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PROGRESS REPORT

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) IN THE EASTERN MEDITERRANEAN REGION

This report is submitted to the Regional Committee in accordance with resolution EM/RC40/R.6 requesting the Regional Director to inform the Regional Committee regularly about the progress of the HIV/AIDS situation and the state of implementation of AIDS control activities in the Region. Accordingly, the report begins with an update on some of the main features of the HIV/AIDS global epidemic with a particular focus on the situation in the Eastern Mediterranean Region. It underlines the nature and dynamics of the epidemic in the Region as well as some indications of the seriousness of the problem as it unfolds. The report reviews the work of the WHO Regional Office for the Eastern Mediterranean in the fields of HIV-related prevention and care for 1998–99. It highlights some of the challenges ahead, based on the consensus recommendations of the Tenth Intercountry Meeting of National AIDS Programme Managers, 24–27 May 1998, Tunis, Tunisia.

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1. GLOBAL AND REGIONAL HIV/AIDS SITUATION

1.1 The global picture

At the end of 1998, well over 33 million adults and children were living with HIV/AIDS in the world while another 14 million people have died from HIV-related disease since the start of the epidemic. Every day there are an estimated 16 000 new infections: 11 men, women, and children every minute. In 1998 alone, it is estimated that 5.8 million new infections occurred, 10% more than just one year earlier. Half of all new infections occur among young people aged 15 to 24, making this an epidemic with particularly serious consequences for future generations. Over 40% of new infections are in women and 10% in children less than 15 years of age. Table 1 and Figure 1 show the distribution of HIV/AIDS cases in different regions of the world.

Table 1. Regional HIV/AIDS statistics and features, December 1998

Region	Epidemic started	Adults and children living with HIV/AIDS	Adults and children newly infected with HIV	Adult prevalence rate[a] (%)	HIV positive women (%)	Main mode(s) of transmission for those living with HIV/AIDS[b]
Sub-Saharan Africa	Late 70s–early 80s	22.5 million	4.0 million	8.0	50	Hetero
North Africa and Middle East	Late 80s	210 000	19 000	0.13	20	IDU, Hetero
South and South-East Asia	Late 80s	6.7 million	1.2 million	0.69	25	Hetero
East Asia and Pacific	Late 80s	560 000	200 000	0.068	15	IDU, Hetero, MSM
Latin America	Late 70s–early 80s	1.4 million	160 000	0.57	20	MSM, IDU, Hetero
Caribbean	Late 70s–early 80s	330 000	45 000	1.96	35	Hetero, MSM
Eastern Europe and Central Asia	Early 90s	270 000	80 000	0.14	20	IDU, MSM
Western Europe	Late 70s–early 80s	500 000	30 000	0.25	20	MSM, IDU
North America	Late 70s–early 80s	890 000	44 000	0.56	20	MSM, IDU, Hetero
Australia and New Zealand	Late 70s–early 80s	12 000	600	0.1	5	MSM, IDU
TOTAL		33.4 million	5.8 million	1.1	43	

[a] The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 1998, using 1997 population numbers
[b] Hetero: heterosexual transmission; IDU: transmission through injecting drug use; MSM: sexual transmission among men who have sex with men

