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Progress report on

HIV/AIDS and the 3 by 5 initiative

Contents

1. Introduction

Globally, in 2005, about 3.1 million people died of AIDS and an estimated 40.1 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.

In late 2003, the 3 by 5 Initiative was launched globally to ensure access to antiretroviral treatment for 3 million people living with HIV/AIDS in low- and middle-income countries by the end of 2005 (the "3 by 5" target). Since then, coverage of antiretroviral therapy (ART) in these countries has more than doubled – increasing from 400 000 to approximately one million people worldwide receiving treatment by December 2005.

The 3 by 5 target has not been achieved; however it has been an important element in the overall international effort to build momentum for expanded access to ART. Invaluable experience has been gained in countries and it has been shown that large-scale HIV treatment access is achievable, effective and increasingly affordable, even in the poorest and most challenging settings. At the same time, the need for both increased financial and technical assistance has become evident in order to keep moving forward.

Despite initial concerns that HIV treatment could divert both resources and attention away from prevention, it is now clear that treatment scale-up actually increases opportunities to undertake effective prevention. As more people become aware of their HIV status and access treatment and care, new opportunities are also arising to provide prevention counselling and commodities, including for people living with HIV/AIDS, as an essential part of the continuum of care.

The Regional Office for the Eastern Mediterranean launched the 3 by 5 Initiative in early 2004 and mobilized political leaders to commit to the provision of decent care and treatment for people living with HIV/AIDS. Since then, the Regional Office has supported countries to develop plans for systematic expansion of treatment services, to develop treatment guidelines, to put the necessary infrastructure in place, to access antiretroviral medicines at the lowest possible prices and to train health personnel.

Surveillance in the Region is still largely inadequate in terms of determining vulnerability and transmission patterns in the population and epidemic trends. It is therefore not possible to construct an accurate epidemiological profile.

2. The burden of the HIV/AIDS epidemic in the Region

2.1 Rising morbidity and mortality due to HIV/AIDS

Table 1 gives an overview on the HIV epidemic situation in the Region. By the end of 2004, the total estimated number of HIV infected people living in the Region had reached 715 000. An estimated 67 000 new infections occurred in 2005. The majority of cumulative reported AIDS cases by June 2005 were due to heterosexual transmission (approximately 52%) and sharing of injection equipment among injecting drug users (approximately 7%).

2.2 Subregional differences and epidemic stages

Data on HIV prevalence in selected population groups are scarce in the Region. Only a few countries collect and report this information to the Regional Office. According to the data available, the HIV/AIDS epidemic has remained at a low level in most countries of the Region (HIV prevalence in the general population <1% and in at-risk groups <5%). However, it has reached a generalized stage (HIV prevalence >1% in the general population) in Sudan and Djibouti, and recently in parts of Somalia (Figure 1). The Islamic Republic Iran exhibits concentrated epidemics among injecting drug users (HIV prevalence >5%). A high prevalence of HIV among injecting drug users has also been established in some cities of Pakistan.

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

Country	Estimated HIV prevalence in adult population (%)[a]	Estimated number of PLWHA[b]	Reported AIDS cases 2004[c]	Estimated number of people needing ART[d,e]	Reported number of people receiving ART[e]
Afghanistan	<0.1	<1000	NA	NA	0
Bahrain	0.2	539[a]	5	<100	NA
Djibouti	2.9	8 985	500	1 650[d]	292
Egypt	<0.1	5 029	63	500[d]	200
Iran, Islamic Republic of	0.1	30 000	75	4 250[e]	400
Iraq	<0.1	200	NA	20[d]	2
Jordan	<0.1	655	6[f]	65[d]	45
Kuwait	NA	2 000[a]	11	NA	NA
Lebanon	0.1	2 195	24	<500[e]	200
Libyan Arab Jamahiriya	0.3	7 000[a]	NA	1500[e]	450
Morocco	0.1	17 000	55[f]	2000[e]	880
Oman	<0.1	2 000	30	250[d]	225
Pakistan	0.1	70 780	55[f]	8 450[e]	132
Palestine	NA	<500	2	50[d]	NA
Qatar	NA	600[a]	NA	60[d]	NA
Saudi Arabia	NA	NA	65	<1000[e]	100
Somalia	NA	43 000[a]	NA	6 000[e]	35
Sudan	2.3	512 000[a]	543	62 000[d]	400
Syrian Arab Republic	<0.1	1 084	18[f]	<100[d]	60
Tunisia	<0.1	941[a]	19[f]	<1000[d]	229
United Arab Emirates	NA	NA	0	NA	NA
Yemen Republic of	0.1	12 000[a]	1 769	1 000[e]	0

