



HIV/AIDS IN MENA: ASSESSMENT AND POLICY RECOMMENDATIONS

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Introduction: The HIV pandemic in the Middle East and North Africa (MENA) region² continues as one of the most devastating health crises ever. UNAIDS and WHO estimate that in 2009, 76,000 people were newly infected with infection in MENA (as defined by UNAIDS) and 24,000 people died of HIV-related causes in this year.³

The recent regional HIV/AIDS epidemiological synthesis report entitled *Characterizing the HIV/AIDS Epidemic in the Middle East and North Africa: Time for Strategic Action*, provides the scientific basis for the policy recommendations detailed here and provides policy makers with an overview of the specific character of the HIV/AIDS (human immunodeficiency virus/acquired immune deficiency syndrome) epidemic in the MENA region. The report also sets out policy and programming recommendations that respond to the

epidemiological and demographic contours of the HIV epidemic in the region, and the conclusions drawn from it can potentially be used as the basis for further research and policy development at the national level. Policy is variously discussed in this report both as a conceptual approach to HIV/AIDS prevention programming and as the concrete form of the programming itself. It offers examples of best practice, makes recommendations on where to target resources and funding, and outlines the most effective strategies in HIV/AIDS prevention. All the information presented in this policy report is based on the comprehensive research, findings, and recommendations recorded in the synthesis report.

Epidemiological patterns in MENA: Two main patterns describe HIV epidemiology in most MENA region countries:

- *A pattern of exogenous HIV exposures* among nationals who contract HIV outside their country and then transmit the virus to their sexual partners on their return to their home country.
- *A pattern of concentrated or low-intensity HIV epidemic* among priority populations. A concentrated epidemic is defined as HIV prevalence that consistently exceeds 5% in at least one priority population. Priority populations comprise injecting drug users (IDUs), men who have sex with men (MSM), and female sex workers (FSWs). *All MENA countries have populations in which concentrated epidemics have the potential to occur.*

In terms of the extent of HIV/AIDS spread, the epidemic in MENA is not homogeneous and can be broken down coarsely into two groups:

¹ Brief is based on the report "Characterizing the HIV/AIDS Epidemic in the Middle East and North Africa: Time for Strategic Action" by Laith J. Abu-Raddad, Francisca Ayodeji Akala, Iris Semini, Gabriele Riedner, David Wilson, and Ousama Tawil, and the related policy note drafted by Camille Nurka. The Quick Note was cleared by Akiko Maeda, HNSHD Health Sector Manager.

² The MENA region as defined for the synthesis report by the World Bank, the Joint United Nations Programme on HIV/AIDS (UNAIDS) MENA Regional Support Team, and the World Health Organization (WHO) Eastern Mediterranean Regional Office, comprises the following countries: Afghanistan, Algeria, Bahrain, Djibouti, the Arab Republic of Egypt, the Islamic Republic of Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, the Syrian Arab Republic, Tunisia, the United Arab Emirates, the West Bank and Gaza, and the Republic of Yemen.

³ UNAIDS and WHO, AIDS Epidemic Update, 2010.

- A core group of MENA countries that have a more modest HIV prevalence that includes most countries in the region.
- A sub-region with considerable prevalence that includes Djibouti, parts of Somalia, and Southern Sudan.

Most MENA countries have a low HIV prevalence, and the regional synthesis data suggest that no evidence exists for a major HIV epidemic in the general population in any of the MENA countries. Djibouti, Somalia, and Southern Sudan stand out from the rest of the MENA region as having a state, or near state, of generalized HIV epidemics. Southern Sudan is of particular concern and could already be in a state of considerable HIV epidemic in the general population, but conclusive evidence is still lacking.

