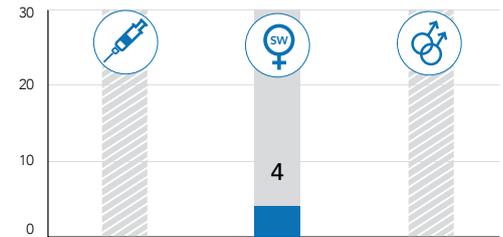
## Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009



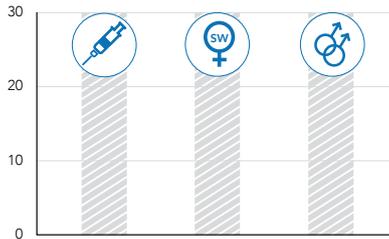
**18 000**  
ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2009 data)  
**13 000 - 24 000**  
[LOW - HIGH ESTIMATE]

• HIV prevalence among Key Populations (%)

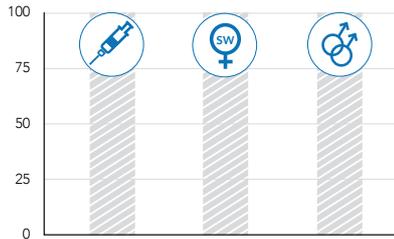


## HIV Prevention Programmes

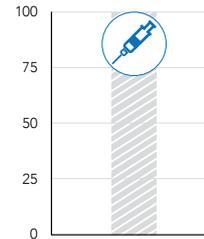
• Key Populations reached with HIV Prevention Programmes (%)



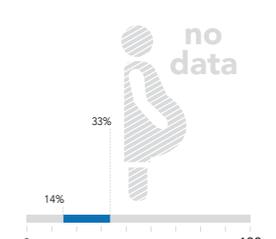
• Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



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



• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)



## Health System Interventions

• Blood safety



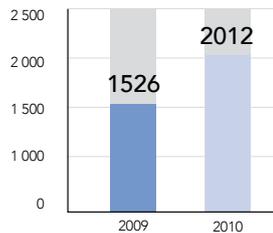
NUMBER OF HEALTH FACILITIES THAT OFFER ART



■ % health facilities providing ART that have experienced stock-out  
■ % health facilities providing ART using CD4 monitoring in line with national guidelines

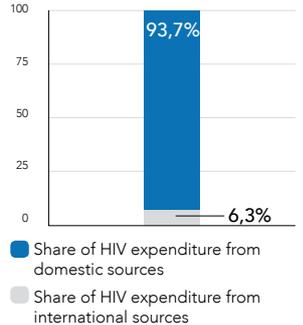
## Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



no data  
ESTIMATED ART COVERAGE  
(2010 data)  
**25% - 43%**  
[LOW - HIGH ESTIMATE]

## HIV expenditure



## Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

■ Yes  
■ No  
■ No data

## Global Fund HIV Grants

Global Fund Grant for HIV/AIDS in progress  Yes  No

**6,9 M**  
GLOBAL FUND GRANT AMOUNTS (PLEGGED) IN US\$

## Presence of associations of People living with HIV



**YES**

Source of information: Country Progress Report 2010, Universal Access Reports 2011, HIV surveillance, programme monitoring and bio-behavioural/behavioural surveys conducted in the country that may not necessarily be nationally representative



Country Overview

Human Development Index	high	GDP (per capita)	28,200 US\$
Life expectancy	75 years	Population	809

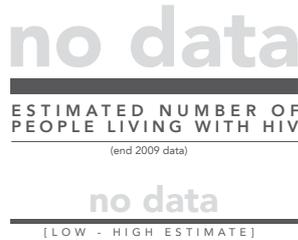
National Strategic plan on HIV and AIDS

Existence of a national strategic plan  Yes  No

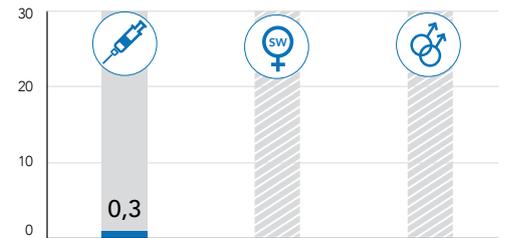
2008 N S P D U R A T I O N 2010

Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009

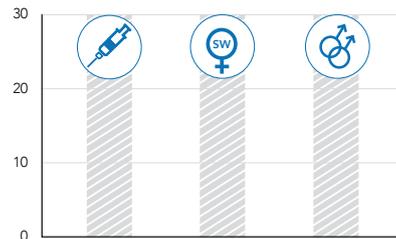


• HIV prevalence among Key Populations (%)

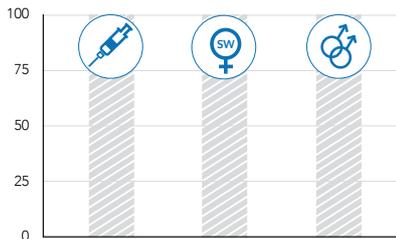


HIV Prevention Programmes

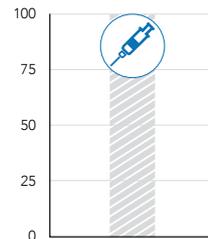
• Key Populations reached with HIV Prevention Programmes (%)



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



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



• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)

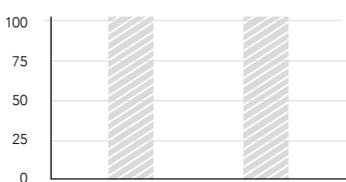


Health System Interventions

• Blood safety



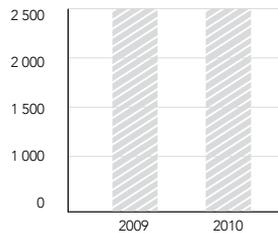
nodata  
NUMBER OF HEALTH FACILITIES THAT OFFER ART



■ % health facilities providing ART that have experienced stock-out  
■ % health facilities providing ART using CD4 monitoring in line with national guidelines

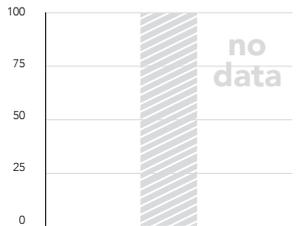
Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



no data  
ESTIMATED ART COVERAGE  
(2010 data)  
no data  
[LOW - HIGH ESTIMATE]

HIV expenditure



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

Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

■ Yes  
■ No  
■ No data

Global Fund HIV Grants

not eligible

Presence of associations of People living with HIV



NO

Source of information: Country Progress Report 2010, Universal Access Reports 2011, HIV surveillance, programme monitoring and bio-behavioural/behavioural surveys conducted in the country that may not necessarily be nationally representative

# DJIBOUTI



## Country Overview

Human Development Index	medium	GDP (per capita)	1,155 US\$
Life expectancy	59 years	Population	879 000

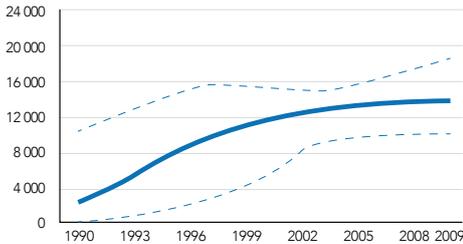
## National Strategic plan on HIV and AIDS

Existence of a national strategic plan  Yes  No

**2008** NSP DURATION **2012**

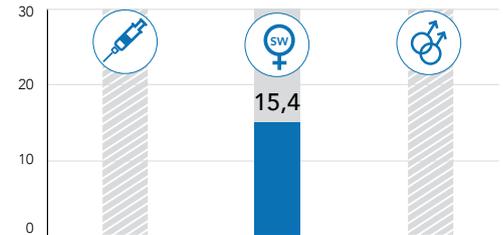
## Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009



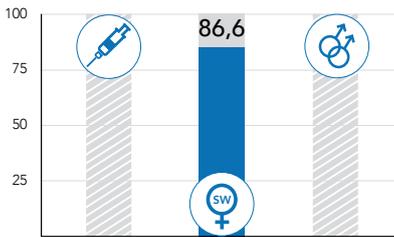
**14 000**  
ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2009 data)  
**10 000 - 18 000**  
[LOW - HIGH ESTIMATE]

• HIV prevalence among Key Populations (%)

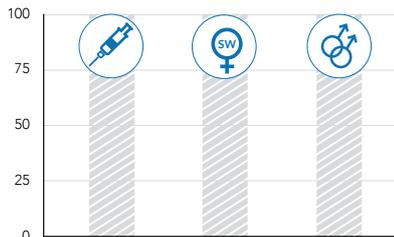


## HIV Prevention Programmes

• Key Populations reached with HIV Prevention Programmes (%)

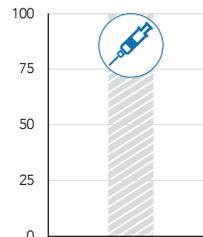


• Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



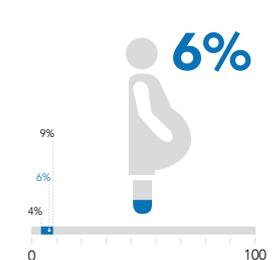
\* for sex workers is the sexual intercourse with the most recent client

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



\* the indicator refers to the last time injecting

• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)



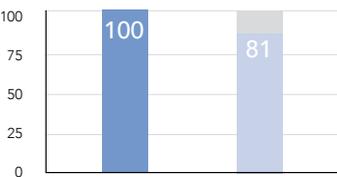
## Health System Interventions

• Blood safety

**100%**

**27**

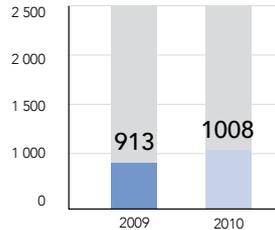
NUMBER OF HEALTH FACILITIES THAT OFFER ART



■ % health facilities providing ART that have experienced stock-out  
■ % health facilities providing ART using CD4 monitoring in line with national guidelines

## Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



**17%**

ESTIMATED ART COVERAGE

(2010 data)

no data

[LOW - HIGH ESTIMATE]

## HIV expenditure



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

## Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

■ Yes  
■ No  
■ No data

## Global Fund HIV Grants

Global Fund Grant for HIV/AIDS in progress

Yes  No

**18,1 M**

GLOBAL FUND GRANT AMOUNTS (PLEGGED) IN US\$

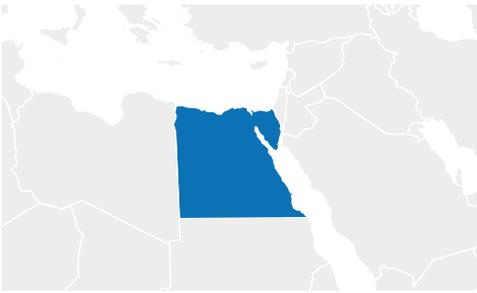
## Presence of associations of People living with HIV



**YES**

Source of information:

