

D. SUMMARY REPORT: HIV/AIDS IN THE MIDDLE EAST AND NORTH AFRICA

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INTRODUCTION: THE GLOBAL IMPACT

The “simple” number of HIV/AIDS cases in the Arab world may not seem alarming. Comparisons, however, are cause for great concern. In North Africa and the Middle East in 2005, there were 510,000 adults and children living with the disease. To the south, where HIV/AIDS is rampant, there are 25.8 million people living with the disease in sub-Saharan Africa. This disproportion may obscure the fact that the Arab-world figures are closer to par with other regions. In Western Europe there are 720,000 people living with HIV/AIDS; in East Asia and the Pacific, 870,000; North America, 1.2 million; Eastern Europe and Central Asia, 1.6 million; Latin America, 1.8 million; South and Southeast Asia, 7.4 million; the Caribbean, 300,000; and in Oceania, 74,000. Combined, there are 40.3 million people around the world living with HIV/AIDS.

IMPACT IN NORTH AFRICA, MIDDLE EAST

The disease is also continuing to spread in North Africa and the Middle East much as it is across the world. In 2005, 67,000 new diagnoses were reported in this region; in other terms, about 13% of all the region’s HIV/AIDS cases were diagnosed just last year. By comparison, there were 3.2 million new diagnoses in sub-Saharan Africa, or 12% of all cases. In Western Europe there were 22,000 new diagnoses, or 3–4% of all cases; in East Asia and the Pacific, 140,000, about 16%; in North America, 43,000, less than 3%; in Eastern Europe and Central Asia, 270,000, or about 15%; in Latin America, 200,000, about 11%; South and Southeast Asia, 990,000, or about

14%; the Caribbean, 30,000, or 10%; and in Oceania, 8,200, or about 9%. All together, there were 4.9 million new HIV/AIDS diagnoses around the world in 2005, or about 12% of all cases. While the Arab world accounted for a small percentage of the world’s new cases, its rate of new infections exceeded the world average.

HIV/AIDS-related death rates for the region are even more alarming. In 2005, about 58,000 children and adults died from the disease, or nearly 12% of all people with a diagnosis. Even in sub-Saharan Africa, “only” about 9% of people died (2.4 million). In Western Europe, 12,000 people died, less than 2% of all cases; East Asia and the Pacific, 41,000, less than 5%; North America, 18,000, less than 2%; Eastern Europe and Central Asia, 62,000, less than 3%; Latin America, 66,000, less than 3%; South and Southeast Asia, 480,000, about 6%; the Caribbean, 24,000, about 8%; and Oceania, 3,600, about 5%. Thus, Arab nations currently have the highest HIV/AIDS-related death rates in the world.

Other telling facts are found in a year-to-year comparison of the Arab world. In 2003 there were 500,000 adults and children living with HIV/AIDS in North Africa and the Middle East. In two years, this grew to 510,000. In 2003 there were 230,000 women living with the disease. But enough died in the intervening two years to counter the growing HIV/AIDS contraction rate, leaving 220,000 women with the disease in 2005. In 2003, 62,000 new diagnoses among children and adults were reported; by 2005, 67,000 new cases were reported. As mentioned earlier, 58,000 deaths from the disease were recorded in 2005, an increase from the 55,000 deaths reported just two years earlier. The adult preva-

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lence rate remained static at around 0.2%.

HIV surveillance remains weak in the Arab world, especially in the Middle East. More comprehensive information is available in some countries, notably Algeria, Libya, Morocco, Somalia, and Sudan. Except for Sudan, national HIV prevalence levels are low in all Arab countries. Those countries with the most reliable information also show trends of increasing HIV infections, especially in younger age groups. This leads to speculation that trends may exist "under the radar" in much of the rest of the region, not just in Algeria, Libya, Morocco, and Somalia.

The main mode of HIV transmission in the Arab world is unprotected sexual contact. Injecting drug use is becoming an increasingly important factor and is the predominant mode of infection in at least two countries, Iran and Libya. Most of the disease is concentrated geographically and among most at-risk populations, including sex workers and their clients, IDU, and MSM. Infections from contaminated blood products, blood transfusions, or lack of infection control measures in healthcare settings remain a problem in the region.

There are many barriers to fighting HIV/AIDS in the Arab world. Already mentioned, there is a paucity of good, detailed information across the region on patterns of HIV transmission, especially the roles of sex work and of sex between men. Better information likely would reveal that HIV is passed through other risky behaviors or in other contexts. Also mentioned, there are strong sociocultural taboos against sex between men, making discussion and information gathering difficult. Little is known about HIV transmission in prisons, but some data suggests elevated risk in this setting. HIV prevention programs and services remain sparse and sporadic; substantive efforts are needed throughout the Middle East and North Africa.

FINDING SOLUTIONS FOR PREVENTION, TREATMENT, AND CONTROL OF HIV/AIDS

The United States Agency for International Development (USAID) funds activities in Egypt, Jordan, and North Africa Region. USAID also has missions in the West Bank and Gaza, Morocco, Lebanon, Yemen, and Iraq, although without designated HIV funding. Through its Asia Near East Bureau, the agency provides assistance to governments, nongovernmental organizations (NGOs), and individuals in most countries in the region.

USAID's experience in Egypt is emblematic of both the HIV/AIDS problem in the Arab world and of the agency's work in the region. The adult HIV-prevalence rate in Egypt is lower than 1%. The difference between reported cases and estimates may indicate weaknesses in the surveillance system and barriers to HIV testing. Again, data are scarce on MSM, largely because of the stigma attached, and on migration and IDU. There are also a large number of Egyptians living abroad, making data collection for them problematic.

