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PROGRESS REPORT

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) IN THE EASTERN MEDITERRANEAN REGION

CONTENTS

1. GLOBAL HIV/AIDS UPDATE

The challenges posed by the global HIV epidemic to both public health and national development continue to grow alarmingly. Today the epidemic is far more extensive than expected based on predictions from ten years ago, and its devastating effects are now clearly apparent in many developing countries. According to recent estimates by WHO and UNAIDS, 36.1 million people were living with HIV at the end of 2000, over 50% more than projections made in 1991. Table 1 outlines HIV/AIDS statistics and features by region as of the end of 2000.

Facing the HIV epidemic is a far more complex endeavour than dealing with any other communicable disease. The levels and patterns of spread vary so widely in different regions, sub-regions and countries that confronting the spread of HIV requires not only specific control strategies but also, as a first step, a basic recognition of the diversity of the situations in which the epidemic unfolds. The considerable differences among countries appear to be associated to sociocultural, educational and economic factors. Countries of sub-Saharan Africa are still the most affected worldwide, however during 2000, the highest rates of increase in HIV infection were registered in Eastern Europe and Central Asia, mainly due to the increasing practice of unsafe drug injecting. Other than injecting drugs, the dynamics of HIV spread in many parts of the world involve prostitution and sex between men, and are often the result of rapid transitions in society and family structures, as well as changes in lifestyles that accompany urbanization, migration, political unrest and globalization. Young people are more likely to be infected by HIV and other sexually transmitted diseases than members of other age groups.

In addition to the well-known consequences on health and health systems, HIV has a drastic impact on the economy and development of the most affected countries. In at least 21 African countries where HIV prevalence had reached 8%, per capita growth is being reduced by 0.4 percentage points each year. This is a considerable loss as most of these countries are already struggling with poverty and fragmented health systems.

The outlook, however, is not without hope since several interventions in prevention and care have been identified to successfully combat the disease and reduce its impact. Furthermore, the unprecedented political mobilization around the problem of HIV/AIDS which occurred during 2000 underlines the growing concern of all nations about the wide spread of HIV, especially in developing countries. The United Nations Security Council in January 2000 passed resolution 1308, which stresses the fact that the HIV/AIDS pandemic poses a risk to stability and security of regions and countries. In 2000 the G8 leaders called for a massive effort to fight infectious diseases that sustain poverty, including HIV, tuberculosis and malaria and committed themselves to supporting improvements in health outcomes among poor communities. Furthermore, United Nations agencies and five major pharmaceutical companies have set up an innovative private/public partnership, the Accelerating Access Initiative. The aim of this initiative is to reduce prices and improve access to antiretroviral drugs for poor people and to develop new and more cost–effective products for prevention, diagnosis and treatment.

Table 1. Features of the HIV/AIDS epidemic by region (December 2000)

Region	Epidemic started	Adults and children living with HIV/AIDS	Adults and children newly infected with HIV	Adult prevalence rate*	% of HIV-positive adults who are women	Main mode(s) of transmission** for adults living with HIV/AIDS
Sub-Saharan Africa	Late 1970s–early 1980s	2.3 million	3.8 million	8.8%	55%	Hetero
North Africa and Middle East	Late 1980s	400 000	80 000	0.2%	40%	Hetero, IDU
South and South-East Asia	Late 1980s	5.8 million	780 000	0.56%	35%	Hetero, IDU
East Asia and Pacific	Late 1980s	640 000	130 000	0.07%	13%	IDU, hetero, MSM
Latin America	Late 1970s–early 1980s	1.4 million	150 000	0.5%	25%	MSM, IDU, hetero
Caribbean	Late 1970s–early 1980s	390 000	60 000	2.3%	35%	Hetero, MSM
Eastern Europe and Central Asia	Early 1990s	700 000	250 000	0.35%	25%	IDU
Western Europe	Late 1970s–early 1980s	540 000	30 000	0.24%	25%	MSM, IDU
North America	Late 1970s–early 1980s	920 000	45 000	0.6%	20%	MSM, IDU, hetero
Australia and New Zealand	Late 1970s–early 1980s	15 000	500	0.13%	10%	MSM
Total		36.1 million	5.3 million	1.1% (average)	47% (average)	

* The proportion of adults (15–49 years of age) living with AIDS in 2000, using 2000 population numbers

** Hetero (heterosexual transmission), IDU (transmission through injecting drug use), MSM (sexual transmission among men who have sex with men)

During the United Nations General Assembly Special Session on HIV/AIDS, held in June 2001, a Declaration of Commitment on HIV/AIDS was adopted to scale up efforts to combat the spread of HIV/AIDS, with specific targets and time-frames in all critical areas including prevention, care, treatment and support. The Declaration is a call for establishing leadership and broad partnerships at all levels in all countries and a tool for developing specific strategies involving communities, young people and people living with HIV/AIDS. The Declaration is also a global call for urgently needed resources. In this regard, a global fund for HIV/AIDS is being established, and a number of countries have announced pledges both to the fund and to the fight against AIDS.