Country Progress Report 2010, Universal Access Reports 2011, HIV surveillance, programme monitoring and bio-behavioural/behavioural surveys conducted in the country that may not necessarily be nationally representative



Country Overview

Human Development Index	medium	GDP (per capita)	2,031 US\$
Life expectancy	69 years	Population	84.5 million

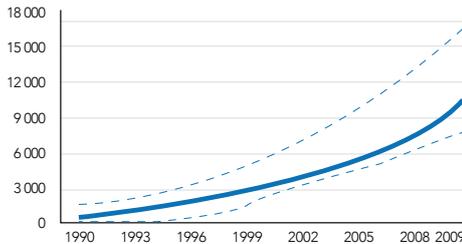
National Strategic plan on HIV and AIDS

Existence of a national strategic plan  Yes  No

2007 NSP DURATION 2011

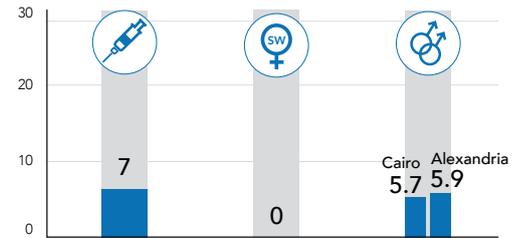
Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009



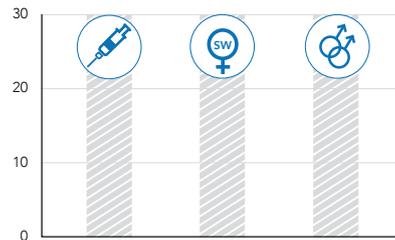
**11 000**  
ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2009 data)  
**8 400 - 17 000**  
[LOW - HIGH ESTIMATE]

• HIV prevalence among Key Populations (%)

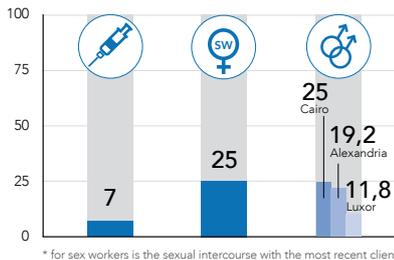


HIV Prevention Programmes

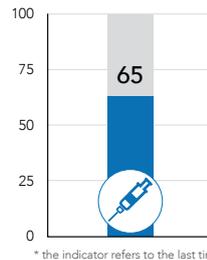
• Key Populations reached with HIV Prevention Programmes (%)



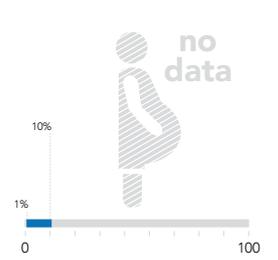
• Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



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



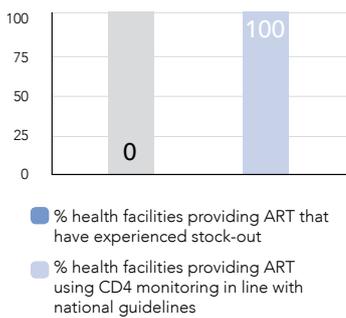
• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)



Health System Interventions

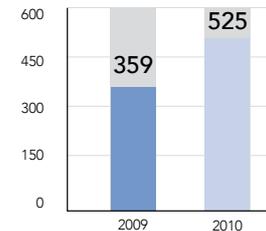
• Blood safety

**100%**  
**6**  
NUMBER OF HEALTH FACILITIES THAT OFFER ART



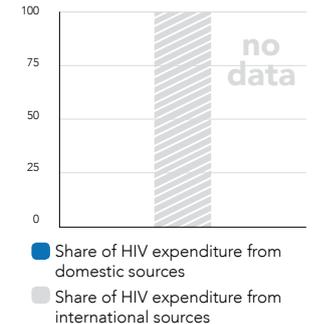
Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



**10%**  
ESTIMATED ART COVERAGE  
(2010 data)  
**4% - 21%**  
[LOW - HIGH ESTIMATE]

HIV expenditure



Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

Global Fund HIV Grants

Global Fund Grant for HIV/AIDS in progress  Yes  No

**8,5 M**  
GLOBAL FUND GRANT AMOUNTS (PLEGGED) IN US\$

Presence of associations of People living with HIV



**YES**

Source of information: Country Progress Report 2010, Universal Access Reports 2011, HIV surveillance, programme monitoring and bio-behavioural/behavioural surveys conducted in the country that may not necessarily be nationally representative



Country Overview

Human Development Index	medium	GDP (per capita)	4,728 US\$
Life expectancy	72 years	Population	75.1 million

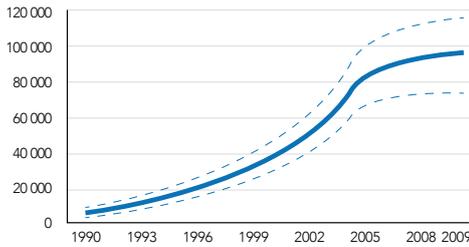
National Strategic plan on HIV and AIDS

Existence of a national strategic plan  Yes  No

2010 NSP DURATION 2014

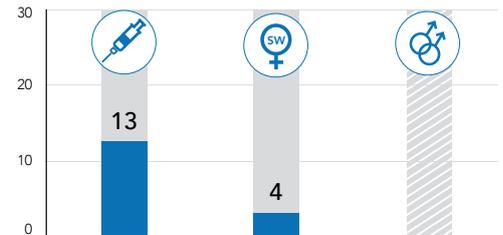
Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009



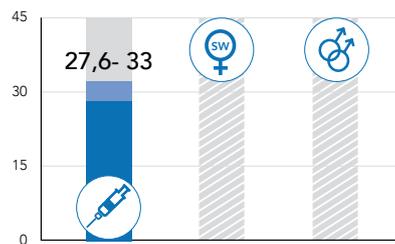
**92 000**  
ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2009 data)  
**74 000 - 120 000**  
[LOW - HIGH ESTIMATE]

• HIV prevalence among Key Populations (%)

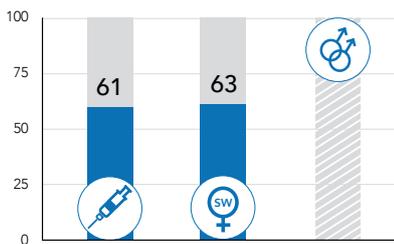


HIV Prevention Programmes

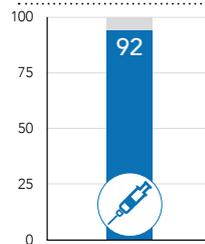
• Key Populations reached with HIV Prevention Programmes (%)



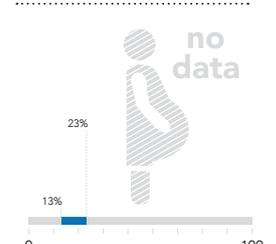
• Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



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



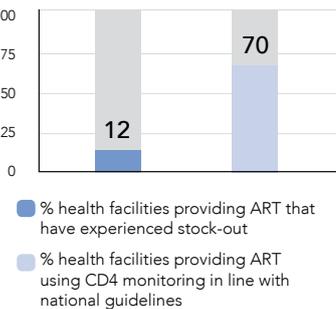
• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)



Health System Interventions

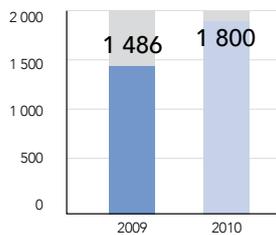
• Blood safety

**100%**  
**271**  
NUMBER OF HEALTH FACILITIES THAT OFFER ART



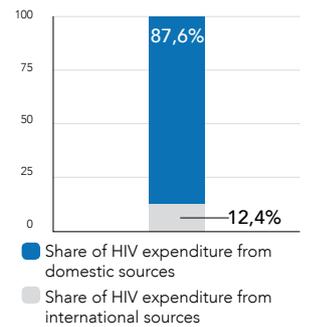
Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



**7%**  
ESTIMATED ART COVERAGE  
(2010 data)  
**6% - 8%**  
[LOW - HIGH ESTIMATE]

HIV expenditure



Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

Global Fund HIV Grants

Global Fund Grant for HIV/AIDS in progress  Yes  No

**25,2 M**  
GLOBAL FUND GRANT AMOUNTS (PLEGGED) IN US\$

Presence of associations of People living with HIV



**YES**



Country Overview

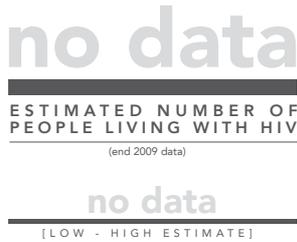
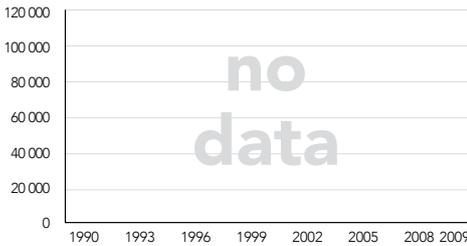
Human Development Index	no data	GDP (per capita)	787,8 US\$
Life expectancy	63 years	Population	31.5 million

National Strategic plan on HIV and AIDS

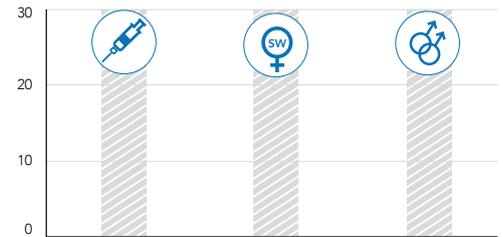
	Yes	No
Existence of a national strategic plan	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009

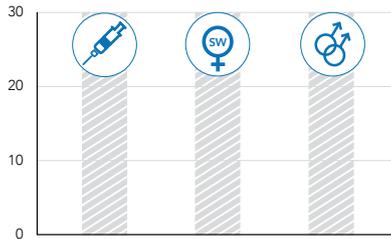


• HIV prevalence among Key Populations (%)

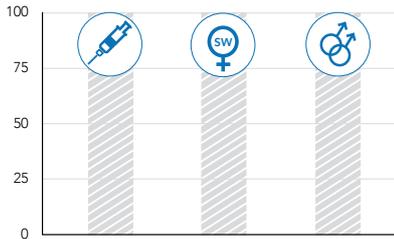


HIV Prevention Programmes

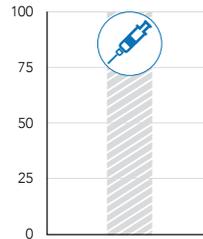
• Key Populations reached with HIV Prevention Programmes (%)



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



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



• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)



