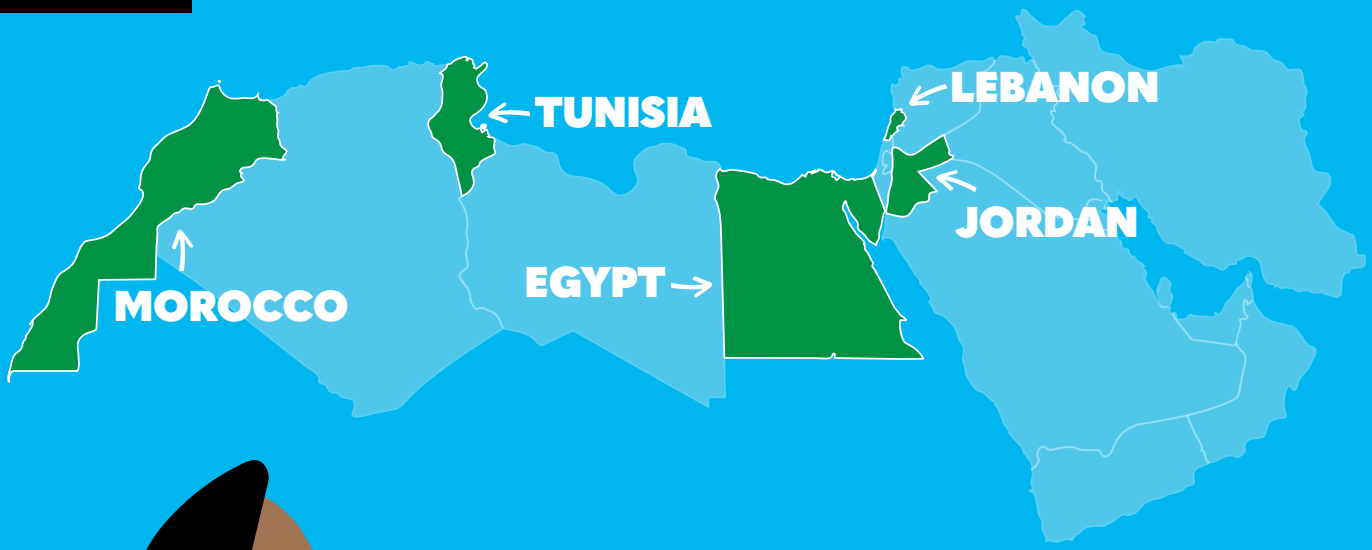
FRONTLINE AIDS

HIV PREVENTION & ACCOUNTABILITY

A MULTI-COUNTRY COMMUNITY PERSPECTIVE

2025



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SUMMARY OF CIVIL SOCIETY ANALYSIS

New HIV infections in the Middle East and North Africa (MENA) surged by 116% from 2010 to 2023. With 22,962 new HIV infections recorded in 2023 – representing 1.77% of global cases – the region is facing a serious HIV prevention crisis. The cost of inaction is high. If not addressed, it could escalate into a generalised epidemic.

Key populations and their partners accounted for an estimated 84% of new infections in 2022, with nearly 20% of new HIV infections among young people aged 15-24. The disproportionate impact on marginalised groups is fuelled by stigma and discrimination, harmful gender norms, low political commitment, and lack of funds.

The region receives only 15% of the funding needed for an effective HIV response. Economic instability and high inflation further diminish the impact of prevention efforts. The impact of the US aid cuts will also have a devastating impact on all health and humanitarian programmes in the region, making it even harder for governments to source funding for HIV initiatives. During times of crisis like these, HIV and the needs of key populations are often not prioritised or included in the humanitarian response agenda.

The 2023 closure of the UNAIDS MENA office and weak coordination among different UN agencies, national governments, and community networks is exacerbating this crisis. Strong regional leadership is critical to ensure governments are held to account on their 2025 HIV prevention targets and commitments.

Civil society and community-led organisations are driving the region's HIV response, but they face limited civic space and inadequate resources. The region also lacks data on health services provided to displaced people, humanitarian efforts, and service coverage, as well as size estimates for key populations, hampering effective strategic planning.

To prevent HIV infections from escalating further, MENA requires sustained and strategic international and domestic funding, along with stronger national political will and regional coordination. UNAIDS should play a key role in fostering regional collaboration, facilitating the exchange of good practices, and supporting cooperation and knowledge-sharing between MENA and other regions.

UN agencies, such as UNAIDS, UNFPA, UNODC, UNICEF and others, could also play an integral role in supporting multisectoral approaches in each country and encouraging greater political commitment, as well as helping to secure additional resources for HIV prevention. This could include calling for innovative financing models and greater support for community-led responses to ensure sustainability and equity in the HIV response.

In parallel, HIV must be better integrated into Universal Health Care (UHC) packages, supported by commitments to improve integration across services and to scale up prevention services for key populations, including community-led services. Priority must be placed on collecting accurate data on key populations, service coverage and prevalence, and submitting this to Global AIDS Monitoring (GAM), both to track progress and to guide targeted interventions. Given the ongoing humanitarian challenges and increasing numbers of displaced people in the region, ensuring that HIV prevention, testing, treatment, and data collection are part of the humanitarian response is critical.

This report provides an analysis of the HIV prevention response, outlining the progress and gaps in five countries: Egypt, Jordan, Lebanon, Morocco, and Tunisia. The findings inform a set of key recommendations aimed at addressing these urgent challenges and strengthening the HIV response in MENA.

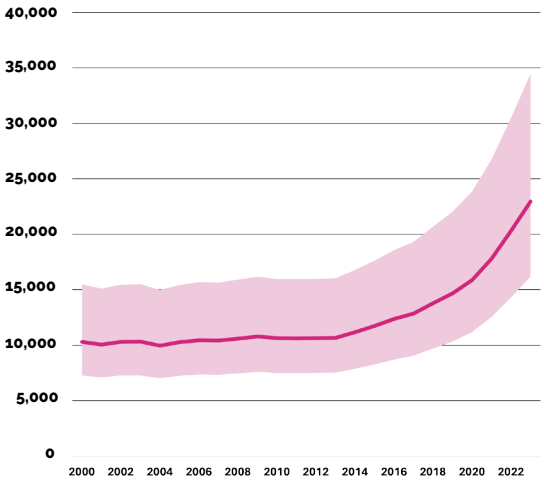
REGIONAL DATA

NEW INFECTION TRENDS & AIDS-RELATED DEATHS

HIV infections are increasing in the Middle East and North Africa, while average global rates are decreasing