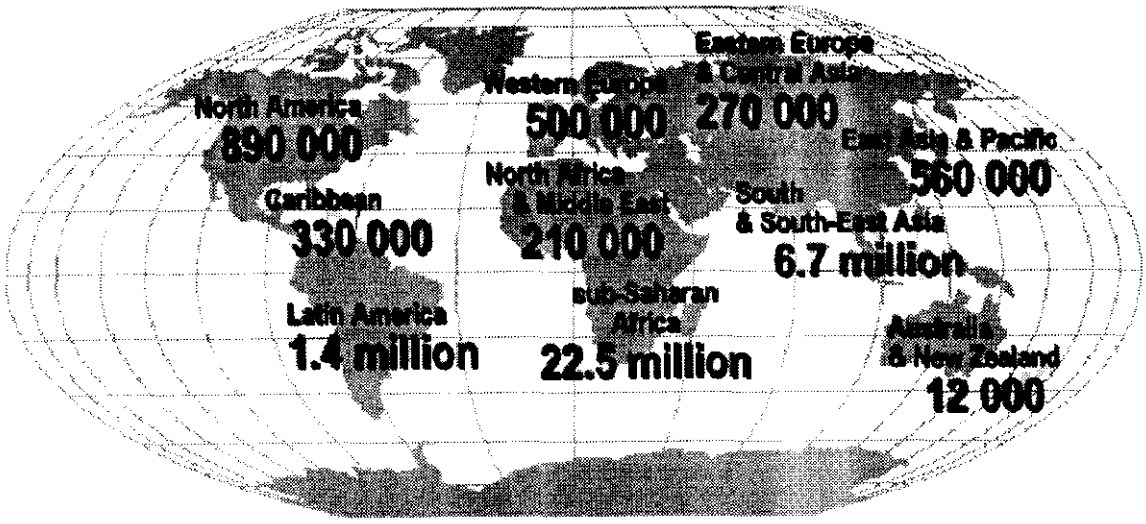

Figure 1. Adults and children estimated to be living with HIV/AIDS as of end 1998
Total: 33.4 million

AIDS now affects every country in the world and the epidemic is frankly out of control in many places. More than 95% of all HIV-infected people live in the developing world. In just the last 3 years, 27 countries have seen their HIV infection rates more than double.

The global epicentre of AIDS continues to be sub-Saharan Africa which has the fastest growing epidemic. Over 8% of all people aged 15–49 in sub-Saharan Africa are infected with HIV. In some African cities, one in five adults and one in three pregnant women are HIV-positive.

Although the epidemic started late in parts of the Pacific, Asia and eastern Europe, new data suggest the risk of explosive epidemics in the future in these areas. Since 1994, all countries of the Pacific have seen HIV prevalence rates increase by more than 100%. China and India, the two most populous countries on Earth, have experienced exponential growth of the infections. With approximately 4 million new infections in just the last 3 years, India today is the country with the largest number of infected individuals. China saw a ten-fold increase in its HIV/AIDS cases between 1993 and 1995. In many countries of eastern Europe and of the former Soviet Union, the HIV increase has been six-fold or more, while rates of syphilis are skyrocketing.

In central and Latin America, the epidemic seems to be affecting mainly the most vulnerable groups. However, while infections are still concentrated in men who have sex with men and drug injectors, transmission through sex between men and women is on the rise. Reported rates of infection among people who inject drugs vary from 5% to 11% in Mexico to approximately 50% in Argentina and Brazil. It was recently estimated that as many as 30% of homosexual men in Mexico may be HIV-positive, and in some localities in the Caribbean up to 8% of pregnant women may be infected.

In the regions of north America and western Europe, the availability of a new more potent anti-HIV drug combination has helped people with HIV to live longer, healthier lives. In the United States of America for example the number of people dying from AIDS fell by two-thirds between 1995 and 1997, when these anti-retrovirals came into wide use. However, each year the number of new HIV infections in north America and eastern Europe has remained stagnant instead of decreasing, with close to 75 000 people acquiring the virus in 1998 alone.

AIDS emerged only 20 years ago and is already killing more people than any other infectious disease. Approximately 2.5 million died from AIDS in 1998, as many as died from malaria. In one year, AIDS moved up from seventh to fourth place among of all causes of death worldwide, is the number one killer in Africa and a primary cause of the disease burden in developing countries. The other leading killers in the world which surpass AIDS (heart disease, stroke and acute lower respiratory infections) are typical causes of death in older age, whereas the tragedy of AIDS is that it targets young adults, that it engenders premature death and disability and that its rate of spread is rising sharply. Sub-Saharan African countries are the hardest hit: almost 12 million cumulative deaths since the start of the epidemic, 2 million in 1998, and an estimated 5500 funerals per day.

In many countries the urgent and massive threat of AIDS to development is becoming visible. Figure 2 shows that in Botswana, Kenya, Malawi, Uganda, Zambia and Zimbabwe, AIDS has already had a major impact upon average life expectancy with concomitant effects on production and the economy. In Botswana for example, where more than 25% of adults are infected, children born early in the next decade can expect to live just past their 40th birthday. Not surprisingly, between 1996 and 1997 Botswana dropped 26 places down the UNDP Human Development Index, a ranking of the country that takes into account wealth, literacy and life expectancy.

