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HIV/AIDS and the 3 by 5 initiative

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1. Introduction

In 2004, about 3.1 million people globally died of AIDS and an estimated 39.4 million were living with HIV, including about 4.9 million who acquired the virus last year. Increasingly, women and girls are affected by the epidemic.

There have been significant and successful efforts to scale up the global AIDS response since 2001. With the 3 by 5 Initiative, WHO and UNAIDS set the ambitious target that by the end of 2005, 3 million people living with HIV/AIDS should be receiving antiretroviral therapy (ART), with the ultimate goal of providing universal access to ART and other HIV services. Global efforts have been coupled with a reduction in the prices of the life-saving antiretroviral drugs and the simplification of the treatment procedures and regimens. As a result, global funding has almost tripled (from US$ 2.1 billion in 2001 to an estimated US$ 6.1 billion in 2004), and access to key prevention and care services has improved markedly. Moreover, at the end of 2004, the number of people receiving ART was estimated to be 700 000 in developing and transitional countries, representing a dramatic increase from the 480 000 receiving ART in mid 2004. The number of women offered services to prevent mother-to-child transmission has increased by 70%. In countries that already provide ART, HIV/AIDS has become a disease that can be both prevented and treated. As a result, attitudes towards HIV/AIDS in those countries are changing and denial, stigma and discrimination are decreasing. New ways to enhance prevention are opening up, as more people want to know their HIV status.

In early 2004, the Regional Office launched the 3 by 5 Initiative in the Eastern Mediterranean Region and has successfully mobilized a number of countries to commit to rapidly scaling up care and treatment for people living with HIV/AIDS.

2. The burden of the HIV/AIDS and sexually transmitted infection epidemic in the Region

2.1 Rising morbidity and mortality due to HIV/AIDS and sexually transmitted infections in the Eastern Mediterranean Region

Table 1 gives an overview on the epidemic situation in the Region. By the end of 2004, the total estimated number of HIV/AIDS cases in the Region had reached 710 500. An estimated 92 000 new infections occurred in 2004, reflecting a substantial increase (> 60%) in incidence compared with 2003. Comparing absolute numbers, new HIV infections in the Region in 2004 were more than in Western Europe and North America combined (65 000). The majority of HIV infections in the Region are due to heterosexual transmission and sharing of injection equipment among injecting drug users. By the end of 2004, 53% of the cumulative number of reported AIDS cases in the Region were from Sudan, Somalia and Djibouti alone, even though Djibouti and Somalia have not reported since 2000.

According to the World Health Report 2003[1], in 2002 HIV/AIDS and sexually transmitted infections (STIs) became the second leading cause of mortality due to infectious and parasitic diseases among people 15–44 years old in the Eastern Mediterranean Region. Among children under 5 years of age, mortality due to HIV/AIDS and STIs is equivalent to 44% of that caused by measles, and represents 4.2% of the deaths caused by infectious and parasitic diseases. Moreover, HIV/AIDS and STIs have contributed to the loss of 2 872 978 years of healthy life, as expressed in disability-adjusted life years (DALYs), particularly among women of childbearing age (1 021 619 DALYs).

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[1] *The World Health Report 2003: Shaping the future*. Geneva, World Health Organization, 2003.

Table 1. The burden of HIV/AIDS in the Eastern Mediterranean Region

Country	Estimated HIV prevalence in adult population (%)[a]	Estimated number of people living with HIV/AIDS[b]	Reported AIDS cases 2004[c]	Estimated number of people needing ART[d]	Reported treatment coverage of known cases in need of ART, Feb. 2005[e]
Afghanistan	NA	NA	NA	NA	NA
Bahrain	0.2	539	5	<100	100%
Djibouti	2.9	9 000	214	1 370	18%
Egypt	<0.1	3 584	63	540	<10%
Iran, Islamic Republic of	0.1	30 000	73	3 200	10%
Iraq	<0.1	<500[a]	NA	<100	100%
Jordan	<0.1	416	6[f]	60	100%
Kuwait	NA	2 000[a]	11	NA	100%
Lebanon	0.1	2 026	24	250	100%
Libyan Arab Jamahiriya	0.3	7 000	NA	700	NA
Morocco	0.1	14 000	55[f]	1 500	100%
Oman	0.1	1 447	24[f]	1 400	100%
Pakistan	0.1	70 000	51[f]	7 000	0%
Palestine		<500	1	50	100%
Qatar	NA	600	NA	60	100%
Saudi Arabia	NA	NA	65	NA	100%
Somalia	NA	43 000	NA	6 450	0%
Sudan	2.3	512 000	454	77 000	<10%
Syrian Arab Republic	<0.1	339	18[f]	<100	100%
Tunisia	<0.1	941	19[f]	224	100%
United Arab Emirates	NA	NA	NA	NA	100%
Yemen	0.1	11 227	45	1 200	0%