2. HIV/AIDS AND STD SITUATION AND TRENDS IN THE COUNTRIES OF THE WHO EASTERN MEDITERRANEAN REGION

2.1 Regional HIV/AIDS epidemiological situation

By most conservative estimates, more than 400 000 people are thought to be living with HIV in the Eastern Mediterranean Region. This is almost double the estimates of previous years, and is due to revised calculations for Djibouti and Sudan in light of new evidence of increased spread in these countries.

All countries of the Region except Afghanistan reported new HIV and AIDS cases during the year 2000. The cumulative number of AIDS cases in the Region since 1987 has reached 10 479, of which 1263 were notified in 2000. Table 2 shows the distribution of reported AIDS cases in the Region by country since the beginning of the epidemic.

Information on HIV/AIDS in the Region remains insufficient. In many countries the epidemiological surveillance system is still weak and the reporting is often delayed and incomplete. Nevertheless, sexual contact appears to be the most common mode of transmission among reported AIDS cases in the Region and accounts for more than 82% of all known routes of transmission. Drug transmission accounts for only 4% of cases although there is growing concern with this route of transmission.

In general, the HIV epidemic in the Region appears to be advancing slowly; however, applying global figures to the Region masks the wide diversity in the level and patterns of HIV epidemic in different countries.

Countries already suffering from complex emergencies are the hardest hit. HIV is severely affecting Djibouti, Somalia and parts of Sudan. Based on recent HIV surveillance data in Khartoum state in Sudan, 2.5% of women attending gynaecology clinics were found to be HIV seropositive, compared to HIV seropositivity rates of 1.86% in pregnant women attending antenatal clinics and 1.35% in blood donors. Up to 3% of pregnant women attending antenatal clinics in Somalia, and 1.6% in Djibouti, have tested positive for HIV.

Table 2. Reported AIDS cases in the Eastern Mediterranean Region, 1987–2000

Country	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	Total
Afghanistan[a]															
Bahrain	1	–	1	2	–	6	3	6	10	11	14	11	9	8	82
Cyprus	5	6	5	6	7	2	7	11	5	18	10	6	13	24	125
Djibouti	–	1	6	51	107	144	144	196	231	358	434	111	267	131	2181
Egypt	3	6	9	7	12	23	29	22	16	14	25	33	34	44	277
Iran, Islamic Republic of	1	3	5	10	25	16	32	19	16	27	40	21	27	68	310
Iraq	–	–	–	–	7	6	21	37	16	15	2	4	6	1	115
Jordan	3	1	6	1	8	7	8	6	2	4	12	11	3	14	86
Kuwait	–	–	1	1	3	2	2	5	4	5	2	19	4	–	48
Lebanon	–	3	5	10	13	7	22	12	18	5	8	37	32	20	192
Libyan Arab Jamahiriya	–	24	5	11	6	9	2	11	16	21	38	396	72	–	611
Morocco	9	14	20	26	28	30	44	77	57	66	92	93	165	87	808
Oman	11	26	26	22	25	32	37	51	28	24	36	33	45	30	426
Pakistan	2	8	9	5	16	18	16	9	19	20	19	23	17	15	196
Palestine	–	4	1	–	1	6	1	3	3	1	9	3	1	3	36
Qatar	19	11	8	6	10	3	7	6	4	2	4	1	11	–	92
Saudi Arabia	3	6	7	5	10	6	12	38	37	100	112	39	24	24	423
Somalia	1	4	3	5	–	–	–	–	–	–	–	–	–	73	86
Sudan	2	64	122	130	188	184	198	201	250	221	270	511	517	652	3510
Syrian Arab Republic	1	2	8	1	7	3	3	4	6	9	8	8	7	7	74
Tunisia	14	23	19	36	36	38	52	50	65	54	62	44	42	44	579
United Arab Emirates	–	–	–	8	–	–	–	–	–	–	–	–	4	–	12
Yemen, Republic of	–	–	–	1	–	3	4	3	11	60	40	34	34	18	208
UNRWA	–	–	–	–	–	–	–	–	–	1	–	1	–	0	2
Total	75	206	266	344	509	545	644	767	814	1036	1237	1439	1334	1263	10479

[a] No data available
– Information not received

In remaining countries, the spread of HIV infection is still limited to specific population groups such as injecting drug users, migrant populations and other groups whose sexual behaviour puts them at risk of HIV infection.

