ENDING THE AIDS EPIDEMIC AMONG YOUNG PEOPLE IN THE MIDDLE EAST AND NORTH AFRICA
ACKNOWLEDGEMENTS

This advocacy report, titled *Ending the AIDS epidemic among young people in Middle East and North Africa*, was led by the UNICEF Middle East and North Africa Regional Office (MENARO) and supported by the WHO Eastern Mediterranean Regional Office (WHO EMRO), the International Organization for Migration (IOM) Jordan, and United Nations Population Fund Arab States Regional Office (UNFPA ASRO).

Shirley Mark Prabhu, Regional Health Specialist, UNICEF MENARO, in coordination with Lisa Johnston, epidemiologist and consultant, UNICEF MENARO, conceived the report and facilitated its production. Lisa Johnston conducted the secondary literature review and data analysis on young key populations, and Keith Sabin and Sonia Arias Garcia, UNAIDS Secretariat Geneva, provided valuable guidance on the HIV data analysis in the Middle East and North Africa (MENA) region.

Hein Marais wrote the final report. He also performed the qualitative analysis and in-depth interviews with key informants (academics, health service providers, non-governmental organization representatives, United Nations officers and young people who belong to key populations from across the region). Interviewees included Rita Wahab and Taline Torikian (MENA Rosa, Lebanon); Nadia Badran (Societies for Inclusion and Development, Lebanon); Hamid Sharifi (HIVHUB, Iran (Islamic Republic of)); Ali Akbar Haghdooost (Kerman University, Iran (Islamic Republic of)); Olfa Lazreg (UNFPA ASRO); Muhammad Shahid Jamil (WHO EMRO); Hamidreza Taherinakhost, Golamreza Seif, Solmaz Jokar and Javid Rostami (UNICEF Iran); Farah Jradi and Joseph Zgheib (IOM Lebanon). For their protection, the young people from key populations who participated are not identified by name.

Sincere thanks to Sowmya Kadandale (UNICEF MENARO) for guidance and support, and to Saba Al-Abadi and Elissar Abul Haj (UNICEF MENARO) for their administrative assistance. Thanks also to Robert Bain (UNICEF MENARO), and to Anurita Bains, Damilola Walker, Bettina Schunter, Lazeena Muna-Mcquay, Rikke Le Kirkegaard and Ruslan Malyuta (UNICEF New York Headquarters) for their inputs to the report.

We wish to acknowledge Anirban Chatterjee, Marleen Renders, Alexandre Schein, Ammar Ammar and Salim Oweis (UNICEF MENARO); Joumana Hermez George (WHO EMRO); Nevin Wilson, Samir Kumar Howlader and Ayah Al Shatnawi (IOM Middle East Response, Jordan); Elfatih Abdelraheem (UNDP Istanbul Regional Hub); Ilya Zhukov (UNFPA New York); Emmanuel Olatunji (The Global Fund); and Mustapha Kamayel and Sadok Amine Ben Hassine (International Planned Parenthood Federation Arab World Regional Office) for their assistance.

Experts on adolescents, young people and HIV provided peer reviews of the report, while a range of individuals affiliated with United Nations and other multilateral agencies provided additional inputs.

Funding for this report was provided in part by MAC Cosmetics and Global HIV Thematic Funds. UNICEF thanks MAC Cosmetics for their contribution to the prevention of HIV/AIDS programme in the Middle East and North Africa.
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**ACRONYMS AND ABBREVIATIONS**

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<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>CSE</td>
<td>comprehensive sexuality education</td>
</tr>
<tr>
<td>MENA</td>
<td>Middle East and North Africa</td>
</tr>
<tr>
<td>NCD</td>
<td>non-communicable diseases</td>
</tr>
<tr>
<td>NGO</td>
<td>non-governmental organization</td>
</tr>
<tr>
<td>PHC</td>
<td>primary health care</td>
</tr>
<tr>
<td>PrEP</td>
<td>pre-exposure prophylaxis</td>
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<tr>
<td>SRH</td>
<td>sexual and reproductive health</td>
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<tr>
<td>STI</td>
<td>sexually transmitted infection</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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<td>UNRWA</td>
<td>United Nations Relief and Works Agency</td>
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<td>World Health Organization</td>
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The Middle East and North Africa (MENA) is one of only two regions in the world with rising numbers of people acquiring HIV. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that about 20,000 people acquired HIV in the MENA region in 2022, a 54 per cent increase since 2010. This is the steepest rise in annual new HIV infections in the world (Figure 1). Almost 20 per cent of new infections were in young people, aged 15–24 years.

These trends are occurring against a backdrop of instability, including armed conflict and forced displacement, which is undermining governance, damaging public infrastructure, and disrupting public health and other essential services (1).

Yet, with an overall HIV burden that is still comparatively low, MENA also has a big opportunity to become the first region to end AIDS as a public health threat. Doing so will require HIV strategies that actually reach the people who are most affected by the epidemic. At the moment, across most of the region, services that can prevent new HIV infections are either lacking or are missing most of the people who are most at risk. Many of them are young people who are struggling with multiple challenges and hardships.

Vulnerable, marginalized populations bear the brunt of the HIV epidemic in the MENA region and they account for the majority of new HIV infections. Most affected are key populations, including people who inject drugs, female sex workers, men who have sex with men, transgender people, people in prison and other closed settings, and their spouses and other sex partners. Subject to harsh stigma and discrimination, these people struggle to access many basic services, including the HIV and other health services they need to protect their health and well-being. The available data suggests that regional median HIV prevalence is 6.6 per cent among men who have sex with men (data from six countries), 1.1 per cent among female sex workers (data from six countries) and 0.9 per cent among people who inject drugs (data from three countries) (2).

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1. INTRODUCTION

1 The 20 countries included in this report correspond to the UNICEF regional classification: Algeria, Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Qatar, Saudi Arabia, State of Palestine, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, and Yemen.

2 With the exception of Sudan, the prevalence of HIV in the adult population in MENA countries is under 0.1 per cent.
Not only are most countries in the region failing to prevent rising numbers of new HIV infections, about half the people living with HIV are not getting the treatment and support they need to stay alive and healthy. United Nations Member States have committed to ensure that at least 95 per cent of people diagnosed with HIV receive treatment and that 95 per cent of those on treatment reduce their HIV viral loads to levels that make it impossible for them to transmit the virus to others (3). The MENA region is a long way from achieving those targets.

In 2022, only 67 per cent of people aged 15 years and older with HIV knew that they had acquired the virus, 50 per cent were receiving life-saving treatment, and 45 per cent were able to reduce their viral loads to levels that no longer pose a threat to their health. As a result, there has been a comparatively slow decline in AIDS-related deaths among people aged 15 years and older: a 19 per cent decrease in MENA between 2010 and 2022, compared with 46 per cent globally.

Very little attention is being paid to the young people affected by this epidemic, who, in the absence of support and services, risk acquiring HIV and transmitting it to others. These young people – some of whom are men who have sex with men, or people who inject drugs, or people who sell or trade sex – struggle with disadvantages that undermine their efforts to use health care and other basic services, obtain an education, or gain employment. Those young populations are key to ending the HIV epidemic in the region. Yet, in some countries, their very existence is denied, and in many others, they are wilfully neglected.

Consequently, the region’s HIV programmes keep losing ground against the epidemic – at a time when almost all other regions are markedly reducing the numbers of people acquiring HIV and succumbing to AIDS-related illnesses each year.

Figure 1. Percentage change in number of new HIV infections, 2010–2022, and number of new HIV infections, 2022, global and by region

Source: UNAIDS 2023 estimates.
HOW WE DEVELOPED THIS ADVOCACY REPORT

This report examines the HIV epidemic and response among young people in the MENA region, using both quantitative and qualitative data. Quantitative evidence was gathered through a review of the latest epidemiological data and HIV programme indicators in the region, as well as reports published by United Nations agencies. Most of the data were retrieved from sources managed by UNAIDS, such as the Key Population ATLAS, the Global AIDS Monitoring system, and the AIDSinfo database.

Qualitative analysis comprised a desk review of journal articles and other publications, as well as in-depth interviews with key informants. The latter included government representatives, health service providers, non-governmental organization (NGO) staff, United Nations officials, and young people who belong to key populations in Egypt, Iran (Islamic Republic of), Jordan, Lebanon and Morocco. The countries were selected based on the HIV situation among young people, the existence of community-led organizations working with young vulnerable populations, and the availability of HIV programmes for young people.

The report focuses particularly on young people who are highly exposed to health threats such as HIV and other infectious diseases, yet are not reached with the protective information, services and tools they need to stay healthy and safe. The report shows that these young people are typically disadvantaged and face multiple difficulties when trying to access basic health services, including for sexual and reproductive health. The obstacles include harsh stigma and discrimination, underfunded and weak public health systems, punitive laws, a lack of youth-friendly services, the costs of services, and overall socioeconomic insecurity.

The report calls on donors, governments, the United Nations and other key stakeholders including the private sector to direct greater effort and resources to protect the health and well-being of young people. It identifies improvements and changes that can help the region reverse its expanding HIV epidemic, as well as improve the health and life prospects of its growing population of marginalized young people.

