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## **XVII International AIDS Conference Regional Session: Middle East August 7, 2008**

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**HAFEDH CHEKIR:** [Speaking in a foreign language]

Nevertheless, the countries are perceived as countries where there is really a low prevalence of AIDS. Nevertheless, the statistics continue showing that the number of cases continue to increase in spite of the fact that we do not have a developed system of the region. All information show an important transition between values particularly when it comes to sexual and reproductive health.

This also shows that this population is information missing. They do not have the necessary amount of information concerning HIV and AIDS. In our country, risk factors are equally important. For example, I can certainly quote blood transmission, IUD's, unprotected sex and mobility due to migration.

It is also important to highlight that preventive programs are rather recent in their implementation. They are not generalized and certainly do not touch the vulnerable populations.

We must note that the health system continues to be rather flimsy, and in order for us to provide a proper answer to this problem; we have to increase the level of work.

I believe that the presentations that you will be listening to will try to describe the AIDS profile in the region and they will be sharing with you the strategies that

will allow them to consolidate the domestic response.

I forgot to tell you that the presentations for this session will be English and French. Those of you wanting to hear the presentation in English will be channel 6, French is channel 7, and Spanish is channel 5. The presentations will also be taped. I turn the floor over to Masseur Abdullah Abdillahi Miguil.

**MALE SPEAKER:** Thank you very much Mr. Chair. Mr. Co-chair and Mr. CHEKIR. I am substituting the Health Minister Abdulla Abdillahi Miguil who could not attend this presentation because he missed his flight because of traffic conditions. Nevertheless, he wanted to recommit his support to you.

Furthermore, he did participate yesterday with the global village, and his words are of asking to continue working on this subject. I will now turn the floor to our speakers. The speakers will be describing what the north and westerly part of Africa situation is. I am asking everyone to actually speak their minds out so we can make strides in the region.

I do want to thank Region Director General and UNAID, the opportunity to co-chair this meeting. The first paper will be given by Dr. Oussama Tawil. He is very well known in our region. He is the General Director for UNAIDS in the region. He will be speaking about the epidemiological situation in our region.

Furthermore, he will also tell us and remind us that we

can never stop fighting against HIV/AIDS and I beg your pardon I could not pronounce his name properly.

**OUSSAMA TAWIL:** I would just like to say that this presentation is a follow up of a presentation also that was done on the first day in a satellite conference, entitled "Know your Epidemic", which was organized by several partners including the World Bank, the UNAIDS Secretariat and WHO. There was a presentation that did a review of the current status of the epidemic as it is known now for the Middle East and North Africa region.

Obviously, I have to say because I am doing a presentation that is covering 22 countries, that I stay a bit on the general level. I know that this does not apply to all the countries, and you can probably point out some of the differences when we get into the discussions, which I hope we will have ample time to. It is already programmed that we should have at least half an hour of discussion in this session.

So first I must say by starting to define the Middle East and North Africa region, everybody probably defines it in a different way, including different UN agencies and international partners unfortunately. But for UNAIDS, the Middle East and North Africa, called in acronym MENA, is covering 22 countries. But I also would like to refer that some of these issues also cover the situation in Pakistan.

Although it is within UNAIDS covered in the Asia context, but with WHO, it is covered in the same region.

As an outline, I would like to focus on four areas. One is the sociopolitical context in MENA. Two is the HIV epidemic trends and patterns. Three is snapshot of the response; maybe it is because we do not have more than a snapshot, but anyway, in terms of response in the region. And I would like to link that with some of the socio-culture and political issues which you probably also will rise in the discussions and debates, and some of the main challenges and opportunities.

How to define the region? I think just to characterize it and profile it a bit. It is still a vast region, although maybe not so highly represented in this conference, but just to note on the side that we have counted at least probably 11 or 12 countries who are represented out of the 22 in this conference. It covers 431 million people and 22 countries excluding Pakistan, which would raise the total quite much higher up.

What is important to note is what is always said about the region, is one-third of the population is below 15 years old, and that obviously has consequences in terms of how we program, and look at the priorities in terms of prevention.

Gender differences are still considerable in this region. There are probably some positive indicators in the

80's and 90's and in this decade in terms of education, work opportunities and public life.

But still, if you look at the situation and number of countries, the differences between men and women in terms of access to education and even if you take the example of Gulf countries where they have high access to education, but low access to work opportunities and of course a much more limited roll in terms of public life. There are some breakthroughs, but still generally it is important to note this aspect when we also talk about vulnerabilities and risks.

Diverse development indicators show that we are talking about a very diverse region. If you look at life expectancy, it varies from 43 years to 79 years of age. Very important to note is the contrasting economic situation. We have the stereotype of this region probably as being the Gulf countries only or being oil rich. The situation is not as such.

We have low income countries, we have middle income countries and we have high income countries, and they are pretty much well divided among these 22. What is important to note also when we talk about resource mobilization and opportunities, is that out of those 22 countries, 14 are entitled to global funds because they are either in the low or low-middle income category.

What is very important to note is that we are a country that although we do not have the highest visibility in terms—

nor the AIDS situation or the response. We always have the highest visibility in terms of the conflicts in this region, political instability and security.

So most of the development of gains we are talking about are continuously questioned by conflicts and wars that span Afghanistan, Iraq, Sudan, Somalia, the Palestinian Territories, sometimes Lebanon and other contacts as well. This is quite important to note because I think this would be one of the issues we need to talk about in terms of the impact also with the political situations on policies and on HIV/AIDS programs.