Alarming signs of increasing rates and levels of spread of HIV are emerging in the Libyan Arab Jamahiriya. After an outbreak of HIV infection among children was uncovered two years ago, the country seems to be facing a significant HIV outbreak among drug users. In 2000 alone, 571 new HIV infections were registered among nationals at the national AIDS programme, almost as many as had been cumulatively reported (611 infections) from the beginning of the epidemic until the end of 1999. Except for 7 cases occurring among children, all cases were among drug users. This could be an indication of a very serious problem and requires national recognition of the problem, intensification of epidemiological investigation and immediate preventive and care actions.

In the Islamic Republic of Iran, a significant increase is noted in the rate of HIV infection among prisoners from 1.37% in 1999 to 2.28% in 2000. In Pakistan, 1.47% of patients with STDs tested HIV positive and in Egypt, 1.47% of a small group of men who have sex with men had the infection.

The findings from HIV screening of tuberculosis patients in few countries point to the need to address seriously the double disease burden of HIV and tuberculosis. The rates of HIV infection among tuberculosis patients are on the rise: 8% in Sudan, 4.8% in Oman, 4.2% in the Islamic Republic of Iran, 2.06 in % Pakistan and 0.6% in Egypt. All rates are several times higher than the HIV rates registered in the general population.

2.2 Dimensions of the STD epidemic in countries of the Region

Sexually transmitted diseases (STDs) are an important cause of morbidity in the Region; however, they are a problem still neglected by the majority of countries. Millions of curable STDs occur in the Region, with only a small fraction actually recognized by the public health system and even fewer reported. In Morocco, for example, recent well-structured efforts to strengthen STD surveillance and control have resulted in estimates of 600 000 STD infections per year.

The findings of recent STD prevalence studies among various population groups in few countries reveal the startling dimensions and progression of the STD epidemic in the Region. Among women attending both gynaecological and antenatal clinics, the incidence of all curable STDs (excluding candida and HIV) is not less than 8% in countries such as Egypt, Morocco and Tunisia. In Sudan, STD incidence rates in the same groups reached 10.5% and 34%, respectively. Studies also show that the risk of acquiring STDs increases many-fold among groups practising high-risk sexual behaviour such as prostitutes, men who have sex with men and injecting drug users. Many of the infections occurring among women may be traced to travel by their male partners. In most countries of the Region, syphilis serology prevalence is still less than 1% in groups of the general population such as blood donors and pregnant women, however, it reaches as high as 36% and 42% in some groups of prostitutes and prisoners.

All available studies and reports confirm striking evolution in the patterns of STDs occurring in the Region over the past decade:

- HIV has been introduced.

- In general, STDs such as gonorrhoea and syphilis have become less common, probably due to the wide and indiscriminate use of antibiotics, but still affect men more than women.

- On the other hand, chlamydia and trichomonas incidence rates have risen significantly, in some countries up to 9% and 23%, respectively.

- Curable STDs registered among women are only a small proportion of all the reproductive tract infections (RTI) that women endure silently, which often reach as high as 47% among both symptomatic and asymptomatic women in some countries in the Region.

- Young people of both sexes between 20 and 29 years are consistently reported to be the ones most affected by STDs compared to other age groups.

- The rising antimicrobial resistance to first-line STD treatments is not a negligible problem. In Tunisia, penicillinase-producing *Neisseria gonorrhoea* is reported in 3% of women with STDs and 42% in women prostitutes. In Sudan, samples tested 100% resistant to penicillin and 64.7% to ceftriaxone.

- The noted patterns of sexually transmitted diseases are mostly based on studies and observations in public health services. Women represent the majority of STD patients in the public sector. This fact implies that a large number of STD patients, mainly men, use services in the private sector.

All available studies from the Region support the conclusion that STDs should be considered a public health priority in most countries. Countries are urged to establish policies and take well-defined comprehensive action to face this epidemic.

