

Middle East and North Africa

2025 DATA

78% increase in number of new HIV infections since 2010

9% decrease in number of AIDS-related deaths since 2010

People living with HIV: 240 000 [200 000–300 000]

New HIV infections: 22 000 [15 000–31 000]

AIDS-related deaths: 6600 [4400–9900]

Testing and treatment cascade (all ages):

People living with HIV who know their HIV status: 66% [47–86%]

People living with HIV who are on treatment: 53% [38–70%]

People living with HIV who have a suppressed viral load: 49% [40–61%]

Elimination of vertical transmission:

Treatment coverage for pregnant women living with HIV: 27% [21–36%]

Vertical transmission rate: 33% [31–36%]

Financing of the HIV response:

Resource availability for HIV: US$ 152 million (63% gap to meet 2030 annual target)

New HIV infections continue to rise

There is substantial variation in the country epidemics and responses in the Middle East and North Africa, and regional averages conceal very different situations. Djibouti, Egypt, Jordan, Lebanon, Morocco, Somalia, Sudan, the Syrian Arab Republic, Tunisia and Yemen account for about 71% of new HIV infections in the region. Sudan and Yemen together account for about 27% of all people living with HIV in the region, and face war and humanitarian crises, with very limited national funding. High-income Gulf countries are part of the region but represent only a small proportion of the HIV epidemic. These contexts require different responses, and regional aggregate indicators should be read with this in mind.

Numbers of new HIV infections in the region overall increased by 78% between 2010 and 2025, from 12 000 [8700–18 000] to 22 000 [15 000–31 000] annually (Figure 15.1), accounting for only 2% of new HIV infections in 2025 globally.[1] Most countries in the region continue to experience increases in numbers of new HIV infections to varying extents, from historically low baseline levels. The HIV response in the region remains far from reaching 2025 testing and treatment targets. The number of AIDS-related deaths is declining slowly, down by only 9% between 2010 and 2025.

Percentage changes in the number of new HIV infections between 2010 and 2025 varied widely across the region. Most countries recorded increases, but Djibouti, Morocco and Somalia were among the few to report declines. In absolute numbers, Algeria, Egypt and Sudan account for most of the regional increase.

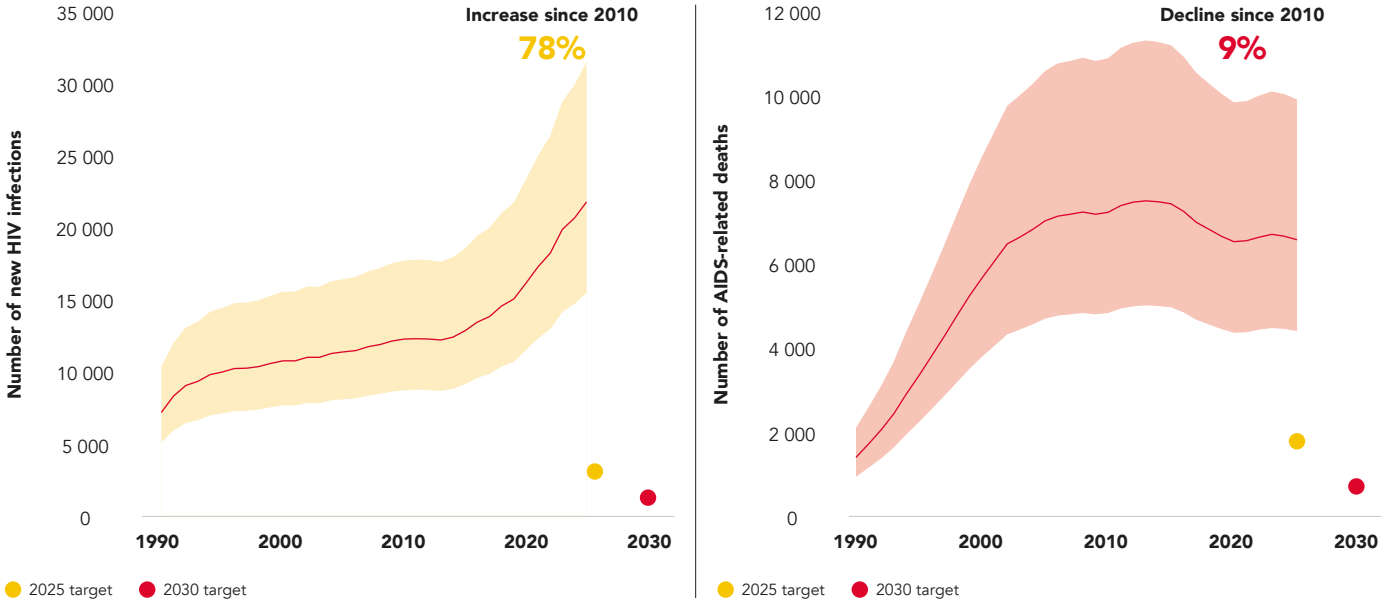
Discriminated and criminalized populations are disproportionately affected by the HIV epidemic. HIV prevalence is highest among people from key populations (Figure 15.2), and 84% of HIV acquisitions in the region occurred among people from key populations and their partners in 2024 (data will next be updated in 2027).[2] For effective strategy, programme planning and impact evaluation, periodic surveys of HIV prevalence among key populations are essential but available from only a few countries and for selected populations.