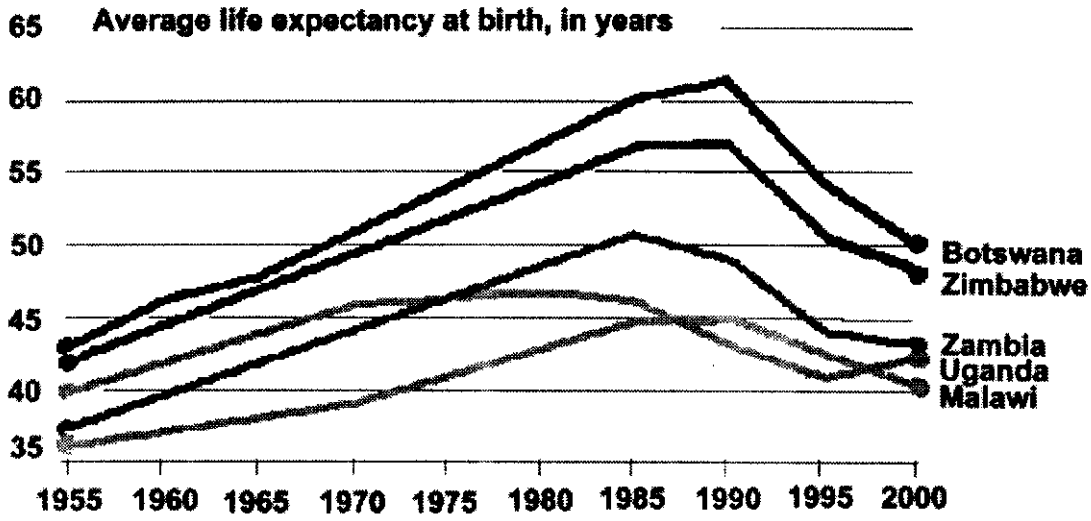

Figure 2. Projected changes in life expectancy in selected African countries with high HIV prevalence, 1995–2000

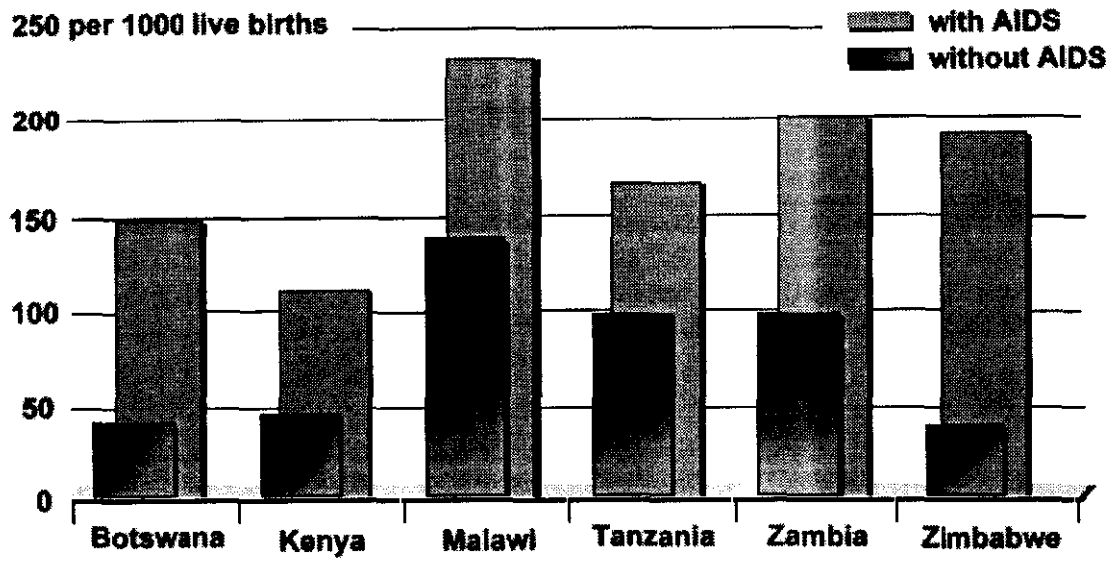

Figure 3. Estimated impact of AIDS on under-5 child mortality rates in selected African countries in 2010

HIV is contributing substantially to rising child mortality and will continue to do so for some time to come unless appropriate action is taken. Figure 3 contrasts the estimated under-5 child mortality in 2010 in six African countries including AIDS and without AIDS, showing the devastating impact that AIDS is expected to have. In addition, the number of children who need care is rising. Global estimates point to 8.2 million orphaned children by end of 1997.

AIDS is costing billions of dollars in direct and indirect costs to individuals, their families, corporations and governments. It is expected that the economy of South Africa will shrink by 1% a year because of AIDS.

However, the good news is that in a number of places, HIV infection rates finally appear to be slowing down, both in industrialized countries and in developing countries as a result of strong prevention programmes and support to people living with HIV/AIDS. In Uganda, for example, which has one of the highest rates of infection, there has been a drop of 40% in HIV infections among pregnant women.

