

Responses and Challenges

Most countries in the MENA region began recording cases of AIDS during the latter half of the 1980s and soon thereafter developed national AIDS committees or programs. But, as in so many other regions, the HIV/AIDS epidemic was not viewed as an urgent issue and national responses languished without much accomplishment for years. Few multilateral or bilateral partners provided any financial aid. To date, 14 out of 19 countries in the region have UN Theme Groups devoted to HIV/AIDS.¹ Between 2000 and 2003, however, several countries began to develop real efforts toward prevention, with the Islamic Republic of Iran and Morocco having the most advanced programs.

National Responses

Currently, the range of responses to the HIV/AIDS threat in the region is wide, but no country has implemented an integrated, multisectoral, national program. Heads of State in Djibouti, Libya, the Islamic Republic of Iran, and most recently Algeria have publicly acknowledged the HIV/AIDS problems in their countries. To date, the Islamic Republic of Iran, Lebanon, and Morocco are implementing some programs for at-risk groups, while Algeria and Djibouti are just beginning. Algeria, Egypt, the Islamic Republic of Iran, Lebanon, Morocco, and the Republic of Yemen have developed or are currently developing National Strategic Plans (NSPs), starting with situational assessments and moving to multisectoral strategy development, prioritization, and costing. Bahrain, Jordan, Libya, Oman, Syria, and Tunisia have expressed an interest in doing the same. When NSPs have been developed, technical expertise has not always been adequate and so plans tend to be generic and could be improved in quality and relevance. Table 2.1 provides a snapshot of the different national responses to the epidemic, while Annex 4 provides more details.

TABLE 2.1

National Response to HIV/AIDS Epidemic

Country	National Strategic Plan (NSP)	Status	Next Steps
Algeria	NSP against HIV/AIDS and STIs 2002–06	Operational plans of 10 sectors and 3 NGOs for 2003–06 developed. \$6.18 million in support on NSP implementation (GFATM ^a).	Ensuring multisectoral coordination. Implementation of the operational plans.
Djibouti	Multisectoral National Strategic Framework on HIV/AIDS 2003–07	11 sectoral plans developed and costed. \$12 million in support of NSP implementation (the World Bank and other partners).	Implementation of the NSP across sectors, including elaboration of operational plans.
Egypt, Arab Rep. of	Assessment of the HIV/AIDS Situation and Response in the Arab Republic of Egypt, 2003	Situation Assessment being validated with national partners.	Development of the NSP.
Iran, Islamic Rep. of	Draft NSP on Prevention and Control of HIV/AIDS 2002–06	Validation at the national level, \$9.69 million in support of NSP implementation, including capacity building of NGOs (GFATM ^a).	Development of operational plans of priority sectors, including costing. Implementation of the NSP.
Lebanon	AIDS NSP in Lebanon for 2004–09	NSP has been finalized and is being widely disseminated to diverse partners. Operation plans are being elaborated.	Validation of the operational plans. Initiation of implementation of the NSP and mobilization of resources.
Morocco	NSP 2002–04	Implementation of the NSP initiated through GFATM resources. \$4.74 million in support of NSP implementation (GFATM ^a).	Development of the NSP from 2005 onwards and operational sectoral plans, including costing. Scaling up implementation and mobilization of resources.
Yemen, Republic of	National Strategic Framework (NSF) on HIV/AIDS (until 2005)	NSF to be updated.	NSF to be updated.

Source: UNAIDS 2003.

a. GFATM resources are indicated for two-year approved funding.

TABLE 2.2

Countries Approved for GFATM Funding for HIV/AIDS Activities (U.S. Dollars)

Country	Grant Amount	Amount Disbursed	Status
Algeria	\$6,185,000	\$0	Grant Agreement Signed
Djibouti	7,271,400	0	Board Approved
Iran, Islamic Rep. of (in two grants)	15,396,000	0	Not Yet Signed
Jordan	1,778,600	983,231	Disbursing
Morocco	4,738,806	3,821,919	Disbursing
Yemen, Republic of	5,500,405	0	Board Approved
TOTAL	40,870,211	4,805,150	

Source: GFATM Web site, accessed October 2004.