If I am to summarize the situation in terms of the epidemic, what we say basically is there is no single HIV epidemic in the region. It is quite diverse when in the global report that has been shared in this conference, we are talking an estimated prevalence of 0.3 in the general population.

But when we look at it in detail, it can be very much under .01-percent prevalence to up to 3-percent prevalence. If we use the categories that are generally used globally, we talk about low prevalence countries, countries in the concentrated epidemic phase, in particular, concerning injecting drug users, but also potentially other populations as well, and a generalized epidemic phase.

I know these categories are not satisfactory, and there is in a sense, overlap between them that we are noting on the

ground, which begs the questions to need to sort of develop a better understanding of the categories in terms of HIV prevalence.

The 2007 report estimates 40,000 new infections in the region, and in terms of the diverse epidemic situation, what we should note is that sexual transmission is the main mode we are talking about. The drug-injecting related transmission is very important in a number of countries. Of course, Iran—and here I do not mention—but definitely Pakistan, Libya and Afghanistan. These are variations also in terms of diversity within the countries.

And although we still talk about most infections and cases being reported among men, there is an increase in terms of racial among women, and we are likely to see and we have already seen more in terms of mother-to-child transmission.

I mentioned the diversity of the epidemic, but this diversity is also within countries, indicating that we might have different—whether we talk about Morocco, Algeria or Sudan; even smaller countries like Djibouti shows diversity in terms of the different regions of the country, which means that we might be looking at different risk and vulnerability factors, but definitely what we find where the data exists.

And here when I talked about in the introduction that there is a learning from the facts, we obviously have a gap in the information that exists, half is already mentioned in terms

of second generation surveillance. We are far from where we should be, and we are basing a lot of these conclusions on what data exists.

Where we have the data, and indicators in terms of behavioral data also, we see that the focus should be on most at risk populations. We know at low levels of condom use and prevention in terms of sex workers and limited availability and access to prevention services in general, and obviously as has been said several times and mirrored throughout this conference, I do not think this region is much different in terms of the focus that we should be doing on men who have sex with men.

I just quote small studies here, but they are significant in terms of the prevalence that we are finding where we thought there was no prevalence among men who have sex with men; including in Egypt and in Sudan.

There is evidence, as in sort of the Asia profile, or other regional profiles of overlap of risk between different patterns of sexual transmission and a very strong also overlap between IDU and sexual transmission.

So more and more, I think we will see evidence of emergence of concentrated epidemics among specific populations and setting in the Middle East and North Africa.

Other aspects of vulnerability that we should focus on and which I think most of the public health actors agree on,

meaning the governments, is changing norms or behavior among younger people, and in the recent generations.

We talk about prison settings and the high risk behavior documented there and the different factors of mobility and migration, whether within the region, between countries or between regions. Here, particularly mobility has been a focus in some of the sub-regions of the Middle East and North Africa. In particular, North Africa itself, but also around the Red Sea and the horn of Africa and Gulf countries with migrant labor within the region and from outside the region. Obviously, we have mentioned socioeconomic and gender disparities.

An examples of the levels of risk, even when we do not have prevalence data on HIV among injecting drug users, we see a very high rate of levels of needle sharing in surveys conducted over the last few years. Here, as I mentioned, the overlap of risk that is noted in the data there is available to us. I would like to talk about now opportunities in terms of the response.

Here, I do not want to be describing the response as being something to be proud of, nor as something to be completely not proud of in the sense of what efforts have been done. I think there has been some progress, but obviously there are big gaps that we should note and we should discuss why these gaps are, and what needs to be done.

Here I have made an effort, which I know is a bit

tricky, to profile the countries in terms of the response; taking into account the epidemiological factors and the response factors between the different countries, and I know if you have strong feelings or difference of opinion with us, it is just to say that these categories are basically overlapping and you see a shift in terms of time.

But where the HIV epidemic is visible in terms of seeing a number of cases developing or in terms of the epidemic developing, we recognize that HIV has been taken within the national priorities, and they have embraced the universal access in terms of access to those who need the HIV prevention care and treatment and support.

These countries I mentioned include Algeria, Djibouti, Morocco, Somalia, Sudan and Iran, and it is related again to some of the social and political issues that have been identified, and I know we have a lot to discuss even about Iran, but I just wanted to point out, because the issue of HIV has mirrored another concern—a social and political concern—around drug use and drug cultivation, drug trafficking, effecting the sub-region, which has partly mobilized the authorities and the NGO partners in Iran to give a particular focus on injecting drug use in the community and also in the prison context.

More adapted to the context of the region, taking into account low-prevalence and more limited visibility, are

countries that may not prioritize this issue as the highest issue, but have developed problematic responses, focusing on most at risk populations, and focusing on people living with HIV.

We come to the third category, which is the quite challenging one, and again, I do not intend to put countries in one category or not, but where the stage of the response is facing political constraints in terms of how AIDS is dealt with, and how AIDS is positioned.

AIDS brings up a number of sensitive issues like sexual behavior, like men who have sex with men, like injecting drug use, and all of you know and also has been mentioned the conference, the incidents that have happened, the waves of arrest that took place with men who have sex with men late last year and earlier this year in Egypt.