1.2 HIV/AIDS situation in the Eastern Mediterranean Region

Analysis of AIDS and HIV surveillance reports received at the Regional Office from countries constitutes the basis of the current understanding of the epidemic in the Region. In general, HIV continues to spread in this Region at a slower rate than in other parts of the world, but steadily nevertheless. Around 210 000 people are estimated to be living with HIV, a little less than 1% of the world figures. A cumulative total of 7424 AIDS cases had been reported by the end of 1998. Although the first reported AIDS cases date back to 1979, most of the cases are clustered in the period from 1990 to1998, with 45% of all new cases being registered in the last 3 years only. Figure 4 shows the annual distribution of new cases in the Eastern Mediterranean Region from 1979 to 1998.

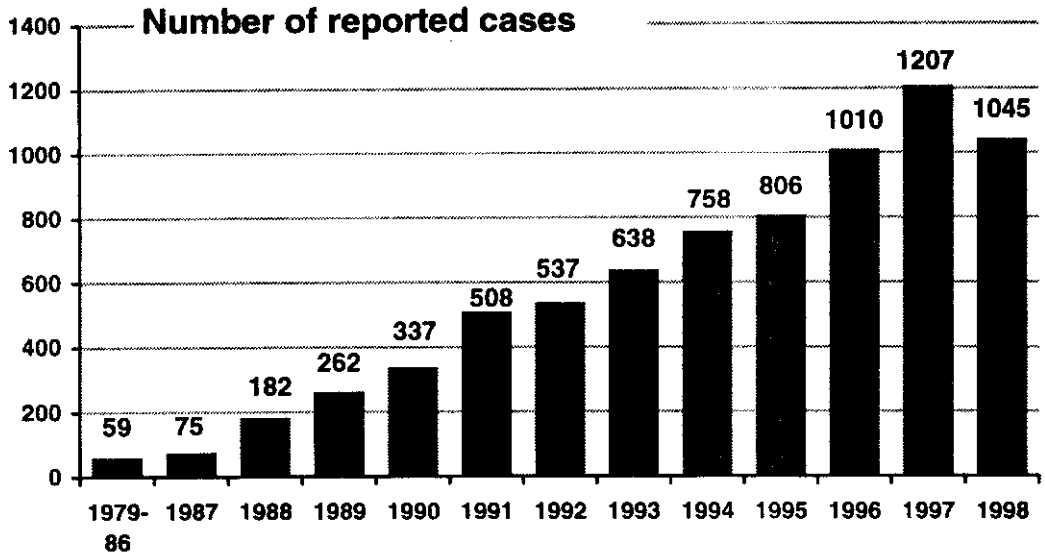

Figure 4. Reported new AIDS cases in the Eastern Mediterranean Region by year, 1979–1998

Countries of the Eastern Mediterranean Region are affected differently by the emerging AIDS epidemic. In a few, the epidemic seems to have taken off while in others the number of new AIDS cases has remained relatively stable over the years. Table 2 shows the distribution of reported new AIDS cases by country. The reported figures from the different countries cannot be used on a comparative basis due to reporting differences. In 1998, for example, Saudi Arabia modified its reporting policy to include only cases detected among nationals and Djibouti has faced difficulties in collecting surveillance data. This explains the significant drop in the number of cases in Djibouti and the overall reported cases in 1998 compared to the previous year. In 1998, Kuwait reported 19 AIDS cases whereas the previous figures never exceeded 5 annually; this follows the revision of the clinical status of 15 asymptomatic HIV-positive cases that have changed into AIDS over the years. Nevertheless, there is apparent development in the AIDS situation in some countries, which warrants closer examination.

Djibouti remains the most affected country in the Region with an annual AIDS incidence rate of almost 7 per 10 000 population. AIDS cases reported from Sudan accounted for about half of all 1998 notified cases from the Region. New AIDS cases in Sudan approximately doubled in 1998 compared to 1997. In Lebanon, a four-fold increase in AIDS from the previous year was observed. While an estimated one-third could be attributed to improved reporting within the country, still the drastic rise in cases raises serious concerns. Table 3 presents AIDS case rates per 100 000 population for the countries with the highest attack rates in the Region.