The report concludes with a set of practical recommendations which, among other things, call for:

- Collecting age and sex disaggregated health data for adolescents and young people to better understand their key health risks and needs, and engaging them in developing HIV and other health programmes to address those needs;
- Investing more in HIV programmes that are focused on the populations who are most at risk for HIV infection, including those who are adolescents and young people;
- Making it easier for young people to access proven prevention options and sexual and reproductive health services, and training health staff to reduce stigma and discrimination in health-care settings;
- Using primary health care as a foundation for effective HIV responses among young people, integrating community health workers as part of those systems, and building stronger linkages between community organizations and formal health services; and
- Increasing opportunities for young people to participate meaningfully in civic life, particularly around education, training and skills development, and employment opportunities.

If acted upon, these and the other recommendations would lay a firm foundation for ending the AIDS epidemic in the MENA region.
SOME OF THE REPORT’S KEY FINDINGS

- Annual new HIV infections in the 20 UNICEF countries in the Middle East and North Africa (MENA) have increased by 43 per cent since 2015, the steepest rise in the world. Almost 20 per cent of those infections are in young people (aged 15–24 years), most of them in Algeria, Egypt, Iran (Islamic Republic of), Saudi Arabia, Sudan and Yemen.

- HIV prevalence in the adult population (15–49 years) is low across the region, but concentrated epidemics – with HIV prevalence of 5 per cent or higher in certain key populations – are underway in several countries. Many of the underlying factors driving the epidemic among them also undermine the health and well-being of adolescents and young people generally.

- Many millions of young people live in precarious conditions and are vulnerable to multiple health threats, but have limited access to essential health and other services. Much of their disease burden, including HIV, is entirely preventable.

- HIV-related services and support for the young people who are most at risk for HIV are scarce. Intense stigma and discrimination deter them from seeking health care, while punitive laws and policies, affordability barriers and fragile health systems also restrict access.

- Condom use among young key populations is very low in some countries, pre-exposure prophylaxis is very difficult to access, and most countries with sizeable populations of drug users shun public health approaches to drug use and dependence.

- Health-care staff seldom have the training to understand and serve the health needs of people who belong to key populations, and youth-friendly services are rare.

- The number of people receiving HIV treatment in the MENA region has doubled since 2015, to approximately 110,000 in 2022, but treatment programmes are missing at least as many people.

- Enabling the adolescents and young people who are most at risk to protect themselves against HIV requires overcoming key obstacles, including weak political leadership and insufficient funding. Total resources for HIV in the region were 82 per cent short of the amount needed to reach the 2025 targets set out in the United Nations Political Declaration on ending AIDS.

- Relaxing the enforcement of restrictive laws against key populations and reducing HIV-related stigma and discrimination, especially in clinics and hospitals, would demonstrably improve countries’ HIV responses.

- A renewed emphasis on primary health care, with linkages to community systems, offers fresh opportunities to reach side-lined populations. That includes supporting community organizations that serve vulnerable young people, and making greater use of community health workers to bridge the gaps between marginalized populations and health-care services.

- Improved HIV-related data, including for adolescents and young people, would support advocacy efforts, the design of effective programmes and the efficient allocation of resources.

- With an overall HIV burden that is still comparatively low, MENA has a big opportunity to become the first region to end AIDS as a public health threat – if it acts quickly to introduce practical changes that protect the health and well-being of its adolescents and young people.
2. THE HIV EPIDEMIC IN THE MIDDLE EAST AND NORTH AFRICA

The Middle East and North Africa is one of two regions where rising numbers of people are acquiring HIV infections. In the 20 UNICEF countries in that region, the annual number of new HIV infections has increased by 43 per cent since 2015 and by 65 per cent since 2000 (Figure 2).

Approximately 20,000 [15,000–28,000] people acquired HIV in 2022, bringing the total number of people living with HIV in the region to about 230,000. More than 85 per cent of new HIV infections in the region occur in five countries: Algeria, Egypt, Iran (Islamic Republic of), Saudi Arabia and Sudan.

**Figure 2.** Estimated annual number of new HIV infections and AIDS-related deaths, Middle East and North Africa, 2000–2022
It is important to note that incomplete data from many countries undermines a full understanding of the epidemiology of HIV across MENA, including among young people. HIV surveillance is erratic and out-of-date in several countries. Health-related behavioural surveys are done sporadically and there is strong resistance against including people younger than that age 18 years in such surveys. In addition, homophobia; the criminalization of drug use, sex work and same-sex intercourse; and stigma surrounding non-marital sex discourage many people from disclosing information about behaviours that are pertinent to HIV (5). However, there are sufficient data to shape a confident description of the overall dynamics of the region's epidemic.

The available evidence shows that most HIV transmission in the region occurs in the context of high-risk sexual and drug-injecting networks (1). While HIV prevalence in the adult population (15–49 years) does not exceed 1 per cent in any MENA country, concentrated HIV epidemics – with HIV prevalence 5 per cent or higher in specific key populations⁵ – have been documented in several countries, mainly among people who inject drugs and men who have sex with men (5). A recent review of studies done over the past 20 years has found rising HIV prevalence in those populations, as well as among female sex workers (Figure 3) (1).

There has been a modest, 12 per cent decrease in the number of AIDS-related deaths in people older than 15 years since 2010 in the MENA region (Figure 4). The epidemic claimed about 7,200 lives in 2022, bringing the number of lives lost to AIDS since 2010 to approximately 102,000.

HIV treatment programmes in the region have grown, but coverage remains well below the global average. An estimated 50 per cent of people living with HIV were receiving antiretroviral therapy in 2022 in MENA, compared with 76 per cent globally. Due to a range of gaps and deficiencies, testing and treatment programmes are missing large proportions of the people who need them.

⁵ Key populations generally refer to sex workers, men who have sex with men, people who inject drugs, transgender people, and prisoners and other incarcerated people.
Figure 3. Trends of HIV prevalence among key populations in the Middle East and North Africa, 1985–2020

Note: The figures include data points for Pakistan, which is not among the countries in the MENA region, as defined by UNICEF.

YOUNG PEOPLE AND HIV

Approximately 4,000 young people (aged 15–24 years) acquired HIV in 2022, the majority of them male. According to UNAIDS, most of them were living in Algeria, Egypt, Iran (Islamic Republic of), Saudi Arabia, Sudan and Yemen (Figure 4), which together accounted for over 90 per cent of new infections among young people across the entire region. A closer look at the trends shows that new infections among young people are rising sharply in Saudi Arabia, increasing steadily in Algeria, Egypt, Sudan and Yemen, and may be levelling off in Iran (Islamic Republic of).

As with older adults, young people’s HIV risk tends to reflect their overall place and status in society, and it shifts over time. That risk can be shaped by their access to education and employment, the stigma and discrimination associated with their sexual identities, their age and gender, their social class, and whether they live in cities and large towns or in more remote settings.

HIV incidence among young people overall is very low in the MENA region, but the risk of acquiring HIV is much higher in certain groups of vulnerable young people, particularly those who are stigmatized and excluded from mainstream society (6). They include young people who are involved in the sex trade, who inject drugs, or who belong to sexual minorities. People belonging to those key populations are at much higher risk of HIV infection than other members of society. Compared with adults in the general population (aged 15–49 years), HIV prevalence was 11 times higher among men who have sex with men, 4 times higher among sex workers, 7 times higher among people who inject drugs, and 14 times higher among transgender people (2).

Figure 4. Geographical distribution of new HIV infections among young people, aged 15–24 years, Middle East and North Africa, 2022

Note: For some countries, the number of new infections is estimated as <1000 or <500; in those cases, the estimates have been rounded to the highest number. Estimates were not available for Bahrain, Djibouti, Kuwait, Lebanon, Libya, State of Palestine, Tunisia and United Arab Emirates.


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6 UNICEF classifies young people as those aged 10–24 years. However, HIV data for people aged 10–14 years are very scarce and their risk of acquiring HIV tends to be extremely low. This HIV report, therefore, follows UNAIDS’s classification of young people as those aged 15–24 years.

7 Recent estimates are not available for Bahrain, Djibouti, Kuwait, Lebanon, Libya, Somalia, Tunisia and United Arab Emirates.
According to the most recent size estimations for young key populations in the MENA region, there were approximately 270,000 adolescent boys and young men who have sex with men about 200,000 young women who sell sex (aged 18–24 years) (7); and about 320,000 young people who inject drugs (the vast majority of them male) (8).

**Young men who have sex with men**

Same-sex relationships are heavily stigmatized and carry criminal penalties, including extremely harsh ones, across most of the region. Consequently, these relationships are almost entirely hidden. In addition to increasing the HIV and other health risks among men who have sex with men, this makes it difficult to collect HIV-related data for them. Nevertheless, some post-2010 survey data are available. They point to concentrated HIV epidemics in this key population, with a median HIV prevalence of about 4 per cent. There appear to be established epidemics in Djibouti, Lebanon, Morocco, Tunisia and Yemen, and emerging ones in Algeria, Egypt and Libya (1). Relatively recent IBBS data have indicated an HIV prevalence of 2.2 per cent in Morocco (2020) (9), 8.2 per cent in Tunisia (2021) (10), and 12.0 per cent in Lebanon (2015) (11), while an earlier IBBS survey found prevalence of 3.2–10.0 per cent across cities in Morocco (2017) (12).

Age-disaggregated data show HIV prevalence of at least 3 per cent in Algeria, Egypt, Tunisia and Yemen and around 2 per cent in Morocco among men who have sex with men and who are younger than 25 years (Figure 5). Across the region, this population is one of the hardest groups to reach with HIV and other health services due to severe stigmatization and discrimination (5).