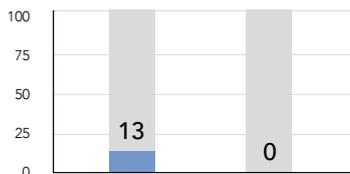
Health System Interventions

• Blood safety

no data

15

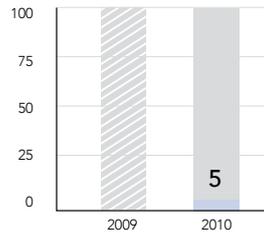
NUMBER OF HEALTH FACILITIES THAT OFFER ART



- % health facilities providing ART that have experienced stock-out
- % health facilities providing ART using CD4 monitoring in line with national guidelines

Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



no data  
ESTIMATED ART COVERAGE  
(2010 data)  
no data  
[LOW - HIGH ESTIMATE]

HIV expenditure

no data

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

Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

Global Fund HIV Grants

Global Fund Grant for HIV/AIDS in progress

Yes	No
<input type="checkbox"/>	<input checked="" type="checkbox"/>

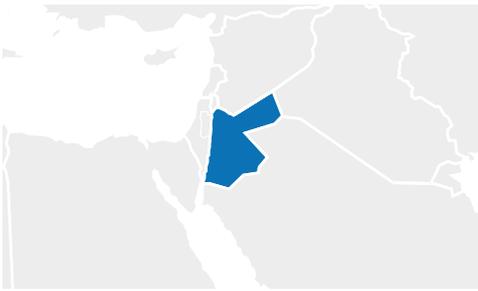
0

GLOBAL FUND GRANT AMOUNTS (PLEGGED) IN US\$

Presence of associations of People living with HIV



Source of information: Country Progress Report 2010, Universal Access Reports 2011, HIV surveillance, programme monitoring and bio-behavioural/behavioural surveys conducted in the country that may not necessarily be nationally representative



Country Overview

Human Development Index	medium	GDP (per capita)	3,466 US\$
Life expectancy	72 years	Population	6 million

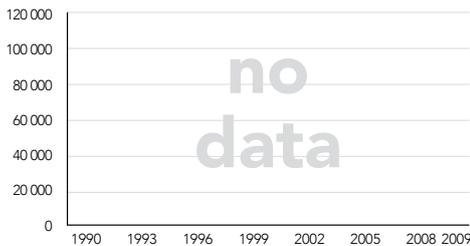
National Strategic plan on HIV and AIDS

Existence of a national strategic plan  Yes  No

2012 N S P D U R A T I O N 2016

Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009



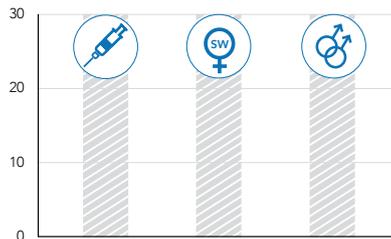
no data  
ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2009 data)  
no data  
[LOW - HIGH ESTIMATE]

• HIV prevalence among Key Populations (%)

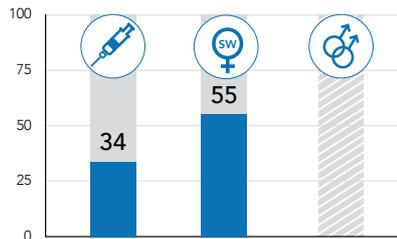


HIV Prevention Programmes

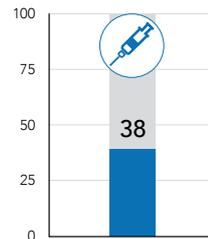
• Key Populations reached with HIV Prevention Programmes (%)



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



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



• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)



Health System Interventions

• Blood safety

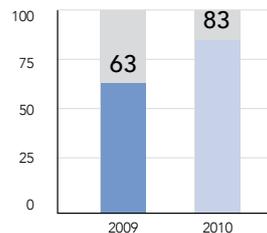
100%  
2  
NUMBER OF HEALTH FACILITIES THAT OFFER ART



■ % health facilities providing ART that have experienced stock-out  
■ % health facilities providing ART using CD4 monitoring in line with national guidelines

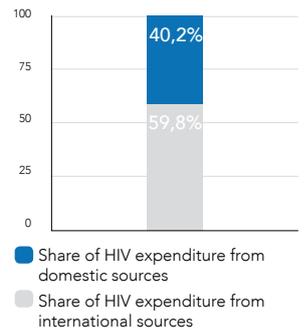
Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



no data  
ESTIMATED ART COVERAGE  
(2010 data)  
no data  
[LOW - HIGH ESTIMATE]

HIV expenditure



Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

Legend:  Yes,  No,  No data

Global Fund HIV Grants

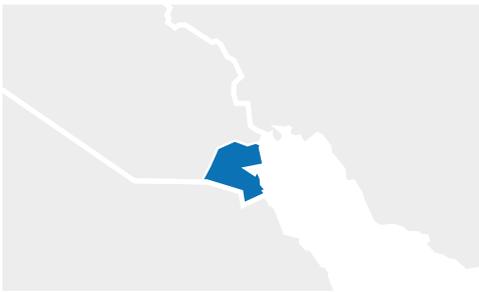
Global Fund Grant for HIV/AIDS in progress  Yes  No

6 M  
GLOBAL FUND GRANT AMOUNTS (PLEGGED) IN US\$

Presence of associations of People living with HIV



YES



Country Overview

Human Development Index	very high	GDP (per capita)	54,1 thousands US\$
Life expectancy	78 years	Population	2.7 million

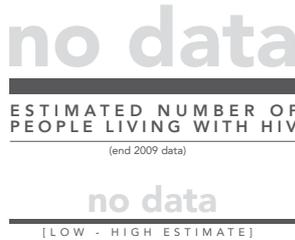
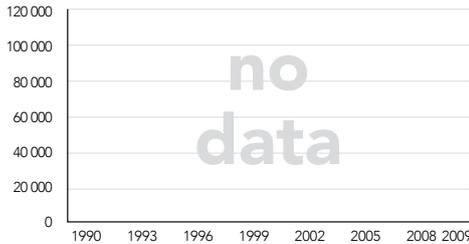
National Strategic plan on HIV and AIDS

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

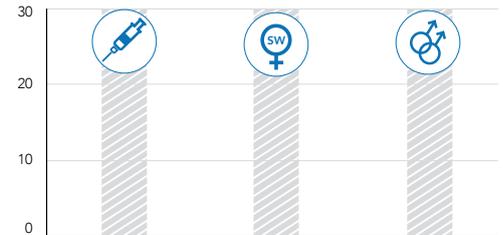
no data

Epidemiology Facts

- Estimated number of people living with HIV 1990 - 2009

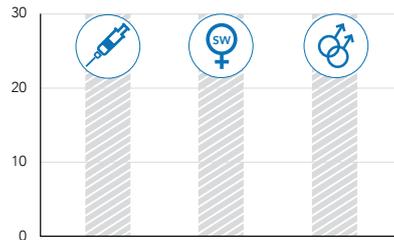


- HIV prevalence among Key Populations (%)

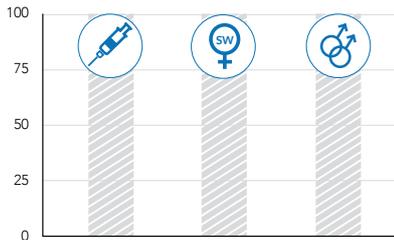


HIV Prevention Programmes

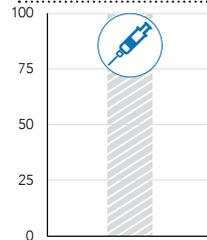
- Key Populations reached with HIV Prevention Programmes (%)



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



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

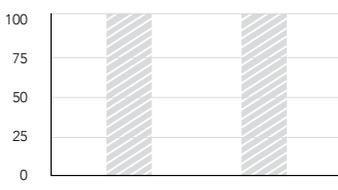


- HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)



Health System Interventions

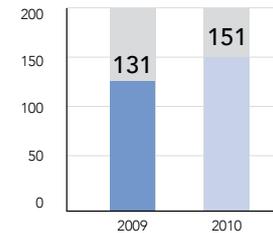
- Blood safety



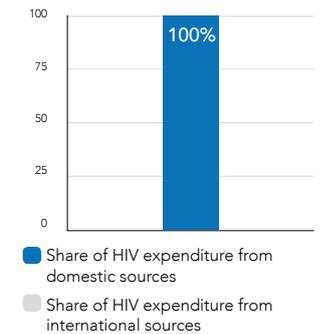
■ % health facilities providing ART that have experienced stock-out  
 ■ % health facilities providing ART using CD4 monitoring in line with national guidelines

Treatment Coverage

- Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



HIV expenditure



Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

Global Fund HIV Grants

not eligible

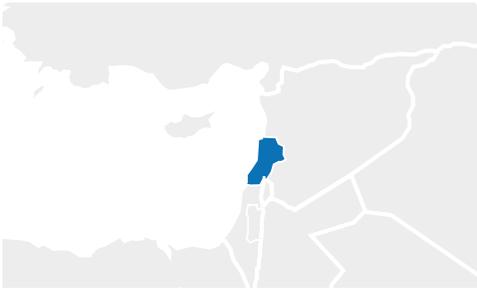
Presence of associations of People living with HIV



NO

Source of information: Country Progress Report 2010, Universal Access Reports 2011, HIV surveillance, programme monitoring and bio-behavioural/behavioural surveys conducted in the country that may not necessarily be nationally representative

# LEBANON



## Country Overview

Human Development Index	high	GDP (per capita)	6,797 US\$
Life expectancy	72 years	Population	4.2 million

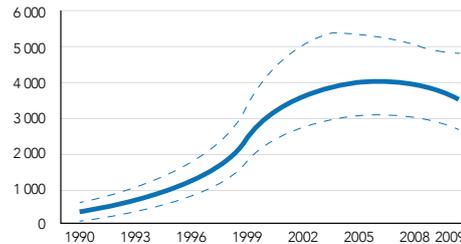
## National Strategic plan on HIV and AIDS

Existence of a national strategic plan  Yes  No

**2004** NSP DURATION **2009**

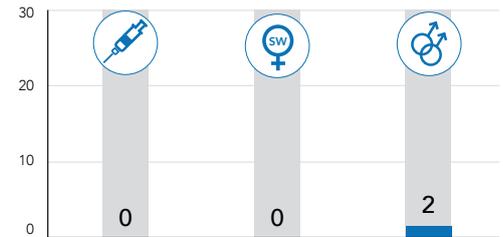
## Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009



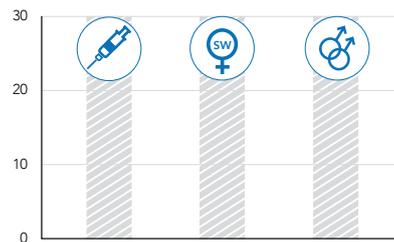
**3 600**  
ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2009 data)  
**2 700 - 4 800**  
[LOW - HIGH ESTIMATE]

• HIV prevalence among Key Populations (%)