NA: information not available
PLWHA: people living with HIV/AIDS
Source:
[a] *Report on the global AIDS epidemic 2004: 4th global report*, UNAIDS. Geneva, 2004.
[b] Country estimates reported to the Regional Office (2003–2004);
[c] Regional database on HIV/AIDS, WHO Regional Office for the Eastern Mediterranean
[d] Estimates provided by countries to EMRO (if available) or 10% of PLWHA
[e] WHO/UNAIDS Report on progress on Global Access to HIV Antiretroviral Therapy (if country figures available) or reports by countries to EMRO
[f] At least data of one quarter are missing

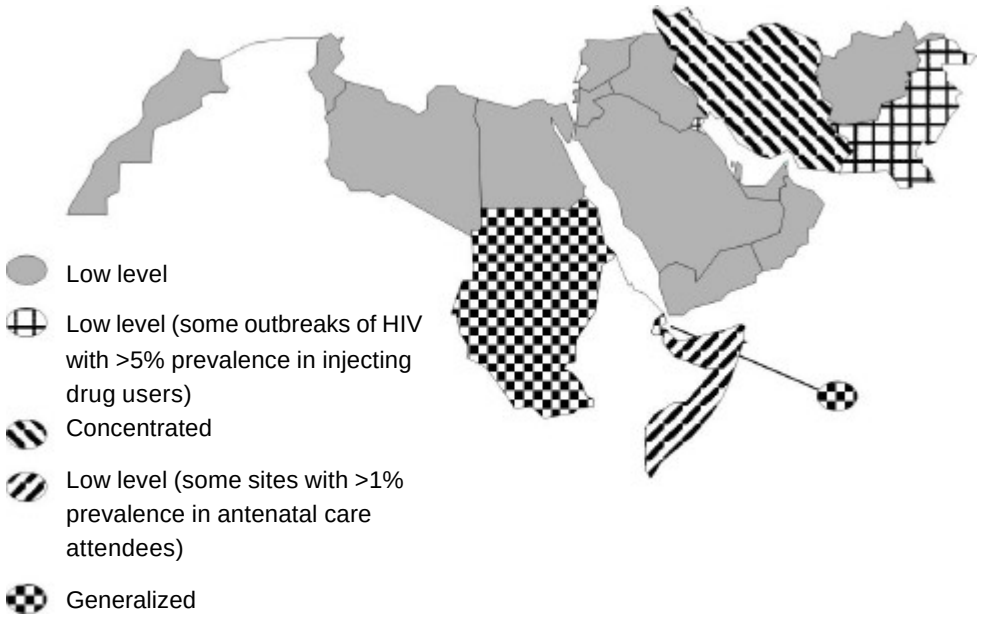

Figure 1. Levels of the HIV epidemic in countries of the Eastern Mediterranean Region

2.3 Age and sex distribution

More than half (56%) of the reported AIDS cases in the Region to date are adults aged between 25 and 39 years; 8.7% are youth aged between 15 and 24 years and 1.7% are children below 5 years of age. 30% of the cumulative total of reported AIDS cases are female.