1 Based on the latest surveillance and programme data and accordingly updated Spectrum national epidemic trend estimates, which replace past Spectrum-based trend estimates (for all years, current and past). Country-level, burden and trend estimates, which together make up these regional totals, are relatively uncertain in the Middle East, due to challenges associated with incomplete and varying programme access and coverage and surveillance among temporary residents, immigrant workers and non-national populations.

2 UNAIDS estimates 2025.

New HIV infections continue to rise across most of the region

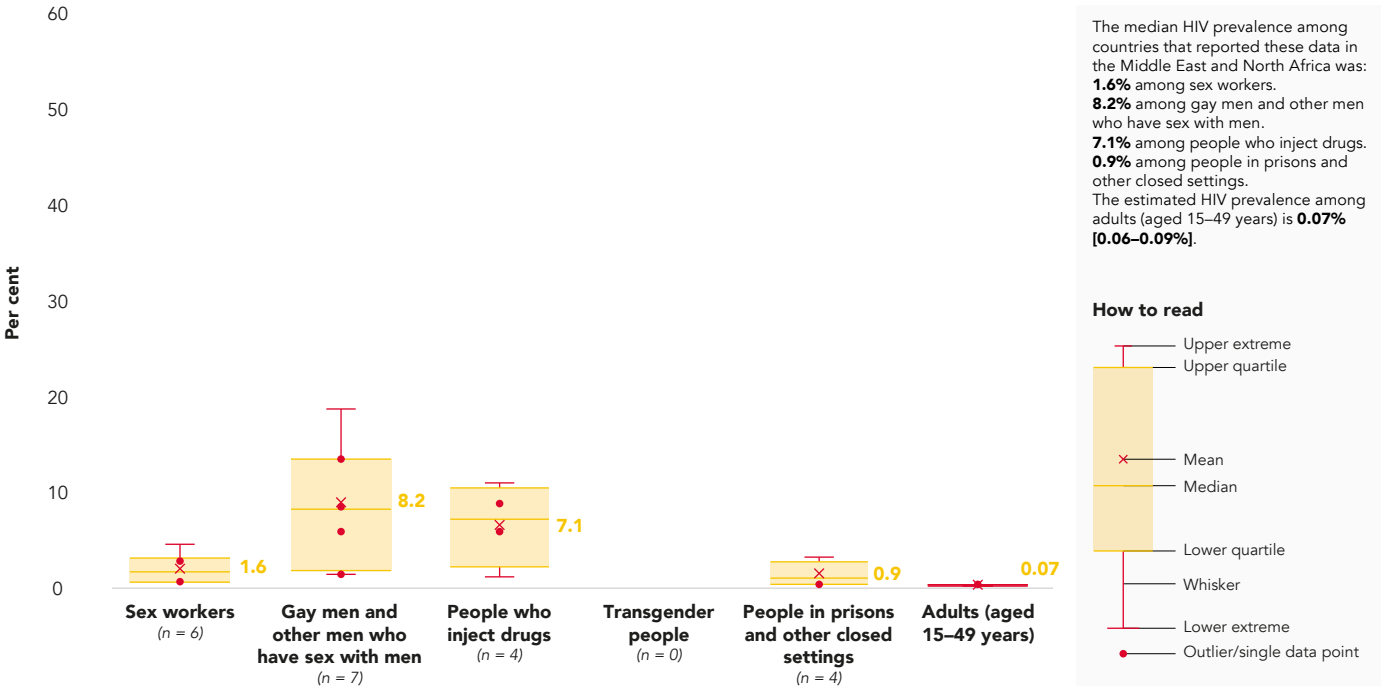
Figure 15.1. Numbers of new HIV infections and AIDS-related deaths, Middle East and North Africa, 1990–2025, 2025 and 2030 targets