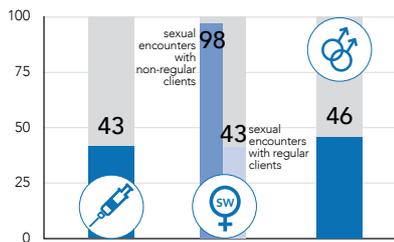


## HIV Prevention Programmes

• Key Populations reached with HIV Prevention Programmes (%)

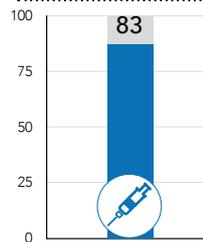


• Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



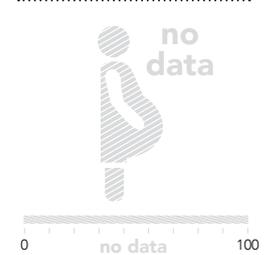
\* for sex workers is the sexual intercourse with the most recent client

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



\* the indicator refers to the last time injecting

• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)



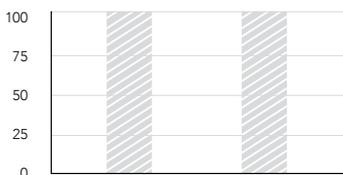
## Health System Interventions

• Blood safety

**100%**

**nodata**

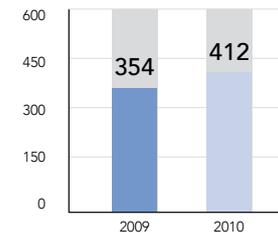
NUMBER OF HEALTH FACILITIES THAT OFFER ART



■ % health facilities providing ART that have experienced stock-out  
■ % health facilities providing ART using CD4 monitoring in line with national guidelines

## Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral

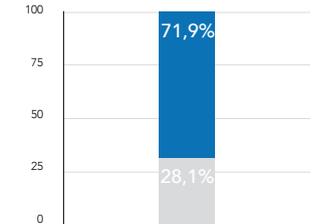


**37%**

ESTIMATED ART COVERAGE  
(2010 data)

**25% - 55%**  
[LOW - HIGH ESTIMATE]

## HIV expenditure



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

## Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

■ Yes  
■ No  
■ No data

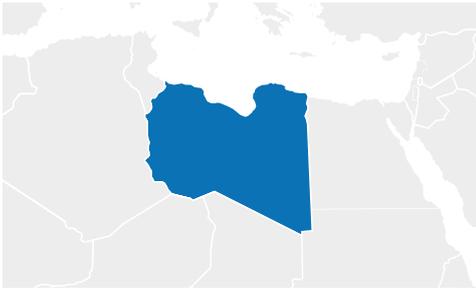
## Global Fund HIV Grants

**not eligible**

## Presence of associations of People living with HIV



**YES**



Country Overview

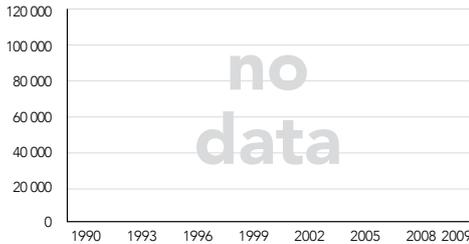
Human Development Index	high	GDP (per capita)	14.4 thousands US\$
Life expectancy	73 years	Population	6.3 million

National Strategic plan on HIV and AIDS

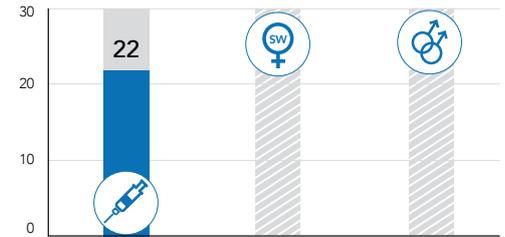
Existence of a national strategic plan  Yes  No

Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009

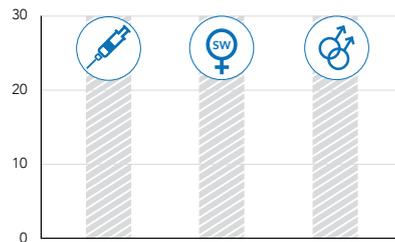


• HIV prevalence among Key Populations (%)



HIV Prevention Programmes

• Key Populations reached with HIV Prevention Programmes (%)

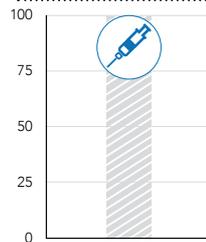


• Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



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

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



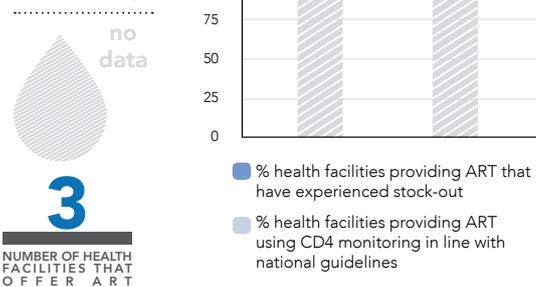
\* the indicator refers to the last time injecting

• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)



Health System Interventions

• Blood safety



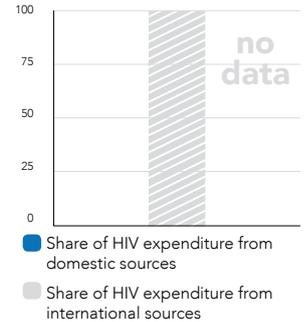
3  
NUMBER OF HEALTH FACILITIES THAT OFFER ART

Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



HIV expenditure



Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

Legend:  Yes,  No,  No data

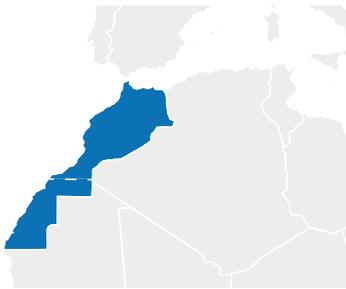
Global Fund HIV Grants

not eligible

Presence of associations of People living with HIV

no data

Source of information: Country Progress Report 2010, Universal Access Reports 2011, HIV surveillance, programme monitoring and bio-behavioural/behavioural surveys conducted in the country that may not necessarily be nationally representative



Country Overview

Human Development Index	medium	GDP (per capita)	2,739 US\$
Life expectancy	72 years	Population	32.4 million

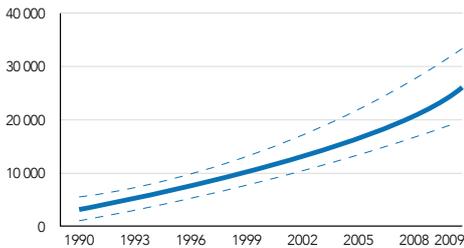
National Strategic plan on HIV and AIDS

Existence of a national strategic plan  Yes  No

2007 NSP DURATION 2011

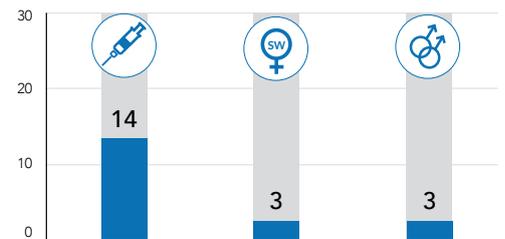
Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009



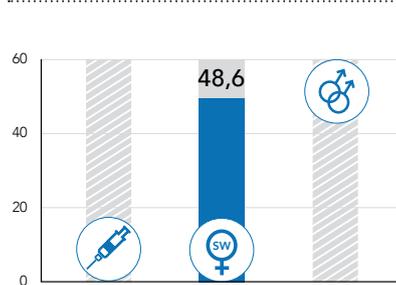
**26 000**  
ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2009 data)  
**19 000 - 34 000**  
[LOW - HIGH ESTIMATE]

• HIV prevalence among Key Populations (%)

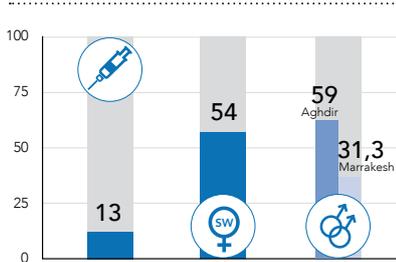


HIV Prevention Programmes

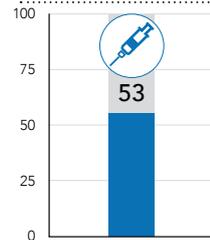
• Key Populations reached with HIV Prevention Programmes (%)



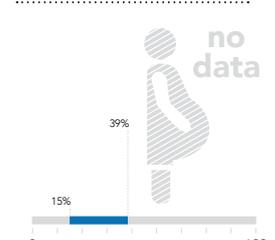
• Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



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

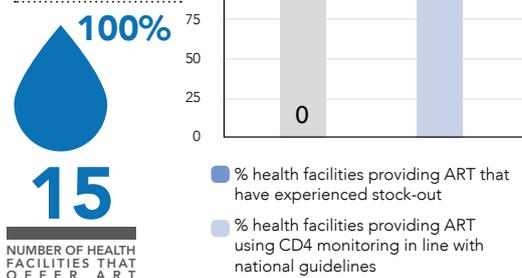


• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)



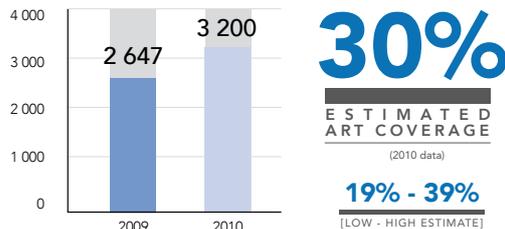
Health System Interventions

• Blood safety

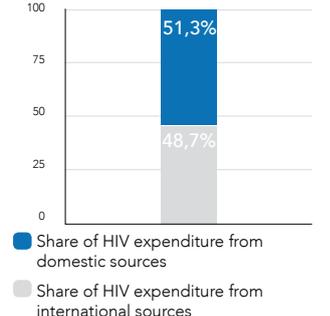


Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



HIV expenditure



Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

Global Fund HIV Grants

Global Fund Grant for HIV/AIDS in progress  Yes  No

**25 M**  
GLOBAL FUND GRANT AMOUNTS (PLEGGED) IN US\$

Presence of associations of People living with HIV

**YES**

Source of information: Country Progress Report 2010, Universal Access Reports 2011, HIV surveillance, programme monitoring and bio-behavioural/behavioural surveys conducted in the country that may not necessarily be nationally representative



Country Overview

Human Development Index	high	GDP (per capita)	18,9 thousands US\$
Life expectancy	74 years	Population	2.8 million