116% ↑
increase in new HIV infections in MENA since 2010

−39% ↓
decrease in new HIV infections globally since 2010

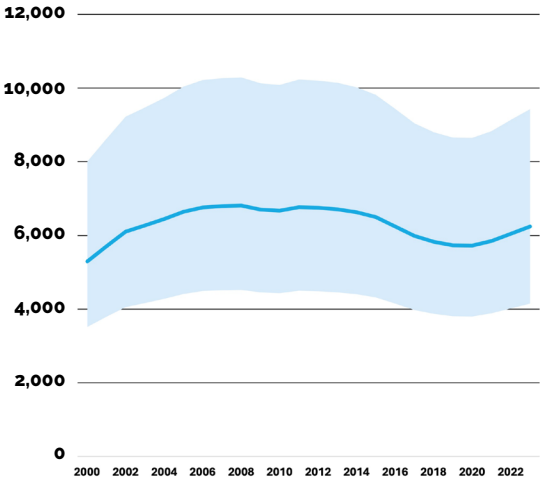


Source: UNAIDS

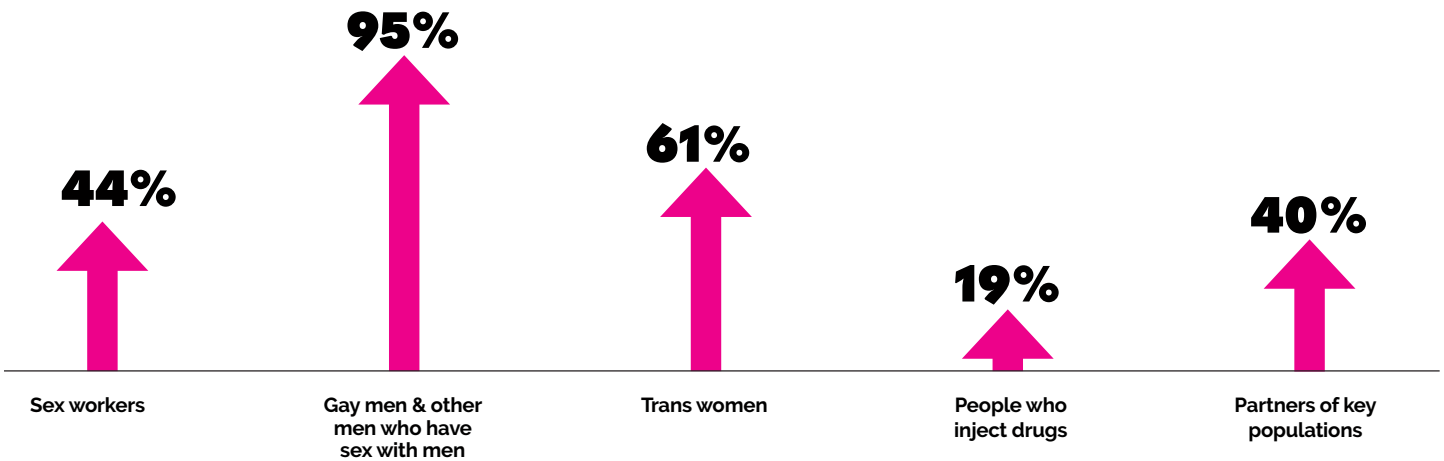
AIDS-related deaths in the Middle East and North Africa are declining more slowly than the global average

−6% ↓
decrease in AIDS-related deaths in MENA since 2010

−51% ↓
decrease in AIDS-related deaths globally since 2010



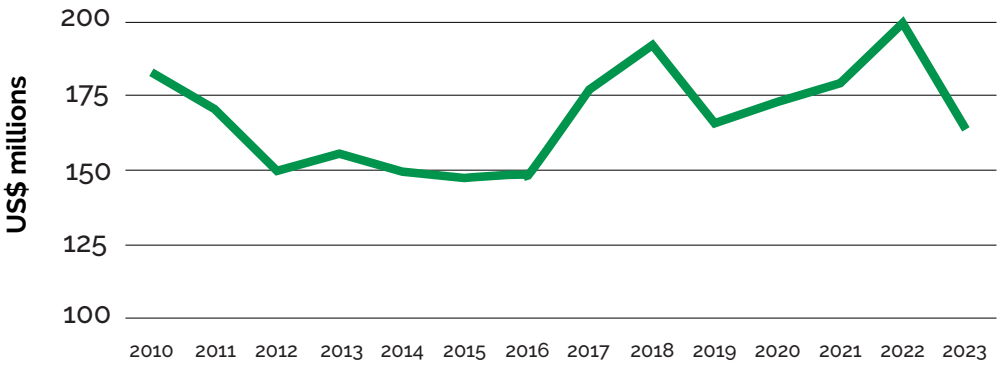
Percentage increase in new infections across different communities between 2010 and 2022



Source: UNAIDS

FINANCING TRENDS

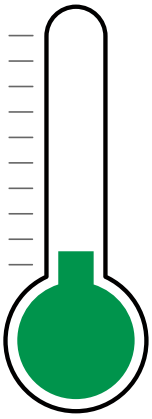
Domestic and international funding for HIV in the Middle East and North Africa is fluctuating, disrupting prevention services



Source: UNAIDS

In 2023, total funding for the MENA region was only $164 million

At less than 1%, this is a fraction of global HIV funding



And only 15% of the fundraising targets have been met for the region

Source: UNAIDS

1 POLITICAL LEADERSHIP

Levels of political commitment to HIV vary across the five MENA countries. HIV generally remains a low priority despite the rising number of infections. Egypt is the only country in the region participating in the Global HIV Prevention Coalition. Although all five countries have national strategic plans, developed with varying levels of input from civil society, these plans are often not readily available online. While most strategies align with UNAIDS 2025 targets, few include specific, measurable goals for each key population group. Additionally, Egypt and Tunisia have strategies that finish in 2025, with no clear succession plans.

Although civil society and community networks play a crucial role across all five countries in delivering community-level HIV prevention services, particularly for key populations, they have limited opportunities to engage with governments in many countries and sometimes feel excluded from key discussions on HIV prevention.

Civic space restrictions remain a significant concern. Although limitations on civil society organisations (CSOs) vary, most countries impose restrictions on foreign funding for non-governmental organisations (NGOs) or are in the process of developing new laws. These regulations often result in lengthy bureaucratic processes, causing significant delays in funding and/or restricting the use of funds.