2.4 Tuberculosis and HIV/AIDS

The overall prevalence of HIV among tuberculosis patients in the Region as reported by end of June 2005 is 0.7%. In 2002–2004, HIV prevalence among tuberculosis patients reached on average 8.2% in Sudan, 3.3% in Yemen, 2.0% in Oman, 1.8% in Islamic Republic of Iran and 0.34% in Morocoo.

2.5 Risk and protective factors

Behavioural risks

Injecting drug use. Injecting drug use in the Region is of major concern. Several countries have reported rising numbers of drug users in addition to increased shifting from non-injecting to injecting modes of drug consumption. Almost all countries, except Djibouti, Somalia, Sudan and Yemen, have reported HIV transmission among injecting drug users. 7% of all AIDS cases reported between 1999 and June 2005 occurred among injecting drug users.

In addition to the established HIV epidemic among injecting drug users in the Islamic Republic of Iran, an epidemic has been emerging in Pakistan during recent years. A study in Lahore and Karachi in 2005 showed HIV prevalences of 0.5% and 23%, respectively. More than a quarter of the study participants reported having shared their most recent injection with someone else. Almost one third of male injecting drug users reportedly had ever paid for sex with a woman. Mobility of injecting drug users between cities was found to be high. Similarly, a behavioural study conducted in the Islamic Republic of Iran in 2004 showed that 45% of injecting drug users interviewed had ever been married, and that around 40% had paid for sex. In a study among 50 female prostitutes in a city in the western part of Iran, 6% of participants were found HIV positive, and all of them reported injecting drug use. These findings highlight the risk of transmission of HIV from injecting drug user populations through bridging groups such as sexual partners of injecting drug users to the general population.

In the Libyan Arab Jamahiriya, around half of the injecting drug users admitted to detoxification treatment in two hospitals in Tripoli between 2000 and 2003 were HIV positive and HIV prevalence among the general population had reached 0.6% in some governorates in 2005. A history of injecting drug use was strongly associated with HIV seropositivity. These findings raise concern that a generalized epidemic may develop, in particular since needle sharing among injecting drug users is common: a behavioural study conducted by UNODC in 2003 showed that one third of injecting drug users had shared needles in the preceeding month.

In Afghanistan, reports indicating a shift in mode of drug consumption to drug injection are increasing. The proximity of Afghanistan to Islamic Republic of Iran and Pakistan and other central Asian countries with high prevalence of HIV among injecting drug users, coupled with this shift in mode of consumption, and with the high mobility of Afghans put Afghanistan at risk of an HIV epidemic among drug users. A study conducted in 2003 in Quetta, Pakistan, among 959 male drug users (14.9% Afghan) showed that Afghan drug users were more likely to have ever injected (18.8% versus 12.3%), to report needle sharing (72.2% versus 48.2%) and to have never heard about HIV/AIDS (95.7% versus 81.7%).

High-risk sexual behaviour. Though systematic assessments of the extent of high risk sexual behaviour in the Region are lacking, based on police reports and media news, prostitution and high-risk behaviour among homosexual men exist in almost every country in the Region. Few countries have conducted behavioural surveys to identify the sexual practices that put prostitutes and men engaging in homosexual relations at a higher risk of HIV transmission. The above-mentioned study conducted in Lahore and Karachi, Pakistan, showed a very low rate of condom use during commercial sex encounters, as reported both by prostitutes (male and female) and by their clients.

A recent qualitative study carried out in Algeria, Lebanon, Morocco and Tunisia showed that men who engage in homosexual relations commonly do not use condoms and that many continue sexual relations with women, either to conceal their homosexuality or because they are bisexual.

Structural risks

Growing youth populations. 45% of the population of the Region is aged below 15 years. Youth are more likely to engage in risky behaviour. 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 behaviour such as casual sex and multiple sexual relationships accompanied by a low rate of condom use.

Poverty, unemployment, labour migration. There are large numbers of migrant labourers in the Region moving from low-income countries to those with middle and high income. The conditions under which migrant labourers live can trigger and increase high-risk behaviour. Extensive mandatory HIV screening of all migrant workers is carried out in many countries of the Region, and deportation based on positive serostatus is widely practised. These practices nurture the false notion that HIV is largely imported from outside countries and HIV transmission within the population is rare.