**Figure 5. HIV prevalence among men who have sex with men, various age ranges, Middle East and North Africa countries with data, post-2010**

<table>
<thead>
<tr>
<th>Country</th>
<th>Total</th>
<th>&lt;25 years</th>
<th>25+ years</th>
</tr>
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<tbody>
<tr>
<td>Algeria</td>
<td>4.7</td>
<td>3.5</td>
<td>1.2</td>
</tr>
<tr>
<td>Djibouti</td>
<td>14.2</td>
<td>6.7</td>
<td>6.8</td>
</tr>
<tr>
<td>Egypt</td>
<td>6.7</td>
<td>5.0</td>
<td>1.2</td>
</tr>
<tr>
<td>Jordan</td>
<td>12.0</td>
<td>3.1</td>
<td>8.2</td>
</tr>
<tr>
<td>Lebanon</td>
<td>2.2</td>
<td>4.9</td>
<td>6.7</td>
</tr>
<tr>
<td>Libya</td>
<td>8.7</td>
<td>4.6</td>
<td>3.1</td>
</tr>
<tr>
<td>Morocco</td>
<td>10.5</td>
<td>5.9</td>
<td>4.6</td>
</tr>
<tr>
<td>Tunisia</td>
<td>11.1</td>
<td>3.1</td>
<td>7.7</td>
</tr>
<tr>
<td>Yemen</td>
<td>12.0</td>
<td>3.1</td>
<td>9.0</td>
</tr>
</tbody>
</table>

Note: Due to often-hostile contexts and the use of different sampling methods, the reliability of HIV prevalence data for key populations varies. In this case, except for Algeria, the data can be considered moderately reliable.

Sources: Bilan des activités des centres de dépistage du VIH/sida 2017 (Algeria); Donnés de routine, Rapport Oct 2018–Sept 2019 Projet Linkages FHI360 (Djibouti); FHI and Freedom (Egypt); IBBS (Jordan and Lebanon); Étude bio-comportementale intégrée RDS (Morocco and Tunisia).
Young people who inject drugs

The region is home to several major drug trafficking routes and is a major transit point for illicit drugs, according to the United Nations Office on Drugs and Crime. The use of illicit opioids has been reported in many countries in the region, and the non-medical use of opioids is increasing (13). The main HIV risk for people who inject drugs is the sharing of non-sterile injecting equipment, though unprotected sex with partners or paid sex clients adds to the risk of transmitting or acquiring HIV.

HIV prevalence among young people who inject drugs is difficult to determine, due to a lack of recent and reliable data. Evidence exists of established HIV epidemics among people who inject drugs in Algeria, Egypt, Iran (Islamic Republic of), Morocco and Tunisia, and emerging HIV epidemics have been observed in parts of Kuwait, Lebanon, Libya, Oman and Syrian Arab Republic. HIV prevalence ranged between 1.3 per cent and 14 per cent in different cities in Morocco, according to studies done in 2017 (12). Surveys have found HIV prevalence of at least 2 per cent in Algeria and Egypt among people who inject drugs and who are under 25 years of age, and HIV prevalence of 10 per cent among their peers in Tunisia (Figure 6).

Data from Iran (Islamic Republic of) and Lebanon suggest that significant proportions of people who inject drugs are under 25 years of age (14, 15). Young people who inject drugs are likely to have multiple HIV risk behaviours (5), including unprotected sex and exchanging sex for money or favours, as seen in studies from Egypt (16), Iran (Islamic Republic of) (17) and Lebanon (15). In a 2014 survey in Syrian Arab Republic, one in five men who have drugs said they had had sex with other men and 55 per cent reported having sold sex (18).

Despite compelling evidence of the effectiveness of harm reduction programmes in preventing HIV and other health threats, these interventions remain very limited in the MENA region, though Iran (Islamic Republic of) is a significant exception. The implementation of harm reduction programmes and opioid

Figure 6. HIV prevalence among people who inject drugs, various age ranges, Middle East and North Africa countries with data, post-2010

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
<th>&lt;25 years</th>
<th>25+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Algeria (2017)</td>
<td>3.4</td>
<td>2.6</td>
<td>4.2</td>
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<tr>
<td>Egypt (2016)</td>
<td>4.2</td>
<td>2.6</td>
<td>4.2</td>
</tr>
<tr>
<td>Kuwait (2017)</td>
<td>0.1</td>
<td>0.1</td>
<td>0.9</td>
</tr>
<tr>
<td>Lebanon (2014)</td>
<td>1.1</td>
<td>0.1</td>
<td>1.1</td>
</tr>
<tr>
<td>Morocco (2017)</td>
<td>7.1</td>
<td>1.1</td>
<td>6.0</td>
</tr>
<tr>
<td>Oman (2012)</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Saudi Arabia (2016)</td>
<td>0.9</td>
<td>0.5</td>
<td>0.4</td>
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<td>Syrian Arab Republic (2011)</td>
<td>8.8</td>
<td>1.9</td>
<td>6.9</td>
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<td>Tunisia (2021)</td>
<td>10.0</td>
<td>2.0</td>
<td>8.0</td>
</tr>
</tbody>
</table>

Note: Due to often-hostile contexts and the use of different sampling methods, the reliability of HIV prevalence data for key populations varies. In this case, the most reliable data were from Iran (Islamic Republic of), Morocco and Tunisia.

Sources: Bilan des activités des centres de dépistage du VIH/sida 2017 (Algeria); voluntary counselling and testing data (Egypt); Behavioral Surveillance Survey, 2018 (Iran Islamic Republic of); addiction centre data (Kuwait); Etude Bio-comportementales intégrées auprès des PID (Morocco); national programme data (Saudi Arabia); Enquête IBBS 2021 Usagers des drogues injectables (Tunisia).
replacement therapy stabilized the Islamic Republic of Iran’s HIV epidemic, with HIV prevalence among people who inject drugs declining from 15 per cent in 2011 to 9 per cent in 2014 (19, 20). The most recent survey data, from 2018, found HIV prevalence of 3.7 per cent in that population. In recent years, however, sexual transmission of HIV appears to have increased in Iran (Islamic Republic of), a reminder of the intersectional nature of HIV risk (21).

**Young women who sell sex**

While the number of women who sell sex in the MENA region is believed to be low, it is estimated that around 6 per cent of men in the general population have, at some point, paid for sex. HIV-related data for sex workers are scarce and come mainly from biological and behavioural surveillance surveys. Based on surveys conducted in 11 countries since 2010, the average HIV prevalence among female sex workers is estimated to be under 1 per cent in most countries, but ranges between 1 per cent and 5 per cent in Algeria, Egypt, Iran (Islamic Republic of), Morocco, Sudan and Tunisia, and is much higher in Djibouti (Figure 7). Age-disaggregated data show HIV prevalence of around 2 per cent and higher in Algeria, Egypt and Morocco among women who sell sex and who are younger than 25 years. Limited study evidence suggests that the median age at which women initiate selling sex is about 23 years (22).

**Figure 7. HIV prevalence among young women who sell sex, various age ranges, Middle East and North Africa countries with data, post-2010**

![HIV prevalence among young women who sell sex, various age ranges, Middle East and North Africa countries with data, post-2010](image)

Note: Due to often-hostile contexts and the use of different sampling methods, the reliability of HIV prevalence data for key populations varies. In this case, the most reliable data were from Djibouti, Iran (Islamic Republic of), Morocco, Sudan and Tunisia.

Sources: Bilan des activités des centres de dépistage du VIH/sida 2017 (Algeria); Donnés de routine, Rapport Oct 2018-Sept 2019 Projet Linkages FHI360 (Djibouti); Al-Shehab Organization Network of Associations for Harm Reduction (Egypt); Behavioral Surveillance Survey, 2020 (Iran (Islamic Republic of)); IBBS (Jordan, Lebanon, Morocco, Sudan, Tunisia).

**Transgender people**

HIV-related data for transgender people is available only for Iran (Islamic Republic of), where a 2015 survey found HIV prevalence of 3.3 per cent among transgender women older than 25 years, and zero infections among those younger than 25 years. Although transgender people are not sampled separately in most countries, they occasionally are included in surveys among men who have sex with men. Morocco was planning to conduct a survey among transgender people in 2023.
BEING YOUNG IN THE MIDDLE EAST AND NORTH AFRICA

Many of the underlying factors that fuel the AIDS epidemic in the MENA region also degrade the health and well-being of people generally, including the many young people who struggle to obtain the support and services they need to live healthy, fulfilling lives.

The population in the MENA region has grown sharply since the mid-20th century, from approximately 100 million to over 480 million in 2021 (23), with adolescents and young people accounting for about one quarter of the total population. Although the “youth bulge” (as a proportion of the total population) appears to have peaked in the early 2000s (24), continued population growth has resulted in an unprecedented number of young people in the region (25). The population aged 15–24 years doubled from 45 million in 1985 to around 90 million in 2010 (26). The region has an historic opportunity to safeguard the health and well-being of this large, young population as it advances into adulthood.

Many millions of young people live in hardship. Except for Egypt, Morocco, Sudan, Syrian Arab Republic and Yemen, at least 70 per cent of young people live in urban areas, many of them in precarious conditions, with limited access to essential services (27). Young people who belong to populations that are ostracized and discriminated against, including those with disabilities, are especially likely to be in socioeconomic distress and to be vulnerable to associated risks and health threats.