HIV prevention forums, such as technical working groups and leadership by Global Fund country coordinating mechanisms, exist in several countries to coordinate the HIV response. However, civil society's involvement is limited, and key populations are generally not well represented, except in Morocco and Tunisia. Egypt also recently revitalised the Egyptian Network for National Associations for AIDS (ENNAA). However, there are still only a handful of organisations working closely with the government. Most HIV programmes are housed in the ministries of health and lack dedicated capacity or sufficient budgets. These challenges are further exacerbated by a volatile regional economic context, fluctuating donor funding, and limited domestic financing.

Outdated and inaccurate data on key population sizes and HIV prevalence hinder effective programme planning across the region. Even when estimates are available, there are often delays or reluctance to publish the data. National strategies frequently overlook certain populations, and the lack of tailored services or clear targets is driven by limited data and funding. Prisoners and trans people are particularly neglected, with minimal data available on these groups, although Tunisia and Morocco are planning to create mapping and size estimate studies for trans people. The lack of regional prioritisation stems from deep-rooted discrimination against LGBTQ+ communities,[1] both within governments and within the society at large.

RECOMMENDATIONS

- ✓ **Update and publish National Strategic Plans promptly, with specific targets to ensure stigma-free healthcare for all key populations.**
- ✓ **Institutionalise the meaningful participation of civil society, key populations, women and youth in strategic decision- and policy-making.**
- ✓ **Acknowledge the role of communities in national HIV prevention responses and increase financing to expand community-led initiatives, alongside removing civic space restrictions.**
- ✓ **Re-establish UNAIDS leadership in MENA to improve coordination, knowledge-sharing, and accountability for HIV prevention commitments.**

[1] LGBTQ+ people are individuals who identify as lesbian, gay, bisexual, transgender, queer, or other diverse sexual orientations and gender identities. This includes men who have sex with men and trans people. However, data on these groups in the MENA region is not consistently tracked. As a result, their experiences are often conflated, making it difficult to gather accurate information on specific needs and challenges.

2 FINANCING

Since 2010, MENA has faced a significant decline in funding from bilateral donors, along with inconsistent financial support from the Global Fund and domestic sources. This has had a significant impact on the sustainability of HIV prevention responses. Despite rising HIV infections, MENA has an 85% funding gap for the HIV response and receives less than 1% of the total global HIV funding investment of almost US$19.8 billion.

Fluctuating HIV prevention funding has severely disrupted programme continuity, staffing, and supply of essential commodities. This instability undermines trust among beneficiaries, who face inconsistent access to services and staff. The unpredictable funding environment also affects organisational sustainability, hindering long-term planning and investment, and programme expansion. While the US is not a major funder of HIV programmes in the region, the recent aid cuts will likely put further strain on health and development budgets, exacerbating existing funding shortages, and pushing us even closer to a new AIDS emergency.

All countries covered in this report, except Egypt, have increased health spending in recent years, achieving the recommended 5-6% of Gross Domestic Product (GDP) to healthcare. No evidence suggests these funds have been directed towards HIV prevention.

Transparency around financing for health and HIV prevention remains a significant challenge. None of the MENA countries in this report have public, up-to-date breakdowns of budgets or spending per prevention pillar. The only recent National AIDS Spending Assessments (NASA) available are for Jordan and Morocco. Other countries reported conducting assessments, but verifying this information has been difficult due to limited access.

Efforts to increase domestic financing for HIV prevention have been undermined by the volatile economic context and rising inflation in the region, impacting funding for the HIV response, meaning less money in real terms each year. Jordan and Egypt have made some progress engaging with the private sector, exploring innovative solutions like social impact bonds. However, these initiatives are often hindered by a lack of political will, widespread stigma, and concerns over the reputational risks of backing HIV programmes.

The implementation of Universal Health Coverage (UHC) in Egypt, Lebanon, Jordan, Tunisia, and Morocco shows varied progress. While all five countries signed the UHC2030 Global Compact in 2018, service coverage remains inconsistent. Recent reforms, such as Egypt's 2018 universal health insurance law, Morocco's 2021 Social Protection Financing Law and Tunisia's 2020 healthcare reform, demonstrate efforts to expand access. However, Lebanon withdrew its UHC legislation in 2023 due to financial constraints. Furthermore, HIV prevention services are often excluded from UHC packages, while the intense levels of stigma and discrimination in the MENA region mean that key populations are extremely likely to be left underserved in the transition to UHC.

RECOMMENDATIONS

- ✓ **Ensure transparency by publishing annual health budgets detailing funding for HIV prevention programmes, including the allocations for antiretrovirals/pre-exposure prophylaxis (PrEP) and key populations..**
- ✓ **Develop plans to boost domestic and international prevention financing, leveraging social impact bonds, private sector investment, and flexible funding models.**
- ✓ **Enhance efforts to safeguard HIV prevention as donor funding reduces. Develop sustainability transition plans to support the shift towards domestic financing, involving civil society. Integrate HIV in UHC packages, with safeguards to sustain services for key populations, including community-led services.**

3 SERVICE DELIVERY

There is a significant gap in programme data, with only Morocco tracking service coverage for key populations. This means countries struggle to develop targets for HIV prevention or to make strategic decisions regarding limited resource allocation.

The reduction in national Global Fund grants has created a political vacuum, leaving CSOs to lead HIV prevention efforts. Services for men who have sex with men and sex workers are not available in all regions and trans people remain largely unacknowledged.

Harm reduction programmes are unevenly implemented. Lebanon, Morocco, and Egypt offer needle and syringe programmes and opioid agonist therapy (OAT),[2] while Tunisia and Jordan have more limited services. Peer education and naloxone[3] distribution are mostly absent.

There is limited data on HIV prevention among prisoners, although Tunisia and Morocco implement harm reduction programmes for people who use drugs in prisons.

Although all countries provide free antiretrovirals (ARVs), which communities applaud, challenges remain in expanding access to HIV treatment. Across the region, only 49% of people living with HIV are on treatment, and just 24% of those achieve viral suppression, which reduces the risk of HIV transmission. In some countries, like Tunisia, these numbers are even lower. Routine viral load and CD4 monitoring[4] are crucial for tracking treatment progress and supporting adherence. While Morocco offers free viral load tests in public facilities, access is limited in Lebanon and Egypt due to costs. However, the introduction of self-testing in Egypt, Lebanon, and Morocco is an encouraging step forward.