While overall, national financial investments on HIV/AIDS have been insufficient in the region, some governments have made serious financial commitments to tackle HIV/AIDS. Recently it has been reported that Libya will allocate \$2 million to the HIV/AIDS response in the country, including prevention and care in prisons and treatment centers for IDUs, but the United Nations Office on Drugs and Crime (UNODC) reports that the Libyan program is in great need of technical input. Six countries (Algeria, Djibouti, the Islamic Republic of Iran, Jordan, Morocco, and the Republic of Yemen) have been approved to receive grants for addressing HIV/AIDS from GFATM in the first three funding rounds (see Table 2.2 for details). Of the six MENA countries approved for funding, only two (Jordan and Morocco) have actually received funds so far. Several countries have begun to seek help in building capacity to carry out research, interventions, and monitoring and evaluation (M&E) with the funding they will receive from the GFATM.

As in other countries in the world, over-reliance on medical doctors characterizes the response in several MENA countries. Until the more recent activation of interest among UN cosponsors, only health departments were involved with HIV/AIDS, with support from WHO/Eastern Mediterranean Regional Office (EMRO). Now, however, UN Theme Group chairs are rotated from among all the UN agencies and are not solely from WHO. While this sets the scene for the consideration of a wider multisectoral response, numerous medical issues remain unresolved and need to be addressed in many of the MENA countries. It has been pointed out that, while the medical establishment is pleased to have ART with which to treat HIV disease, there are very few doctors and other health workers who understand how to use ART. Health services in most of the region's countries are not yet prepared to manage the opportunistic infections among many HIV patients. In the poorer countries of

the region, health services are generally weak and inadequate and require considerable input in the areas of injection safety, monitoring and screening of blood donations and transfusions, universal precautions, confidentiality, counseling training, and a nondiscriminatory attitude toward HIV/AIDS patients.

Integrating Prevention with Treatment at the National Level

More recently, a number of countries have taken the initiative of offering ART free of charge, despite the cost. In Algeria, the government has made the drugs available free of charge to eligible patients since 1998. By the end of 2003, 100 individuals were under treatment at a cost of \$10,000–\$15,000 per year for triple therapy, as lower prices have not been negotiated thus far. Similarly, the Lebanese Ministry of Health (MoH) has provided ART free of charge to citizens since 1998 and highly active antiretroviral therapy (HAART) has been available in the private market since 1997. In 2002, 144 individuals were receiving ART at an approximate cost of \$1,000/person/month. In Morocco, the government has provided ART to all eligible Moroccan citizens since 1999. By the end of 2003, there were 523 individuals under treatment at a cost of \$100/person/month, because prices were negotiated through the UNAIDS/WHO Initiative in 2001. In the richer countries, ART is available to citizens for free. The Saudi Arabian health department recently announced plans to build three AIDS-specific research and treatment facilities (United Press International 2004).

Yet, despite the investment in ART by some countries, prevention among high-risk groups lags far behind. Stigma and a social environment that marginalizes many of those at greatest risk continue to retard adequate responses and also have a negative influence on the development of adequate surveillance. To quote a recent publication by an expert group,

Even with recent declines in the price of antiretroviral therapy, lifetime costs for treating a case of HIV infection in a developing country will nevertheless be substantial. Unless the anticipated growth in new infections is prevented, the burden on treatment and care systems in low- and middle-income countries will be unsustainable over the long run, even with dramatically greater global assistance for the purchase and delivery of drugs. To preserve the hope of effective long-term treatment for the 40 million people currently living with HIV/AIDS, prevention efforts must be redoubled (Global HIV Prevention Working Group 2003, p. 22).

While the possibility now exists for ART in many MENA countries, failure to integrate treatment with focused efforts to reduce stigma and

eliminate taboos, and implement targeted prevention activities for high-risk groups, will result in costly and unsustainable treatment programs in the future. In this regard, the importance of having efficient surveillance systems to ensure evidence-based interventions cannot be overemphasized.