Source: UNAIDS epidemiological estimates 2026 (https://aidsinfo.unaids.org/).

Despite low overall HIV prevalence, the epidemic remains concentrated among key populations

Figure 15.2. HIV prevalence among people from key populations compared with adults in the general population (aged 15–49 years), reporting countries in the Middle East and North Africa, 2021–2025



Source: Global AIDS Monitoring 2022–2026 (https://aidsinfo.unaids.org/); UNAIDS epidemiological estimates 2026 (https://aidsinfo.unaids.org/).
Note: n = number of countries. Total number of reporting countries = 19. Data presented are from fewer than five reporting countries: people who inject drugs (Algeria, Egypt, Morocco, Tunisia) and people in prisons and other closed settings (Bahrain, Morocco, Oman, United Arab Emirates). The adult prevalence uncertainty bounds define the range within which the true value lies (if it can be measured). Narrow bounds indicate that countries reported similar prevalence, while wide bounds indicate greater disparity in the reported prevalence.

Although based on limited data, the apparent epidemic patterns underscore the need for scaled-up HIV interventions for people from key populations and young people and to reduce the societal and structural barriers that limit their access to needed services. Given the region's low overall HIV prevalence, numbers of new infections could be reduced rapidly and a rise in prevalence prevented if countries implement appropriate and effective measures that address the needs of the populations at greatest risk of HIV.[3]