Women's status. Data derived from the World Bank Development Indicators show that HIV prevalence rates are lower when women have access to education and income opportunities. In several countries in the Region women lack access to education and to income generation. The adult female literacy rate in the Region is 53%, and 74% are enrolled in primary schools. Moreover, access to maternal care is lacking: only 53% of deliveries are attended by trained health personnel. This is a major obstacle to effective interventions for the prevention of mother-to-child transmission of HIV.

Conflict and emergency situations. Several countries in the Region, including Afghanistan, Iraq, Palestine, Somalia and Sudan, are in conflict or post-conflict situations or are subject to some kind of emergency. Such settings increase the vulnerability of people to HIV transmission due to displacement, destruction or deterioration of health and social services, and lack of prevention materials such as clean needles in health care settings or blood safety test kits.

2.6 Religious, cultural and social values

Cultural, social and religious values that promote protective behaviour, such as sexual abstinence before and outside marriage and abstinence from alcohol and other drugs, are certainly reducing vulnerability to HIV. However, the silence surrounding sexuality and sexual behaviour limits the possibility for information and education of youth and for setting up preventive interventions for people at risk. The stigma and discrimination towards vulnerable and high-risk populations forces these populations underground and makes epidemiological surveillance and effective interventions extremely difficult if not impossible.

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

3.1 Strategic planning

In early 2005, the Regional Office initiated a consultative process for the development of a regional health sector strategic plan for 2006 to 2010. The process involved national programme managers, the HIV/AIDS Regional Advisory Group (ARAG), technical advisers from WHO and regional HIV/AIDS experts, and resulted in the regional strategic plan for strengthening health sector response to HIV/AIDS and sexually transmitted infections for the period 2006–2010. This strategy was endorsed by the Regional Committee in September 2005. In addition, the Regional Office developed the regional strategic plan for HIV and tuberculosis for 2006–2010.

At the national level, the Regional Office supported Bahrain, Iraq and Tunisia in the development of their national plans.

3.2 Expanding access to HIV/AIDS treatment and care

An estimated total of 75 000 people living with HIV/AIDS in need of ART are living in the Eastern Mediterranean Region. Of these, more than 70% live in Sudan alone.

The shortfall in access to life-saving ART is still large: as of June 2005 only 5% of people in need are receiving ART. Besides obstacles related to the cost of ART and lack of health system infrastructure and skilled personnel, the high levels of stigma and discrimination that still persist in the Region seriously impede the uptake of counselling and HIV testing services and health care seeking of people living with HIV.

However, progress in expanding access to antiretroviral therapy must be acknowledged, in particular in countries where ART previously was not available or was very limited.

? In Somalia (north-west zone), the first ART site was established in June 2005 in a collaborative effort involving national authorities, United Nations agencies and nongovernmental organizations. By December 2005, 72 people living with HIV/AIDS received medical care; out of these 35 are receiving ART.

? In Sudan, free ART was initiated in Khartoum during 2003, and medical teams have been trained with WHO support to initiate ART at additional sites to a current total of 10 sites, including 3 in southern Sudan. Joint ART and voluntary counselling and testing facilities are under renovation to ensure their adequacy for clinical and psycho-social care. Some logistic difficulties delayed the procurement of antiretroviral medicines with resources from the Global Fund to Fight AIDS, Tuberculosis and Malaria, but these have been largely overcome and antiretroviral medicines are now being distributed in country.

? Pakistan has successfully procured generic antiretroviral medicines from India, supported by a grant from the Global Fund. The first public ART clinic opened in October 2005 in Islamabad and by December 2005 a total of 35 patients received ART. An additional 100 patients are cared for by a nongovernmental organizations. During 2005, 12 voluntary testing and counselling centres provided services in Pakistan.