Secondary education is vital to support adolescents’ passage into adulthood and their attempts to fashion viable livelihoods and live healthy lives. Schooling also offers a range of protective benefits for adolescent health and well-being and is an important platform for health interventions. Taken as a whole, the current generation of youth in MENA is the largest and most well-educated (28) generation of young people in the region's history. However, the majority of young people still do not have secondary education-level skills. On average, an estimated 9 per cent of boys and 12 per cent of girls of lower-secondary school age, and 28 per cent of boys and 34 per cent of girls of upper-secondary school age are out of school (29). Out-of-school levels are even higher in Djibouti, Iraq, Syrian Arab Republic and Yemen; the latter three countries have been severely damaged by war and conflict.

In a context of conflict and political unrest, stunted education opportunities, and a lack of decent job opportunities, secure livelihoods are very difficult to achieve and maintain. Around 20 per cent of young men and 44 per cent of young women (aged 15–24 years) are not in education, employment or training (29), and the rate of youth unemployment is among the highest in the world, averaging at 28 per cent in 2021 (Figure 8). The unemployment rate among young women was over twice the rate among young men, reaching 49 per cent in 2021 (30) – partly reflecting the low levels of female labour force participation across the region (31).

Across the region, conservative gender norms and widespread gender discrimination block women’s and girls’ full participation in civic, social and economic arenas. While the constitutions of most countries formally recognize equality between men and women, few countries have laws expressly prohibiting discrimination. Under personal status laws and codes, men and women have unequal rights in marriage and unequal rights in divorce. In societies governed by patriarchal patterns of kinship, discrimination against women and their social discrimination are frequently sanctioned, and women are vulnerable to both domestic and institutionalized violence. In some countries, powerful conservative forces are seeking to further restrict women’s and girls’ rights and freedoms (27).
The lifetime prevalence of domestic violence in the region is high, ranging from 35 per cent in Lebanon, 50 per cent in Jordan and 54 per cent in Yemen, to 89 per cent in Türkiye. Rates of physical violence are also high: 26–32 per cent in the State of Palestine, Syrian Arab Republic and Tunisia, 66 per cent in Lebanon and 95 per cent in Türkiye, while extremely high lifetime rates of sexual violence were reported in Iran (Islamic Republic of) (82 per cent) and Türkiye (75 per cent) (32).

Despite formal legal and policy protections, domestic and family violence are often not penalized. This is due partly to cultural and political contexts that tolerate violent behaviours towards women (32), and partly to the weak enforcement of relevant policies. According to the United Nations Population Fund (UNFPA), national policies for addressing gender-based violence tend to be poorly resourced and coordinated implementation is often lacking. This is especially the case in countries experiencing political instability and conflict (33).
Many millions of people in the MENA region live in trying conditions marked by economic insecurity, social discrimination and inequality, and the reality or threat of war and conflict. One in five people in MENA live in close proximity to conflict (34), and a large number of adolescents and youth are exposed to violence and its consequences (35).

In 2022, there were almost 2 million refugees and 6.7 million internally displaced persons under the age of 18 years, and 2 million children and adolescents registered with the United Nations Relief and Works Agency (UNRWA) (29). Young people affected by conflict and displacement are at substantial risk of poor health and other threats to their well-being, including the destruction of basic infrastructure, degraded institutional capacities and disrupted education. Surveys from the past decade show that overall, at least 30 per cent of adolescents in Iraq and Sudan, more than 40 per cent in Yemen and over 60 per cent in Syrian Arab Republic were not in upper-secondary school. Completion rates were lower for girls than boys in about half the countries where these data were available (29). Conflict has also weakened social cohesion (1, 5, 35). A 2016 study by United Nations High Commissioner for Refugees (UNHCR) found that the MENA region was experiencing the worst deterioration of social cohesion due to conflict and war in the world (36).

**Figure 9. Numbers of refugees and internally displaced persons under the age of 18 years in the Middle East and North Africa, 2021**

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internally displaced persons</td>
<td>3,470,981</td>
<td>3,201,334</td>
</tr>
<tr>
<td>Refuges and asylum seekers</td>
<td>1,001,720</td>
<td>958,010</td>
</tr>
<tr>
<td>UNRWA registered persons</td>
<td>1,023,283</td>
<td>974,970</td>
</tr>
</tbody>
</table>

YOUNG PEOPLE’S HEALTH AND WELL-BEING

Despite challenges, the MENA region can markedly improve both individual and public health outcomes by preventing and effectively managing illness and disease among young people. Much of the disease burden among young people in the region is preventable, and many of the risk factors for poor health can be reduced or removed.

The effects of poor health among young people accumulate as they grow older, and manifest in chronic health problems, an ongoing need for treatment and care, and premature death (40). The World Health Organization (WHO) estimates that nearly two thirds of global premature deaths, and one third of the burden of disease in adulthood are associated with conditions or behaviours that begin in people’s youth (41).

Across the region, the burden of disease has largely shifted away from communicable and maternal causes, towards non-communicable chronic causes in the region. Communicable diseases (mainly tuberculosis, neglected tropical diseases and malaria, HIV and other infectious diseases) account for less than 10 per cent of cases of poor health among young people in the region (29).

Non-communicable diseases (NCDs), including cancers and cardiovascular disease), mental health issues, and injuries are the leading causes of poor health. NCDs account for almost half the disease burden in girls and young women aged 10–24 years and over one third among their male peers (29). Poor reproductive health, including a high unmet need for contraception and adolescent childbearing, also contribute to morbidity and mortality in many countries in the region. Overall, adolescent boys and young men experience a higher burden of poor health than their female peers.

Mental health, sexual health and substance use have become increasingly important issues for adolescents and young people in the region (see Box 2). Modelled estimates based on Global Burden of Disease data indicate that 1 in 6 young people aged 10–24 years, or 22.5 million people, were experiencing mental health difficulties in 2019, with girls and young women especially affected. Almost a quarter of the total disease burden among young people is due to mental health difficulties (29)—issues which tend to be on the margins of public health priorities, but which are also closely linked to other health threats, such as HIV (40).
Averting and managing adverse health outcomes among young people require reducing risk factors and increasing protection in their families, communities and wider societies (48). Their health and life prospects are heavily affected by socioeconomic and other inequalities (including unequal access to education and employment); exposure to stigma and discrimination; the availability and quality of health services; and political and military conflict (29).
3. YOUNG PEOPLE’S ACCESS TO HIV AND RELATED SERVICES

HIV and related health programmes operate in every country in the MENA region. However, services that cater to the specific needs of people who are most at risk for HIV are unevenly available or, for some countries and populations, entirely absent. This partly reflects the strained and fragile state of public and community health systems in many countries, due to funding shortages, staffing losses, damage due to war and conflict, and shifting health-care needs. It is also tied to deep-set stigma and discrimination against marginalized populations. Affordability is a major barrier to receiving health care, especially for noncitizen communities, such as migrant workers and refugees, who may be excluded from subsidized healthcare (49).

According to Global Burden of Disease study data, many youth – especially young women, youth in rural areas and youth with disabilities – lack adequate access to basic health services and health information. There is high unmet need for contraception, for prevention and treatment of sexually transmitted infections (STIs), and for mental health care (40, 50).

An array of other obstacles further limits vulnerable young people’s abilities to obtain the information and use the services they need to protect their health (51). Legal and policy barriers, such as age-of-consent and spousal consent requirements, restrict access to health services. Intense stigma and discrimination towards key populations, especially people belonging to sexual minorities, deter them from seeking HIV information or using HIV and reproductive services. Youth-friendly health services are rare and health-care providers very seldom have the training or inclination to understand and serve the needs of people who belong to key populations. NGOs, many of them community-led, are filling some of these gaps. They provide valuable services, though typically on a small scale, mostly in larger cities, and with limited funding for outreach activities with neglected populations.
Nine countries in the MENA region have a national adolescent health programme, and six have a national youth policy. Youth participation and engagement in the development of national health strategies are being promoted in Algeria, Egypt, Morocco, Sudan and Syrian Arab Republic, but it is not clear whether such efforts are demonstrably affecting the actual design and delivery of health services for young people. Health-care systems across MENA (as in many other regions) struggle to meet many of the common health needs of young people, not least their sexual health and mental health needs. In addition, most national health strategies do not make provision for public health financing for vulnerable young people.

In general, young people’s sense of citizenship and public trust is weakened by conflict, violence, poor economic conditions and social marginalization. According to Arab Barometer survey results for 2021, only 28 per cent of 18–29-year-olds in the surveyed MENA countries said they trusted their public institutions (37). Trust in the business sector was also low (38). Limited data on the extent of youth participation in public affairs in the MENA region, suggest that about 1 in 5 people aged 18–29 years volunteered with a local group or organization in 2018 (39).

**COMPREHENSIVE SEXUALITY EDUCATION**

Young people need accurate information on how to protect themselves and others from acquiring HIV and other STIs. Data reported to the Global AIDS Monitoring system (from 10 countries) show very low levels of HIV knowledge among young people in the region, between 4 per cent and 25 per cent, depending on the country (Figure 10). However, most of data on knowledge are at least a decade old; additional and more current data documenting young people’s HIV knowledge are needed to see whether knowledge levels have improved in recent years.

UNFPA research has found that adolescent girls and young women in the region generally have limited knowledge about contraception and how to avoid acquiring STIs, including HIV (53). Low levels of HIV knowledge partly reflect the state of comprehensive sexuality education (CSE) in the MENA region (5). CSE is intended to present young people with the information and skills they can use to make informed decisions about their reproductive and sexual health (54). Studies show that curriculum-based CSE contributes to delayed initiation of sexual activity, less risk taking, and increased use of contraception. There is no evidence that it increases early sex, sexual risk-taking or infection rates of HIV and other STIs (55, 56).