Table 2. Reported AIDS cases in the Eastern Mediterranean Region by country, 1979–1998

Country	79–86	87	88	89	90	91	92	93	94	95	96	97	98	79–98
Afghanistan	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Bahrain	0	1	0	2	1	3	4	4	5	8	5	15	11	59
Cyprus	3	5	6	5	6	7	2	7	11	5	18	10	6	91
Djibouti	0	0	1	6	51	107	144	144	196	231	358	434	111	1783
Egypt	2	3	6	9	7	12	23	29	22	16	14	25	33	201
Iran, Islamic Republic of	0	1	3	5	10	25	16	32	19	16	27	40	21	215
Iraq	0	0	0	0	0	7	6	21	37	16	15	2	4	108
Jordan	1	3	1	6	1	8	7	8	6	2	4	12	11	70
Kuwait	1	0	0	1	1	3	2	2	5	4	5	2	19[a]	45
Lebanon	9	0	3	5	10	13	7	22	12	18	5	8	35	147
Libyan Arab Jamahiriya	0	0	0	0	5	2	3	2	3	2	3	7	5	32
Morocco	1	9	14	20	26	28	30	44	77	57	66	92	93	557
Oman	6	11	26	26	22	25	32	37	51	28	24	36	33	357
Pakistan	6	2	8	9	5	16	18	16	9	20	19	19	23	170
Palestine	0	0	4	1	0	1	6	1	3	3	1	9	3	32
Qatar	8	19	11	8	6	10	3	7	6	4	2	4	1	89
Saudi Arabia	13	3	6	7	5	10	6	12	38	37	100[b]	112[b]	39	388
Somalia	0	1	4	3	5	...	...	...	...	...	...	...	...	13
Sudan	2	2	64	122	130	188	184	191	201	257	221	270	511	2343
Syrian Arab Republic	1	1	2	8	1	7	3	3	4	6	9	8	8	61
Tunisia	6	14	23	19	36	36	38	52	50	65	54	62	44	499
United Arab Emirates	...	...	...	...	8	...	...	...	...	...	...	...	...	8
Yemen, Republic of	0	0	0	0	1	0	3	4	3	11	60	40	34	156
Total	59	75	182	262	337	508	537	638	758	806	1010	1207	1045	7424

... Information not received

[a] Not all AIDS reported here by Kuwait occurred in 1998

[b] Includes expatriates

Table 3. AIDS case rates per 100 000 population in selected countries of the Eastern Mediterranean Region, 1998

Country	Population (000)[a]	Reported AIDS cases in 1998	AIDS case rate per 100 000 population
Djibouti	634	111	17.50
Bahrain	582	11	1.89
Sudan	27 899	511	1.83
Oman	2 401	33	1.37
Lebanon	31 44	35	1.11
Cyprus	766	6	0.78
Tunisia	9 326	44	0.47
Morocco	27 518	93	0.33
Republic of Yemen	16 294	34	0.21
Saudi Arabia	19 494	39	0.20
Jordan	5 774	11	0.19

[a] Source: United Nations Population Division, 1997

The reporting of risk factors is the least complete and in a few country reports, unknown causes have reached a proportion of 60% of all cases. Notification of high risk sexual and other HIV-related behaviour remains a sensitive matter. Nevertheless, sexual contact is by far the most commonly reported mode of transmission for HIV in the Region. In 1998, 89% of all AIDS cases were due to sexual transmission, with a predominance of heterosexual transmission and only 2% homosexual transmission. Transmission through contaminated blood or blood products has decreased in recent years and was reported as the cause of 4% of all AIDS cases in 1998. This mode of transmission is attributed partly to organ transplant or blood transfusion that occurred outside the country concerned and to persistently poor blood safety in a few countries. Injecting drug use has been the mode of transmission in 4% of all reported AIDS cases annually since 1990. This is a considerable proportion, and comparable to global figures. Perinatal transmission is reported in 2% of cases, but in a few countries constitutes a significant proportion of the reported cases.

AIDS cases indicate an infection that happened at least one decade earlier whereas HIV surveillance and estimates can provide a better understanding and monitoring of the present situation of the epidemic. Some countries of the Region have been able to carry out HIV epidemiological surveys on selected groups at higher and lower risk of HIV. In 1998, HIV prevalence among specific groups has remained very low in most of the countries, except for Djibouti, which exhibits already the features of a generalized[1] epidemic. The rates of HIV infection in Djibouti have reached as high as 22% in sexually transmitted disease (STD) patients, 27% in prostitutes, 18% in tuberculosis patients, 2.9% in pregnant women, and 2.3% in blood donors.

[1] HIV epidemic stages are defined as:
- Low level: HIV prevalence has not consistently exceeded 5% in any of the defined sub-population
- Concentrated: HIV prevalence consistently over 5% in at least one defined sub-population. HIV prevalence is below 1% in pregnant women in urban areas.
- Generalized: HIV prevalence consistently over 1% in pregnant women nationwide.