a Source: UNAIDS. Report on the Global AIDS Epidemic 2004: 4th Global Report

b Source: Country estimates reported to EMRO

c Source: EMRO country reports database

d 10%–15% of estimated number of people living with HIV/AIDS

e Survey of national programme managers (percentage of patients receiving triple ART therapy of those known to be in need) or other reports to EMRO

f Data from at least one quarter missing

NA Information not available

2.2 Subregional differences and epidemic stages

Data on HIV prevalence in selected population groups are scarce in the Region, as only a few countries collect data and report them to the Regional Office. According to the data reported by countries and based on various studies done in countries of the Region, the HIV/AIDS epidemic is at a low level in most countries (HIV prevalence less than 1% in the general population and less than 5% in at-risk groups). However, it has reached a generalized stage (HIV prevalence greater than 1% in the general population) in Sudan and Djibouti (Figure 1). In 2004, sentinel sero-surveillance was established among women attending antenatal care in Somalia. Prevalences greater than 1% were reported from some urban sites in Somalia, indicating that Somalia is at risk of developing a generalized epidemic as well. Figures from the Islamic Republic of Iran show a concentrated epidemic among injecting drug users (HIV prevalence greater than 5%). Alarming figures about potential risks of outbreaks among injecting drug users are being noted in Bahrain, Libyan Arab Jamahiriya, Oman and Pakistan. For example, a study among injecting drug users in Karachi, Pakistan reported an HIV prevalence of 23%.

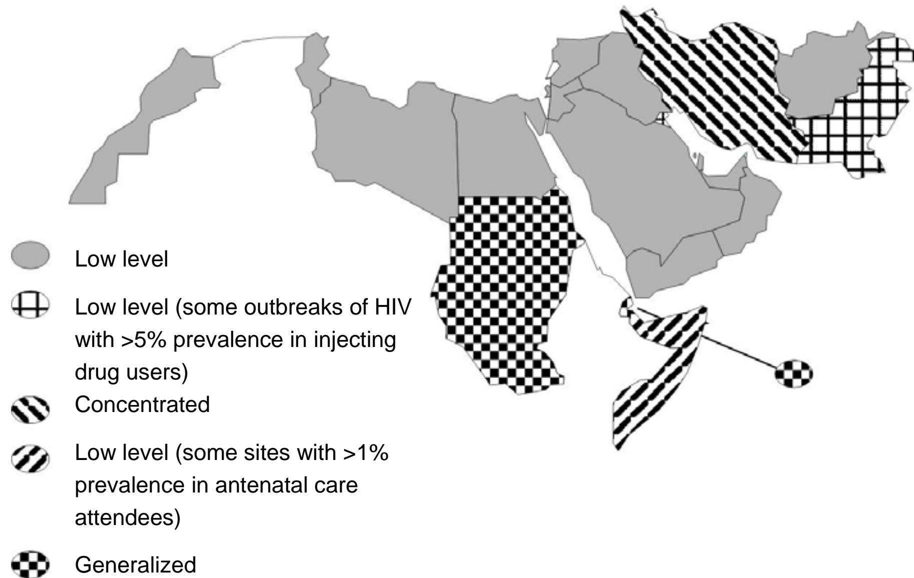

Figure 1. Levels of the HIV epidemic in the Eastern Mediterranean Region

2.3 Age and sex distribution

Of the cumulative reported AIDS cases, the age group most affected in the Region is that between 25 and 39 years of age (58.4%). Children under the age of 5 years represent 1.9% of the total reported AIDS cases, however, and the trend of infection among them is rising. The proportion of AIDS cases among children under 5 years increased from 0.8% of reported cases in 2000 to 4% in 2004, suggesting failure to contain mother-to-child transmission of HIV. To date, 28% of the cumulative total of reported AIDS cases have been among females.