And here again, I am saying that in Egypt there is an important problematic response, but unfortunately, some of the political challenges we face as well. Iran is another example, just to mention the recent arrest of two actors in terms of the HIV response that happened in late June and which as been brought to the international attention.

Lastly, are the issues of the security and post-conflict context countries? We are there; we do not know really the impact, and where we have last challenges. I mentioned the countries, and some of these countries such as

Afghanistan and Iraq, there is an effort, and the Palestinian territories to address this issue.

I have two minutes, so I will just try to say some things which are very fast. I think in terms of the challenges, in terms of prevention, the focus has been more and more on the most at risk populations, but this work is only beginning, and is far from going forward. But I would like in the presentations afterwards to get a glimpse of the type of problematic approaches on sex work, treatment, care and support. Although there have been initiatives by many of the governments to provide free access to care, to treatment, there is essentially a big gap in terms of the 7-percent coverage of those in need of services.

A positive sign as I mentioned, that 14 countries have possible access to Global Fund resources and meet the criteria. In the last three or four years, we have seen 431 million dollars being channeled in terms of the AIDS response in this region. This may be nothing in comparing to some of the other regions, but in comparing to what we had before, definitely something moving forward.

Services are there mostly through the support of the Global Fund, but far under utilized and access still remains very limited. There is substantial movement forward by the associations and support groups of people living with HIV and civil society, which also Noel will speak of.

Here is just an example of also moving forward in terms of sex work programs, starting from some initial pilot initiatives and lessons learned from Morocco and Lebanon, and trying to adapt that in other countries of the region. I will not go into detail on this.

I would like just to situate, as a closing, in terms of three challenges. In terms of reaching scaling-up towards universal access; political commitment, the issues of stigma and discrimination, including in particular for most at risk populations, such as men who have sex with men and sex work and scaling up the response.

I would just like to conclude with a picture to note the diversity of the situation in this region. Thank you very much.

**MALE SPEAKER:** [Speaking in a foreign language].

**AMAL KARAOUAOUI:** Good afternoon. Today I will try to present some of my experiences in the field work, which is a proximity approach in the Middle East and North of Africa, and we will speak about the orientation for the future.

In the Middle East and North of Africa, or MENA region, homosexuality and sex work are part of the forbidden issues. If I ask you "do you have homosexuals in your region? Do you have sex workers in the region?" Of course everybody has, also in our country, but their religious and cultural conflicts does not allow us to get in touch with a MSM or to the sex workers.

We have broken the silence, thanks to the proximity approach, and the community participation. I will tell you which are the vulnerability factors, as I said before we do have sex workers in our region, and we also have homosexuals in our region like in any other place in the world, but our context is a little bit different, and the vulnerability factor therefore are also different.

If I talk about vulnerability sector, the first word would be silence. Sexual relations do exist, but no one wants to talk about them. We have also ambiguous legislation. We do have legislation, but it is ambiguous. We have laws which could be implemented, but they are also ambiguous for the vulnerable population, stigmatization, marginalization are other factors of vulnerability. They limit the access to information and the means of privation, limited access to health services, social services and legal services.

Now we are talking about a sexual world where they have little perspective of having a better life and that has to do with the socioeconomic and political context. Another risk factor would be the exposition linked to the life style, and in particular to the risky practices.

Key strategies: In fact, we drive in the MENA region to apply certain strategies, particularly those that I am going to mention now. Everything continues to be difficult, but at least we could start with the proximity work and key

strategies.

First we have multi-sectorial partnerships with the participation of the Ministry of the Interior, the Minister of Health, NGO's in the private sector. We have to have clear and favorable policies. We also need programs with multiple elements.

Here I am going to speak about the sex workers, men and women. And for them, the multi-component program is quite important. We need to promote safe sexual practices, we have to promote health services, and we also have to advocate in favor of respect to human rights.

Before talking about the challenges we have on the field, I would like to explain the context where the challenges have been little by little in Morocco, Algeria, Egypt, Oman and the Sudan. Why did we choose those countries? But I am going to mention three examples. I will speak about Oman, Algeria and Sudan, so you can see the context and the experiences that we have in all three countries in relation to other experiences in the region.

This is Oman, before talking about the sex workers in Oman, I would like to mention that it is very important to analyze the situation and that was done with a national plan of the fight against HIV in Oman, after analyzing the situation, we have had several interventions and we are going to explain which is the interventions for sex workers.

This [inaudible] of Oman has a situation of the sex worker which is different from the different nationality we have original from Oman, from Philippines, from Lebanon, from Thailand, a lot of Chinese women too are sex workers.

All of these people work in the [inaudible] when I speak about a situation of sex workers in Oman, I have to make a difference between the nationalists and the foreign. For the national it is quite difficult, because Oman is a small country where everybody knows everyone. On the other hand, the Oman national sex workers have to be hidden. Now, the foreigners could be working in clubs, in bars and massage parlors too.

This population, this group of sex workers has a limited access to information or to social [inaudible] services, they are subject to exclusion and marginally [inaudible]. When I speak about that, I cover all of this no matter the nationality that even for the nationals, everybody knows everyone, and sex workers were known and they are excluded and they are marginalized both nationals and foreigners.

In relation to the men having sex with other men, MSM, this is a sexual practice which is marked by a big silence. They face limited access to the information, and to health services, social services and legal services.