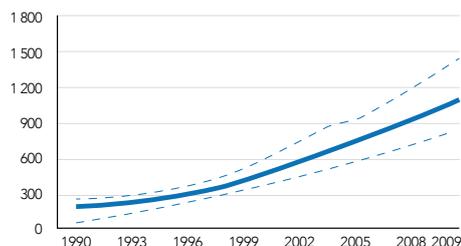
National Strategic plan on HIV and AIDS

Existence of a national strategic plan  Yes  No

2008 NSP DURATION 2011

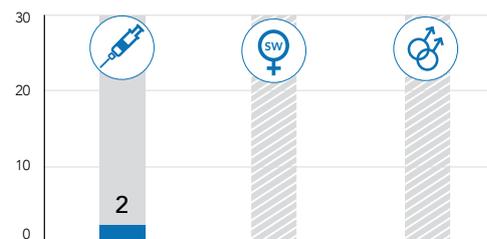
Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009



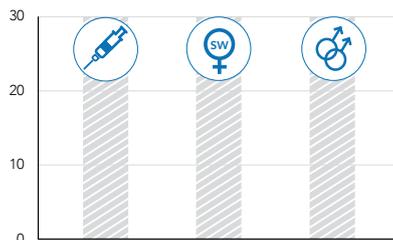
**1 100**  
ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2009 data)  
**<1 000 - 1 400**  
[LOW - HIGH ESTIMATE]

• HIV prevalence among Key Populations (%)

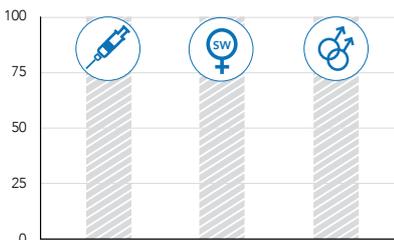


HIV Prevention Programmes

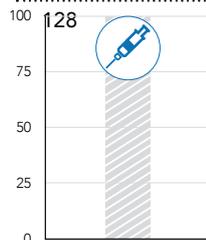
• Key Populations reached with HIV Prevention Programmes (%)



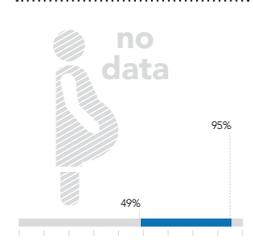
• Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



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



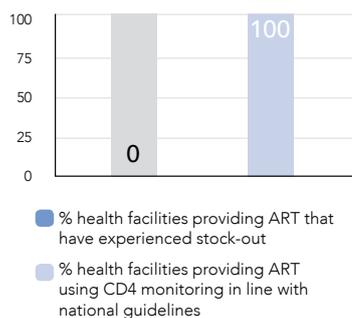
• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)



Health System Interventions

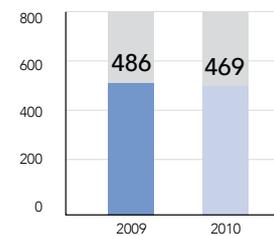
• Blood safety

**0%**  
**15**  
NUMBER OF HEALTH FACILITIES THAT OFFER ART



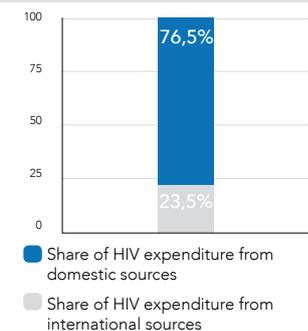
Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



**45%**  
ESTIMATED ART COVERAGE  
(2010 data)  
**35% - 56%**  
[LOW - HIGH ESTIMATE]

HIV expenditure



Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

Global Fund HIV Grants

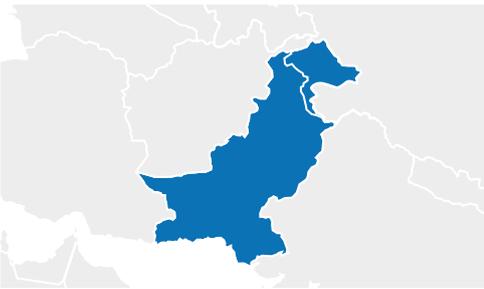
not eligible

Presence of associations of People living with HIV



**NO**

# PAKISTAN



## Country Overview

Human Development Index	medium	GDP (per capita)	1,010 US\$
Life expectancy	63 years	Population	184.8 million

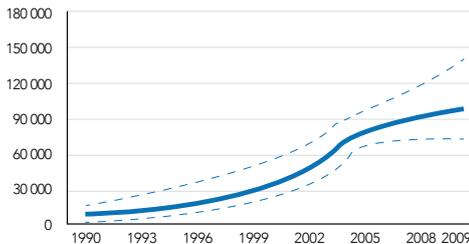
## National Strategic plan on HIV and AIDS

Existence of a national strategic plan  Yes  No

**2008** NSP DURATION **2013**

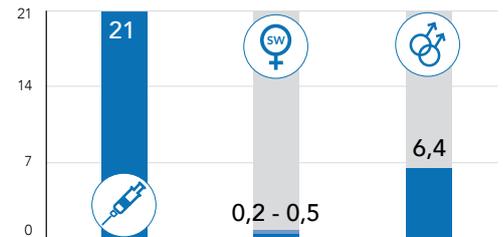
## Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009



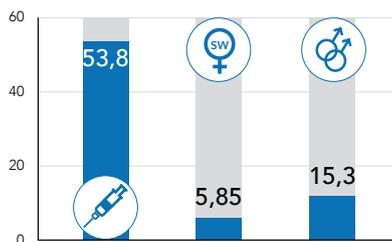
**98 000**  
ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2009 data)  
**79 000 - 120 000**  
[LOW - HIGH ESTIMATE]

• HIV prevalence among Key Populations (%)

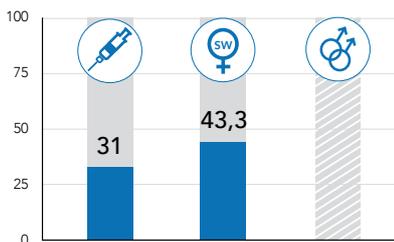


## HIV Prevention Programmes

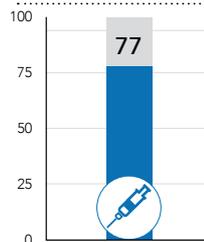
• Key Populations reached with HIV Prevention Programmes (%)



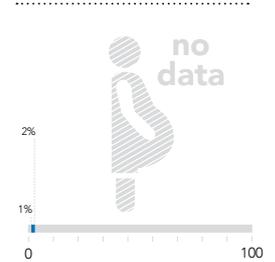
• Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



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



• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)



## Health System Interventions

• Blood safety

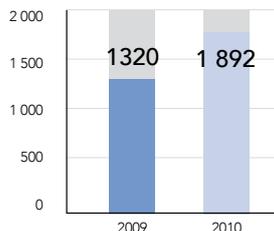
**87%**  
**1**  
NUMBER OF HEALTH FACILITIES THAT OFFER ART



• % health facilities providing ART that have experienced stock-out  
• % health facilities providing ART using CD4 monitoring in line with national guidelines

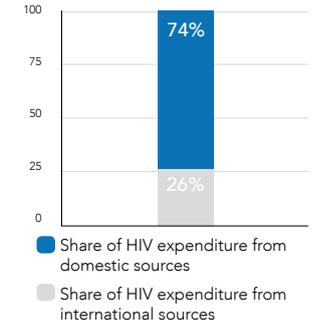
## Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



**9%**  
ESTIMATED ART COVERAGE  
(2010 data)  
**4% - 13%**  
[LOW - HIGH ESTIMATE]

## HIV expenditure



## Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

• Yes  
• No  
• No data

## Global Fund HIV Grants

Global Fund Grant for HIV/AIDS in progress  Yes  No

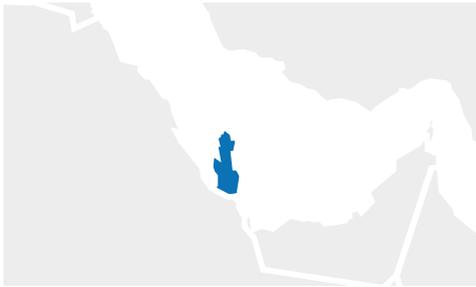
**18,1 M**  
GLOBAL FUND GRANT AMOUNTS (PLEGGED) IN US\$

## Presence of associations of People living with HIV

**YES**

Source of information:

Country Progress Report 2010, Universal Access Reports 2011, HIV surveillance, programme monitoring and bio-behavioural/behavioural surveys conducted in the country that may not necessarily be nationally representative



**Country Overview**

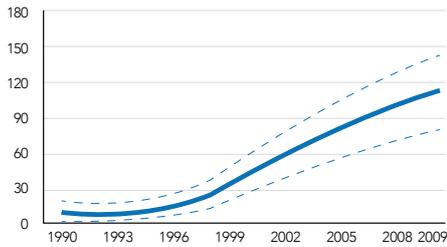
Human Development Index	very high	GDP (per capita)	89 thousands US\$
Life expectancy	76 years	Population	1.509

**National Strategic plan on HIV and AIDS**

Existence of a national strategic plan  Yes  No

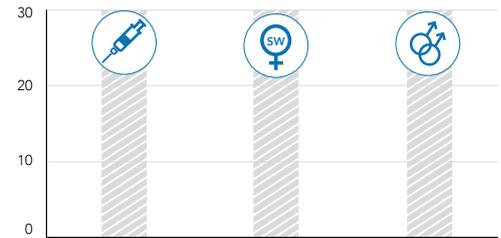
**Epidemiology Facts**

• Estimated number of people living with HIV 1990 - 2009



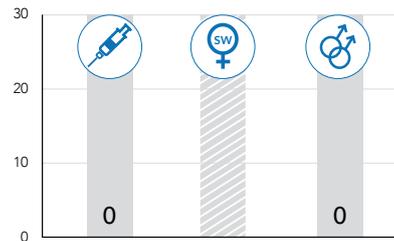
**<200**  
ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2009 data)  
**< 100 - < 200**  
[ LOW - HIGH ESTIMATE ]

• HIV prevalence among Key Populations (%)

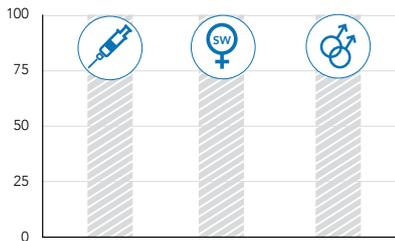


**HIV Prevention Programmes**

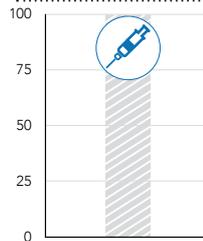
• Key Populations reached with HIV Prevention Programmes (%)



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



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

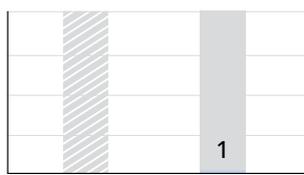


• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)



**Health System Interventions**

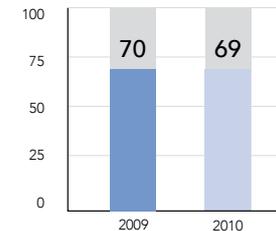
• Blood safety



■ % health facilities providing ART that have experienced stock-out  
■ % health facilities providing ART using CD4 monitoring in line with national guidelines