Private Sector

The private sector has barely been tapped to further HIV/AIDS prevention in the region. One exception that is known is the Coca Cola Foundation intervention in Egypt. It has made condoms available in selected workplaces and has conducted a study to design promotional and awareness campaigns. It is working with the UN Theme Group in Egypt where it hopes to pilot this program with eventual scale-up throughout North Africa.

Donor and Thematic Responses

UN Agencies

Since the beginning of 2002, more UN agencies have become active in the HIV/AIDS field. Both EMRO and UNAIDS now have several persons working at the regional level and are trying to improve staffing at the country level too. The United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP), and the United Nations Population Fund (UNFPA) now have regional posts specifically dedicated to HIV/AIDS. The United Nations Educational, Scientific, and Cultural Organization (UNESCO), International Labour Organization (ILO), and UNODC have begun to focus on HIV/AIDS in the region, although without increased dedicated staffing.

EMRO has held a series of meetings primarily on STIs, National AIDS Program (NAP) management and evaluation, the GFATM, counseling, and access to care. More recently, EMRO has prioritized treatment in the region as part of the global "3 by 5 Initiative," which aims to provide treatment access to 3 million infected persons worldwide by the end of 2005. In addition to its role in coordinating the UN response to HIV/AIDS, UNAIDS receives Program Acceleration Funds (PAF) for small projects. Information on those funds and their use in the MENA region (including the Sudan and Somalia) can be found in Annex 5.

While the general domain of action is set to some degree by each UN agency's global mission, specific strategies and activity plans have been

slow to develop and reach the implementation stage. Several meetings have been held to decide what could be done and by whom. Overall, these meetings reflect a positive change in the region with the growing interest of UN agencies, the mobilization of some financial resources, and the desire to involve new national partners in the HIV/AIDS response. A global HIV Prevention Working Group estimated in 2003 that \$23 million was devoted to HIV/AIDS programs during 2002 in the MENA region (as defined by UNAIDS) but that, to respond to the growing epidemic in the region, annual expenditures of \$192 million would be required for HIV prevention activities by 2005, based on prevalence rates estimates for 2002 (Global HIV Prevention Working Group 2003). These figures indicate that mounting the kind of prevention response capable of preventing a significant outbreak of HIV/AIDS will require a tenfold increase in spending. It is important to note that those estimates were based on the insufficient data on the epidemic.

Vulnerable Populations—Prevention and Care

Despite continued indications of increasing risk factors, not much research has been conducted to investigate them and design appropriate interventions. The following summarizes the little research that has been conducted with regard to risk factors.

Injecting Drug Users

According to the Working Group mentioned above, less than 1 percent of IDUs in the region have access to harm reduction interventions that can substantially reduce the spread of HIV. Increasing numbers of HIV-positive cases have been detected in Libya and among Libyans visiting Tunisia since 2000, and UNODC is now sponsoring a rapid assessment on drug and HIV/AIDS in Libya. In Oman, the percentage of all HIV cases caused by IDU transmission has been rising. Although Oman has been quite open about its epidemic, no specific interventions for IDUs have been developed as yet. The Theme Group on HIV/AIDS in Algeria is conducting a rapid assessment response for IDU. Also in Egypt, UNODC has undertaken some preliminary outreach to IDUs in Cairo and Alexandria, identifying about 400 IDUs during the first attempt.

Prisons are frequently high-risk areas for the transmission of HIV, especially if IDUs are continuing to gain access to injectable drugs while in prison. The Islamic Republic of Iran has developed a model intervention that UNODC would like to extend to other countries. Both Algeria and Lebanon are also developing HIV/AIDS interventions in the prison setting.

Sex Workers and Their Clients

The Working Group indicates that, in MENA, only about 5 percent of CSWs and their clients have access to behavioral interventions that can prevent the spread of HIV. Very little work has been done with sex workers and almost none with their client groups. There was an outreach program for sex workers in Djibouti, and testing of sex workers has taken place in Algeria, Egypt, the Islamic Republic of Iran, Lebanon, Jordan, Morocco (including male sex workers), and Syria. However, there have been no attempts to develop sex worker programs using the known best practice approaches that include social development and empowerment. This is largely due to the official denial of their existence and legal persecution. The Islamic Republic of Iran has been taking the first tentative steps to develop an outreach program with street sex workers in Teheran. Registered sex workers in Tunisia (numbering about 300) are regularly tested and treated for STIs and provided with condoms. Of considerable concern is the growing level of commercial sex work in Iraq, with no efforts yet made to diminish the inevitable spread of HIV or STIs in such a conflict situation.