There is also a stigmatization and marginalization, there is a mobility because they have to work underground and

the MSM has very little access to healthcare and they cannot tell their situation to the doctor, they cannot admit that they have sex with other men, and in any case, they do not want to see a doctor, and they do not want to go to a hospital, even if it is a private hospital.

This is something for reflection and orientation, the approach of proximity in terms of intervention strategy and the direct link with the proper services, have allowed us to have centered reflection with the people that work in that field. The idea is to approach the groups interested in that situation and to imply them at the level of conception and the implementation of the programs that affect them.

So it is important to work within that population in order to apply the proximity approach. This is very important in the debate, and in the [inaudible] it is important to explain to the community which is the program, which is the implementation and which is the follow up of the program.

In Oman, the constitution of Oman, is against such a cultural context of the country. This is a very important challenge when I talk about the sex workers and I say that we have Chinese, Thai, Moroccan and from Lebanon. The proximity approach has to be different from any group, there has to be a different approach for each nationality.

I will speak about the challenges in the region, and in this case I will take the case of Algeria. The Algerian

country has done this based with position in relation to the program of prevention in favor of sexual workers and MSM. After several surveys, when I speak about these positions, we need the association at the level of the national program, NGO's, international organization, in order to give a proper response to the problems affecting this group. So we have had certain surveys done in depth in order to find more data in Algeria.

The implication of the communities for the reflection, the implementation and the decision making about the programs that will respond to the needs of the groups that are involved in this problem; the proximity approach that was initiated in Algeria, will guarantee the link between the population and the different services, and this is also in Oman. Sometimes, the sex workers and the MSM has to be—the approach is that they have to exceed the limits of the capital city.

This picture is a section for information of resources of any levels, this is after the program for training by peers. I want to give an idea of which are the challenges in Sudan. The proximity approach for the sex workers has very important challenges. The situation is a little bit different.

The idea or the main activity is ladies that sell tea and coffee on the street, and after the tea, after the coffee that they sold, they offer also a sexual relationship. We call them occasional sex workers.

But also, we have a professional sex workers. When we speak about the Sudan context, we know that it is very difficult, but it is feasible to have polities and to have some outreach to people that have direct access to the population.

In this picture you can see a session for the formation for the training of outreach workers that can provide peer training in order to involve people in the program. This is a peer training where they have many women, most of them sex workers, which come from different parts of the country to receive this peer training.

Before talking about the specific challenges, I will give you several examples that we have to mention, because the examples are different, and most of the contexts are very complex. We could go to the free work, we could get attached with the groups, but there is a lot of silence about this activity and we have to find the proper compromise between keeping the silence and respecting the silence and trying to convince men to be part of the program.

We can speak about the keys on the field. These are the persons that we can find everywhere in Morocco, Sudan, Lebanon, Egypt. These are people that go to Oman, and they have a direct confrontation, and they mingle between the population. But these are the ones who are more concerned about getting the proper services.

They want to have information on the field by means of

a proximity approach, and through this work and their experience, the target groups can give a different orientation to the interventions. It is important to have a round of applause for these activities.

All the people that you see here, they come from Morocco, from Algeria, Sudan, Oman, Egypt, and Tunisia. Before going to the conclusions, I say that these key features of the field are very important, and that is why I would like to give homage to these people.

As a conclusion, the demand that supposes the offer, and the sexual relationship exists also in the region of the Middle East and out of Africa the sexuality is still taboo, but thanks to the proximity approach we were able to break the silence and to take a position and this is in every country that I have mentioned.

Of course, this approach has also served as a caveat. We need a clear, sociological framework and we have direct conflict with the involved population, the proximity approach should be based on listening to the needs and to have a link with the services, but they have to be proper services.

Now, we still have some questions. Of course, we have had some experiences which is remarkable for the population at risk, but we still have some interrogation, the proximity approach is going to be done by whom, first question; the serious society or the first serious society and then that will

get in touch with the groups involved, and then the group should become an actor of action and then it will be only the action, which is the role of the civil society for that community, which is the position of the community because they also will have ownership of work or they have to share the experience in the region and the rest of the world? Which are the next steps?

In relation to the next steps I have to be fast and I do not have much time, but in relation to the next steps we have to consider an immediate prospective and then in the near future. First we will see which are the immediate prospective. I have mentioned in the first place the field intervention to keep people in the field.

It is important to insure the motivation and the reinforcement of the capacity of the actors on the field. We can use the proximity approach yes, but it has to be specific for the different groups and different sub-groups.

I had mentioned because we are going to discuss with the Chinese or the Thai or the Moroccans, the message will be different, the language will be different and the type of approach is different. Also, to assure the quality of services by means of constant follow up systems.

We also need quality in the follow up. We have to imply more and more the communities in the process of reflection, conception, implementation and the follow up of the

program.

It is important to have the communities inquire a certain ownership of a program in order to have better services and end up in appropriate policies. We want to approach that population, but sometimes the policies does not help us as a social society. The civil society and the government, they have to work together, otherwise, they cannot have success. Thank you very much.

**MALE SPEAKER:** Thank you. I understand the emotion when you talk about the workers on the field, the key people, the partnership about different people, the MSM's, the sexual workers and the question that we still have to answer, the last presentation will be Newel Lahouel, from Algeria. The talk will be 'Part of the Solution'- People Living with HIV. Engaged as Key Actors to Achieve Universal Access in Middle East and North of Africa. I would call her a "warrior" against AIDS. So I give her the floor.