More than half of 15 reporting countries in MENA have set policies and/or strategies for school-based sexuality education (including Djibouti, Egypt, Lebanon, Morocco, Oman, State of Palestine, Syrian Arab Republic and Tunisia) (52). However, it is unclear to what extent those policies and/or strategies are being implemented. A 2019 desk review found that only one country, Tunisia, had some form of CSE in its current school curricula; Jordan, Morocco, the State of Palestine and Sudan have signed commitments to include CSE in their school curricula at some point in the future (54). It is also not clear whether teachers are properly trained and supported to provide quality sexuality education, or whether the curricula are indeed taught at all schools.

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9 Egypt, Iraq, Lebanon, Oman, Saudi Arabia, Sudan, Syrian Arab Republic, United Arab Emirates, Yemen.

10 Iraq, Jordan, Kuwait, Morocco, Yemen.
In addition to many other benefits, sexual and reproductive health (SRH) services are vital entry points for preventing and managing HIV and other STIs. Although a majority of countries in the region have policies that provide for access to effective contraception, actual access to SRH services is limited. Social, cultural, financial, legal and other obstacles stand in the way of obtaining appropriate SRH services, relevant information and counselling (52). Especially affected by limited access are adolescents and young people; persons with disabilities; refugees and migrants; persons belonging to sexual minorities; and other ostracized groups, such as sex workers and people who use drugs.

The available data suggest that the unmet need for SRH services in the MENA region is about 15 per cent, which is higher than the global average of about 10 per cent, and that unmet need in the MENA region is especially high among young people, with girls affected the most (5, 57). Surveys done by UNFPA in 2017–2018 found that Lebanon, Libya and Oman, for example, offered no or very few SRH services at primary health-care facilities (where it would be easier and less embarrassing for young women to seek those services) (58). In a majority of MENA countries, at least one third of young women who have a need for family planning services are not using a modern method of contraception. This unmet need is reflected in the region’s adolescent fertility rates, which are higher than the global average (of 42 births per 1000 girls) in Egypt, Iraq, State of Palestine, Sudan and Yemen (Figure 11) (29).
The unmet need for SRH services stems from a range of factors, including financial and health system constraints, unsupportive family and community contexts, and the stigma surrounding extramarital sex. Other barriers include restrictive laws and policies (such as those requiring parental or spousal approval), an unwillingness among health staff to serve the SRH needs of young people, affordability issues, people’s own sense of embarrassment, their concerns about confidentiality, and their fear of stigma (52). Many of these same hindrances stand in the way of accessing HIV-related information, services and products—and they are magnified for young people who belong to populations that are routinely stigmatized and discriminated against.

### Youth-friendly services are increasing

Nominally youth-friendly sexual health services—focused mainly on SRH services—have been developed in Egypt, Iraq, Jordan, Lebanon and Morocco (27). Some countries are also emphasizing the integration of SRH services into primary health care in a bid for greater service equity, accessibility and acceptability. However, primary health-care staff often are not adequately trained to inform, counsel and care for youth (52) and they especially lack the awareness and skills to serve the needs of young people who belong to key populations.
HIV PREVENTION

In the few countries reporting these data, HIV prevention coverage\textsuperscript{11} for key populations is low, especially for young people\textsuperscript{(59)}. Among women who sell sex, the highest coverage was 22–23 per cent in Iran (Islamic Republic of) and Morocco, while among young men who have sex with men prevention coverage ranged from 11 per cent in Algeria to 38 per cent in Tunisia and 47 per cent in Morocco. Only two countries have reported prevention coverage among young people who inject drugs: Iran (Islamic Republic of) (23 per cent) and Morocco (25 per cent) (see Figure 12). There are no data for transgender people.

Figure 12. HIV prevention programme coverage among young key populations in Middle East and North Africa countries with recent data

Condom use

Condom use is a vital HIV prevention method, particularly in countries where rates of viral load suppression\textsuperscript{12} are low and pre-exposure prophylaxis\textsuperscript{13} is difficult to access. Condoms are relatively inexpensive and remain the only method for simultaneously preventing HIV and other STIs, and unintended pregnancies.

\textsuperscript{11} The percentage of survey respondents who reported receiving at least two HIV prevention services (i.e., condoms and lubricant; counselling on condom use and safe sex; testing for sexually transmitted infections; receiving new, clean needles or syringes) from a non-governmental organization, health-care provider or other source in the previous three months. See: UNAIDS. Indicators and questions for monitoring progress on the 2021 Political Declaration on HIV and AIDS — Global AIDS Monitoring 2022 (https://www.unaids.org/en/resources/documents/2022/global-aids-monitoring-guidelines).

\textsuperscript{12} When effective HIV treatment is taken regularly and consistently, it leads to suppression of the virus to a point where it becomes undetectable. The evidence shows that when people living with HIV have an undetectable viral load, there is zero risk of them transmitting HIV to others during sexual intercourse. See: Rodger AJ, Cambiano V, Bruun T, Vernazza P, Collins S, Degen O, et al.; PARTNER Study Group. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. Lancet. 2019;393(10189):2428-2438; and Bavinton BR, Prestage GP, Jin F, Panuphak N, Grinsztejn B, Fairley CK, et al.; Opposites Attract Study Group. Strategies used by gay male HIV serodiscordant couples to reduce the risk of HIV transmission from anal intercourse in three countries. J Int AIDS Soc. 2019;22(4):e25277.

\textsuperscript{13} Pre-exposure prophylaxis involves HIV-negative people taking antiretroviral medications to prevent them from acquiring HIV infection.
In the MENA region, condom use varies widely among young key populations, and it is very low in some countries. In the eight countries reporting these data, an average 51 per cent of young women who sell sex said they had used a condom at last sex with a paying partner. Condom use levels were very low in Egypt and Sudan and exceeded 70 per cent only in Lebanon (Figure 13) (60). In smaller studies among sex workers of all ages, condom use tends to be least common with non-paying partners (22).

Among young men who have sex with men, condom use at last anal sexual intercourse with a male partner averaged at a very low 38 per cent for the region (based on data from seven countries) and ranged from under 20 per cent in Egypt and Yemen to a little over 50 per cent in Algeria and Morocco (Figure 14). Older studies from Jordan (61), Lebanon (62, 63), Morocco (64) also found low rates of condom use in this key population. Only four countries have reported data on condom use among young people who inject drugs, with the values ranging from an extremely low 2 per cent in Egypt to 50 per cent in Tunisia (Figure 15).

Figure 13. Percentage of young females who sell sex (aged 18–24 years) who reported using a condom at last sexual intercourse with a paying partner, by country, Middle East and North Africa, studies from 2014–2021

Source: Data reported to Global AIDS Monitoring system, as of 2023; and UNICEF analysis, 2023.

Figure 14. Percentage of young men who have sex with men (aged 18–24 years) who reported using a condom at last sexual intercourse with a male partner, by country, Middle East and North Africa, studies from 2011–2020

Source: Data reported to Global AIDS Monitoring system, as of 2023; and UNICEF analysis, 2023.

14 The very high prevalence of male circumcision (which substantially reduces the risk for men acquiring HIV during heterosexual intercourse) in the MENA region has probably contributed to limiting HIV acquisition among male clients of sex workers.
Pre-exposure prophylaxis

When taken as an oral pre-exposure prophylaxis (PrEP), a combination of antiretroviral drugs can be highly effective in preventing HIV infection. Currently in the MENA region, only Morocco provides this powerful prevention tool on any significant scale, with about 800 people having used it at least once in 2022 (65). Several other countries have adopted the WHO recommendations on oral PrEP in their national HIV guidelines, but actual provision is very low.

Harm reduction services

The positive public health impact of comprehensive harm reduction – including needle-syringe distribution, opioid agonist therapy and overdose treatment – is clearly established in the scientific literature (2). Those services help reduce the health, social and economic harms of drug use to individuals, communities and societies, and the evidence shows that they do not lead to increased drug use (67).

Iran (Islamic Republic of) is an instructive example of what can be achieved even in an otherwise conservative context. Its Ministry of Health manages an extensive harm reduction programme, which is credited with causing a steep drop in new HIV infections between the early 2000s and early 2010s (1, 68). However, the rest of the region largely lacks the political will to apply – or even facilitate – a public health approach to drug use and dependence. Political support for harm reduction is limited (69) and countries have been slow to include harm reduction services in their national HIV strategies.

Needle and syringe programmes were available on some scale in Algeria, Egypt, Iran (Islamic Republic of), Lebanon, Morocco and Tunisia in 2021, while opioid agonist therapy was available in Iran (Islamic Republic of), Morocco, the State of Palestine and (since 2020) in Algeria. Egypt was preparing to provide opioid agonist therapy, but Lebanon was reportedly experiencing major difficulties continuing its services due to its economic crisis. Opioid agonist therapy was available in some prisons in Iran (Islamic Republic of), Lebanon, State of Palestine and Morocco (69). Given the indications that people who use drugs are starting to inject at earlier ages in some countries, harm reduction should also be tailored for younger users and should be linked to other services, including mental health care and social services (68).
HIV TESTING, TREATMENT AND OTHER SUPPORT

When people living with HIV adhere to effective HIV treatment and succeed in suppressing their viral loads to undetectable levels, they can live long, healthy lives and are unable to transmit the virus to others (70). The number of people receiving antiretroviral therapy in the MENA region has doubled since 2015, to approximately 110,000 in 2022. However, compared with other regions, MENA is underperforming. In 2022, approximately

- 67 per cent [58–79 per cent] of adults living with HIV in the MENA region knew their HIV status (compared with 86 per cent globally);
- 50 per cent [43–59 per cent] of people living with HIV were receiving life-saving antiretroviral therapy treatment (compared with 76 per cent globally); and
- 45 per cent [39–53 per cent] of people living with HIV were virally suppressed (compared with 71 per cent globally).