Men Who Have Sex with Men

The only countries in the region so far known to have been relatively open about MSM are Lebanon and Morocco, where both surveys and outreach have taken place. Through a local NGO, Lebanon has been developing an outreach intervention for MSM in some “cruising” areas of Beirut. Egypt has conducted research on MSM but has not organized an intervention directed to their needs. Special efforts may be needed to ensure equity in access to ART, care, and support for these marginalized groups. Regionwide, only a minority of MSM have access to behavioral interventions to curb the spread of HIV (Global HIV Prevention Working Group 2003).

Migrants/Mobile Populations/IDPs/Refugees

Discussions have taken place with the Organization of the Petroleum Exporting Countries (OPEC) regarding the possibility of funding two initiatives that would address the issues of HIV among people who move around in the region. One is the Horn of Africa Initiative, which includes Djibouti, Ethiopia, Eritrea, Somalia, Sudan, and the Republic of Yemen. The second is the Sahara Initiative, including Algeria, Libya, Mali, Mauritania, Morocco, Niger, and Tunisia. The International Organization for Migration is involved, and these efforts will deal with numerous issues,

including legal and illegal migration through Tamanrasset, Algeria. Multiple issues exist regarding refugees with HIV, including their rights to medical care, their potential deportation, family support, and so on. Regular migrants, such as men leaving Egypt for work in the Gulf States, are mandatorily tested for HIV before they leave. This testing has been noted as an opportunity for HIV education, including the teaching of condom use skills.

Truck drivers, especially on the heavily trafficked transport corridor between Djibouti and Ethiopia, have high susceptibility to HIV/AIDS infection. Other mobile populations, such as fishermen, particularly in the Republic of Yemen, require attention too. Regional bodies, like the Gulf Cooperation Council, could be brought into discussions on these topics.

People Living with HIV/AIDS

Over the past few years, progress has been made in a few countries in bringing people living with HIV/AIDS (PLWHAs) into association with the NAPs, most markedly in Algeria, Djibouti, Egypt, the Islamic Republic of Iran, Lebanon, and Oman. In October 2003, at the 11th International Conference for People Living with HIV/AIDS in Kampala, Uganda, UNICEF sponsored the attendance of PLWHAs from Algeria, Egypt, the Islamic Republic of Iran, Lebanon, Oman, and Tunisia. The West Bank and Gaza is reported to have 22 PLWHAs for whom support is sought. To date, no PLWHA support mechanism has been developed in the Republic of Yemen or Libya and only a small program in Djibouti is in place. In Lebanon support groups are developed by doctors and social workers who are associated with NGOs.

Antidiscrimination laws for PLWHAs have not been developed in the region as yet and a considerable amount of work is required to develop enabling policies for migrants and refugees. One very encouraging recent exception is the permission granted by the MoH in Lebanon to provide ART to infected Palestinian refugees living within Lebanon's borders.

Children and Youth

Some formative research on youth and vulnerable populations has been conducted in Algeria, Djibouti, Jordan, Lebanon, Morocco, Syria, Tunisia, and the Republic of Yemen. Quality varies considerably, and it does not seem that these studies have identified the contexts and meanings of risk behaviors among youth in any country. UNFPA has funded an ongoing youth intervention in Tunisia. Collaborators include the Arab Boy Scouts, International Planned Parenthood Federation (IPPF), and

other NGOs. The first interagency meeting on young people and children was held in December 2002 in Cairo. OPEC funded UNFPA for a literature review in Lebanon, Morocco, Syria, and the Republic of Yemen. UNICEF has begun to contribute to the effort.