2.3 Epidemiological determinants of the HIV/AIDS and STD epidemic in the countries of the Region

HIV/AIDS respects no international borders and favours no nationalities. The internal and international migrations, rapid urbanization and civil and social unrest that prevail in many areas of this Region facilitate the spread of the virus. The occurrence of HIV in one country inevitably links to another. Throughout the Region, changing social norms and lifestyles, especially among younger generations, increase the concerns about the future course of the HIV and STD epidemics. Human behaviour and social conditions that spread the virus are present in all countries of the Region and the epidemic could easily spread in all of them if targeted and effective prevention and care interventions are further delayed. Clearly, no country is immune.

The trend of illicit drug use, more specifically injecting and sharing needles, is on the increase, which makes drug addicts highly vulnerable to HIV infection. Except for Sudan and the Republic of Yemen, all other countries of the Region have reported HIV transmission through injecting drug use. This mode of transmission is frequently associated with HIV/AIDS in Bahrain, Egypt, Islamic Republic of Iran, Morocco, Oman, Pakistan and Tunisia. If left unchecked, the epidemic among these vulnerable populations has the potential to explode, affecting the community as a whole.

There is considerable geographical mobility among populations within the Region and also outside the Region. Such mobility affects large number of countries such as Egypt, GCC countries, Lebanon, Morocco, Pakistan, Somalia, Sudan, Tunisia and Republic of Yemen. Among mobile populations, there is usually considerable risk of contact with casual sex partners, while the situation of refugees is of concern in countries with complex emergencies. Despite the fact that endogenous spread does occur in all these countries, migrants are at increased vulnerability and require better targeted prevention and care efforts.

3. RESPONSE TO HIV/AIDS AND STD EPIDEMICS AT THE REGIONAL AND COUNTRY LEVEL

3.1 National responses to the AIDS and STD epidemics

More than a decade ago, countries in the Region started to develop a base of strong dedicated HIV/AIDS national programmes. Today, the challenge is to rehabilitate these programmes and revitalize their actions in facing the challenges of the epidemic.

A variety of HIV/AIDS and STD activities exist in most countries, including HIV/AIDS epidemiological surveillance, information and education campaigns and some forms of care. However, in all countries without exception, national programmes of HIV/AIDS and STD operate vertically in ministries of health and in isolation from other national health programmes. Examples of sound and effective use of innovative communication methodologies and preventive interventions are rare. The scope, quality and details of the surveillance data vary widely within and between countries, making it difficult to ascertain the magnitude of the problem. Determinants of the epidemic, including behavioural aspects, are seldom studied or addressed so as to understand the infection patterns and define the risk groups and explain why they continue to be infected. The screening of certain groups who are not necessarily groups at high risk of infection, such as foreign workers, remains the largest HIV testing activity in many places. Finally, it is not clear how national AIDS programme planning relates to national health policies and strategies.

Nevertheless, a few countries of the Region have been successful in introducing innovative approaches in prevention and care of HIV/AIDS and STDs. These innovative approaches include mobilization of nongovernmental organizations in Lebanon, decentralization of STD care in Morocco, national HIV/AIDS strategic planning in Pakistan, and HIV harm reduction among prisoners injecting drugs in the Islamic Republic of Iran. Central to this success is the political will to deal with AIDS as a real threat that requires

addressing vulnerability wherever it exists and creating open environments that enhance the well-being of the people and communities living with HIV/AIDS.

3.2 Regional response to the HIV/AIDS and STD epidemics

WHO has strongly supported national AIDS programmes from their inception, and is committed to reinforcing national responses in order to keep the epidemic from further spread. The regional programme hopes to achieve this target by generating reliable information about the epidemic and monitoring its impact; introducing and adapting innovative techniques; building national capacities; and improving health system responsiveness to HIV/AIDS.

At the centre of this approach is the new Regional Office initiative for strengthening integrated approach for control and prevention of infectious diseases, which started with Iraq, Pakistan and Sudan. Also, closer collaboration with tuberculosis programmes was initiated at the meeting of managers of national tuberculosis programmes in the Eastern Mediterranean Region, which took place in Amman, Jordan in September 2000. While the meeting discussed the progress in DOTS in the Region, it also recommended collaborative activities between national tuberculosis and AIDS programmes to include advocacy and social mobilization, training and implementation of sero-prevalence surveys among tuberculosis patients.