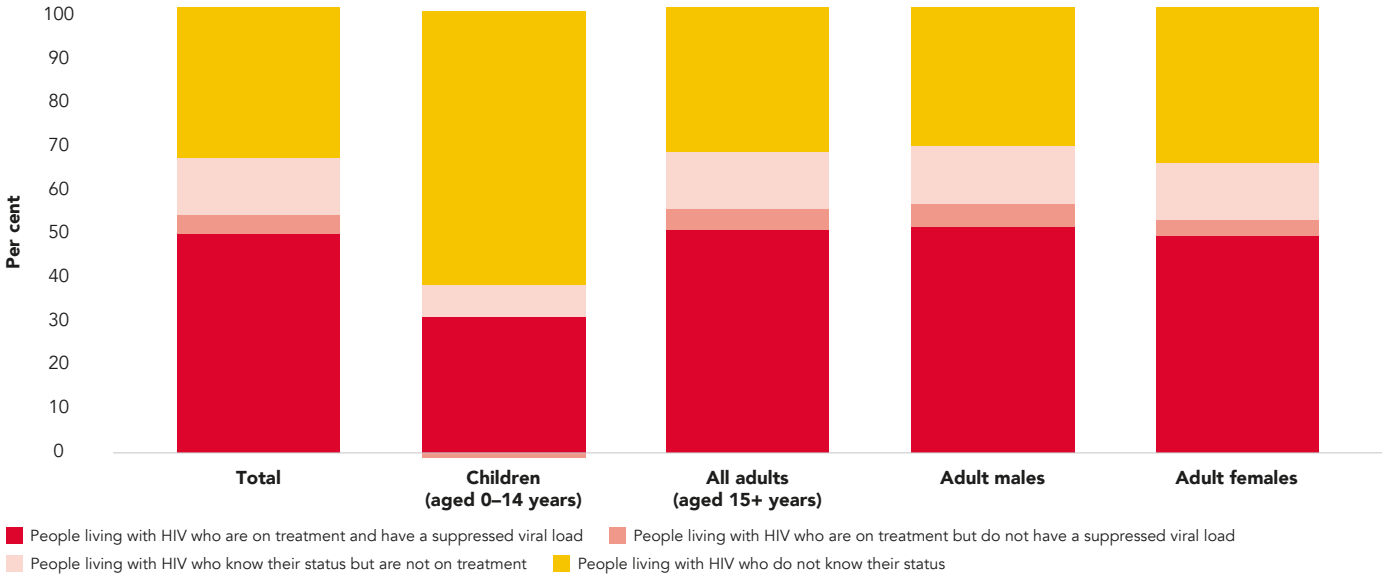
Service coverage remains a major gap

Treatment coverage is the region's major gap: only 53% [38–70%] of people living with HIV in the region are on antiretroviral therapy, well below the global average of 78% [59–94%]. Coverage is markedly lower among children, at only 30% [21–39%]. Saudi Arabia is the only country in the region on track to meet all three 95–95–95 targets (Figure 15.3).

An estimated 27% [21–36%] of pregnant women living with HIV in the region received antiretroviral medicines for prevention of vertical transmission in 2025, driving a vertical transmission rate of 33% [31–36%], more than double that in any other region. Integration of routine HIV testing during antenatal care visits is recommended to reduce the number of new child infections. To improve paediatric antiretroviral therapy coverage, infants born to women living with HIV need follow-up, including HIV testing until the end of breastfeeding. Community outreach and targeted index testing approaches may be considered to diagnose children who were not diagnosed earlier.

The HIV response remains a long way from achieving the coverage targets for HIV by 2025 in the Middle East and North Africa

Figure 15.3. HIV testing and treatment cascade, by age and sex, Middle East and North Africa, 2025



Source: UNAIDS epidemiological estimates 2026 (https://aidsinfo.unaids.org/).

3 Mumtaz G, Chemaitelly H, AlMukdad S, Osman A, Fahme S, Rizk NA, et al. Status of the HIV epidemic in key populations in the Middle East and North Africa: knowns and unknowns. Lancet HIV. 2022;9:e506–e516 (https://doi.org/10.1016/S2352-3018(22)00093-5).

Reporting on the uptake of pre-exposure prophylaxis (PrEP) remains minimal across the region and is therefore difficult to assess because few countries report, and where data exist, coverage is low or uneven. Of 16 countries in the region that reported on PrEP, only Lebanon reported that 374 people received PrEP in 2025, although Morocco has implemented PrEP for several years. Rollout of new technologies such as lenacapavir and long-acting formulations should be facilitated by national registration and affordable access.

Harm reduction programmes are implemented unevenly. Egypt, Lebanon and Morocco offer needle–syringe programmes and opioid agonist maintenance therapy, but Jordan and Tunisia have more limited services. Peer education and naloxone distribution are mostly absent. Limited data are available on HIV prevention among people in prisons and other closed settings, although Morocco and Tunisia implement harm reduction programmes.[4] Services for gay men and other men who have sex with men and sex workers are not available in all areas. Transgender people remain particularly underserved. In sum, major gaps in programme data and service coverage for key populations continue to limit the ability to assess access and guide prevention programming.

HIV knowledge among adolescents in some countries in the region is alarmingly low. In Jordan, 9.3% of young women and 21.5% of men have correct comprehensive knowledge of HIV transmission and prevention;[5] in Tunisia, these figures are 12.4% of young women and 12% of young men.[6] Morocco and Tunisia have formally introduced comprehensive sexuality education in schools, but access to this type of education remains limited in other countries and more action is needed. The specific needs of adolescent girls and of women living with HIV, including sexual and reproductive health services and gender-responsive, stigma-free care, also require attention (see below).