HIV prevalence in MENA: The specific constellation of HIV prevalence in MENA can be understood through the interaction of three population types: priority, bridging, and general. HIV spreads most rapidly in the *priority* populations, which have higher levels of risk behavior: IDUs, MSM, and FSWs are normally the first groups to experience the burden of the HIV epidemic. Subsequently, HIV spreads from those groups to the *bridging* populations (usually the sexual partners of the high-risk populations), who may or may not pass the infection to the general population. Among MENA populations, a sizable fraction belongs to what could be labeled *potential bridging populations*, such as clients of sex workers, other sexual partners of priority populations, truck drivers, fishermen, and military personnel. From the evidence, those populations do not appear to be key contributors to the dynamics of HIV infectious spread in MENA and are not, at least so far, effectively bridging HIV infection to the general population. Although no evidence shows a clear dynamic contribution of bridging populations to HIV transmission in MENA, potential bridging populations *do* engage in considerable levels of risky sexual behaviors that need to be monitored and addressed. The general pattern in MENA countries points toward growing epidemics in priority populations. The synthesis report argues that these high-risk groups are where curtailing HIV

spread to below sustainability would control the HIV epidemic in the whole population. As Jenkins and Robalino have noted, “Small groups of people involved in high-risk activities can form the core of transmission for a nation.”⁴ Hence, targeting priority populations plays a key role in addressing HIV prevention needs.

Populations and Risk Groups: World Bank HIV/AIDS reports since 2003 have consistently listed IDUs, MSM, and FSWs and their clients as populations that are immediately at high risk in comparison with the general population. This report terms those high-risk groups *priority populations*. *Vulnerable populations*, by contrast, form a subset of the general population that is generally at low risk of HIV exposure—such as prisoners, youth, and mobile populations—but that is at risk of adopting practices that may put them at higher risk of HIV infection. When those vulnerable populations engage in higher-risk practices, they become part of the priority or bridging populations. This report recommends that policy be directed toward intervention in risky practices first among at-risk populations and then among vulnerable populations.

Priority populations: A hallmark of high-risk behavior in MENA is the intersection where the risk factors of priority groups overlap. If HIV establishes itself in one priority population, it can easily spread through the overlapping risks to other priority populations. In addition, the chance of contracting HIV is increased within the same risk group if multiple risk behaviors are present. For example, one person can occupy two of the risk groups simultaneously.

Injecting drug users: MENA is a major source, route, and destination for the global trade in illicit drugs and injecting drug use (IDU) is a persistent and a growing problem in MENA, with 0.2% of the total population—close to a million people—injecting drugs. HIV has already established itself among a number of IDU populations in MENA, whereas it is still at low or nil prevalence in other populations. Levels of risky behavior practices, such as

⁴ Jenkins and Robalino, “HIV/AIDS in the Middle East and Northern Africa”, 2003.

sharing of injecting equipment, are generally high, thus affirming the potential for further HIV spread among IDUs.

Men who have sex with men: form the most hidden and stigmatized risk group of all HIV risk groups in MENA. Social stigmatization and legal persecution of male sex workers (MSM) have made state interventions challenging and have presented difficulties for researchers seeking to access and document trends among this population. There is evidence that HIV is spreading among MSM, but data are still too limited to fully document the trend. Although MSM in MENA generally have a reasonable level of awareness of HIV/AIDS and of modes of transmission and methods of protection (specifically through condoms), misconceptions about the risk of HIV acquisition also exist.

Female sex workers (FSW): Economic pressure, family disruption or dysfunction, and political conflicts are major drivers of commercial sex work in MENA. Commercial heterosexual sex networks are the largest of the three priority group networks in MENA. However, HIV prevalence among FSWs continues to be at low levels in most countries and does not appear to be well established in many of the region's commercial sex networks. HIV prevalence among FSWs is, nevertheless, much higher than that in the general population and FSWs in MENA countries report (a) considerable levels of risky sexual behavior, including roughly one client per calendar day; (b) low levels of condom use, particularly in areas of concentrated HIV epidemics among SWs (Djibouti); (c) anal in addition to vaginal sex; (d) clients or sexual partners who inject drugs; and (e) the fact that they inject themselves with drugs.