**NEWEL LAHOUEL:** Good afternoon, I am Newel Lahouel. I work with the Algerian Association representing people living with AIDS. I want to apologize if I speak about some histories of further regions that do not involve the country that you might be interested, but the MENA region, which is the Middle Eastern, North of Africa will comprise Algeria, Djibouti, and Lebanon. Their leadership and their visibility of a people living with AIDS in the MENA region is an example of Algeria,

Djibouti, Lebanon, Sudan, after 1998. The participation has several meetings and in different countries and in the region, after 2001.

I want to mention the declaration of Algeria in November of 2005. That was the first regional workshop of people living with HIV/AIDS in 15 countries of the region. This is the result of the long process of exchange of information and therefore we could adopt the regional declaration based on the current priority needs. You can finally understand right here, outside this room.

So we have prepared a framework of reference that we have prepared for and by the people living with HIV, despite the differences in languages and cultures. We have done several things, maybe they are not still enough, but we could establish some communication about people living with HIV in Morocco, Tunisia, Yemen, Iran, Libya and Jordan. We have group of people that support the movement of people living with HIV.

After Algeria declaration we decided to get together in May, 2008 in Tunisia in our [inaudible 0:48:28] regional meeting. The advance achieved after dedication of Algeria was quite remarkable. There were many things in favor of universal access. In [inaudible] we gave access to an important number of people living with HIV with a better coverage.

We have better quality of servants, we have a biological follow up, or was centralized. We also provide

psycho-social support and we have initiative of certain activities that give birth to income, that the income generated is not enough, but we also have some activities in prevention. We have the participation of people living with HIV for the promotion of the triage and screening.

What else do we have to do? Well, we need more national response, and therefore we need more coordination. We want to apply and to implement and enforce the existing laws. We want support to the fight against stigmatization and dehumanization and we want to support technical aid in order to guarantee universal and free access.

We work also with the governments and other partners in order to insure the universal access to prevention, treatment, support, and psycho-social counseling. We need to develop individual and collective action.

We want to fight stigmatization and communization we want to mobilize our resources including the exchange of medication by people living with HIV. We want to cooperate with the regional leaders and other actors in order to fight this information. For example, the Minister of Religious Affairs in Iran is collaborating with high association.

There are some pictures here. This is a preparation of a workshop for training. I would like to say I will thank the people of [inaudible] for their visibility, because some of them are part of our region and of our organization and I am so

glad that they give the visibility to the MENA region, and I expect that change will come to our region and we will live a good life like the rest of the world. Thank you. [Applause]

**MALE SPEAKER:** [Speaking in foreign language]. And we have several eminent people, especially. We have the participation from Amal Karaouaoui, from Morocco, and another personality, friends of Lebanon, who have helped the attention in our country to reach the level that it needs to have, although much remains to be done. And now, I turn the chairmanship over to my colleague to the Regional Director from [inaudible] so he can give us the conclusions and then open the floor to questions and answers.

**HAFEDH CHEKIR:** Thank you very much. I want to thank the speakers for the presentation they gave in the rather complicated frameworks. These are frameworks that are rather trailblazing in the area. They have helped up mobilize the civil society and have also helped us mobilize the principal groups as well as allowed us to establish the political alliances, and the alliances needed with the social actors so we can implement the programs.

What they did was make obvious what the needs are that we still have to work with. We need to begin gathering data in order to promote and have the decision makers focus and are a lot more global concerning the national responses in relationship to HIV so they can begin to incorporate their

programs with the legislation.

We also need programs that will allow us to act rather quickly in favor of the groups that are at risk. Especially with MSM's and sex workers. Including the three presentations, we have heard three different accesses. Number one, how can we improve the prevention programs in our region? Because prevention is very, very important.

How can we improve so we can begin working with the less favored categories such as, once again, sex workers and MSM's. The next point that I picked up as important is how to reinforce the health systems as well as the National Health Response System to help reach the millennium goals. As with every category with the population, whether these are pregnant women or these are people that are sick, so that we can reduce mother-to-child transmission.

The third item that I picked up was that this point of view has to be centered on human rights because on account of the current social and political conditions, we need an adhesive social teamwork and refocus law in favor of human rights, human right for men, human rights for women, human rights for people. This is the associated network. We can work this through the network of people who are living with HIV.

I believe this is the time to open the floor, and anyone wishing to pose questions we will ask you to stand up to

the microphone and maybe you can help us issue the proper recommendations and now you have the floor. But you do need to walk over to the microphone please.

**MALE SPEAKER:** Good afternoon, I come from the Association in Lebanon. I do want to congratulate you for the extraordinary work that you are doing in the Arabian countries, but before I do want to ask you that there are several groups that have been condemned to death, especially in the MENA region, and this context messages such as save your lives, use a condom is rather ironic because MSM's are punishable by death.

On the other hand, where they are criminalized, they are penalized, not criminalized perhaps, there is a flagrant violation to human rights, and people are in prison, in a context like that, how can we do any follow up studies on MSM's because in Lebanon, in spite of the programs that we have to fight AIDS, there really are difficulties in convincing MSM's to go to clinics and to visit the necessary clinics to receive treatments.

How can we help change laws in the MENA areas and how can we begin to make the networks known? And I am sure these networks will soon be targeted by the government, so how can we help the MSM's to begin to use the services in a political context as the one that I just described?