Closing these gaps will require legal reform and stronger, disaggregated HIV data systems for key populations prioritized under the 2026–2031 Global AIDS Strategy, including the removal of punitive laws and policies that restrict access to services.[7] Scale-up of access to services such as self-testing and community-based confidential HIV testing and counselling would be an important step. Opportunities and new technologies such as self-testing, long-acting antiretroviral medicines and PrEP formulations, and community- and nongovernmental organization-led interventions should be considered in the region, and continued funding should be secured and expanded as a basis for a sustained response.

4 Brighton: Frontline AIDS; 2025 (https://frontlineaids.org/wp-content/uploads/2025/03/MENA-HIV-report_ENGLISH_Singles_FINAL.pdf).

5 Department of Statistics Jordan, ICF. Jordan population and family and health survey 2023. Amman, Jordan and Rockville, MD: Department of Statistics and ICF; 2024 (https://dhsprogram.com/pubs/pdf/FR388/FR388.pdf).

6 Rapport des resultats de l'enquete par grappes a indicateurs multiples (MICS) Tunisie 2023 [in French]. New York: United Nations Children's Fund; 2023 (https://mics.unicef.org/sites/mics/files/2025-05/Tunisia%202023%20MICS_French.pdf).

7 The global AIDS strategy for 2026–2031: united towards ending AIDS. Geneva: Joint United Nations Programme on HIV/AIDS; 2026 (https://www.unaids.org/en/resources/documents/2026/2026%E2%80%932031_Global-AIDS-Strategy).

Legal and societal barriers continue to limit access to HIV services and delay progress towards the 10–10–10 targets

Many countries in the region retain punitive and criminalizing laws related to HIV and key populations. Progress towards reaching the 10–10–10 societal enablers targets[8] remains slow. Only three countries do not criminalize HIV nondisclosure, exposure or transmission and have not used general criminal laws to prosecute cases in the past 10 years. Six countries have laws criminalizing transgender people; 18 countries have laws criminalizing some aspect of sex work; 16 countries have laws criminalizing same-sex sexual acts, including the death penalty in six countries; and 17 countries have laws criminalizing possession of small amounts of drugs.

Stigma and discrimination marginalize people from key populations and deter them from seeking HIV-related health services. Strong social taboos, punitive laws and affordability barriers restrict access to HIV-related health services. Out-of-pocket health spending in the region is among the highest in the world.3 Community-led monitoring through quantitative and qualitative research with 641 women from key populations in Lebanon, Mauritania, Morocco and Tunisia highlighted the discrimination and intersecting forms of exclusion that hinder access to health care.[9] In a study involving 4246 people from key populations in these four countries,[10] 74% of people who inject drugs, 71% of sex workers and 59% of transgender respondents reported experiencing discrimination, and 50% of sex workers reported being refused care. The proportion reporting refusal of care rose from 12% among respondents with no vulnerability factor (key population or migrant status), to 26% among respondents with one vulnerability factor, and 48% among respondents with two or more vulnerability factors.

Community-led organizations of people living with, affected by or at risk of HIV play a critical role in advocacy, delivery, monitoring and ensuring sustainability of services. Community-led monitoring9 in Lebanon, Mauritania, Morocco and Tunisia indicates that 78–91% of respondents in each key population group and among migrants reported having received counselling or support from a community worker or association. Civic space restrictions remain a significant concern. Although limitations on civil society organizations vary, a number of countries impose restrictions on foreign funding for nongovernmental organizations (Figure 15.4). These regulations often result in lengthy bureaucratic processes, causing significant delays in funding or restricting the use of funds. Lack of country reporting on these important areas also limits the data available.