PrEP is available in Egypt, Tunisia, and Lebanon but is limited to sero-discordant couples[5] and men who have sex with men. PrEP is more widely available in Morocco, including for sex workers and displaced people. Post-exposure prophylaxis (PEP) is available in all countries but is limited to healthcare workers and survivors of sexual assault.

Progress towards eliminating vertical transmission[6] of HIV in the MENA region is hampered by inconsistent service delivery and ad hoc stockouts. While some countries have incorporated HIV prevention into maternal health programmes, there are significant gaps in testing, treatment, and service coverage.

Data on condom distribution and usage is inconsistent. Where figures are available, they often show low levels of coverage, with stigma continuing to be a significant barrier across all countries. Although data is patchy and legislation unclear, most countries report restricted access to HIV testing for young people.

HIV knowledge among adolescents in the MENA region is alarmingly low: only 5-25% of young people aged 15-24 are aware of HIV transmission and prevention. Morocco and Tunisia have formally introduced comprehensive sexuality education in schools, but access to this type of education remains limited in other countries.

RECOMMENDATIONS

- ✓ **Provide CD4 and viral load testing at no charge, as recommended by the World Health Organization.**
- ✓ **Invest urgently in accurate, timely data collection for key populations to improve prevention programming.**
- ✓ **Scale up the full range of HIV prevention and treatment approaches for all who need them, including harm reduction services, PrEP, PEP, prevention of vertical transmission, condom programming, and sexuality education.**

[2] Opioid agonist therapy (OAT) is a treatment for opioid dependence that uses prescribed medications like methadone or buprenorphine to help manage withdrawal symptoms.
[3] Naloxone is a medication used to quickly reverse opioid overdoses.
[4] A viral load test measures the amount of HIV in the blood. It is used to monitor antiretroviral therapy and assess how well treatment suppresses the virus. CD4 cells are white blood cells that help protect the body from infections. A CD4 test measures these cells in the blood. In people with HIV, a higher CD4 count means better immune control.
[5] Sero-discordant couples are couples in which one partner is HIV-positive and the other is HIV-negative.
[6] Vertical transmission of HIV refers to the transmission of the virus from one generation to the next, during pregnancy, childbirth, or breastfeeding.

4 LAWS & POLICIES

Laws, policies, and conservative social and cultural norms create significant barriers to HIV prevention, particularly for key populations, and for all women and girls.

The criminalisation of sex work in all five countries fuels stigma, discrimination, and abuse, often perpetuated by law enforcement. In some cases, condoms are viewed as evidence of sex work, further discouraging people from carrying or using them. Civil society offers support, but limited funding restricts impact.

Personal drug possession is also heavily criminalised. Needle exchange and (OAT) programmes have expanded, but they are mostly available in urban areas. A lack of trained healthcare providers, stigma, and reliance on punitive rather than public health-based approaches deter people who use drugs from seeking care.

Egypt, Morocco, Tunisia, and Lebanon explicitly criminalise same-sex relations, while Jordan uses laws against "public indecency" and religious doctrine to target LGBTQ+ people. Political shifts have led to crackdowns on LGBTQ+ people, while anti-rights movements are exacerbating stigma and discrimination and seeking to limit access to HIV and sexual and reproductive health (SRH) services. Tunisia – once seen as a pioneer, with some progressive health policies – is now facing a rising conservative backlash threatening to reverse hard-won gains.

Only Morocco has published a recent Stigma Index survey, although reports are underway in both Egypt and Tunisia. Many stigma indicators are not reported on regularly. While some countries have made progress, behavioural and structural interventions are often deprioritised, with civil society leading these efforts.

Trans people are not legally recognised in any of the countries in this report. Access to gender-affirming care is limited, with some progress only in Tunisia and Lebanon. Societal stigma and restrictive laws remain significant barriers for trans communities.

Egypt, Jordan, Lebanon, and Morocco have a national human rights commission. Some are relatively new, and these commissions do not always address all issues or communities. While civil society documents human rights violations, the governments do not consistently report or monitor them.

Morocco also has a human rights and HIV strategy, including an analysis of laws impacting the HIV response, with the National Council for Human Rights recommending legal improvements. However, these are still to be acted on.

Despite encouraging efforts, harmful gender norms and weak gender-based violence laws restrict access to essential HIV prevention and wider SRH services for women and young people.

RECOMMENDATIONS

- ✓ **Review and repeal laws criminalising key populations and address challenges posed by anti-rights movements.**
- ✓ **Adapt policies to support human rights approaches and sensitise duty bearers and law enforcement on the human rights of key populations and people living with HIV.**
- ✓ **Act on Stigma Index recommendations and scale up evidence-based programmes.**
- ✓ **Strengthen human rights reporting, provide legal redress, and invest in community-led accountability monitoring.**
- ✓ **Collect data on gender-based violence and address harmful gender norms to create a safer environment for women and girls.**

5 INTEGRATION

The COVID-19 pandemic, along with the other ongoing economic and humanitarian challenges in the region, has resulted in increased poverty and inequality, as well as changes to the labour market. Combined with the large HIV funding shortfall, this has hampered the delivery of integrated HIV prevention services, limiting what is possible in MENA countries.

There is growing recognition of the need to integrate HIV services within broader health frameworks, particularly under UHC. Jordan and Morocco have national strategic plans that include other disease areas, like hepatitis C, or other sexually transmitted infections (STIs). In Lebanon, the National AIDS Programme has merged with the TB programme to improve coordination. However, overall integration remains fragmented due to various challenges, and HIV continues to be deprioritised in many countries.

Integration of HIV and sexual and reproductive health services (SRH) are still in the early stages across most countries. However, there are some examples of progress. Tunisia's National Family Planning Office offers integrated reproductive health services with free STI treatment, and Jordan is piloting SRH and HIV integration alongside a new SRH strategy, with the support of the UN Population Fund (UNFPA).

Harmful gender norms and gender-based violence are key drivers of HIV infections among women in MENA. Although gender-based violence programmes exist, they often fail to connect with HIV prevention efforts and remain fragmented. As a result, women – particularly those living with or most affected by HIV – are frequently excluded from comprehensive support, which is typically only available through CSOs rather than through integrated services.

The MENA region faces significant humanitarian challenges, including ongoing conflicts, natural disasters, and large numbers of migrants, refugees, and internally displaced people. While each country approaches these challenges differently, the integration of HIV into humanitarian responses remains inconsistent and is often inadequate. Global-level guidance on providing HIV services in humanitarian settings is outdated; even when services are available, there is a lack of monitoring and data to track progress.