**MALE SPEAKER:** -Stock Holland, working out of South

Africa, my question is regarding the conflict situation specifically [inaudible] We know it from two sources, Dr. Mwahad [misspelled?] in '99 he did nicely map the diversity of the HIV in Lebanon, and in 2005 I was working in South Sudan, and also we know from the [inaudible] Sudan, they come from different cultures where there are different HIV sub-types.

And I wonder if there is any specific plan to map [inaudible] to the countries where there used to be conflict in the MENA area, because this will have clinical significance for them when they start treatment. Thank you.

**HAFEDH CHEKIR:** The organizers are asking to please stand next to the microphone so you can appear in the camera.

[BREAK IN AUDIO]

**MALE SPEAKER:** --from Morocco. My question is for Mrs. Karaouaoui. Amal, I want to first to thank you for this very interesting presentation, and I wanted you to know that HIV testing and counseling is not only part of any HIV prevention program, but also the key entry point to all key interventions. I wanted to know what was the--starting from your field experience, what was the approach adopted in your Outreach prevention program?

**AMAL KARAOUAOU:** [Speaking in a foreign language].

**MALE SPEAKER:** -in the presentation you spoke about the risk groups, you mentioned the sex workers and you spoke about MSM's. First we were told that one-third of the people in the

population are less than 15 years of age, and I know there is another portion that are between 15 and 24 years of age.

And I heard the presenter speak about behavioral modification, but we have not even spoken about the youngsters in the MENA region and neither have we spoken about the youth participation in decision making. I believe that youngsters are really not incorporated nor given a rather significant role to play. When it comes to improving prevention, the youth participation will definitely be a factor to improve prevention.

**NADIA BADRAM:** My name is Nadia Badram [misspelled?] I am the person in charge of the AIDS project in Lebanon. As part of the AIDS project, we do have a proximity work issue similar to what you mentioned with the sex workers, we also approach people who inject narcotics or drugs.

I know in some of the countries in the MENA region, people do not always have access to the Global Fund. This is the case for the country of Lebanon, so what would the United Nations agencies wish to do, what kind of associations or partnerships will you be undertaking with us in order to target the proximity type of work and long term.

The problem is sometimes we begin working. We were able to carry out the work for a year and a half, and then the project sadly is abandoned. Therefore, long-term, what perspective do these programs have, especially those countries

that do not have an access to the Global Fund. Thank you.

**ABELA SHAKARA:** Thank you, my name is Abela Shakara [misspelled?] and I am the coordinator of UNAID in Mali. I have been working in Western Africa for 10 years, and there are several comments I would like to share. These are comments and not questions. I want to begin by congratulating the speakers. They were very good presentations.

I have always admired community work, and the proximity type of approach, yet I still have several comments in relationship to recent programs. There are very, very old programs in place. For example, in Algiers and Morocco and I believe it would be worth emphasizing those issues that would improve the health in the region.

Number one, we need to integrate reproductive health services. This is a tool that we need to begin using and number two, we need to decentralize activities, number three, we need to use the health sector services because of the health sectors are quite developed in every region.

And finally, I would like to second the words from the previous speaker. We need to get close to all of the youngsters, not only tell those youngsters who are at risk. We have a whole infrastructure in place that we cannot begin using so I just to conclude, we can use these sector networks which are in place.

**SIETO CASHISECT:** My name is Sieto Cashisect

[misspelled?] I am from Tunisia, and I am studying at the University of Washington in the city of Seattle. My comment is related to women in the Middle Eastern and Northern Africa region.

I have often heard about many activists, but I would like to talk about married women. Married women who married at a very young age, and they marry men who suddenly have sex with other men or inject intravenously, and I would like to draw the attention to people drafting policies in the region, so they can at least look into what is happening, because this is a group that is extremely vulnerable and they do deserve a special occasion.

**EDMOND MALUT:** Good afternoon, my name is Edmond Malut [misspelled?]. I come from Morocco, and I would like to thank these speakers for their presentations and congratulate Noel for the power that she has and for the courage for speaking up front. That is the first association that was created for people that live with HIV, and I do hope that Noel can continue with-

**MALE SPEAKER:** -my belief that the problem with the region is, I do not know, people are rather [inaudible] I do not know if this is part of their region or their culture. You know we will say oh yeah, there is some prevention programs, okay, okay, but these are rather specific programs and they are not long lasting, we can never say that a sex worker in Morocco

has an access to HIV testing or access to any other form of medical prevention.

So what can we do in order to have the proper types of programs in Beirut, in Casablanca, and in any other countries, so MSM's and sex workers can have the proper access to these services.

Only 7-percent of the people have access to treatment, and only 1-percent of the population can access the mother-to-child prevention treatment. This is really a disaster. What we have to ask people to be accountable because it is not always society that will stigmatize and discriminate.

The responsibility comes from the government itself, because we still have lost the stigmatizing as well as unfortunately, we do not have any governments here yet the United Nations must also be accountable to UNAID and the WHO need to reply and be accountable and say why are you not doing anything in our region?

I am not blaming them specifically, but they are part of the problem and I am under the impression that we are certainly not going forward, we have not gained anything, we are living in a rather unsatisfactory situation and we have done so for a very long time.

I believe it is time, it is time to ask for governments to be accountable and we need to ask international institutions to be accountable as well. I will be turning the floor over to

the speaker since we have a few minutes left. And I turn the floor over to Osama.