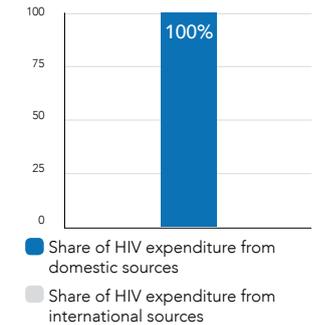
**Treatment Coverage**

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



**no data**  
ESTIMATED ART COVERAGE  
(2010 data)  
**no data**  
[ LOW - HIGH ESTIMATE ]

**HIV expenditure**



**Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups**

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

**Global Fund HIV Grants**

**not eligible**

**Presence of associations of People living with HIV**



**YES**

Source of information: Country Progress Report 2010, Universal Access Reports 2011, HIV surveillance, programme monitoring and bio-behavioural/behavioural surveys conducted in the country that may not necessarily be nationally representative

# SAUDI ARABIA



## Country Overview

Human Development Index	high	GDP (per capita)	18,6 thousands US\$
Life expectancy	72 years	Population	26.3 million

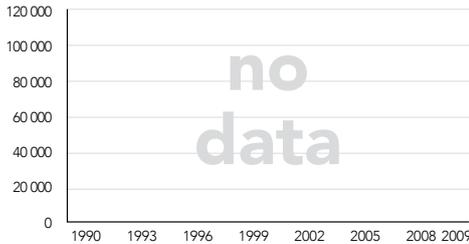
## National Strategic plan on HIV and AIDS

Existence of a national strategic plan  Yes  No

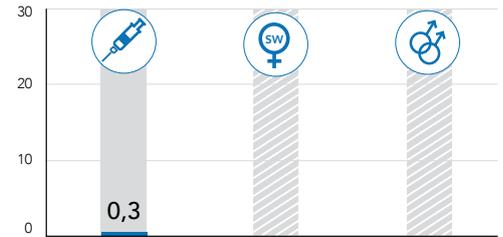
**2010** NSP DURATION **2015**

## Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009

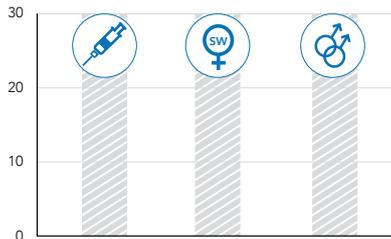


• HIV prevalence among Key Populations (%)

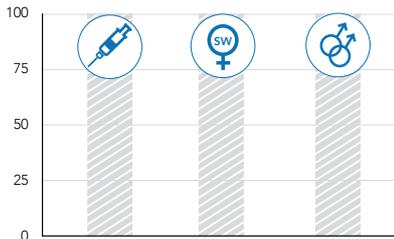


## HIV Prevention Programmes

• Key Populations reached with HIV Prevention Programmes (%)

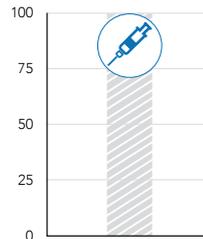


• Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



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

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



\* the indicator refers to the last time injecting

• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)

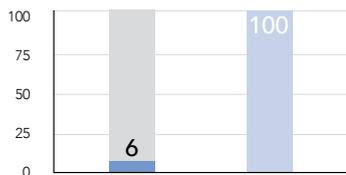


## Health System Interventions

• Blood safety



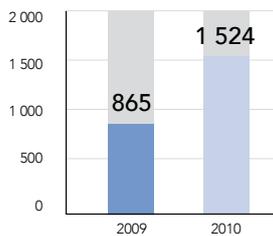
NUMBER OF HEALTH FACILITIES THAT OFFER ART



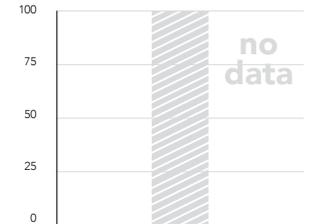
• % health facilities providing ART that have experienced stock-out  
• % health facilities providing ART using CD4 monitoring in line with national guidelines

## Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



## HIV expenditure



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

## Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

• Yes  
• No  
• No data

## Global Fund HIV Grants

not eligible

## Presence of associations of People living with HIV

**YES**

Source of information:

Country Progress Report 2010, Universal Access Reports 2011, HIV surveillance, programme monitoring and bio-behavioural/behavioural surveys conducted in the country that may not necessarily be nationally representative

# SOMALIA



## Country Overview

Human Development Index	no data	GDP (per capita)	298 US\$
Life expectancy	48 years	Population	9.3 million

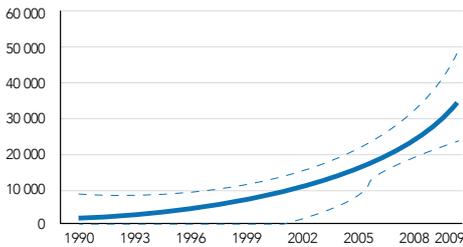
## National Strategic plan on HIV and AIDS

Existence of a national strategic plan  Yes  No

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

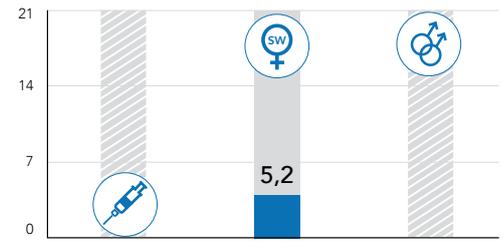
## Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009



**34 000**  
ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2009 data)  
**25 000 - 48 000**  
[LOW - HIGH ESTIMATE]

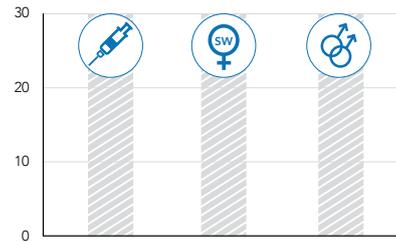
• HIV prevalence among Key Populations\* (%)



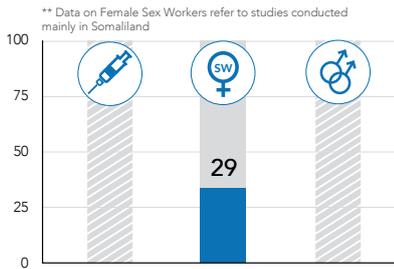
\* Data on Female Sex Workers refer to studies conducted mainly in Somaliland

## HIV Prevention Programmes

• Key Populations reached with HIV Prevention Programmes (%)

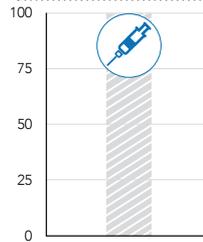


• Key Populations\*\* reporting the use of a condom during the last sexual intercourse\* (%)



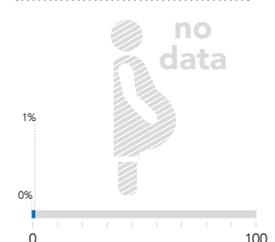
\*\* Data on Female Sex Workers refer to studies conducted mainly in Somaliland

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



\* the indicator refers to the last time injecting

• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)



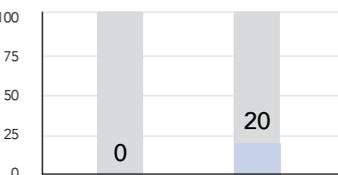
## Health System Interventions

• Blood safety

**0%**

**10**

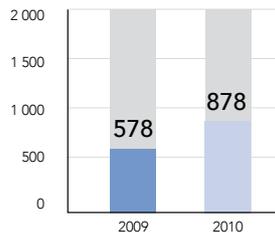
NUMBER OF HEALTH FACILITIES THAT OFFER ART



■ % health facilities providing ART that have experienced stock-out  
■ % health facilities providing ART using CD4 monitoring in line with national guidelines

## Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



**3%**  
ESTIMATED ART COVERAGE  
(2010 data)  
**3% - 5%**  
[LOW - HIGH ESTIMATE]

## HIV expenditure

**no data**

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

## Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

■ Yes  
■ No  
■ No data

## Global Fund HIV Grants

Global Fund Grant for HIV/AIDS in progress  Yes  No

**48,8 M**

GLOBAL FUND GRANT AMOUNTS (PLEGGED) IN US\$

## Presence of associations of People living with HIV



**YES**

Source of information: Country Progress Report 2010, Universal Access Reports 2011, HIV surveillance, programme monitoring and bio-behavioural/behavioural surveys conducted in the country that may not necessarily be nationally representative

# SUDAN\*



## Country Overview

Human Development Index	low	GDP (per capita)	1.699 US\$
Life expectancy	59	Population	42 million

## National Strategic plan on HIV and AIDS

Existence of a national strategic plan  Yes  No

**2010** NSP DURATION **2014**  
The data refers to North Sudan only

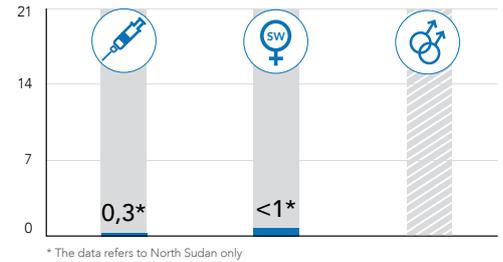
## Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009



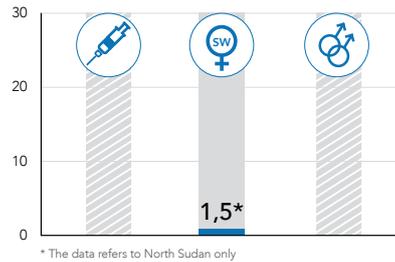
**260 000**  
ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2009 data)  
**210 000 - 330 000**  
[ LOW - HIGH ESTIMATE ]

• HIV prevalence among Key Populations (%)

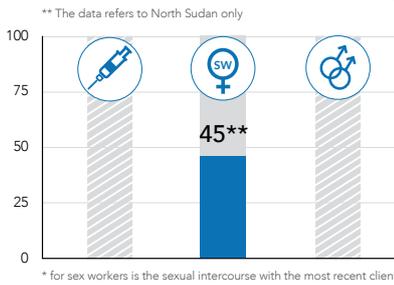


## HIV Prevention Programmes

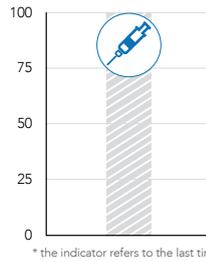
• Key Populations reached with HIV Prevention Programmes (%)



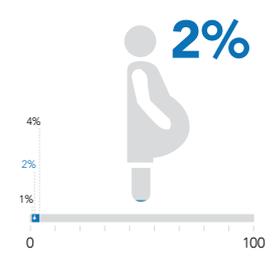
• Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