The biggest gaps are for diagnosing HIV infections and then ensuring that the people who are diagnosed as HIV-positive are able to quickly receive life-saving antiretroviral therapy (Figure 16). Close to one third of the estimated people living with HIV in the MENA region in 2022 did not know they had acquired the virus. Community-led testing services are also unevenly available. In addition, the demand side requires attention: focused and targeted awareness-raising and demand-creation among young key populations are needed. Digital and social network platforms, along with more “traditional” outreach approaches, can be useful for doing so.

Very little is known about the extent to which young members of key populations are aware of their HIV status. In the three countries that have reported those data, HIV testing and awareness was especially low among young people who inject drugs and young men who have sex with other men (see Figure 17).

Figure 16. Percentage of people living with HIV who knew their HIV status, Middle East and North Africa, 2022

The region, on the whole, is also not performing well at linking people who test HIV-positive to treatment services: overall, about 80 per cent of people who knew they were living with HIV were receiving antiretroviral treatment, leaving 20 per cent untreated (Figure 18). Treatment coverage was highest in Saudi Arabia and Kuwait (>90 per cent) and it exceeded 70 per cent in Lebanon, Morocco and Oman in 2022. But several of the countries with the largest populations of people living with HIV were doing relatively poorly at diagnosing and linking people who are HIV-positive to treatment. However, data reported to UNAIDS show that the vast majority of people who do start treatment – at least 90 per cent – keep taking their antiretroviral drugs and achieve viral suppression (Figure 19), which protects their health and makes it impossible for them to transmit the virus to others.

Figure 17. HIV testing and awareness of HIV status among young key populations, Middle East and North Africa, as of 2023

Source: Data reported to Global AIDS Monitoring system, as of 2023.

15 HIV and other health data in some of the Gulf states only include the de jure populations and therefore may be missing some the de facto populations such as migrant workers and refugees.
It is important to note that the HIV treatment coverage data cited here are based on government records or registrations of people who have been diagnosed with HIV, are receiving treatment, and are virally suppressed. These official records are believed to miss many people who belong to key populations and who are reluctant or afraid to engage with health bureaucracies.
4. ENDING AIDS AMONG YOUNG PEOPLE: OBSTACLES AND OPPORTUNITIES

The Middle East and North Africa has a huge opportunity to become the first region to end its AIDS epidemic. The scale and character of its epidemic means that adequately resourced and focused interventions could swiftly reduce new HIV infections and bring life-saving treatment and care to everyone who needs it.

Many of the improvements needed to overcome the AIDS epidemic overlap with core features of primary health care (PHC). As outlined in the 1978 Declaration of Alma-Ata, PHC is aimed at responding more effectively, appropriately and equitably to people’s basic health-care needs, while also addressing the underlying social, economic and political causes of poor health (71). Well-functioning PHC is a cornerstone of a strong health system (72).

In addition to its preventive aspects, PHC requires making health care accessible and affordable to all individuals and families and providing it in ways that are relevant and acceptable to them. Extensive community engagement and participation is, therefore, a vital part of PHC (72, 73). A renewed emphasis on PHC offers fresh opportunities to overhaul basic health services and to do more to tackle the underlying factors that expose people to poor health. Better preventive health care, greater access to health services and support, and stronger community engagement supports everyone’s health, including that of vulnerable adolescents and young people. Those improvements are also essential for achieving universal health coverage and for ending the AIDS epidemic among young people (74).

Seizing that opportunity requires removing the obstacles that obstruct HIV responses. Those include insufficient political will to take effective action against the epidemic; fragile and under-resourced health systems; absent or inappropriate HIV interventions; widespread stigma and discrimination that are mirrored in punitive laws and policies; and neglect of community health systems.

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16 Four core strategic levers can be used for PHC: political commitment and leadership, governance and policy frameworks, funding and allocation of resources, and the engagement of communities and other relevant stakeholders. See Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization and UNICEF; 2020 (https://iris.who.int/bitstream/handle/10665/337641/9789240017832-eng.pdf?sequence=1).
Political will and funding

HIV responses in the MENA region are being held back by insufficient funding, particularly for programmes that focus on the populations who are most at risk for HIV (59). In some cases, the very existence of such populations is denied; more typically, social taboos discourage attention to the health needs of those populations (1). Other realities contribute to this reluctance. In several MENA countries, conflict and protracted political and economic instability have forced public health lower down the ranks of perceived priorities.

More than half of the countries in the region (among them those with the largest AIDS epidemics) have stand-alone national AIDS strategies. Some have adopted specific policies that could boost their HIV responses, but those policies are not always implemented. For example, a majority of countries have adopted national guidelines for the provision of PrEP, but only Morocco provides this highly effective prevention option on a remotely significant scale (75).

Funding for HIV programmes in the region lag very far behind needs: in 2022, financial resources available for HIV in the region fell 82 per cent short of the amount needed to reach the 2025 targets set out in the Political Declaration on ending AIDS (3). The funding available per person living with HIV in 2022 was about 10 per cent lower than it had been in 2010 (76).

Justifying large investments in a robust HIV response can be challenging, especially when countries contend with political and economic instability, conflict emergencies and natural disasters, and host large numbers of refugees and displaced populations. Nonetheless, the HIV epidemics in most of the region are still small enough to yield to modest investments in programmes that are well-targeted and integrated with PHC systems and community systems. Effective advocacy for such investments and actions requires compelling evidence, including the HIV-related data that are in short supply across much of the region.

Punitive and other obstructive laws

Punitive laws sanction stigma and discrimination against vulnerable populations and drive them away from HIV and other health services and support. They also stand in the way of collecting important HIV-related data, and they legitimize a reluctance to provide services that serve the needs of ostracized populations (1).

The MENA region has some of the most restrictive laws against key populations in the world (Table 1). According to data reported to UNAIDS, sex work is criminalized across the entire region, as is the possession of even small amounts of narcotics (there are no data for Yemen). Consenting sex between adults of the same sex is criminalized in almost all countries, and it carries the death penalty under certain conditions in Iran (Islamic Republic of), Iraq, Qatar, Saudi Arabia, United Arab Emirates and Yemen. Transgender people are criminalized or have been prosecuted in more than half of the 12 countries reporting these data (77).
**Table 1. Laws and policies scorecard, Middle East and North Africa, 2023**

<table>
<thead>
<tr>
<th>Country</th>
<th>Criminalization of cross-dressing</th>
<th>Criminalization of possession of small amounts of drugs</th>
<th>Criminalization of same-sex sexual acts in private</th>
<th>Criminalization of sex work</th>
<th>Criminalization of transgender people</th>
<th>Criminalization/prosecution of non-disclosure or exposure to HIV transmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Algeria</td>
<td>No</td>
<td>Yes</td>
<td>Yes, imprisonment (up to 14 years)</td>
<td>Yes</td>
<td>Yes</td>
<td>Neither criminalized nor prosecuted</td>
</tr>
<tr>
<td>Bahrain</td>
<td>Yes</td>
<td>No laws penalizing consensual sex</td>
<td>Yes</td>
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<tr>
<td>Djibouti</td>
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<td>No laws penalizing consensual sex</td>
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</tr>
<tr>
<td>Egypt</td>
<td>Yes, only under certain conditions</td>
<td>Yes</td>
<td>Yes, penalty not specified</td>
<td>Yes</td>
<td>No</td>
<td>Neither criminalized nor prosecuted</td>
</tr>
<tr>
<td>Iran, Islamic Republic of</td>
<td>Yes</td>
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<td>Yes</td>
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<td></td>
<td>Neithr criminalized nor prosecuted</td>
</tr>
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<td></td>
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<tr>
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<td>Yes, only under certain conditions</td>
<td>Yes</td>
<td>Yes, imprisonment (up to 14 years)</td>
<td>Yes</td>
<td></td>
<td>Both criminalized and prosecuted</td>
</tr>
<tr>
<td>Lebanon</td>
<td>Yes</td>
<td>Yes, imprisonment (up to 14 years)</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Libya</td>
<td>Yes</td>
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<td>Yes, imprisonment (up to 14 years)</td>
<td>Yes</td>
<td>Yes</td>
<td>Both criminalized and prosecuted</td>
</tr>
<tr>
<td>Morocco</td>
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<tr>
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<td>Yes</td>
<td>Yes, imprisonment (up to 14 years)</td>
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<td></td>
</tr>
<tr>
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<td></td>
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</tr>
<tr>
<td>Saudi Arabia</td>
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<td>Yes, death penalty</td>
<td></td>
<td></td>
<td>Criminalized</td>
</tr>
<tr>
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<td>Yes</td>
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</tr>
<tr>
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<td>Yes</td>
<td>Yes, imprisonment (up to 14 years)</td>
<td>Yes</td>
<td></td>
<td>Prosecuted</td>
</tr>
<tr>
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<td>Yes</td>
<td></td>
<td>Criminalized</td>
</tr>
<tr>
<td>United Arab Emirates</td>
<td>Yes</td>
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<td>Yes, death penalty</td>
<td>Yes</td>
<td></td>
<td>Both criminalized and prosecuted</td>
</tr>
<tr>
<td>Yemen</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes, death penalty</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source: Laws and Policies Analytics, UNAIDS, 2023.*
Punitive laws targeting key populations should be removed or reformed in favour of public health approaches. However, the prevailing social and political contexts in the region make that highly unlikely in the immediate future. In addition, framing such an appeal in human rights terms, while justified, is unlikely to be an effective approach in settings where assertions of cultural and family values tend to eclipse individualistic, rights-based claims.