? In Egypt during 2005, 200 people living with HIV/AIDS were provided with ART through the government and nongovernmental organizations (57% of estimated in need). The national AIDS programme plans to provide treatment to all known people living with HIV/AIDS in need by end of 2006. Two antiretroviral medicines are procured from international pharmaceutical companies, while two are being locally produced.

? In Djibouti ART services are currently available in eight centres in Djibouti city. At the end of September 2005, 292 people living with HIV/AIDS received ART, representing approximately 20% of those in need. Services for the prevention of mother-to-child transmission have been established at five antenatal clinics.

? In order to provide prevention and care services effectively to those at highest risk of HIV infection and transmission, the Government of the Islamic Republic of Iran developed the concept of 'triangular clinics' in 2000. Triangular clinics provide: 1) basic health care including treatment and preventive services for sexually transmitted infections; 2) HIV treatment including ART; 3) harm reduction services including substitution therapy and prevention of unsafe injection practices. 73 triangular clinics across 28 provinces provided services in 2005, reaching 2450 injecting drug users with methadone substitution therapy. The Islamic Republic of Iran aims at reaching 120 000 injecting drug users by the end of 2006.

3.3 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 2.7% of the total reported AIDS cases in 2004. The safety of blood transfusions is of concern, particularly in Afghanistan, Iraq, Pakistan, Somalia and Sudan.

The Regional Office supported a situation assessment and the development of a workplan for strengthening infection control. The curriculum of the nursing school was reviewed and recommendations were proposed to ensure appropriate inclusion of infection control. In Pakistan, WHO supports 100% of blood transfusion screening in the earthquake affected areas.

Counselling and testing

Voluntary counselling and testing (VCT) services have proven to help in the identification of people living with HIV/AIDS. Among the countries that report the results of HIV testing in the VCT facilities, a higher rate, compared with the general population, of HIV positive tests has been noted in Egypt (0.06%), Islamic Republic of Iran (1.4%), Morocco (2.07%), Yemen (6.15%) and Sudan (15.9%). Despite the established evidence on the effectiveness of VCT in attracting the persons who are likely to have the infection, this service is not available in all the countries of the Region. Where it is available, its coverage is usually limited to certain areas or certain population groups.

The Regional Office supported capacity building in VCT by providing counsellors from Iraq, Libyan Arab Jamahiriya, Sudan, Syrian Arab Republic and Yemen with training opportunities in Egypt and Morocco, as well as outside the Region in Uganda.

Targeted interventions: youth and vulnerable groups

A survey carried out by the Regional Office in early 2005 showed that the majority of countries in the Region are still hesitant to develop and implement prevention programmes targeting populations at high risk of HIV including injecting drug users, prostitutes and their clients and homosexual men. WHO, UNAIDS and several UNAIDS co-sponsor agencies are offering support to countries to develop their capacities in this respect. The Islamic Republic of Iran has made significant advances in reducing injecting drug use-related HIV transmission by introducing needle and syringe exchange programmes and substitution treatment for opioid dependent persons within and outside prisons.

The Regional Office has fostered information sharing with regard to harm reduction, through sponsoring the participation of relevant individuals in international forums, as well as documenting the best practice experience of the Islamic Republic of Iran. Moreover, the Regional Office has provided in-country technical support to the Islamic Republic of Iran to scale up harm reduction and increase coverage of its services. The Regional Advisory Panel on the Impact of Drug Abuse (RAPID), convened by the Regional Office, included the HIV perspective in a draft resolution on substance abuse that was later endorsed by the 52nd Regional Committee in 2005. The resolution notes the concern of Member States over the public health consequences of drug use in particular with regard to the HIV epidemic, and urges them to make available a wide range of approaches and interventions addressing drug use problems, including harm reduction.