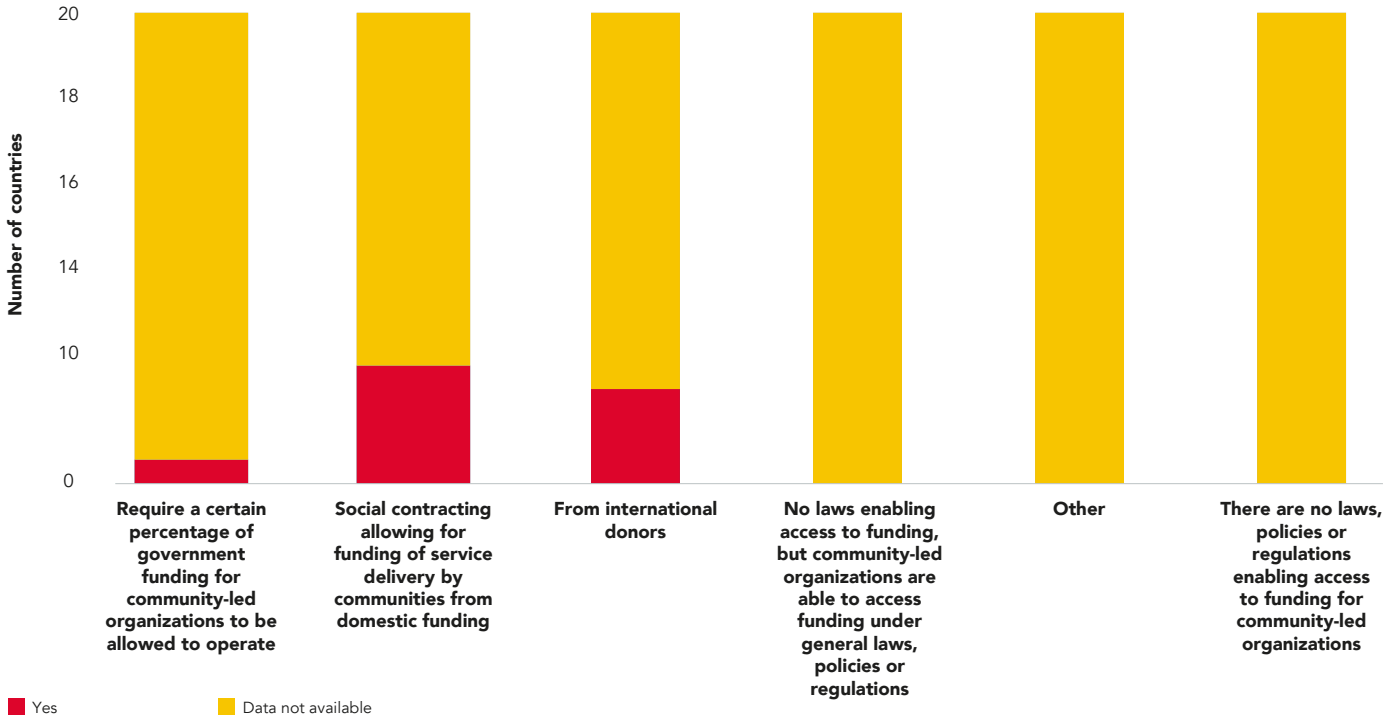
Community observatories that document barriers to health-care access and turn communities' lived experiences into evidence for advocacy and dialogue with decision-makers have been developed across five countries in the region. Data collected through community-led monitoring of

8 The 10–10–10 targets include that by 2030, less than 10% of people living with, at risk of or affected by HIV experience stigma and discrimination; less than 10% of women, girls, people living with, at risk of or affected by HIV experience gender inequality and violence; and, less than 10% of countries have restrictive legal and policy frameworks that lead to the denial or limitation of access to services.

9 Women's access to healthcare in the MENA region: barriers, discrimination and intersectional exclusion (Lebanon, Morocco, Tunisia, Mauritania). Morocco: International Treatment Preparedness Coalition—Middle East and North Africa Region; 2025 (https://itpcmena.org/en/bibliotheque/res-010-acces-a-la-sante-des-femmes-dans-la-region-mena-barrieres-discriminations).