All countries except Tunisia have humanitarian plans in place, with Jordan and Egypt receiving support from UN agencies. In Jordan and Morocco, humanitarian plans include health components, but HIV and harm reduction are not explicitly referenced. In Egypt, support focuses on refugees and displaced populations; treatment for HIV and hepatitis C is available to these communities free of charge. Across all countries, CSOs provide care without discrimination. However, some governments are reluctant to provide healthcare to undocumented migrants.

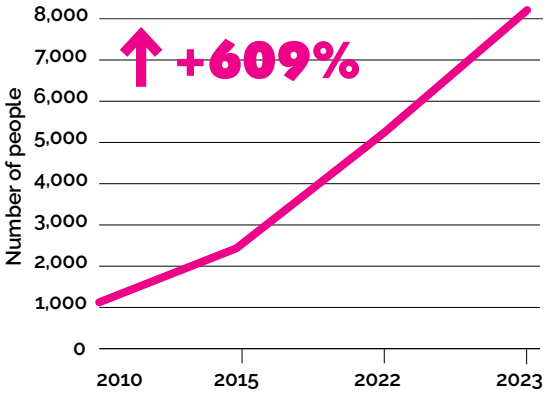
RECOMMENDATIONS

- ✓ **Integrate National HIV Strategic Plans with other health areas, such as TB, SRH, and hepatitis, ensuring HIV prevention is part of UHC packages, with services for key populations.**
- ✓ **Include HIV and harm reduction in humanitarian response plans, providing comprehensive support for marginalised communities; allocate dedicated funding for HIV prevention, testing, and treatment interventions.**
- ✓ **Design interventions with a gender-sensitive approach, collecting gender-disaggregated data to inform policies, and ensure that HIV and gender-based violence programming is explicitly linked.**

EGYPT

EPIDEMIC TRENDS

Percentage change in new infections since 2010 (all ages)



Source: UNAIDS

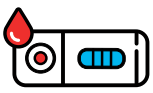
GENDER-BASED VIOLENCE

15.1% (2018)

of women and girls (15-49) have experienced physical/sexual violence by a current or former partner in the last 12 months

Source: UN WOMEN

IS PARENTAL CONSENT REQUIRED FOR ADOLESCENTS TO ACCESS HIV TESTING?



YES,
for adolescents younger than 18

Source: UNAIDS

LAWS AND BARRIERS FACED BY KEY POPULATIONS

Same-sex sexual acts	CRIMINALISED
Sex work	CRIMINALISED
Drug use or possession for personal use	CRIMINALISED
Criminalisation of trans people[7]	INDIRECTY CRIMINALISED
HIV transmission, non-disclosure, or exposure[8]	NOT CRIMINALISED

Source: UNAIDS, ILGA World, Human Dignity Trust

KEY POPULATIONS

Size estimates	Date
Sex workers	2014
Men who have sex with men	2014
People who use drugs	2014
Trans people	NO DATA
Prisoners	NO DATA

Source: UNAIDS Key Populations Atlas

ANALYSING STIGMA

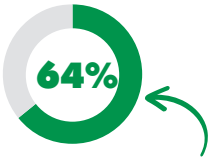
Latest Stigma Index on people living with HIV and key populations

NO DATA

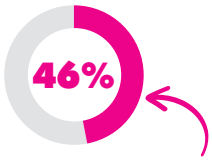
Source: GNP+

PROGRESS TOWARDS 95/95/95 HIV TARGETS

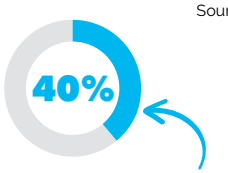
Source: UNAIDS



People living with HIV who know their status



People living with HIV on treatment



People living with HIV who are virally suppressed

PROGRESS

- Egypt is the only MENA country that is part of the Global Prevention Coalition. The Egyptian National Network Against AIDS (EANNA) and the HIV Prevention Technical Working Group are both active.
- A new national HIV strategy is being developed with input from civil society, referencing men who have sex with men for the first time and emphasising harm reduction and access to treatment.
- Prevention services were recently extended to prisoners. HIV testing and counselling is provided through 16 government centres and nine mobile units. Some youth-friendly clinics have also been established, but barriers remain. ARVs are free of charge; PEP access is limited to healthcare workers and victims of rape; PrEP is only available for sero-discordant couples. Free HIV services are available to refugees and other internally displaced people. Following a successful HIV self-testing pilot, there is hope for broader implementation.
- The Egyptian constitution guarantees non-discrimination and the right to health, but some medical professionals may still refuse care. Efforts to address HIV-related stigma in healthcare settings exist, but funding is limited.

GAPS

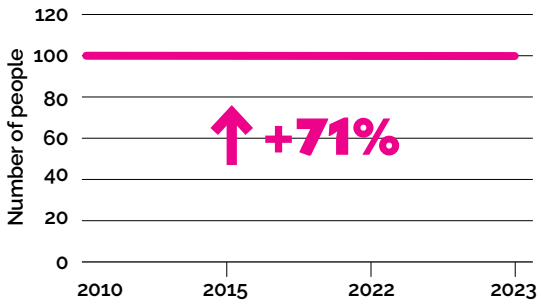
- The 609% increase in new HIV infections in Egypt between 2010 and 2023 is alarming. Many organisations maintain good government relationships, but strict registration regulations and foreign funding controls constrain civic space, hampering swift programme implementation and HIV advocacy.
- Although there is a detailed breakdown of the health budget, including the national AIDS programme, it is not publicly available, making it difficult to track investments. Sustainability of services is a concern; HIV is not included in UHC implementation. High levels of stigma create additional barriers and efforts to diversify HIV funding are limited. The Resource Mobilisation Committee, created to address funding, remains largely inactive.
- Viral load and CD4 tests are not always free and access to HIV testing for under 18s requires parental consent.
- The Egyptian political landscape is challenging. Key populations face criminalisation, stigma, discrimination, and human rights violations. Humanitarian crises strain HIV funding and support for key populations and people living with HIV, yet these communities receive inadequate humanitarian support. The government relies heavily on civil society and UN agencies for critical services.

[7] Some countries directly criminalise trans people, with specific laws targeting gender identity or expression. However, trans people can also be targeted much more indirectly using different types of legislation, such as offences related to public order, public indecency, and vagrancy.
[8] Egypt does not have any HIV-specific laws, but there are examples of the criminal laws being used against those living with HIV.