3.4 Strengthening surveillance and operational research

As described above, country surveillance systems have remained inadequate. Most countries rely exclusively on case notification and sporadic sero-surveillance activities. Often sampling methodologies are inconsistent, thus compromising the comparability of results and the establishment of epidemic trends. Moreover, surveillance systems suffer from under-reporting and failure to capture the most vulnerable groups. However, in low prevalence settings it is important to systematically monitor prevalence in those at most risk of acquiring infection. Reporting of HIV/AIDS to the Regional Office, too, is marked by delays and inconsistencies: by February 2006, 19 of the 22 countries still had not submitted surveillance reports on the third quarter of 2005.

In 2005, in order to build the required technical capacity in countries to implement effective surveillance for HIV and sexually transmitted infections (STI), the Regional Office in collaboration with Family Health International, developed a regional HIV/STI surveillance training package to be used for regional as well as national training courses on surveillance. The regional training workshop on HIV surveillance was held in Cairo. Moreover, the Regional Office supported fellowships for candidates from the Islamic Republic of Iran and Iraq to attend courses on surveillance at the Knowledge Hub for HIV/STI surveillance in the WHO European Region (Zagreb, Croatia).

Technical assistance was provided to the Islamic Republic of Iran, Pakistan and Yemen to assess existing HIV and/or STI surveillance systems, assist in planning for strengthening these systems following WHO/UNAIDS recommended principles and techniques and train national experts on surveillance techniques.

WHO Somalia took responsibility for the implementation of a first round of sentinel HIV/STI surveillance in 2004–2005. The results of the first round of HIV/STI sentinel surveillance have been approved by the political leadership and are currently being used for advocacy of an intensified response to the HIV epidemic.

Each year, the Regional Office supports 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 2005, 21 studies on HIV/AIDS and STI from 9 countries were carried out, covering the areas of infection control, HIV/AIDS/STI knowledge attitudes and practices, behavioural studies, HIV prevalence in special population groups, programme reviews, resistance to antiretroviral medicines, surveillance, assessment of service delivery and management of STIs.

3.5 Control of other sexually transmitted infections

The Regional Office took initial steps towards the establishment of a Regional Sexually Transmitted Infections Task Force whose membership is open to STI experts, programme managers and academic institutions from the Region. STI experts met in June 2005, developed aims, objectives (advocacy of public health approaches to STI, resource mobilization, provision of technical assistance) and suggested initial activities including the establishment of an active STI Network Secretariat. The Secretariat will become functional in May 2006 and will be based in Tunis within the WHO Mediterranean Centre for Vulnerability Reduction.

3.6 Resource mobilization

In 2005, a number of countries succeeded in mobilizing additional resources in support to their HIV/AIDS programme activities from various sources. Sudan was successful in obtaining approval for a new Global Fund proposal. Pakistan, Djibouti and Somalia maintained their support from the World Bank. UNAIDS supported countries either through PAF (Programme Acceleration Funds) or mobilization of support from donors such as the Organization of the Petroleum Exporting Countries, Department of International Development (UK) and others. WHO contributed around US$ 2 million during 2005, largely through the 3 by 5 Initiative, which has been supported by the Governments of Canada and Sweden.

4. Future challenges and plans

The need to build consistent high-level political commitment and the necessary sense of urgency remains in most countries of the Region. Even where strong commitment exists and treatment programmes are now in place, obstacles to scaling up persist. These include: concerns about financial sustainability and the need for more and better coordinated technical support; insufficient availability of simple dosing formulations and a lack of easy-to-administer, palatable drugs for children; weak procurement and supply management systems for medicines and diagnostics; and the need to implement service models that standardize and streamline health care delivery, build sustainable human resources capacity and integrate HIV treatment and prevention with reproductive health and other disease control programmes at the different levels of the health system. Accelerating prevention efforts remains an important challenge for all countries.

In 2006–2007, the Regional Office will focus support on the following areas:

- Strengthening surveillance and operational research
- Health system infrastructure development and technical capacity building in the provision of a continuum of prevention, treatment and care services in the health sector
- Strengthening HIV prevention and care targeting those at most risk, in particular promoting harm reduction interventions for injecting drug users.