UNICEF has been conducting policy reviews, covering conventions on reproductive and human rights that prioritize young people, communications, advocacy, and orphans. It is investing in a Web site with an information technology organization and has employed professional media staff with public health expertise. Another study has also been sponsored by UNICEF on policy and covenants regarding young people. With UNICEF's contribution, Jordan has embarked on a major education campaign among youth in and out of schools. UNICEF also sponsors KAP (knowledge, attitude, practice) studies on young people's issues.

UNESCO has been developing an HIV/AIDS curriculum for the education sector, which is very conservative. It has been trying to build relations between NAPs and the education departments of different countries. They are translating into Arabic materials on human rights and young people.

Further Challenges and Gaps

General Awareness

In the majority of countries, no ongoing national education efforts have taken place. The Islamic Republic of Iran is now developing such a campaign for the general public. When efforts have been made, the messages have been vague, as in Egypt, and are seldom repeated. While Tunisia has been able to promote the use of condoms using humor and cartoons, its efforts appear to have been primarily concentrated on youth. UNICEF is considering a communication strategy for the region.

In a few countries like Oman and Jordan, it is apparent from surveys among young adults that the majority of people have a minimal working knowledge about HIV/AIDS. However, that knowledge is typically lacking in specific information on how to prevent oneself from acquiring an infection (for example, abstinence until marriage, being faithful to a faithful uninfected partner, using condoms, and using clean new needles) and includes much misinformation as well, such as believing that HIV is transmittable through contact with objects. Most striking is the severe extent of stigma reflected in the findings of surveys wherever they are conducted in the region. The association of HIV with immoral behaviors has been promulgated so thoroughly that an enormous effort will be needed to counteract this. Unless stigma and discrimination are reduced, efforts

to promote VCT, or offer ART, will be hampered, and few people will seek information from hotlines or other public sources.

It will not be possible to make progress in combating the epidemic unless AIDS becomes visible, stigma is challenged and people living with HIV are encouraged to play their part in a community-wide AIDS response. This requires resolve and courageous leadership at various levels, particularly by government and religious leaders (The Synergy Project/USAID 2003).

Advocacy

The interface between service providers, including NGOs, medical providers, and so on, and the actual affected community members (those already infected and those most likely to become infected, that is, CSWs, MSM, IDUs), is fraught with communication and rights and power-related problems. Advocacy to address the social and policy issues that provoke these problems has not yet been conceived. While most UN agencies are aware of the need to advocate for political leadership and commitment, efforts to confront what is considered to be politically too sensitive are still generally lacking. Giving voice to the most at-risk groups to solve their problems remains limited. One exception took place at a recent UNAIDS/UNODC meeting on IDUs, which several ex-IDUs attended.

In addition to these issues, advocacy will be needed to extend the overall response beyond the confines of health and will require multisectoral approaches. Ministries of education, transport, military, shipping, and ports—as well as those dealing with women, youth, and social welfare—must all be mobilized to participate appropriately in HIV/AIDS prevention and support.

Capacity Building

Capacity building has been discussed many times in the region, and has included suggestions made by regional expert networks, but little has been accomplished. No serious attempts have been made to engage academic institutions or individuals in much-needed research. In Egypt and Jordan, Family Health International (FHI) with USAID are providing technical assistance on VCT and other efforts. IPPF has some expertise, particularly with women and sex workers, but to date few existing NGOs or local community-based organizations (CBOs) have developed prevention programs aimed at the most at-risk groups in the community. Many consider such programs impossible, given the lack of legal support for IDUs, MSM, and CSWs. Technical work—such as conducting studies,

training and supervising peer educators and outreach workers, and implementing a useful monitoring process—requires dedicated full-time staff with appropriate skills. These skills will have to be developed through capacity building activities in nearly all countries of the region.