**OUSSAMA TAWIL:** I would like to say first of all that the issues you are raising, which are extremely important and to the point, are the answers that should be given by the governments, by you, by the civil society partners and by the UN and other international partners.

Again, I am not passing the ball around, I think what we have been trying to do is create a platform for NGO's to come together and to lift their capacity in terms of resource mobilization capacity for the people living with HIV, for having a dialog with the government actors and other sectors and other international partners.

So I think this is one thing we should note. What can the UN do and what can UNAIDS with a few person do except sort of create a platform for a solution which is going to come from the countries, in the countries and in the communities concerned and in the populations concerned. That is the way we see it in terms of moving forward.

Nevertheless, that is why I would like to say that there are here governments that are in this room as well, and they are the different UN agencies that support these actions they should also speak up to these questions.

I would like to point out, starting with the most difficult issue, which is probably what George posed, is that

what do we do in an environment which is completely repressive with regards to men who have sex with men, but also can be in the context of sex work or migrants or sometimes even the context of drug users or injecting drug users.

I do not think that we have sufficient response for that. A programmatic response that we are trying to start activities where we can, does not suffice without a dialog with the governments on the policies and the discriminatory practices that are involved.

I would like to cite the example of Egypt and I would cite that this is a question that we put to ourselves, UNAIDS, what is our role UNAIDS, for example, and representing UNAIDS the family, the other UN agencies, when the government takes a decision to arrest a number of people partly because they are men who have sex with men, partly because of their HIV status.

And we have continued to have this dialog with the Minister of Health in Egypt, with the other sectors of the government concerned, including when we could have the contact with the ministers to influence the situation.

We have worked with the human rights group in Egypt, and on the human rights watch on this issue, because they are partners in this, and we have tried to do what we can in terms of improving the conditions of those who were imprisoned, and were basically were put in the quite bad conditions and not having access to treatment.

We have tried to insure access to treatment, and we have tried to insure better conditions, which partly, because of this advocacy that some of you have joined in have brought about a bit of change but we are not there yet, because that could re-happen again.

There is a policy dialog that needs to be done with the governments and we have to examine what role to do that. If you have any strong opinions on how we should go forward in this, and maybe I should ask that what we have been doing in the question of MSM, we mention the issue of [inaudible] of Oman, there are other countries which have moved forward on some of these issues, like Tunisia and so forth.

We have tried to work where the environment was possible and where we could to the authorities concerned, bring out the issue of the importance of men who have sex with men, the need for prevention and so forth.

We are at the beginning of the road, and I do agree with you that if we do not challenge and talk openly with the governments about policy issues, I am not sure how far we can succeed. But I also leave it to the governments here who have different contacts and examples, to see how they have dealt with this issue.

As far as young people is concerned, I think there is this focus on young people, and here maybe I will digress that question to our colleagues from UNFPA and UNICEF and the

governments as well and the actors in terms of what is being done with young people. I did not correctly, as I did not mention enough in terms of that aspect.

In terms of internally displaced in conflict situation, in Sudan, also in terms of mobilization resources, in very difficult circumstances, in the Palestinian territories and Somalia, we have worked with the Global Fund and other partners to mobilize resources for those populations, including the internally displaced populations, and that is a priority for the Sudanese program. There is also priority in terms of for Somalia; if I can cite those examples.

I think the Global Fund issue may be put it back on the Global Fund in a sense, because this challenge is the same as what the Latin America countries have been saying of the high middle income countries, Lebanon is an example, but there are others which could benefit from this support.

In terms of the issues of access to treatment; I mean [inaudible] said a strong statement about where we are at and the accountabilities for that. This is a fair judgment. We look at things in terms of how they have developed.

If you look at treatment, one of the credits that goes to many of the governments of this region is that those who have had the resources, have tried to provide access to treatment, and have provided it free of charge.

The whole problem is to how many are they providing

services to, to account for the 7-percent figure we have, and what accounts for us bridging that gap and there's no excuse that within one or two years it is not 17-percent or 27-percent, but 37-percent.

And I think this is where we have to make the difference. I think one of the problems is not only in terms of access, to treatment, but access to long-term counseling and testing services, and Outreach programs and so forth to link up these services.

In other words, we are providing treatment in some countries and paying for the cases they know they are providing over 80-percent treatment to them, but there are probably a few thousand more unknown, and this has to be bridged somehow programmatically.

The Global Fund Resources provides us that opportunity to do that, otherwise, maybe Gabrielle can say a few words also no bridging that gap in terms of access to patients.

I do not want to take the floor because there is a lot of other questions, but I give it to whoever would like to contribute to answer.

**AMAL KARAOUAOUI:** I would like to speak about the debate of men having sex with men. It is with really very specific social cultural context it has been very, very difficult to allow these people to allow these people to have appropriate access to the services.

I do believe it is important. The experiences we have lived are important in the region so we can continue working with the groups at risk. We need to continue working with the multi-sectorial probably [inaudible] and the proximity type of treatment is essential.

We see sometimes for example, and we can see demonstrations on the street the workers, workers that do work out in the field that are the link between the vulnerable groups and the quality services. We cannot be working alone. We have to have the motivation from the whole world.