2.4 Tuberculosis and HIV/AIDS

Levels of HIV infection among tuberculosis patients have been rising and in 2002–2004 reached on average 8.2% in Sudan, 3.3% in Yemen, 2.0% in Oman and 1.8% in the Islamic Republic of Iran. A recent study from the Islamic Republic of Iran (2002–2004) showed 56.5% of HIV positive prisoners who injected drugs were co-infected with tuberculosis.

2.5 At-risk and vulnerable groups

There is only very limited information on HIV prevalence among population groups that are at particularly high risk. Some countries have identified at-risk groups to be prostitutes, men engaging in homosexual relations, injecting drug users and prisoners. In Sudan, a 4.3% prevalence of HIV was found among female prostitutes. Behavioural information on female prostitutes is only available from Lebanon and shows a very low rate of condom use with clients as well as with regular partners. Between 1999 and 2004, reported HIV prevalence among prisoners ranged from 2.3% in the Islamic Republic of Iran to and 0.03% in Egypt. In the Near Eastern subregion, comprising Egypt, Jordan, Lebanon, Palestine and Syrian Arab Republic, men engaging in homosexual relations represent 16.2% of the total reported AIDS cases. No further information about this population group is available, except a behavioural study from Lebanon showing a high rate of unprotected sex among men engaging in homosexual relations, with a high number of casual partners as a common behaviour.

7.7% of all AIDS cases reported between 1999 and 2004 are attributed to injecting drug use. Systematic monitoring of HIV in injecting drug users led to the detection of consistently high HIV prevalence among this group in the Islamic Republic of Iran and to the detection of outbreaks in Pakistan. In Tunisia, 38% of cases among men are attributed to injecting drug use. In Bahrain and

Islamic Republic of Iran, respectively, 64% and 74% of all reported HIV cases are associated with injecting drug use. A report from the Libyan Arab Jamahiriya shows a 51% prevalence of HIV among injecting drug users admitted to one hospital. In Bahrain and Oman, alarming rises in the rates of positive HIV tests among drug users were noted in 2003, followed by a decrease in 2004. As the number of drug users tested for HIV fluctuates widely, selection bias is likely to distort the picture and reliable conclusions on trends in any of the population tested cannot be drawn. Behavioural studies from Egypt and Lebanon show that sharing injecting equipment among injecting drug users is a common practice.

So-called bridging populations, who are at risk of HIV infection through contact with high-risk groups and transmitting HIV to low-risk populations, are sexual contacts of injecting drug users, long-distance drivers, men in uniform, internally displaced populations and migrants. Several behavioural studies from countries of the Region suggest that awareness of HIV modes of transmission and methods of prevention among young people is low and that young people are engaging in unsafe sexual behaviours such as casual sex and multiple sexual relationships accompanied by a low rate of condom use.

2.6 Sexually transmitted infections

The magnitude of the burden of STIs is not well known in most countries of the Region. STI surveillance in the countries of the Region is based only on routine STI case reporting. Based on the limited STI data reported to the Regional Office, as well as from the few studies carried out in countries of the Region, it can be stated that all STIs have been observed in the Region, and that the figures are alarming at times (Table 2). Trichomoniasis appears to be the most common STI, followed by gonorrhoea and, to a lesser extent, syphilis. Moreover, STI prevalence among particularly vulnerable groups such as prostitutes and men engaging in homosexual relations were studied only in Egypt, showing a prevalence (of any STI) of 36.5% and 23% respectively.

Table 2. Selected studies on STI prevalence in different populations in countries of the Region*

Country	Year	Population	Population size	Syphilis (% positive)	*Neisseria gonorrhoeae* (% positive)	*Chlamydia trachomatis* (% positive)	*Trichomonas vaginalis* (% positive)
Libyan Arab Jamahiriya	1991/1992	STI patients					
		Male	187	19.0	36.0	NA	NA
		Female	1562	40.0	4.0	NA	NA
Egypt (Alexandria)	1999	Dermatology patients					
		Male	54	5.6	14.8	NA	0
		Female	36	0	0	NA	8.3
Egypt (Cairo)	2001	FSW	52	5.8	7.7	7.7	19.2
		MSM	80	7.5	8.8	8.8	1.3
		IDU	150	1.3	2.7	2.7	0.7
		ANC	607	0	2.0	1.3	0.7
Pakistan	2002	ANC	600	0.4	0	0	7.7
Yemen (Sana'a)	2002	Outpatient clinic	68	1.5	10.3	NA	29.9
	2003/2004	Outpatient clinic, female	200	0	5.0	NA	18.5
Jordan	2003	Obstetrics and gynaecology patients	1248	NA	0.7	1.2	12