Levels of HIV knowledge among sex workers appear to vary substantially in MENA, and available evidence suggests that misconceptions exist about HIV transmission among FSWs and that many are not using testing and counseling services. FSWs tend to seek treatment for STIs through self-treatment or through friends rather than through knowledgeable health personnel. FSWs who have low socioeconomic status, who have poor

HIV knowledge, or who are not able to afford condoms or to negotiate condom use are at particularly higher risk of HIV.

Vulnerable populations: People are said to be in a state of vulnerability if their living conditions are prone to shifting factors that would place them at risk. MENA has several vulnerability factors, and the settings of vulnerability are diverse, with a large section of the population belonging to one or multiple vulnerability settings. The MENA region has three key vulnerable populations: (a) prisoners; (b) mobile populations, including migrant workers, refugees, and internally displaced persons (IDPs); and (c) young people. Among the groups listed, prisoners are the most vulnerable. Mobile populations have an extensive presence across the region, but their HIV prevalence levels and epidemiological characteristics are still not well known. Youths often endure immense challenges (such as unemployment, displacement, homelessness, and drug dependence) that may compel them to engage in risk behavior.

Policy and Programs: For any HIV response to be successful and cost effective, it must be tailored to the epidemiological reality of HIV transmission patterns. In the MENA region, scaling up HIV prevention for those who are most at risk is imperative. HIV/AIDS policy in MENA was initially implemented primarily through the health sector. From those beginnings, a range of innovative intervention strategies have since become available to policy makers: (a) surveillance; (b) blood screening; (c) condom distribution; (d) behavior change communication; (e) testing and counseling; (f) information, education, and communication materials; (g) peer education; (h) safe injection facilities; (i) STI control; (j) antiretroviral therapy (ART); and (k) programs for prevention of mother-to-child transmission (PMTCT). However, the experience of researchers, scientists, policy makers, people living with HIV (PLHIV), NGOs, and civil society representatives has shown that limiting the response to the health sector is ineffective and that a multisectoral response is needed. Although the acquisition of knowledge about the epidemic over time is reflected in the changes in policy response—from large

investments in ART to the development of national AIDS strategic plans—strategies still have room for improvement. Surveillance and research have always been crucial components in policy recommendations, yet the region continues to grapple with limited information and capacity, and its national strategic plans reveal a prevention strategy that is limited in scope and scale. Prevention among priority populations at higher risk of HIV infection and vulnerable populations is a funding priority, yet prevention remains largely unprioritized in policy. Generic and routine planning, competing priorities, limited human capital, and lack of monitoring and evaluation impede prevention efforts in the region. At the national level, policies remain inadequate and do not sufficiently engage with the epidemiological evidence. Very few prevention programs in MENA have adopted a comprehensive approach that uses research data in consultation with concerned populations to create the right mix of intervention strategies that are adaptable to the national epidemiological context and the specific risk contexts. Morocco and the Islamic Republic of Iran are notable exceptions, having made commendable progress in developing and implementing their prevention strategies. Those promising examples should be the rule and not the exception.

Conclusion: Public acknowledgment of the HIV/AIDS epidemic in the region has been a recent development. In 2000, HIV/AIDS had only just begun gaining recognition as a leading public health, social, and development concern. By 2003, several MENA countries were at various stages of development or implementation of national strategic plans and had begun to make real efforts toward prevention. Today, MENA governments are making progress in acknowledging that priority populations exist and in working with nongovernmental organizations (NGOs) to provide and extend HIV prevention services (including social support networks) to priority groups.

HIV infection has already reached all corners of the MENA region, and most HIV infections are arising within the already existing sexual and injecting-drug risk networks. The analytical

insights drawn in the report from a synthesis of thousands of studies and data sources indicate that MENA countries must develop robust surveillance systems to monitor HIV spread among priority populations. Effective and repeated surveillance of priority populations across MENA is key both to knowing conclusively whether HIV spread is indeed limited to priority populations and to detecting emerging epidemics among those groups at an early stage. This surveillance strategy offers a window of opportunity for targeted prevention at an early stage of an epidemic, when halting new infections among priority populations is a less resource-intensive exercise than having to bear the cost in the later stages of massive epidemics among some subpopulation groups.

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