USAID's budget for the country included \$3.5 million in fiscal year 2004 for infectious diseases, HIV/AIDS, and tuberculosis, and \$3.1 million in 2005. Among other things, funds support: an HIV/AIDS hotline that receives more than 1,000 calls per month; the establishment of new epidemiological surveillance units in Egypt's governorates; and development of a sentinel behavior surveillance site for HIV/AIDS and sexually transmitted infections. Funds are also helping to: renovate HIV/AIDS inpatient wards in Cairo, Alexandria, and Minia Fever Hospitals; expand the HIV control program to 14 demonstration hospitals; extend an information campaign and provide education on infection control and safe injection practices; enhance care and support for people living with

HIV/AIDS; and bolster quality control of public laboratories. USAID also helped prepare and release a set of booklets about proper home-based care for people living with HIV/AIDS.

The agency also supports human capacity development: training hospital staff to manage HIV/AIDS patients and developing clinical curricula for doctors and nurses. It backs a local NGO that is managing Egypt's first outreach center for IDUs by helping to train outreach workers and peer educators. It hopes to increase access to anonymous HIV/AIDS counseling and testing, supporting the first counseling and testing center at the central laboratory of the Ministry of Health and Population; develop policies and guidelines for all counseling and testing centers and materials and curricula for training counselors; and establish a national monitoring and evaluation plan for counseling and testing.

In Jordan, HIV prevalence is also low, less than 1%, with the majority of cases found in populations engaged in high-risk behavior. Sexual relations are thought to be the primary mode of transmission, accounting for 53.5% of all infections. USAID's challenges in Jordan are similar to the sociocultural and religious factors found in other Arab nations. For example, the concept of anonymous testing is foreign, and not an acceptable means of surveillance; condoms are promoted only as a family planning method; high-risk behaviors are not acknowledged officially and the social consequences for some are severe; there is no systematic access to vulnerable subpopulations and NGOs are unwilling to work with them; data about the disease and its control are inadequate for decision making; and where HIV/AIDS knowledge gaps exist, there is little community dialogue or involvement to fill them in.

USAID provided Jordan \$1.7 million in 2001–2004. The allocation for 2005 was \$0.8 million, and for 2006–2009 is anticipated at \$0.8 million or

more. Related activities include support to the Ministry of Health to purchase laboratory equipment to test viral loads in individuals living with HIV; support to the Jordanian National AIDS Program Counseling and Testing Hotline Center, for a day clinic to provide antiretroviral drugs and condoms; and training for health educators.

Other work includes strengthening collaborations with local organizations; behavior-change communication, namely peer-education workshops to raise HIV/AIDS awareness among young adults; coordinating World AIDS Day activities with the Ministry of Health and NGOs; helping the ministry develop protocols and relevant materials to begin surveillance; providing technical assistance for a limited behavioral surveillance survey within a single at-risk population; and supporting the National AIDS Program and its partner NGOs to ensure that monitoring and evaluation systems remain in place and are valid.

USAID's Asia Near East Bureau activities include projects such as the Health Policy Initiative: People Living with HIV/AIDS, International HIV/AIDS Alliance: Men Who Have Sex with Men, and Family Health International: Behavioral Surveillance.

The Health Policy Initiative included a five-day seminar in Tunisia, in February 2006, *Training for Leadership and Networking in the Middle East and North Africa*. Participants, some of them women, came from nine countries in the Middle East and North Africa, representing NGOs recognized organizations.

Activities under the International HIV/AIDS Alliance include capacity building for organizations to promote HIV/AIDS prevention among MSM in Algeria, Lebanon, Morocco, and Tunisia. In the first three of those countries, other work promoted rapid assessment of MSM, followed by a regional workshop in July 2004 to review and validate the data collected. A report on the assessment was distributed in French, but is also available in English. Also in Algeria, Lebanon, Morocco, and Tunisia, Participatory Community Assessments training was supported by USAID in late 2005.

For the Behavioral Surveillance initiative, USAID, in conjunction with UNAIDS and WHO provided regional training on integrated HIV surveillance systems in 2005. For 2006, planned activities include translation of behavioral surveillance survey manuals, related supplements, and generic protocols into Arabic; providing technical assistance to one or two countries to build local capacity; developing national surveillance systems; promoting rapid assessments of the current situation and response to HIV/AIDS; providing technical assistance to develop national HIV/AIDS and STI surveillance plans; holding consensus meetings with all relevant stakeholders to gain approval for the developed surveillance plans; expanding services; and improving monitoring and evaluation of HIV/AIDS programs to improve understanding of successful interventions, their cost, and how they can be replicated and sustained.

USAID is also allied with the Global Fund to Fight AIDS, Tuberculosis and Malaria, a program that has been active in the Arab world. Recent grants have gone to Algeria, Jordan, Mauritania, Morocco, Sudan and Yemen.

Looking ahead, USAID plans to focus on information and its dissemination. It will continue to improve surveillance systems in the region to glean better data for decision-making, and will conduct surveillance in high-risk groups and link them to prevention activities. The agency will review past programs to determine lessons learned and gaps, help develop national policies and strategic plans, encourage proper social-behavioral studies of vulnerable populations, "learn how to reach hidden groups in quiet ways" (in USAID's own words), make better use of NGOs and regional expertise, and develop a framework for addressing regional issues such as migration and the drug trade.

RESOURCES

For more information:

International Programs Center, Population Division, U.S. Census Bureau, HIV/AIDS Surveillance Data Base, June 2000

USAID/Jordan Website: <http://www.usaidjordan.org>

USAID HIV/AIDS Website for Jordan: http://www.usaid.gov/our_work/global_health/aids/Countries/ane/jordan.html

USAID/Global Initiatives: http://www.usaid.gov/our_work/global_health/aids