Nonetheless, even where the removal of such laws may be politically unrealistic, there is scope for relaxing or adapting their enforcement in favour of public health objectives, as seen in the Islamic Republic of Iran’s extensive harm reduction programme (68), for example, which now extends into some prisons, as well. More supportive policing practices – or, at a minimum, less police harassment and violence – could help avert substantial numbers of new infections and enable more people to seek and benefit from HIV care (78). For that to happen, decision-makers need to be aware of the compelling evidence showing that punitive laws are associated with increased HIV risk and infection (79, 80), and that their removal or non-enforcement is associated with significant decreases in HIV infections and other health threats (81).

Sensitivities surrounding sex – especially involving young, unmarried people – have resulted in parental consent laws that restrict adolescents’ access to HIV and related health services in several MENA countries (Table 2) (82). The unmet need for SRH services among adolescent girls and young women is high; there are almost 900,000 births to adolescent girls each year (29). Laws requiring spousal consent for married women to access SRH services exist in only one country (82), but even in the absence of legal restrictions, women in some other countries struggle to obtain contraception and other SRH services unless they are married (83).
### Table 2. HIV-related parental consent restrictions, Middle East and North Africa, 2023

<table>
<thead>
<tr>
<th>Country</th>
<th>Laws requiring parental consent for adolescents to access:</th>
<th>Laws requiring spousal consent for married woman to access:</th>
<th>Parental consent for adolescents to access:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Contraceptives, including condoms</td>
<td>HIV testing</td>
<td>SRH services</td>
</tr>
<tr>
<td>Algeria</td>
<td>Yes</td>
<td>Yes, for adolescents younger than 18 years</td>
<td>No</td>
</tr>
<tr>
<td>Bahrain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Djibouti</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Egypt</td>
<td>Yes, for adolescents younger than 18 years</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Iran, Islamic Republic of</td>
<td>Yes</td>
<td>Yes, for adolescents younger than 18 years</td>
<td>No</td>
</tr>
<tr>
<td>Iraq</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jordan</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Kuwait</td>
<td>Yes</td>
<td>Yes, for adolescents younger than 18 years</td>
<td>No</td>
</tr>
<tr>
<td>Lebanon</td>
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<td></td>
<td></td>
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<tr>
<td>Libya</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Morocco</td>
<td>No</td>
<td>Yes</td>
<td>Yes, for adolescents younger than 18 years</td>
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<td>Oman</td>
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<td>Saudi Arabia</td>
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<td>No</td>
<td>Yes, for adolescents younger than 18 years</td>
</tr>
<tr>
<td>Sudan</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Syrian Arab Republic</td>
<td>Yes</td>
<td>Yes, for adolescents younger than 18 years</td>
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</tr>
<tr>
<td>Tunisia</td>
<td>Yes, for adolescents younger than 18 years</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>United Arab Emirates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yemen</td>
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</tr>
</tbody>
</table>

Stigma and discrimination

Stigma and discrimination are ever-present threats, including at the primary health-care level and especially for people belonging to stigmatized minorities. The fear of denigration and harassment from health workers deters vulnerable young people from using health services (84), and limits the collection of HIV-related and other health data for populations who are most affected by HIV (5, 85). For non-married women trying to access SRH information and services, stigma and discrimination can also be a routine problem: many young women are unable to access SRH information and services in ways that spare them ridicule and embarrassment (83).

Moralizing approaches to HIV and dismissive attitudes towards people belonging to key populations—especially those who are young—are common, including among health-care workers (86, 87). Tunisia is one of very few countries which collects data about the avoidance of health care due to stigma or discrimination among young key populations. In a 2021 survey, 4 per cent men who have sex with men and 10 per cent of young women who sell sex said they had been refused health care due to their sexual identity or the fact that they sold sex (88). In research from Iran (Islamic Republic of), 32 per cent of young women who sold sex (some of them young) reported avoiding seeking health care due to stigma and discrimination (89), as did 30 per cent of people who inject drugs in Morocco (90), and almost 80 per cent of young men who have sex with men in Algeria (91). There are currently no published data on health-care use among transgender people in the region.

Internalized stigma further undermines effective action against HIV (1). Young people living in contexts where they are exposed to intense stigma, discrimination and social exclusion are especially vulnerable to mental health difficulties (92), which in turn are associated with increased risk taking, less engagement with HIV prevention and lower adherence to treatment (93, 94).

Ridding health services of stigma and discrimination should be a priority. That can occur as part of basic health system strengthening, by adding training and service protocols that foster relevant awareness and knowledge among health-care staff. The training can be introduced as part of curricula and in-service training. Linkages between NGO providers and state- and private-run services can also help. In Lebanon, for example, MENARosa arranges dialogues between women living with HIV and health-care staff. Another idea is to post health-care “mediators” at specific health facilities to support vulnerable young people as they seek information and care (83).

HIV-related data for young key populations

There is an urgent need for better HIV-related data in the MENA region (95), particularly for young people. With very few exceptions, the current data are incomplete and outdated. Most countries do not routinely collect or publicize data on epidemiological HIV risk factors (5), nor do they consistently collect or report age- and sex-disaggregated data. Size estimates for key populations are available for 11 countries but are of varying quality. Almost one third of MENA countries have few or no HIV data on key populations (19).

Data for young members of key populations are especially rare and are derived mostly from HIV biological behavioural surveillance surveys. Many countries have not conducted these surveys for several years, and the surveys hardly ever include people younger than 18 years of age, thereby missing the 15–17-year-olds who may at be risk of HIV infection in their near futures. Recent, post-2016, HIV prevalence and other indicator data for young people are available in only five countries in the region (Algeria, Egypt, Iran (Islamic Republic of), Morocco and Tunisia) and population size estimates for young key populations are available only for Morocco and Tunisia.

The overall lack of actionable data on HIV prevalence, risk factors, and intervention coverage among key and vulnerable populations prevents a full understanding of the scale and dynamics of the epidemic. The collection and sharing of more and better relevant data would provide a boost for advocacy efforts, and it would support both the design of more effective programmes and more efficient allocation of resources.
Stressed, unaffordable and exclusionary health services

Public health systems in many countries are under heavy strain, due to under-investment, damage caused by conflict and natural disasters, and shifting health-care needs. This has led to substandard public health infrastructure and services. In a multi-country survey in 2021, only 38 per cent of young people aged 18–29 years in the MENA region said they were satisfied with their health-care systems (37).

Affordability is a big barrier to receiving health care. Across much of the region, the burden of health care rests increasingly on individuals and their families, with out-of-pocket health spending in the MENA region among the highest in the world. Out-of-pocket spending represented 28 per cent of total health-care expenditure across the region, compared with 18 per cent globally (30).

Health services are exclusionary in other respects, too. Merely enquiring about sexual health information and services can be difficult and humiliating, especially for young people, while stigma and discrimination deter many people from seeking health care.

Stronger efforts to build resilient PHC systems, with linkages to community systems, are necessary across the region. Those efforts should focus on serving vulnerable people who are not being reached, including young people. Doing so would provide a basis for proactively tackling many of the health challenges they face, including HIV.

Those services should be designed and offered in ways that recognize that the health needs of adolescents and young people differ from those of children and adults. They should be youth-friendly and, ideally, should serve young people in their diversity, recognizing that not all young people have the same experiences and needs.

Depending on the setting, some health needs of vulnerable young people could be addressed via more-or-less standard health care packages (like sexual and reproductive health, and maternal newborn, child and adolescent health) and as part of a comprehensive public health approach that aims to benefit all young people. HIV-related elements can be integrated in those packages. Such approaches could help serve some of the HIV-related needs of young female sex workers, for example, especially if it’s supported by efforts to reduce stigma and discrimination at health facilities. But in contexts of severe intolerance towards sexual minorities, that approach is unlikely to work for young men who have sex with other men, or for transgender people. The criminalization of drug use means an approach within standard health care packages is unlikely to work for people who inject drugs. New ways are needed to reach those young people with safe services and support, which include strong community organizations that are engaged and working closely with PHC systems.
Community health systems

Reversing and eventually ending the HIV epidemic in the MENA region requires bringing services and support to the young people who are most at risk for HIV, but who are excluded from existing health systems. The past decade has seen renewed emphasis globally on community health systems to better serve people’s health-care needs. The Community Health Roadmap partnership, for example, has focused since 2018 on health promotion and services outside formal health facilities, including via nongovernmental organizations and community health workers. When deployed as part of primary health care systems, community health workers play vital roles in bridging the gaps between individuals, communities and health-care services, especially when these workers are recruited from the communities they serve and are trained, paid and equipped well (96). A new initiative, the Community Health Delivery Partnership, is seeking to boost primary health care further, including by supporting country-led efforts to integrate community health workers into their human resource and health sector plans (97). These efforts are particularly relevant for serving the HIV and other health-care needs of vulnerable adolescents and young people.

Community-led and -based organizations can provide services and support that are convenient, youth-friendly, and free of stigma and discrimination, and they can link poorly-served populations with other health services in ways that meet their needs and earn their trust.