JORDAN

EPIDEMIC TRENDS

Percentage change in new infections since 2010 (all ages)



Source: UNAIDS

GENDER-BASED VIOLENCE

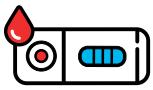
Source: Ministry of Justice, Ministry of Health

13.5% (2018)

of women and girls (15-49) have experienced physical/sexual violence by a current or former partner in the last 12 months

IS PARENTAL CONSENT REQUIRED FOR ADOLESCENTS TO ACCESS HIV TESTING?

Source: Ministry of Justice, Ministry of Health



YES,
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LAWS AND BARRIERS FACED BY KEY POPULATIONS

Same-sex sexual acts[9]	NOT CRIMINALISED
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Drug use or possession for personal use	CRIMINALISED
Criminalisation of trans people	NO DATA
HIV transmission, non-disclosure, or exposure[10]	CRIMINALISED

Source: UNAIDS

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Men who have sex with men	NO DATA
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Trans people	NO DATA
Prisoners	NO DATA

Source: UNAIDS Key Populations Atlas

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Latest Stigma Index on people living with HIV and key populations

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Source: GNP+

PROGRESS TOWARDS 95/95/95 HIV TARGETS

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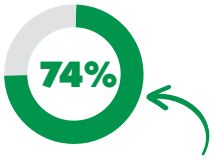
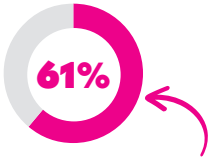
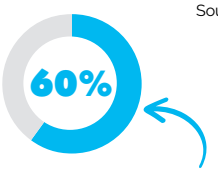


People living with HIV who know their status



People living with HIV on treatment



People living with HIV who are virally suppressed

PROGRESS

- Jordan's new national HIV strategy (2022-2026) aligns with global targets and acknowledges all relevant key population groups. The National Reproductive and Sexual Health Strategy (2020-2030) includes HIV-specific indicators and, for the first time, explicitly references "reproductive rights".
- Health financing has increased over the last decade, but HIV investments have not. Most of the country's HIV funding comes from domestic sources, and the government is exploring innovative financing options, including social impact bonds. Jordan has also made significant progress in implementing UHC. While HIV is included, stigma towards key populations creates barriers to accessing services.
- Jordan has introduced legal reforms aimed at fostering an enabling environment for people living with HIV, including changes to employment policies in the public sector. CSOs are playing a pivotal role in supporting the rights and well-being of affected communities, including efforts to monitor and address challenges faced by key populations.
- Jordan's Humanitarian Response Plan mentions free healthcare in refugee camps, which includes HIV.

GAPS

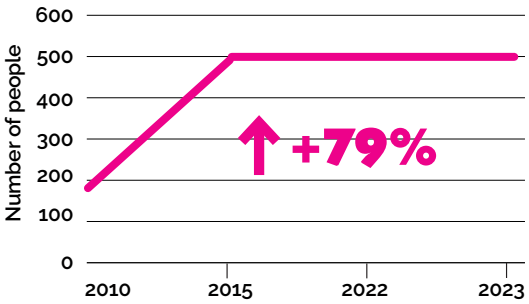
- Jordan's Ministry of Health is underfunded and understaffed, limiting its capacity to coordinate the national response.
- Lack of recent data on new HIV infections and population size estimates hampers programme design.
- HIV prevention is largely deprioritised by government and CSOs play a crucial role in reaching marginalised communities. Civic space is restricted, and access to funding and decision-making spaces are limited.
- While there are no specific laws criminalising LGBTQ+ individuals or people living with HIV, there are no legal protections either. No Stigma Index has been conducted, but civil society and communities report widespread stigma, discrimination, and human rights violations.
- Harmful social and gender norms further limit access to HIV prevention services, including condoms. Oral PrEP remains unavailable, and PEP is only accessible to healthcare workers and rape survivors.
- Jordan's Humanitarian Response Plan mentions free healthcare in refugee camps, with displaced people outside of these camps still paying for services.

[9] The General Iftaa Department issued a Fatwa on Sexual Relations from an Islamic Perspective (Fatwa No. 3670) in 2021, declaring that "homosexuality is illegal under Islamic law", as is advocating for LGBTQ+ rights. However this is not legally binding. Aspects of Jordan's Penal Code, such as laws against "cross-dressing" or acts of "public indecency" are also used to criminalise LGBTQ+ people.
[10] There are general provisions in Jordan's Penal Code that could be relevant to HIV criminalisation, but no prosecutions have been brought to date.

LEBANON

EPIDEMIC TRENDS

Percentage change in new infections since 2010 (all ages)



Source: UNAIDS

GENDER-BASED VIOLENCE

Source: UN WOMEN

NO DATA

of women and girls (15-49) have experienced physical/sexual violence by a current or former partner in the last 12 months

IS PARENTAL CONSENT REQUIRED FOR ADOLESCENTS TO ACCESS HIV TESTING?

Source: SIDC Lebanon

YES,

for adolescents younger than 16

LAWS AND BARRIERS FACED BY KEY POPULATIONS

Same-sex sexual acts	CRIMINALISED
Sex work	CRIMINALISED
Drug use or possession for personal use	CRIMINALISED
Criminalisation of trans people[11]	CRIMINALISED
HIV transmission, non-disclosure, or exposure[12]	CRIMINALISED

Source: UNAIDS, ILGA World, Human Dignity Trust

KEY POPULATIONS

Size estimates	Date
Sex workers	2018
Men who have sex with men	2018
People who use drugs	2014
Trans people	NO DATA
Prisoners	NO DATA

Source: UNAIDS Key Populations Atlas

ANALYSING STIGMA

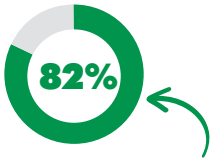
Latest Stigma Index on people living with HIV and key populations

NO DATA

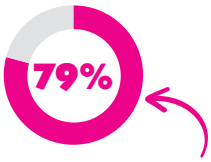
Source: GNP+

PROGRESS TOWARDS 95/95/95 HIV TARGETS

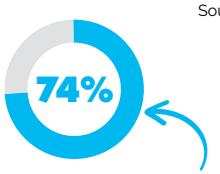
Source: UNAIDS



People living with HIV who know their status



People living with HIV on treatment



People living with HIV who are virally suppressed

PROGRESS

- Lebanon's 2023-2028 National Strategic Plan – developed with the Lebanese AIDS Network Association and others – covers key populations. However, funding gaps could hinder implementation.
- In 2024, the Ministry of Public Health merged HIV and TB programmes. While some called for greater integration with family planning, civil society supported the transition plan, recognising economic pressures Civil society provides prevention services to key populations, and supports gender-based violence programmes. They reduce stigma by working with the Internal Security Forces to protect people living with HIV, and developed professional standards for midwives and social workers. Advocacy groups challenged discriminatory laws against LGBTQ+ people, with some courts ruling favourably.
- An updated Integrated Bio-Behavioural Surveillance (IBBS) study for men who have sex with men was conducted in 2023. However, data for sex workers, trans people and prisoners are limited. Amid the conflict, civil society carried out a needs assessment for key populations. with the government supplying additional ARVs, PrEP, and testing kits, extending the ARV distribution period.