* Prevalence of STI is not comparable between the studies as laboratory techniques vary
FSW Female sex workers
MSM Men who have sex with men
IDU Injecting drug users
ANC Antenatal care attendees
NA Information not available

2.7 Potential health and economic impact

Besides causing the loss of life of thousands of people, the growing HIV/AIDS epidemic will potentially have a major impact on the economy in countries of the Region in terms of both direct health expenditures and indirect costs due to absenteeism and productivity losses. The World Bank estimates that the average growth rate of potential Gross Domestic Product (GDP) could be reduced by 0.2% to 1.5% per year for the period 2005–2025 as a result of the epidemic. In turn, successful policies that lead to increased condom use and expanded access to safe needles for injecting drug users could lead to enormous savings.

3. Health sector response to the HIV/AIDS epidemic and the 3 by 5 Initiative in the Region

3.1 Expanding access to HIV/AIDS treatment and care

An estimated total of 110 000 people living with HIV/AIDS in the Region, 72.7% of them living in Sudan alone, are in need of ART. There is a huge shortfall in access to ART, particularly in resource-constrained countries of the Region, many of which also have a high burden of disease. This leads to high death rates among people living with HIV/AIDS. With significant reductions in the price of antiretroviral drugs, however, combined with global commitment to support resource-constrained countries in the delivery of ART, universal access to ART has become feasible.

During 2004, national commitment to ensure the people in need receive effective care, treatment and support has been increasing in countries of the Region. Following a Regional Advocacy and Briefing Meeting on the 3 by 5 Initiative held in February 2004, Djibouti, Egypt, Islamic Republic of Iran, Libyan Arab Jamahiriya, Pakistan, Somalia, Sudan and Yemen officially declared their commitment to expanding access to treatment and care. Seven of these countries (except Pakistan) sent letters to the Director-General of WHO stating their commitment to the goal of the 3 by 5 Initiative and requesting to be included in the Initiative. A regional target of providing access to antiretroviral therapy for 70 000 people living with HIV/AIDS who need it was set, in consultation with the countries.

During 2004 and early 2005, efforts focused on ensuring country preparedness to scale up access to treatment. Technical assistance was provided to countries in several areas such as resource mobilization, guideline development, capacity building, procurement and supply management and planning treatment scale-up. The Regional Office published and disseminated the strategic framework of the 3 by 5 Initiative in Arabic. In addition, WHO is strengthening the capacity of its country offices to provide timely and intensified technical support. One international staff (3 by 5 Officer) was recruited for Sudan and the establishment of a similar position for Djibouti is in process. A major constraint in 2004 and early 2005 was a delay in mobilization of financial and human resources for the 3 by 5 Initiative; only in early April were funds made available to the Regional Office to support activities in countries other than Sudan.

3.2 Accelerating prevention

Blood safety, infection control

Reported AIDS cases attributed to blood and blood product transfusion have shown a steady decrease since 1993, dropping from 12.1% to 0.4% of the total reported AIDS cases in 2003. In 2004, a sudden rise to 0.5% was noted, driven by unexpected rises in Pakistan (7 cases), Egypt (5 cases) and Saudi Arabia (4 cases), who in previous years reported 0–1 cases. These figures reflect the serious efforts of countries to ensure blood safety and infection control; however, the alarming rise in 2004 indicates that continuous and additional efforts should be maintained.

According to the data available to the Regional Office, safe blood and blood product transfusion and injection practices are regulated by law and enforced in Bahrain, Djibouti, Egypt, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Lebanon, Palestine, Qatar, Syrian Arab Republic, Tunisia and United Arab

Emirates. Such laws do not exist in Oman, Somalia and Sudan. No information is available from other countries.

Prevention of mother-to-child transmission

The strategies known to prevent mother-to-child transmission include protecting women of childbearing age from HIV, preventing unwanted pregnancies among women who are infected with HIV and preventing the transmission of HIV from infected pregnant women to their infants during pregnancy and labour and after delivery through breastfeeding.

Through the World AIDS Campaign 2004, WHO advocated for better education, awareness and equal rights in treatment and care for women and drew the attention of countries to the importance of targeting women. Moreover, efforts to scale up access to ART will also help reduce mother-to-child transmission, as current ART regimens reduce the probability of transmission of the virus from the mother to her infant from around 30% to around 4%.