These community organizations can also detect service gaps (for example, through community-led monitoring) and help hold health systems accountable (98), devise improvements and innovations (for example, shifting to online services during the COVID-19 pandemic), and advocate for better and more equitable health care overall. There is growing evidence of the value and impact of their work in HIV responses and in strengthening health systems generally (99, 100).

In several MENA countries, community-based and other non-governmental organizations are providing important services for young people who belong to key populations. In Lebanon, for example, NGOs such as Helem (101), Proud Lebanon (102), and Marsa (103) have been providing HIV and STI services for men who have sex with men, and other key populations. Soins Infirmiers et Developpement Communautaire (known as SIDC) (104), runs outreach programmes for young people that use peer educators to reach drug users and young people who sell or trade sex. NGOs in Tunisia are providing services that include psychosocial support for survivors of violence, social aid and referrals to welfare services or hospitals for further assistance and care (83). The Tunisian Association for Reproductive Health, a member association of International Planned Parenthood Federation Arab World region is deploying migrant peer educators to reach migrant communities with SRH and HIV information, prevention tools, and voluntary testing services (105).

Active civil society networks include the Regional/Arab Network Against AIDS (106), Middle East and North Africa Harm Reduction Association (107), International Treatment Preparedness Coalition MENA (108), MENARosa (109) (which works with women affected by HIV), Middle East and North Africa Network for People who use Drugs (110), and M-Coalition (111) (a regional health advocacy network focusing on the health needs of sexual minorities). In addition to providing or supporting service provision, they perform advocacy and lobbying, share good practices and seek to develop functional relationships with governments.

To fulfil their potentials, community organizations need more funding and capacity-building support, along with legal and regulatory environments that allow them to operate without harassment (1). Across the region, however, these organizations tend to be small, underfunded and under-staffed, and many operate in hostile regulatory and political environments that make their work excessively difficult, including for securing funding for activities focused on young key populations.
Data collected by UNAIDS show that funding levels for community-led organizations are far below the commitments made in the 2021 Political Declaration on ending AIDS, with most of it coming from international donors (2). There is a major opportunity for the Global Fund, for example to continue assisting on this front. National HIV strategies or frameworks (which exist in most MENA countries) can serve as an entry point for donor support to community organizations that work with and serve vulnerable young populations.17

Social contracting is an attractive option, as well. It involves state entities contracting community organizations to provide certain services. This can boost the reach and impact of HIV and related programmes, while offering NGOs a way to diversify their funding sources and allowing governments to facilitate (at arm’s length) possibly controversial but vital health services for marginalized populations (112).

Social contracting can also foster stronger trust and understanding between NGOs and public health systems. In hostile contexts, it is very difficult to functionally link community-led HIV activities with relevant public health services. But it is possible, as seen in countries like Algeria, Lebanon, Morocco and Tunisia, where NGOs are important providers of HIV and related services for key populations, sometimes via collaboration with national AIDS programmes.

NGOs are also becoming increasingly adept at using digital channels and platforms to provide services and support. Relatively high levels of connectivity in the region18 make it viable to use social media, dating platforms and other digital channels for health and well-being education outreach, including for HIV and sexual health, to young people. An example is the innovative, culturally sensitive and topical online informational service operating in Egypt, known as “Love Matters” (113).

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17 Algeria, Egypt, Iran (Islamic Republic of), Kuwait, Libya, Oman, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic and Tunisia all have a national AIDS strategy or policy; see UNAIDS Laws and Policies Analytics, 2023 (https://lawsandpolicies.unaids.org/topicresult?i=453&lan=en).

18 Mobile phone use in the MENA region has grown from about 26 per cent in 2005 to over 100 per cent in 2015, which is above the world average. Internet access rose from 8 per cent in 2005 to at least 37 per cent in 2015, which is higher than in the rest of the developing world. See: Arab Human Development Report 2016. Youth and the prospects for human development in a changing reality. UNDP Regional Bureau for Arab States: New York; 2016 (https://hdr.undp.org/system/files/documents/ahdr2016enpdf.pdf).
Countries in the Middle East and North Africa can end their AIDS epidemics – if they ensure that the young people who are most at risk can access and use the information, tools and services that protect against HIV. Those young people tend to be vulnerable to many other health threats, as well, due to their socioeconomic circumstances, their limited access to education and viable livelihoods, their exposure to social and institutional discrimination, and their poor access to the basic information and services they need to protect their health and improve their well-being.

The recommendations below reflect the advice of key informants and interviewees, priorities in the 2021 Political Declaration on AIDS, and lessons from successes achieved among vulnerable young people elsewhere the world. If these actions are taken, the MENA region will have a strong foundation for becoming the first region to reach the 2030 goal of ending its AIDS epidemic as a public health threat.

### Improve health data collection and use for young people

- Collect age-disaggregated data, including for young people aged 15–19 and 20–24 years, to guide effective HIV programmes – including data for key population size estimates; HIV-related risk behaviours and determinants; experiences of stigma, discrimination and violence; mental health; and HIV programme coverage, access and quality.
- Invest in research (including qualitative research) to understand the drivers of poor health among young people and identify their key needs and priorities.
- Analyse, share and use the data for designing and assessing HIV and related programmes.

**The 2021 Political Declaration on AIDS** commits countries to collect and use granular, disaggregated HIV-related data in ways that protect people’s confidentiality and rights to privacy. (All countries in the MENA region, except for Syrian Arab Republic, voted in favour of the Political Declaration.) (114)
Invest in integrated HIV programmes and focus them for maximum impact

- Focus HIV programmes on the key populations who are most at risk for and affected by HIV, including those who are adolescents and young people.
- Increase national financial contributions for prevention programmes and allocate those resources efficiently by focusing the programmes where they have the biggest impact. Use improved strategic information to guide those decisions.
- Make it easier for adolescents and young people who are most at risk for HIV infection to access proven prevention options like condoms, pre-exposure prophylaxis, harm-reduction services and HIV self-testing kits, including by partnering with community-led organizations.
- Adapt service operating hours, train and educate health staff to reduce stigma and discrimination in health-care settings, and make greater use of youth-friendly outreach approaches, mentoring and peer support.

The 2021 Political Declaration on AIDS commits countries to fully fund the HIV response; prioritize comprehensive packages of HIV prevention services; and ensure they are available and used by 95 per cent of people at risk of HIV infection.

Strengthen and use primary health care as a foundation for an effective HIV response among young people

- Empower and enable all vulnerable young people, including those with disabilities, to access essential health-care information and services by ensuring they are youth- and key population-friendly, affordable and free of stigma.
- Engage young people in developing and delivering HIV and other health programmes that address their priority health and well-being needs (including for SRH, mental health, and communicable and non-communicable diseases).
- Train health-care staff, social workers and community volunteers to better understand and serve the needs of vulnerable adolescents and young people, and to protect their privacy and confidentiality.
- Develop stronger, practical linkages between community-led or -based providers and state- and private-run health services to build awareness and change behaviours among staff.
- Join the Global Partnership for action to eliminate all forms of HIV-related stigma and discrimination (115) and act on its commitments.
- Remove or, at a minimum, relax the enforcement of punitive laws that drive vulnerable young people away from health and social services (including for mental health), and end police and institutional harassment against them.
- Provide free and quality mental health and psychosocial support services that are integrated into primary health care as part of the minimum services/benefit package for all young people, including those who are refugees, displaced, migrants, out of school and otherwise marginalized.

The 2021 Political Declaration on AIDS commits countries to work towards the vision of zero HIV-related stigma and discrimination; end discriminatory laws, policies and practices; and ensure equitable access to HIV services and support.
5. Recommendations

Empower and strengthen community systems, including through increased access to funding

- Devote more funding, capacity development and technical assistance to support and integrate community health workers as part of primary health care systems, and ensure that they are trained, supplied and paid well.

- Provide funding and technical support to community organizations and initiatives that can strengthen community health systems, using national AIDS strategies (as well as maternal, child and adolescent health, and youth strategies) as entry points.

- Empower, enable and support community organizations to provide integrated HIV and related services to vulnerable young people and link them with other safe and relevant spaces and services.

- Remove or relax legal and regulatory barriers that stand in the way of community organizations providing HIV and other health services to vulnerable young people.

- Promote and facilitate stronger functional linkages between community organizations and formal health services to strengthen referral and support systems.

- Support community organizations to use outreach activities, including via social media, to build awareness, disseminate information, and foster demand for HIV and related services for vulnerable young people, including intergenerational dialogues.

- Permit and enable government structures to develop closer working relationships with capable community organizations, including through social-contracting arrangements for providing specific services. Reduce administrative and other hurdles that overly complicate such relationships.

- Increase opportunities for the meaningful participation of young people in civic life, particularly around education, training and skills development (including digital skills), and employment opportunities.

- Make full use of mobile phone technologies, social media platforms (including artificial intelligence bots) and telemedicine methods to increase people’s knowledge, access and use of prevention, testing and treatment options, and engage celebrities to promote advocacy messages.

- Create platforms/hotlines for providing psychosocial support services, as well as safe places for young people.

- Use art and popular culture to spread awareness about HIV and related risks, such as theatre and other types of in-person or digital channels for raising awareness, with the presence of counsellors to follow up on activities and support and educate participants.

The 2021 Political Declaration on AIDS commits countries to increase engagements with community-led organizations; strengthen support for community-led HIV services; and ensure that relevant networks and communities are sustainably financed and are included in HIV decision-making.
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