10 Data from FORSS Observatory, to be published December 2026 (https://www.forss-program.com/).

Figure 15.4. Policies and regulations governing access to funding for community-led organizations



Source: People Living with HIV Stigma Index 2.0 studies, 2021–2024.
Note: Experiences of stigma and discrimination in healthcare settings are measured as having experienced at least one of the following because of HIV status in the previous 12 months: denial of care, advised not to have sex, being the subject of gossip or negative talk, verbal abuse, physical abuse, avoidance of physical contact, and sharing of HIV status without consent.

service delivery were shared with national institutions and have already impacted policy and programmatic changes, including strengthening of referral systems (Lebanon), improved confidentiality of services (Tunisia), certification of health centres and training on stigma and discrimination in health-care facilities (Morocco), and introduction of free HIV testing in key sites (Mauritania). Data collected through community observatories are integrated into national data collection to improve access to services and accountability.9 Community observatories offer a model that can be scaled up to other countries and integrated into national monitoring systems with sustainable funding.

Domestic investment is rising, but a substantial funding gap continues to threaten the HIV response

HIV resources available for the response in the region increased to US$ 152 million in 2025, driven by a 44% increase in domestic financing, including in Algeria and Egypt. At the same time, domestic resources accounted for 91% of total HIV financing in 2025, up from 80% in 2024. Meanwhile, international financing declined by about −40%, reflecting decreases in Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) support and the absence of United States Government funding, which contributed US$ 5 million in 2024. Funding from other international sources remained stable. Despite these gains, available resources met only 37% of estimated total HIV resource needs in 2025, leaving a 63% funding gap (Figure 15.5).

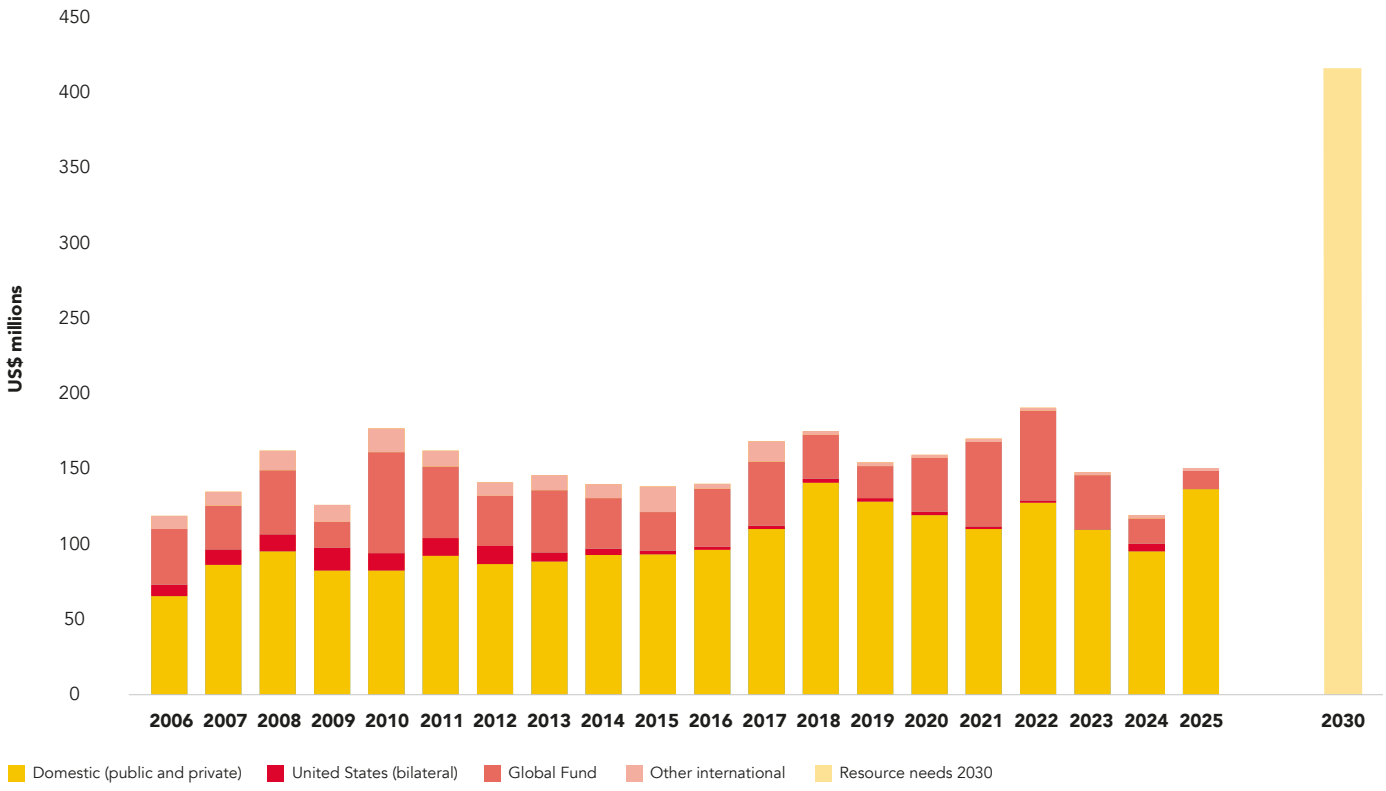
Sustainability planning will be critical in this context to avoid the risks of disruptions to the supply of antiretroviral medicines and HIV tests, rising ARV purchase prices outside of pooled procurement schemes, and the loss of harm reduction and community-based services currently funded from external sources. Restrictions on foreign funding for community-led organizations and civil society exacerbate these risks. Costed and inclusive transition plans are needed and should be developed in consultation with communities to secure a safe transition of HIV programmes.