GAPS

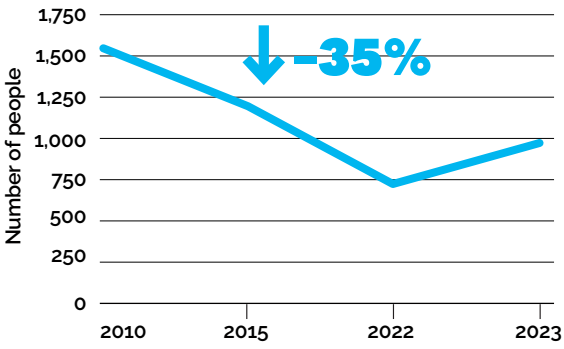
- HIV is not a priority in Lebanon's 2023-2030 National Health Strategy: Vision 2030 and the National AIDS Programme depends on Global Fund support with no contingency plan if funding ends. The ongoing conflict has exacerbated the situation; large numbers of displaced people are stretching already constrained resources.
- While progress has been made in other health areas, HIV is not integrated into Lebanon's gender-based violence response. The focus is on family planning and child health, neglecting women living with or most affected by HIV.
- Poor financial transparency and unreliable data prevent thorough tracking of HIV investments, and the lack of UHC means HIV-related services are not covered by social security or private insurance. High levels of stigma and discrimination create further barriers to access.
- PrEP has been offered to men who have sex with men, but Lebanon still leaves other key populations underserved. Outdated treatment guidelines, stigma, anti-rights campaigns, and laws criminalising key populations further hamper civil society efforts.
- Although HIV testing without parental consent is available for adolescents over the age of 16; with parental consent is required for adolescents younger than 18 for treatment

[11] Some countries directly criminalise trans people, with specific laws targeting gender identity or expression. However, trans people can also be targeted much more indirectly using different types of legislation, such as offences related to public order, public indecency, and vagrancy.
[12] For Lebanon, Article 604 and 606 amended in the Lebanese Penal Code is often used.

MOROCCO

EPIDEMIC TRENDS

Percentage change in new infections since 2010 (all ages)



Source: UNAIDS

GENDER-BASED VIOLENCE

Source: UN WOMEN

10.5% (2018)

of women and girls (15-49) have experienced physical/sexual violence by a current or former partner in the last 12 months

IS PARENTAL CONSENT REQUIRED FOR ADOLESCENTS TO ACCESS HIV TESTING?

Source: UNAIDS

YES,
for adolescents younger than 18

LAWS AND BARRIERS FACED BY KEY POPULATIONS

Same-sex sexual acts	CRIMINALISED
Sex work	CRIMINALISED
Drug use or possession for personal use	CRIMINALISED
Criminalisation of trans people[13]	INDIRECTY CRIMINALISED
HIV transmission, non-disclosure, or exposure[14]	NOT CRIMINALISED

Source: UNAIDS, ILGA World, Human Dignity Trust

KEY POPULATIONS

Size estimates	Date
Sex workers	2017
Men who have sex with men	2017
People who use drugs	2017
Trans people	NO DATA
Prisoners	2023

Source: UNAIDS Key Populations Atlas

ANALYSING STIGMA

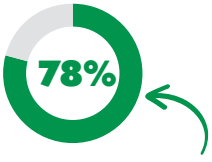
Latest Stigma Index on people living with HIV and key populations

2022

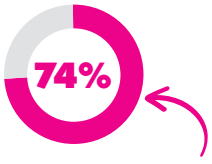
Source: GNP+

PROGRESS TOWARDS 95/95/95 HIV TARGETS

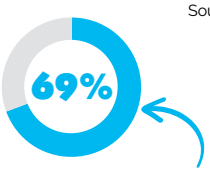
Source: UNAIDS



People living with HIV who know their status



People living with HIV on treatment



People living with HIV who are virally suppressed

PROGRESS

- Morocco is politically committed to HIV prevention and has a new Integrated Strategic Plan for HIV, STIs, and viral hepatitis (2024-2030), which includes meaningful participation with key populations. The national technical working group meets regularly, with civil society driving the response.
- The 2022 data for all key populations revealed high HIV prevalence in specific settings and was used to guide programming. Men who have sex with men, female sex workers, and displaced people can access PrEP through local associations. Service coverage is tracked for most communities but could be higher.
- Funding comes from the Ministry of Health and the Global Fund, with the majority of funds allocated to ARVs, while the budget for prevention has increased.
- Around 70% of the population has health insurance, although coverage is much lower among marginalised communities. While HIV services are included, high levels of stigma create barriers to access.
- Morocco has a National Council for Human Rights and a National Strategy on Human Rights, HIV, and TB. The 2022 Stigma Index has shown reduced stigma since 2016.
- Community organisations remain the locomotive of HIV prevention, leading HIV testing and interventions to reduce stigma and playing an integral role in delivering services during humanitarian crises, such as the 2023 earthquake.

GAPS

- Civil society is very active but relies heavily on donor funding. Laws governing civil society are less restrictive than in many other countries in the region, but laws criminalising drug use, sex work, and abortion affect access to services for these communities.
- Stigma and discrimination against LGBTQ+ communities persist, hindering service access and contributing to human rights violations. While 14.5% of victims used available violation redress mechanisms, there is room for improvement. Lack of disaggregated data also limits programming for trans people.
- The 2022 national spending assessment lacked a detailed breakdown of the budget, making tracking progress difficult. The National Ministry of Health funds the majority of the HIV response, but sustainability remains a concern. Greater private sector involvement is needed.
- Despite PrEP availability, access remains limited in rural areas with low levels of community outreach.
- Harmful gender norms persist and stock fluctuations have occasionally limited access to ARVs, HIV tests, and condoms, affecting coverage.
- A humanitarian response plan was implemented in Morocco following the 2023 earthquake. However, coordination challenges between departments have impacted service delivery.