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



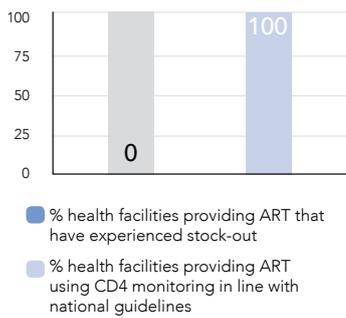
• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)



## Health System Interventions

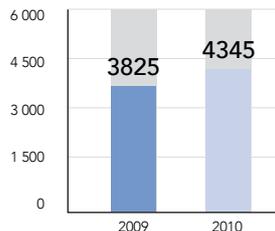
• Blood safety

0%  
**32**  
NUMBER OF HEALTH FACILITIES THAT OFFER ART



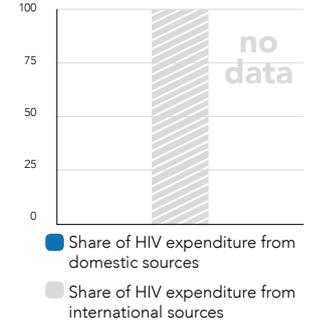
## Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



**5%**  
ESTIMATED ART COVERAGE  
(2010 data)  
**2% - 5%**  
[ LOW - HIGH ESTIMATE ]

## HIV expenditure



## Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

■ Yes  
■ No  
■ No data

## Global Fund HIV Grants

Global Fund Grant for HIV/AIDS in progress  Yes  No

**154,4 M**  
GLOBAL FUND GRANT AMOUNTS (PLEGGED) IN US\$

The data includes both the GF amounts of North and South Sudan, respectively 105,5 M, and 48,9 M

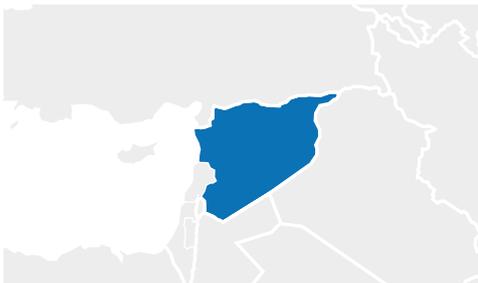
## Presence of associations of People living with HIV

**YES**

Source of information:

Country Progress Report 2010, Universal Access Reports 2011, HIV surveillance, programme monitoring and bio-behavioural/behavioural surveys conducted in the country that may not necessarily be nationally representative

\* data presented on this page applies to both Sudan and South Sudan and belongs to 2010 and before, when Republic of South Sudan was not yet established.



Country Overview

Human Development Index	medium	GDP (per capita)	2,572 US\$
Life expectancy	72 years	Population	22.5 million

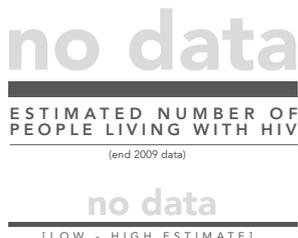
National Strategic plan on HIV and AIDS

Existence of a national strategic plan  Yes  No

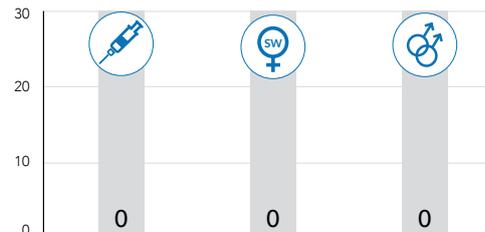
**2011** NSP DURATION **2015**  
The data refers to North Sudan only

Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009

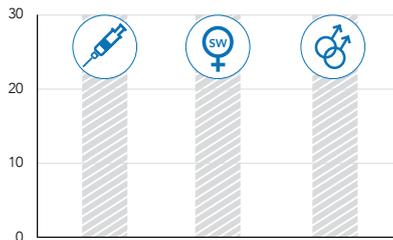


• HIV prevalence among Key Populations (%)



HIV Prevention Programmes

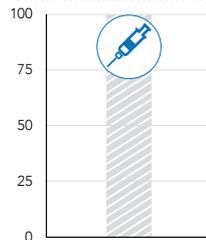
• Key Populations reached with HIV Prevention Programmes (%)



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



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



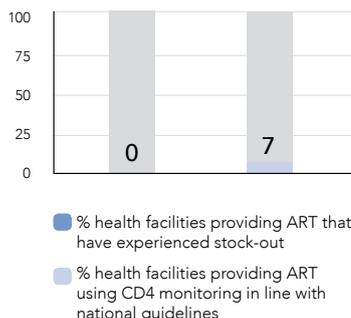
• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)



Health System Interventions

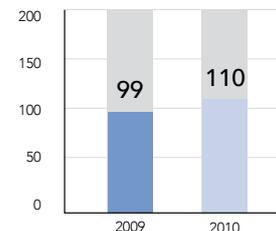
• Blood safety

**0%**  
**14**  
NUMBER OF HEALTH FACILITIES THAT OFFER ART

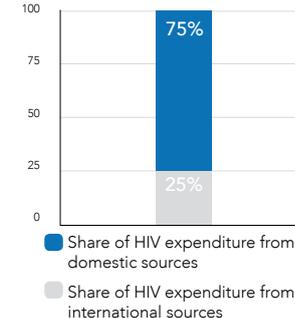


Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



HIV expenditure



Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

Global Fund HIV Grants

Global Fund Grant for HIV/AIDS in progress  Yes  No **0**  
GLOBAL FUND GRANT AMOUNTS (PLEGGED) IN US\$

Presence of associations of People living with HIV

**NO**

Source of information: Country Progress Report 2010, Universal Access Reports 2011, HIV surveillance, programme monitoring and bio-behavioural/behavioural surveys conducted in the country that may not necessarily be nationally representative

# TUNISIA



## Country Overview

Human Development Index	medium	GDP (per capita)	3,876 US\$
Life expectancy	75 years	Population	10,4 million

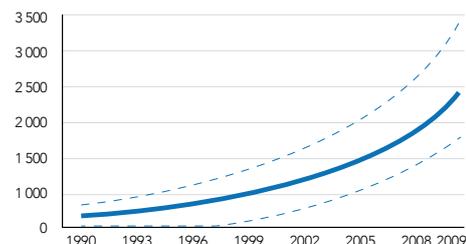
## National Strategic plan on HIV and AIDS

Existence of a national strategic plan  Yes  No

**2006** NSP DURATION **2010**

## Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009



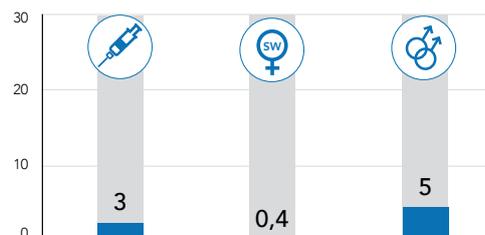
**2 400**

ESTIMATED NUMBER OF PEOPLE LIVING WITH HIV  
(end 2009 data)

**1 800 - 3 300**

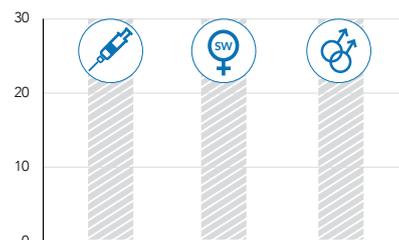
[LOW - HIGH ESTIMATE]

• HIV prevalence among Key Populations (%)

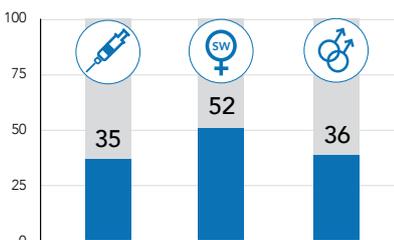


## HIV Prevention Programmes

• Key Populations reached with HIV Prevention Programmes (%)

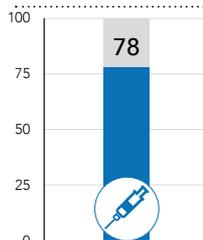


• Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



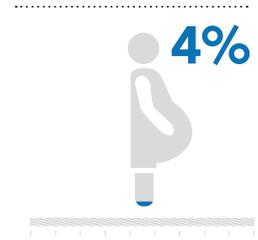
\* for sex workers is the sexual intercourse with the most recent client

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



\* the indicator refers to the last time injecting

• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)

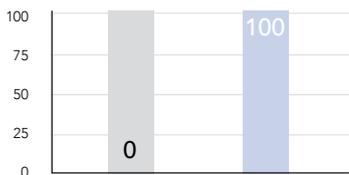


## Health System Interventions

• Blood safety

**100%**  
**4**

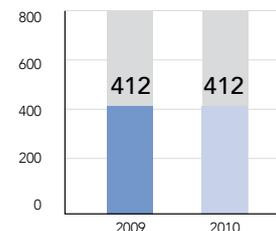
NUMBER OF HEALTH FACILITIES THAT OFFER ART



■ % health facilities providing ART that have experienced stock-out  
■ % health facilities providing ART using CD4 monitoring in line with national guidelines

## Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral

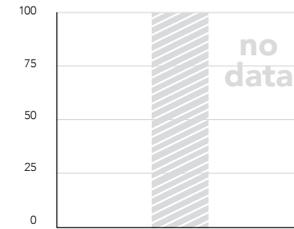


**10%**

ESTIMATED ART COVERAGE  
(2010 data)

**3% - 24%**  
[LOW - HIGH ESTIMATE]

## HIV expenditure



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

## Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

■ Yes  
■ No  
■ No data

## Global Fund HIV Grants

Global Fund Grant for HIV/AIDS in progress  Yes  No

**16,1 M**

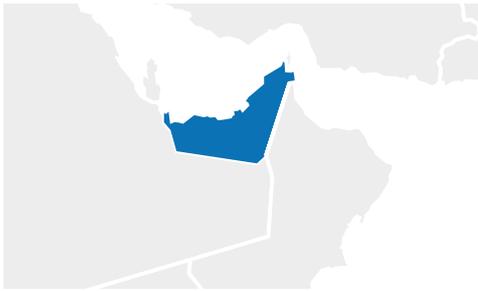
GLOBAL FUND GRANT AMOUNTS (PLEGGED) IN US\$

## Presence of associations of People living with HIV

**YES**

Source of information:

Country Progress Report 2010, Universal Access Reports 2011, HIV surveillance, programme monitoring and bio-behavioural/behavioural surveys conducted in the country that may not necessarily be nationally representative



Country Overview

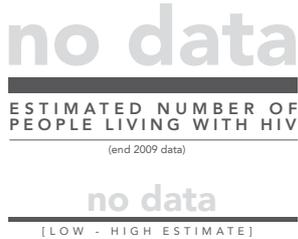
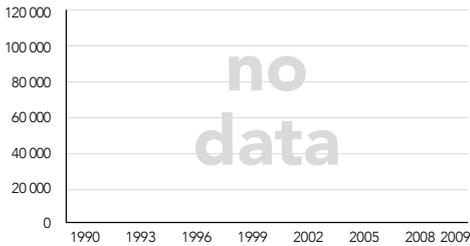
Human Development Index	very high	GDP (per capita)	64 thousands US\$
Life expectancy	78 years	Population	4.7 million