In 2000, the AIDS and sexually transmitted disease (ASD) unit in the Regional Office focused on conducting a regional situation analysis as well as updating and revising key prevention and care strategies. To this end, three regional consultations were held recently to advise on vulnerability reduction, updating of surveillance for HIV/AIDS/STD as well as development of strategies for STD prevention and care in the context of the Eastern Mediterranean Region. Furthermore, HIV prevalence estimates for the countries of the Region were reviewed and updated based on available surveillance data and discussed in the eleventh meeting of the national AIDS programme managers in July 2001.

As WHO has adopted a strategy of scaling up the response to HIV/AIDS, which was mandated by World Health Assembly resolution WHA 54.10 of May 2001, the Regional Office has started to expand staffing of its ASD unit in order to improve its guidance and support to countries of the Region.

The Regional Office, in collaboration with headquarters, will take part in September 2001 in the development of the Global Health Sector Strategy (GHSS) for strengthening the health sector response to HIV/AIDS. The essential elements for appropriate response of the health sector will be identified, as well as the implications for action from the regional perspective.

All above milestones of action have been the technical basis for the development of the 5-year regional HIV/AIDS and STD strategic plan which is to be presented to the Forty-eighth Session of the Regional Committee for the Eastern Mediterranean.

In addition, the regional programme for AIDS and sexually transmitted diseases has supported specific country activities in priority areas, namely: second generation surveillance; targeting vulnerable groups mainly youth; counselling and supporting people living with HIV; STD care and control; national strategic planning. This was achieved through technical support and monitoring of JPRM activities as well as specific country-based projects that are funded by UNAIDS. Among completed projects are the Jordanian and Syrian projects on youth, a project in Lebanon on counselling of people living with AIDS (PLWA) and reduction of HIV/AIDS vulnerability in Morocco. The Republic of Yemen's project on care of PLWA and Djibouti's STD projects are still under implementation.

The Regional Office aims at expanding partnerships for HIV/AIDS in the Region and has hosted the office of the UNAIDS intercountry programme adviser to facilitate collaboration and cooperation in the Region.

3.3 Strengthening and expansion of the AIDS Information Exchange Centre

The AIDS Information Exchange Centre is a collaborative initiative between the ASD and Health Information units in the Regional Office and is funded by UNAIDS. It aims at meeting country needs in HIV/AIDS information adequately and efficiently. In 2000 The Centre organized a regional World AIDS Day campaign, under the slogan 'Men can make a difference' and produced supportive materials and a web page on the Regional Office site. The web page provided a forum for countries to post their contributions and exchange experiences in conducting AIDS campaigns, which included production of printed materials, holding official gatherings and mobilization of the mass media and nongovernmental organizations. In addition, 16 UNAIDS technical documents were adapted and translated into Arabic as a basis for an up-to-date Arabic HIV/AIDS/STD library.

An HIV/AIDS/STD information needs assessment study was completed. Findings highlighted the need to reinforce preventive messages related to STD control using mainly television, radio and social communication. It was also evident that sectors other than health have not yet become involved in information and communication about HIV. Guided by the results of the study, the centre plans to develop a communication strategy that meets the identified information needs.

4. A RENEWED APPROACH TO COMBAT HIV/AIDS AND STD IN THE REGION: THE 5-YEAR HIV/AIDS AND STD REGIONAL STRATEGIC PLAN

The recent global developments as well as the changing scale and nature of the epidemic in the Eastern Mediterranean Region have significant implications for the countries of our Region. It is important at this critical turning point that countries take decisive action to enhance the preparedness of the health sector and produce more tangible results in combating HIV/AIDS and other sexually transmitted diseases. At present, combating HIV requires approaches that differ from traditional approaches. Because AIDS is a communicable disease, it poses a public health problem that warrants a public health response. It is simply not enough

to include HIV/AIDS at the bottom of the list of many competing health problems facing ministries of health. In this case, the cost of inaction will be too high.

Total government recognition of the threat of the HIV epidemic is required, as well as full engagement in the fight against AIDS. Denial and complacency will worsen the epidemic and by the time AIDS becomes more visible, it will be too late to prevent its further spread. An evidence-based approach must be followed in interventions for HIV/AIDS in the countries of the Region.

The 5-year Regional Strategic plan for HIV/AIDS and STD will be presented to the Forty-eighth Session of the Regional Committee for the Eastern Mediterranean for approval. This document identifies priorities for action, ways to enhance prevention and care and the resources and technical support that will be needed.