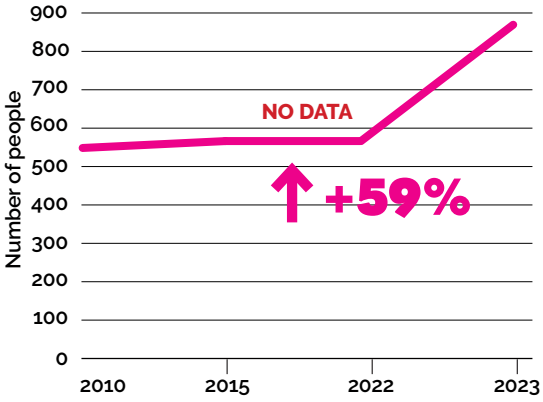
[13] Some countries directly criminalise trans people, with specific laws targeting gender identity or expression. However, trans people can also be targeted much more indirectly using different types of legislation, such as offences related to public order, public indecency, and vagrancy.

[14] Although there are no specific provisions in Morocco's criminal code to punish HIV non-disclosure, exposure or transmission, prosecutions have been carried out under assault law. Two cases have been reported to date, both resulting in not guilty verdicts.

TUNISIA

EPIDEMIC TRENDS

Percentage change in new infections since 2010 (all ages)



Source: UNAIDS

GENDER-BASED VIOLENCE

10.1% (2018)

Source: UN WOMEN

of women and girls (15-49) have experienced physical/sexual violence by a current or former partner in the last 12 months

IS PARENTAL CONSENT REQUIRED FOR ADOLESCENTS TO ACCESS HIV TESTING?

Source: UNAIDS

YES, for adolescents younger than 18

LAWS AND BARRIERS FACED BY KEY POPULATIONS

Same-sex sexual acts	CRIMINALISED
Sex work	CRIMINALISED
Drug use or possession for personal use	CRIMINALISED
Criminalisation of trans people[15]	INDIRECTY CRIMINALISED
HIV transmission, non-disclosure, or exposure[16]	CRIMINALISED

Source: UNAIDS, ILGA World, Human Dignity Trust

KEY POPULATIONS

Size estimates	Date
Sex workers	2011
Men who have sex with men	2011
People who use drugs	2011
Trans people	NO DATA
Prisoners	2018

Source: UNAIDS Key Populations Atlas

ANALYSING STIGMA

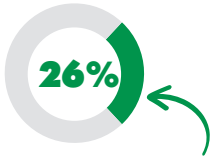
Latest Stigma Index on people living with HIV and key populations

ONGOING

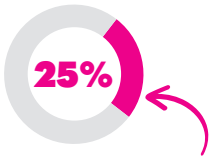
Source: GNP+

PROGRESS TOWARDS 95/95/95 HIV TARGETS

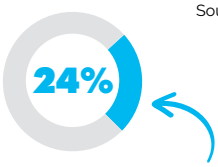
Source: UNAIDS



People living with HIV who know their status



People living with HIV on treatment



People living with HIV who are virally suppressed

PROGRESS

- The National Strategic Plan (2021-2025) prioritises prevention and key populations, including men who have sex with men. Updates are underway to reduce human rights barriers to HIV services, emphasising gender-based violence. Government health expenditure increased after COVID-19; the Global Fund is the main international donor. The Country Coordination Mechanism leads the HIV programme, and transition planning includes exploring social impact bonds.
- ARVs and PEP are available to key populations without restrictions, supported by clinical guidance. There is a vertical transmission prevention plan, and laws prohibit stigma towards people living with HIV. The first Stigma Index 2.0 is being implemented, and human rights violations are tracked via REAct.[17] Efforts to reduce stigma in public health centres have improved staff attitudes, while a civil society sensitisation pilot facilitated easier access to PrEP for key populations.
- The 2017 law on violence against women included comprehensive sexuality education, introduced by the Ministry of Education for ages 5-18 in 2019. However, implementation remains limited.

GAPS

- Tunisia has restricted civic space and, due to competing demands, HIV is not prioritised. Despite increased domestic health financing, limited funds are allocated to HIV prevention.
- Although 90% of the population has health insurance, gaps in prevention coverage limit its impact. High levels of stigma and discrimination continue to act as a barrier. Stockouts and lack of HIV prevention partners in some regions also undermine progress.
- Data on key populations is scarce, and size estimates are outdated, affecting programme quality.
- Organisations providing HIV prevention services are sometimes seen as promoting homosexuality, drug use, and sex work. Proposed amendments to Decree Law No. 2011-88[18] would also strengthen control over CSOs and limit funding. The stigma against LGBTQ+ communities is fuelled by misinformation, crackdowns on influencers, and arrests.
- Gender norms restrict women's access to SRHR and HIV prevention. Although abortion is legal, access is limited. There are no self-testing opportunities or community testing guidelines, and condom use remains low. The government lacks a humanitarian response plan and resists providing healthcare to undocumented migrants.

[15] Some countries directly criminalise trans people, with specific laws targeting gender identity or expression. However, trans people can also be targeted much more indirectly using different types of legislation, such as offences related to public order, public indecency, and vagrancy
[16] HIV is one of many conditions listed under Tunisia's 'communicable disease' law. The penal code also contains a provision relevant to HIV transmission, but no prosecutions have been confirmed.
[17] The Rights – Evidence – ACTion (REAct) tool has been developed to record, monitor, and respond to human rights violations that happen when people access HIV and health services.
[18] Decree Law No. 2011-88 in Tunisia protects the freedom of association, making it easier to register and operate without government interference.

METHODOLOGY

UNAIDS has set ambitious goals to reduce new HIV infections and eliminate structural barriers to HIV prevention by 2030. These targets emphasise the need for equitable access to prevention services, strong community leadership, and government accountability to ensure effective national responses.

Frontline AIDS has worked with advocates across Egypt, Jordan, Lebanon, Morrocco, and Tunisia to assess national HIV prevention efforts in these countries. They reviewed key policy documents and gathered input from government and community stakeholders to provide a comprehensive analysis of national responses.

This report captures the perspectives of civil society and communities, offering an independent assessment of national and regional progress. The resulting summary highlights successes and persistent gaps and serves as a critical complement to official government reports, thus ensuring that community voices remain central to HIV prevention efforts.

ACKNOWLEDGEMENTS

We deeply appreciate all the civil society partners and communities for their joint efforts and leadership in developing this report.

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Design: Jane Austin and Dave Bridges

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