Increased domestic funding, sustainability planning and commitment to the HIV response will be essential, with engagement of the affected communities. Available data do not show what proportion of these domestic resources reaches key population programmes and community-led organizations, and mechanisms to fund community-led services, such as social contracting, are needed urgently to secure sustainability of these services into the future.

There is growing recognition of the need to integrate HIV services within broader health frameworks, particularly under universal health coverage. Jordan and Morocco have national strategic plans that cover other disease areas, such as hepatitis C or other sexually transmitted infections. In Lebanon, the National AIDS Programme has merged with the tuberculosis programme to improve coordination. Overall integration remains fragmented, and HIV continues to be deprioritized in many countries in the region.[11]

Resource availability remains well below the needs in the region

Figure 15.5. Resource availability by funding source (2006 -2025), and 2030 needs, Middle East and North Africa region



11 HIV prevention and accountability, a multi-country community perspective. Amsterdam: Frontline AIDS; 2025 (MENA-HIV-report_ENGLISH_Singles_FINAL.pdf).

The HIV response in the region is affected by extensive sociopolitical, economic and humanitarian crises. In Sudan, 21 million people are assessed as needing humanitarian health assistance,5 but 70% of health facilities are not operating in hard-to-reach areas.2 Financial support from the Global Fund enabled the replenishment of antiretroviral medicine stocks through new storage hubs outside Khartoum, helping an estimated 96% of people living with HIV who were on treatment before the conflict to remain on antiretroviral medicine eight months into the war.[12, 13]

Improved, disaggregated HIV-related surveillance and programme monitoring, with ensured confidentiality, will be instrumental to boosting and optimizing the region's HIV response.[14]

Ending AIDS as a public health threat in the region will require stronger political commitment, increased funding—including support for community-led and other civil society organizations that serve the needs of people living with, at risk of or affected by HIV—and lifting of legal and social barriers.

12 Sudan's unsung heroes: protecting people living with and affected by HIV amidst conflict and famine. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (https://www.unaids.org/en/resources/presscentre/featurestories/2024/april/20240415_sudan).

13 Sudan: delivering vital health services despite conflict and displacement. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria; 2025 (https://www.theglobalfund.org/en/stories/2025/2025-04-02-sudan-delivering-vital-health-services-conflict-displacement/).

14 Karbasi A, Fordjuoh J, Abbas M, Iloegbu C, Patena J, Adenikinju D, et al. An evolving HIV epidemic in the Middle East and North Africa (MENA) region: a scoping review. Int J Environ Res Public Health. 2023;20(5):3844 (https://doi.org/10.3390/ijerph20053844).