Counselling and testing

Voluntary counselling and testing services have proven to help in the identification of people living with HIV/AIDS. Among countries that report the results of HIV testing in voluntary counselling and testing facilities, a higher rate of HIV positive tests compared with the general population was noted in Egypt (0.06%), Islamic Republic of Iran (1.4%) and Sudan (14.9%). Despite established evidence on the effectiveness of voluntary counselling and testing in attracting people who are likely to have the infection, this service is not available in all countries of the Region. Where it is available, its coverage is usually limited to certain areas or population groups.

Targeted interventions: youth and vulnerable groups

With the exception of the Islamic Republic of Iran, countries have not taken firm action to prevent outbreaks among marginalized and vulnerable groups. Most countries of the Region have no projects aimed at HIV/AIDS prevention among vulnerable groups. Others may have small-scale projects with limited effectiveness, and often low coverage. An exception is the Islamic Republic of Iran, which has made significant progress in the reduction of drug abuse harm by introducing needle and syringe exchange programmes and substitution treatment for opioid dependence within and outside prisons.

Youth populations are also being addressed by most countries, mainly with information, education and communication interventions. However, coverage of such interventions varies widely among countries, ranging from national coverage to limited coverage of one or two major cities. Other types of youth-specific interventions, such as counselling and testing and condom distribution, remain limited in terms number of countries implementing them as well as in terms of within-country coverage.

3.3 Strengthening surveillance and operational research

Surveillance in the Region is often very weak, relying in most countries on case notification and ad hoc studies or irregular sero-surveillance activities. Moreover, surveillance systems are often characterized by under-reporting, failure to capture the most vulnerable groups and delayed reporting. This results in huge gaps in understanding the dynamics of the epidemic, and hence affects all areas of the response. Consequently, monitoring the epidemic at the regional level is a major challenge; in addition to the country level surveillance problems, regional reporting is also marked by delays and inconsistencies. As of the end of March 2005, 15 of the 22 countries of the Region had failed to complete their 2004 reporting to the Regional Office: Islamic Republic of Iran, Iraq, Jordan, Kuwait, Libyan Arab Jamihiriya, Morocco, Oman, Pakistan, Qatar, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen.

The Regional Office supports annually a number of operational research studies in the field of HIV/AIDS and STIs through its Small Grants Scheme for Tropical and Other Communicable

Diseases. Between 2002 and 2004, 22 research studies on HIV/AIDS and STIs from 7 countries were supported by the Scheme, covering the areas of infection control, behavioural studies, prevalence in special population groups and programme reviews.

3.4 Resource mobilization

In 2004, more than US$ 23 million was committed from the national budgets of countries of the Region. A number of countries succeeded in mobilizing additional resources in support to their HIV/AIDS programme activities. Eight countries in the Region obtained approval for Global Fund proposals (up to the 4th round) with a total budget of US$ 146 513 212. Activities in Djibouti, Pakistan and Somalia are being supported by the World Bank. WHO and UNAIDS have contributed around US$ 2 million.

4. Future challenges and opportunities

Progress has been remarkable wherever political leadership is strong and supportive of national AIDS programmes and where joint efforts of the public sector and civil society have been fostered. Yet investments in HIV/AIDS prevention and care are not sufficient in many countries. Besides the fact that many of those infected with HIV are unaware of their HIV status, denial, discrimination and other negative attitudes continue to seriously impede access to HIV/AIDS prevention and care. Furthermore, access to ART is unacceptably low in the Region, with obvious inequities between low-resource countries and those that are relatively wealthier.

In several countries in the Region, especially those worst affected by the HIV epidemic, the health sector is facing severe shortages of human, infrastructural and financial resources and many competing health programme priorities. Furthermore, several countries in the Region are in complex emergency or post-conflict situations that result in high population mobility and displacement, posing enormous challenges for the provision of even the most basic health services.

The years ahead also offer great opportunities. Countries of the Region can draw on a wealth of knowledge and experiences amassed over 20 years of global effort in responding to HIV/AIDS. Furthermore, new opportunities are being created through global determination to increase resources for prevention, for scaling up life-saving antiretroviral treatment and for research into preventive and treatment approaches through such initiatives as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the 3 by 5 Initiative.