Sexually Transmitted Infections and Reproductive Health

Millions of curable STIs occur in the region, with only a fraction actually recognized by the public health system and even fewer reported. In Morocco, for example, recent well-structured efforts to strengthen and decentralize STI surveillance and case management have resulted in estimates of 600,000 STIs per year. With support from FHI, the NAP in Egypt carried out an evaluation of selected reproductive infections in various Egyptian populations in Greater Cairo between 1999 and 2000. Findings reveal high prevalence of curable STDs, reaching 36.55 percent and 23.8 percent in a small group of CSWs and MSM, respectively. In addition, 8.3 percent of women attending family planning clinics, 5.35 percent of drug users, and 4 percent of women attending antenatal clinics had at least one STI (FHI, Ministry of Health and Population, USAID 2002). The Egyptian study indicates the need for a strong national STI prevention and control strategy and for a doubling of efforts to address vulnerable and high-risk groups. Such efforts are needed in all countries.

Research, Monitoring, and Evaluation

Surveillance in the region is very weak and improving this situation requires a considerable investment over a long period of time, starting with an assessment of laboratory capacity. It may be possible to focus on the behavioral side of second-generation surveillance in that it is a less territorially defined area. Nonetheless, considerable investment in building capacity will be needed.

Systematic rapid assessment and response studies on drug use, focusing particularly on injectable drugs and those that can become injectable, are needed throughout the region. In 1999, UNODC (then known as the United Nations Office of Drug Control and Crime Prevention [UNODCCP]) sponsored a well-executed, thorough study with biomarkers in the Islamic Republic of Iran. Since then, others have been carried out in Egypt, Lebanon, and, more recently, Libya.

Few studies have been conducted that adequately explain the structure and functioning of the sex trade, the number of sex workers, the proportion of men in the population who access sex workers, their occupations, or other essential information for developing much-needed interventions.

Small studies have been carried out on MSM in a few countries, and even fewer have explored the contexts and meanings of risk behaviors and where they take place. Earlier anthropological literature documented a traditional form of transgender prostitution in Oman, but no follow up on this issue in any country has taken place. Given that the majority of MSM is composed of men for whom the male-to-male sexual act has no implication for identity, the numbers involved are far higher than those who openly espouse a gay or local transgendered identity label. These men nearly always also have sex with women and most are or will be married. Efforts to reach these men, albeit quietly and in a way not to threaten their safety, must be supported for the health of the general public.

M&E is an area in which, as yet, there is little capacity and the appropriate institutional framework has not yet been developed. The Bank has supported a national M&E officer in Djibouti and UNAIDS introduced such posts in Morocco and Sudan in 2004. There is renewed recognition of the need to move on this effort, as evidenced by GFATM grants that include strengthening M&E in selected countries. However, all countries should be encouraged to learn how to monitor and periodically evaluate their programs. M&E capacity building activities need to be planned in a coordinated manner by donor organizations and should not just be designed to meet individual reporting needs.

Summary and Key Messages

During the last few years, national responses have advanced to some extent in most countries. In several countries, a process has taken place through which plans have been made and resources acquired. But even where funds have been made available, capacity to use them remains underdeveloped. The major gaps in response that need support either at the national, donor, or area levels include the following:

- Increasing political will and commitment among leaders, raising awareness of the general populace to the dangers of HIV/AIDS, and targeting the high-risk groups that are the drivers of the transmission of the infections with specific interventions. Achieving this will entail creating an enabling policy environment, including reducing the stigma associated with the disease. In countries where NSPs are yet to be developed, this would be a critical first step.
- Strengthening country-level surveillance and information systems to better track the epidemic and target interventions to vulnerable groups in the region. Vulnerable groups that have been identified in the region are IDUs, CSWs and their clients, MSMs, prisoners, and the youth.

- Raising the priority given to HIV/AIDS research that should include analyzing the relevance of NSPs, readiness of countries to address the epidemic, cost of treatment, and care and prevention among other areas.
- Capacity building in all areas of HIV/AIDS programming including but not limited to the following areas: designing and implementing HIV/AIDS strategic plans, strengthening surveillance and research systems, encouraging multisectoral collaboration, working with NGOs, and designing and implementing quality interventions targeted at-risk groups and M&E.

Note

1. Algeria, Djibouti, the Arab Republic of Egypt, the Islamic Republic of Iran, Jordan, Lebanon, Libya, Morocco, Oman, Saudi Arabia, Syria, Tunisia, West Bank and Gaza, and the Republic of Yemen.

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