National Strategic plan on HIV and AIDS

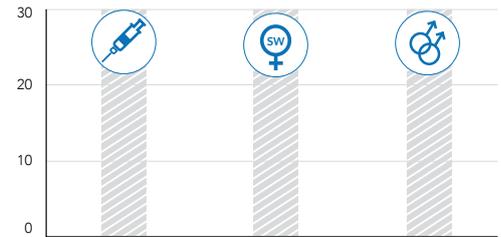
	Yes	No
Existence of a national strategic plan	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009

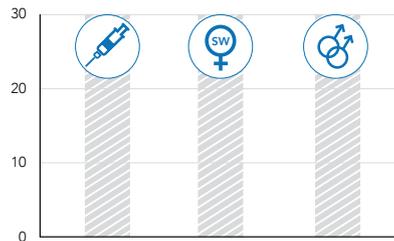


• HIV prevalence among Key Populations (%)

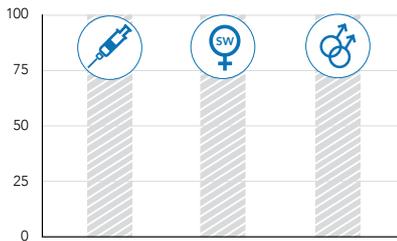


HIV Prevention Programmes

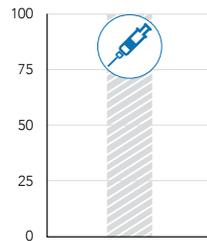
• Key Populations reached with HIV Prevention Programmes (%)



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



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

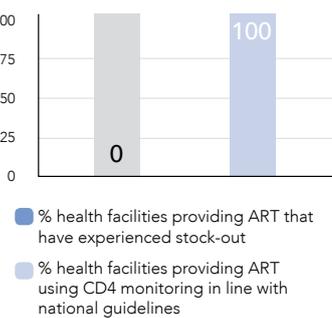


• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)



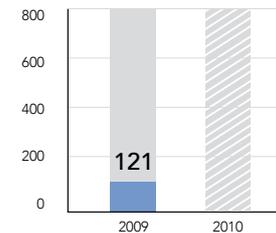
Health System Interventions

• Blood safety

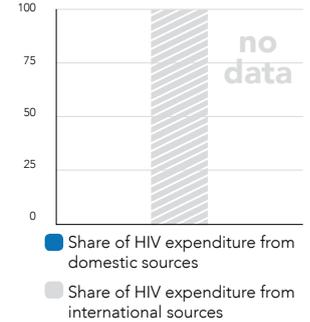


Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



HIV expenditure



Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

Global Fund HIV Grants

not eligible

Presence of associations of People living with HIV



NO

Source of information: Country Progress Report 2010, Universal Access Reports 2011, HIV surveillance, programme monitoring and bio-behavioural/behavioural surveys conducted in the country that may not necessarily be nationally representative

# YEMEN



## Country Overview

Human Development Index	medium	GDP (per capita)	1,356 US\$
Life expectancy	64 years	Population	24.3 million

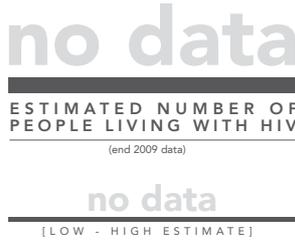
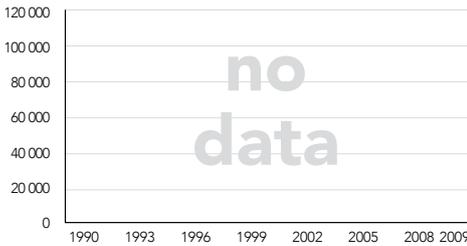
## National Strategic plan on HIV and AIDS

Existence of a national strategic plan  Yes  No

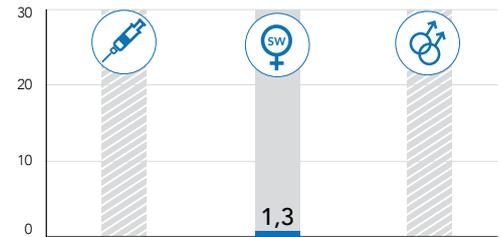
**2009** NSP DURATION **2015**

## Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009

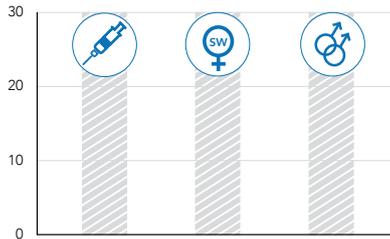


• HIV prevalence among Key Populations (%)

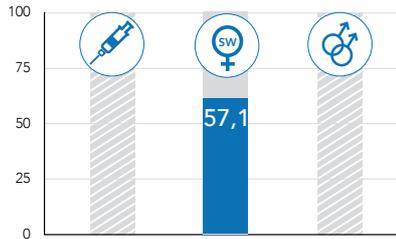


## HIV Prevention Programmes

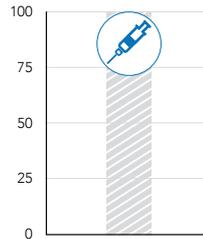
• Key Populations reached with HIV Prevention Programmes (%)



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



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

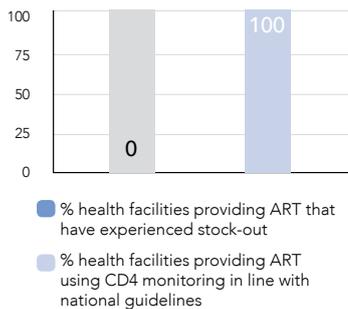


• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)



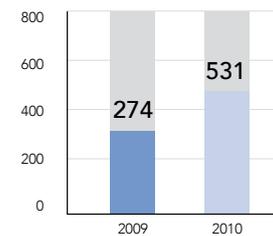
## Health System Interventions

• Blood safety

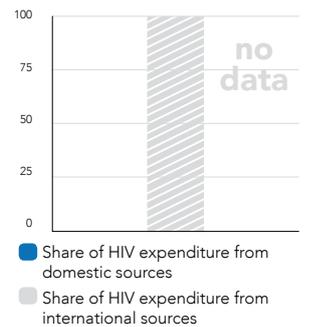


## Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



## HIV expenditure



## Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

Legend:  Yes,  No,  No data

## Global Fund HIV Grants

Global Fund Grant for HIV/AIDS in progress  Yes  No

**10,5 M**

GLOBAL FUND GRANT AMOUNTS (PLEGGED) IN US\$

## Presence of associations of People living with HIV



**YES**

# OCCUPIED PALESTINIAN TERRITORIES

## Country Overview

Human Development Index	no data	GDP (per capita)	no data
Life expectancy	72.5 years	Population	4.1 million

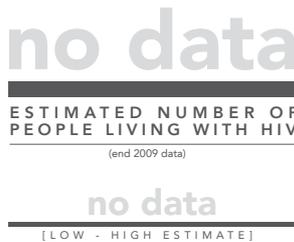
## National Strategic plan on HIV and AIDS

Existence of a national strategic plan  Yes  No

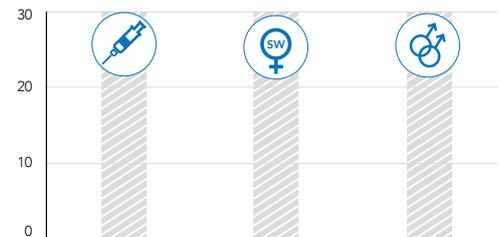
**2010** NSP DURATION **2015**

## Epidemiology Facts

• Estimated number of people living with HIV 1990 - 2009

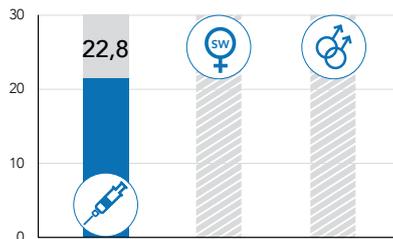


• HIV prevalence among Key Populations (%)

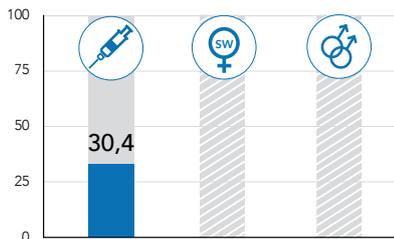


## HIV Prevention Programmes

• Key Populations reached with HIV Prevention Programmes (%)

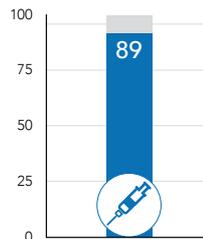


• Key Populations reporting the use of a condom during the last sexual intercourse\* (%)



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

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



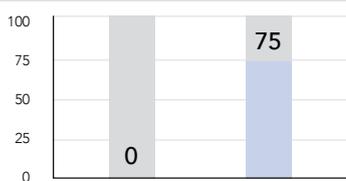
\* the indicator refers to the last time injecting

• HIV Positive pregnant women who receive ARV to prevent Mother-To-Child Transmission (%)



## Health System Interventions

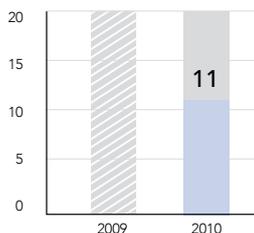
• Blood safety



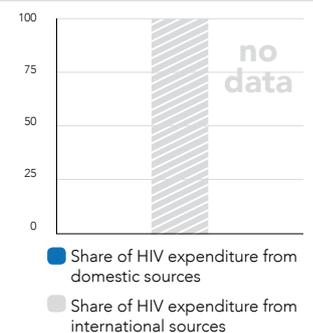
■ % health facilities providing ART that have experienced stock-out  
■ % health facilities providing ART using CD4 monitoring in line with national guidelines

## Treatment Coverage

• Reported number of adults and children with HIV infection who are currently receiving Antiretroviral



## HIV expenditure



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

## Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key population at higher risk and vulnerable groups

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

■ Yes  
■ No  
■ No data

## Global Fund HIV Grants

Global Fund Grant for HIV/AIDS in progress  Yes  No

**5 M**  
GLOBAL FUND GRANT AMOUNTS (PLEGGED) IN US\$

## Presence of associations of People living with HIV

**NO**

Source of information: Country Progress Report 2010, Universal Access Reports 2011, HIV surveillance, programme monitoring and bio-behavioural/behavioural surveys conducted in the country that may not necessarily be nationally representative

This document was developed with inputs from UNAIDS regional cosponsors



unicef



World Food Programme



UNITED NATIONS  
Office on Drugs and Crime



World Health Organization





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