We cannot be doing things alone, and the services that are being donated are broader services, and we need to multiple the associations with other NGO's, this is what will strengthen us and this is what will make our voices heard even better and like I say, Dr. Kankouri [misspelled?] you spoke about testing, about HIV testing I believe at the proximity type of work will fail if it is not related to policy services.

And I would like to emphasize the word quality, because if for example, with six workers, having a test and using a condom are not the only two important issues.

Our research proved that we need to overcome the legal barriers before we can begin solving the health problems. And yes of course, we do undertake the HIV testing; nevertheless, I need to insist on the following issue. The context in each region is very different, sometimes it is very tough, but

likewise, we have been able to apply certain activities and that is right now, what will we be doing in the future? This takes us to the next subject which are the perspectives.

What perspectives will we be using? The perspectives include working with the association, having a multi-sectorial focus, we need to be prepared to have better advocacy and we need to improve access to health services and this is what I wanted to share.

**FEMALE SPEAKER:** --I will have a few comments on the access to treatment in the regions, which you all know when you look at the figure of 7-percent of the people who are estimated to be in need of treatment if the lowest all over the world.

Osama already said that the countries in the region in the recent years have almost all of them made big efforts to establish treatment and care services, there are only two countries, Afghanistan and Iraq that have not yet, at this point in time, services for people in need of treatment, and Afghanistan is working hard and will have it during this year.

They established these services, and now many of them find that not as they hoped many people would come and utilize the services and want to have that treatment, no, it is only quite few who are coming. Why is that the case?

The main problem is that most people who have HIV in the region, do not know that they have HIV. There are certainly some who have it, and have reasons why they would not

go and utilize services, but this is a very, very small minority.

Most of the people just do not know that they are HIV infected, and therefore cannot have access to treatment. There is also a possibility and this is something where we are also working hard with the governments, that the doctors and nurses that might come across persons with symptoms of HIV, do not really detect it, they do not recognize that that might be HIV and then ask and offer to these people to have a test so that they then could be enrolled in treatment.

So I think a major reason why people—even though there are testing and counseling facilities, which are voluntary in most of the countries of the region, they do not utilize these services, it must have to do with the fact that it is not a real viable option for many to have an HIV test. Viable in terms of if I am at risk and I know I am at risk, this is the first thing that has to be the case.

I am not very inclined to go for testing with the services that are available in countries because of stigma, because of fear of non-confidentiality, because of fear of certain laws that are in countries that might make my life even worse after I have had the test than before, so these are so many different approaches that we need from so many different ends, so that more people will want to know their HIV status, will know it, and then will have access to treatment.

We, like UNAIDS and others, UNFPA are working with governments from all these ends to improve the situation, but it takes time, so I think that joining with you people living with HIV with NGO's and working together to influence governments, to make some policy and political regulation changes also, and to provide services that as it has been mentioned are integrated in the existing services, so that broad access will be possible.

It is very important, and for this purpose, one activity which is very important needs to happen and needs to happen more in the countries. Health workers have to undergo a [inaudible] range raising training in terms of reduction of stigma, of misconceptions they have.

They have them all over the world, but in this region, not much has been done yet to change this among the health workers, so that the integrations of health workers will be possible in reproductive health services, in primary healthcare as it is needed. That is as much as I want to say at this point.

**MALE SPEAKER:** [Speaking in a foreign language].

**MALE SPEAKER:** --the time assigned to us has been expired. I want to thank you Mr. President because you let me tell this little comment. I would like to underline every important issue that has not been debated, which is a problem of the women, people that do not have any voice. Most people

think that the AIDS problem is not a social or medical problem, it is a problem of human rights.

Our region does not respect human rights, and even less the right of women. It is important to resist the mandatory AIDS test in the job or to deny Visa's. These are very important elements in the region. I would like to underline at this point on the useless and mandatory AIDS test.

**HAFEDH CHEKIR:** Thank you for this information. The problem is that I think we do not have any more time, we have eroded the certain time. Just one more?

**FEMALE SPEAKER:** I work for the Global Fund, and I want to refer to the question posed by the Lebanese lady saying that some people are not eligible for receiving resources of the Global Fund. I think that you should restudy and resend again the eligibility conditions because maybe it was not really started.

The region situation which is not as bad as it is presented, even after what the Moroccan Representative spoke. All people should be eligible for getting resources from the Global Fund and it is not only beneficial in Morocco, there are more countries like Palestine.

For example, we are quite happy with the participation of these countries and the way they have used their resources to make quality innovations. We have to work in different countries and they have different and specific conditions. It

is difficult to compare cultural and social situations, but I was surprised to see that in Morocco they have started to work with drug addicts, the work you do for sex workers, for us, this is of great importance.

No, I did not go to Egypt, but I repeat this is not as bad, it is not ideal, because we did have several challenges to overcome, but I remain optimistic if we work with the civil society and all their partners, the private sectors, we will arrive to a successful conclusion. Thank you.

**HAFEDH CHEKIR:** Therefore I have to adjourn this session because we have depleted the time. I thank you very much to the panelists, and this little question about the support of the [inaudible] and the UN Fund for Population, and the whole system as a nation.

And there is also an approach about the friends of the human rights that we will cover, all the social categories and every risk situation; and so it is important for improving the legislation, but with the participation of the different social act in order to find an equilibrium and necessary condition for right at that change.

I am sorry, we have to adjourn this session. Thank you very much and this session is adjourned.

[END RECORDING]