HIV/AIDS Epidemic in Arab States

Editorial

Volume 2 Issue 7 - 2015

Refat Sadeq*

Department of Microbiology, Zagazig University, Egypt

***Corresponding author:** Refat Sadeq, Department of Microbiology, Zagazig University, Faculty of Medicine, Borg Agyad, Mashaya Mansoura, Egypt, Tel: 002- 01003737012; Email: egyrefat@gmail.com

Received: November 20, 2015 | **Published:** November 23, 2015

Editorial

HIV/AIDS is a great problem and number of cases is growing. Nearly half a million people are living with HIV in the Middle East and North Africa (MENA). While other parts of the world have made strategies in combating the spread of the HIV/AIDS. In 2012 UNAIDS (the Joint United Nations Programme on HIV/AIDS), estimated 270,000 people were living with human immunodeficiency virus (HIV) in the countries of the Middle East and North Africa.

The increased prevalence of infection and growing in numbers in the Arab region has been attributed to poverty, low standard of education, religion misunderstanding, unemployment, war and conflict, large population movements including refugees and migrants, gender inequality, sexual and gender-based violence including the trafficking of women, and HIV-related stigma and discrimination. Also misleading in the region, due to under-reporting and the absence of consistent and accurate surveys add more factors to propagation.

The epidemic is generally concentrated in vulnerable populations at higher risk, such as men-who-have-sex-with-men, female and male sex workers, and injecting drugs users. Most Arab countries do not have programmes allowing for exchange of syringes.

Again, lack of awareness, the absence of voluntary testing and of sexual education, social taboos, as well as poverty, are among the factors driving HIV in the region. "Arab governments and societies deny the epidemic and the absence of voluntary testing means that for every infected person we have ten others that we do not know about. In Egypt, Elisa testing is only done in blood donation and immigration to nearest Arab countries for work, not followed by any test of confirmation or any step of management for positive cases. When it is discovered, more than half of the people living with HIV in Egypt have been denied treatment in healthcare facilities, the cause may be religion shame or high price of treatment. In many Arab countries, HIV is already a concentrated epidemic within the community of men who have sex with men (MSM). Reports denoting surveillance about HIV were few in numbers. The study found that Egypt is the only Arab country that has already conducted two rounds of HIV surveillance, with a third one planned in the future. The prevalence of HIV/AIDS in a 789 men sample of the MSM community in Cairo, Alexandria and Luxor is 5.8%.

Sudan and Tunisia were the two other countries with concentrated epidemics in MSM communities, with a prevalence level of 7.8% and 4.9%, respectively. Jordan and Lebanon have lower rates of prevalence at 0.2% and 3.7%, respectively. "The methodology of these studies was sound. However, these numbers should be interpreted carefully as they are from only one such study in each of these countries.

Other Arab states, such as Algeria, Djibouti, Libya, Somalia, the Gulf countries, and the Palestinian Occupied Territories did not have any recent prevalence studies for the team from WCMC-Q to work with, so details of the status of the HIV/AIDS epidemic remains very limited there. "Some other countries, such as Syria and Yemen, have some relatively recent HIV prevalence measures from HIV testing data indicating zero prevalence. However the quality and representativeness of these point-prevalence measures remains limited." Non National organizations did not help to make real surveillance in MENA. Also Arab states have not yet developed coherent national policies regulating HIV and AIDS in the workplace and existing national legislation often lacks explicit provisions to safeguard against discrimination in the workplace.

The workplace offers an effective setting to promote information, education and communication on HIV and AIDS and to contribute to a national response to the HIV pandemic. HIV prevention and treatment programmes have proven to be less costly and more effective if initiated early, allowing people living with HIV to lead long, healthier and more productive lives. The world should put the new international labour standard emphasizes the work in universal access to HIV prevention, treatment, care and support, and contains provisions on potentially life-saving prevention programmes and anti-discrimination measures at the national and workplace levels. Moreover, it highlights the significance of employment and income-generating activities for workers and people living with HIV.

For example, in most MENA countries, the rate of condom use among MSM was generally below 25%, with the only exceptions being Lebanon and Oman. The lowest rate was found in Egypt. General knowledge of condoms was relatively high- but knowledge of their protective effects much lower. In the Arab world, many men who have sex with men are often forced to marry to conform to societal expectations. This may put their female partners at an increased risk of HIV exposure. So Policymakers in the Middle East and North Africa should address this growing health challenge from a public health perspective. This will also limit the potential for HIV transmission to spread to other population groups.

"If we continue burying our heads in the sands and ignoring these marginalized communities the epidemic will explode from a concentrated population to the general population. Our socioeconomic realities mean that many MSM marry and they may transfer the virus to their wives."

Citation: Sadeq R (2015) HIV/AIDS Epidemic in Arab States. J Hum Virol Retrovirol 2(7): 00068. DOI: 10.15406/jhvrv.2015.02.00068