In other countries, some of the findings indicate the complexity of an epidemic, which is invisible as a whole, while HIV is gaining a foothold in specific population groups. Increased level of infection is seen, for example, among patients with sexually transmitted diseases (3.2% in Sudan, 2.9% in Republic of Yemen), and among tuberculosis patients (1.4% in Oman and 0.7% in Egypt). In Sudan, the risk of HIV in pregnant women, still the best indicator of HIV in the general population was noted to be 2.9% in 1997. Reported rates of HIV among blood donors were 1.5% in Somalia and 1.4% in Sudan. Prisoners are commonly tested in countries of the Region and HIV prevalence rates seem to be significant in some countries (Bahrain 2.3%, Pakistan 1.4%). Among drug injectors, HIV prevalence rate in 1998 was found to be 0.89% in Bahrain and 0.5% in each of Islamic Republic of Iran, Libyan Arab Jamahiriya and Morocco.

1.3 The changing patterns of the HIV epidemic in the Eastern Mediterranean Region

Countries of the Region have somehow succeeded in curtailing the first wave of the HIV epidemic regionally, a wave which was caused by contaminated blood and blood products. Now that HIV is reaching high levels in those who are most likely to contract and spread the infection, such as STD patients and drug injectors, containing the epidemic will become more difficult. The overall picture of the epidemic may appear patchy, however there is growing evidence that the Region may not continue to be immune to wider HIV spread.

Isolated outbreaks of HIV infections have been registered in several countries. These include the case of dialyzed patients in Egypt, children in the Libyan Arab Jamahiriya where recently 370 paediatric HIV infections were discovered[2], and drug injectors in the Islamic Republic of Iran, especially those in prisons. Furthermore, a considerable number of the cases registered recently represent an endogenous transmission, and the infection of some groups such as blood donors and pregnant women means that the virus is becoming increasingly present in the communities as a whole.

Injecting drug use in particular may fuel the next wave of the HIV epidemic in the Region. Already it is the most common cause of AIDS in some countries such as Bahrain and Islamic Republic of Iran (respectively, two-thirds and half of all 1998 cases). In Tunisia, injecting drug use is responsible for more than one-third of AIDS cases. In Egypt, a non-negligible proportion of 10% of all reported AIDS cases has occurred among drug injectors. HIV prevalence rates in this group reached as high as 5.7% in 1996 in the Islamic Republic of Iran, and in Pakistan, 5.4% out of 703 drug injectors tested in 1995. Recent studies by the United Nations Drug Control Programme in a few countries of the Middle East, namely Egypt, Islamic Republic of Iran and Lebanon, indicate that the magnitude and future of the drug abuse problem are not to be underestimated. By most conservative estimates, the numbers of addicts are counted in millions in this part of the world. A high proportion of them inject drugs. Sharing and using unclean needles are very common practices among those injectors. Greater effort is needed to better understand the dynamics of this HIV sub-epidemic among drug users. This includes consideration of the extent of the risk of HIV spreading to the general population, especially since injecting of drugs

[2] As declared by the Secretary General of Health and Social Security, Libyan Arab Jamahiriya, at the Round Table meeting at the World Health Assembly, May 1999.

seems to be intimately linked to other vulnerable situations such as migration, youth and prisons.

Population mobility is important in this part of the world and is believed to clearly influence the shape of the epidemic in some countries of the Region. Whether to escape conflict situations or in search of work opportunities, migrants are often unaccompanied by their families and more vulnerable to risk of HIV infection. Migration contributes significantly to the spread of HIV in Lebanon, Tunisia, and to some extent the Republic of Yemen. In Lebanon, for example, more than half of all cases of AIDS reported in 1998 was among Lebanese migrant to west Africa. It has been also linked to the increasing numbers of women who are infected by the virus. A similar situation exists among Tunisian migrants to west Europe.

Sexually transmitted diseases are not uncommon in the Region. It is estimated that around 10 million cases occur in this Region every year, but less than 6% were reported in 1998. Rates are noted to be higher among young adults and in urban areas. STDs are an important indicator that high-risk sexual practices do exist in the Region. Findings from national surveys on knowledge, attitudes and practices related to HIV in some countries, substantiate this concern. It appears that premarital and out of marriage sexual relationships are not uncommon.

As in other places in the world, it is clear that youth are more vulnerable to HIV/AIDS than other groups in this Region. In some countries newly diagnosed AIDS cases seem to occur among younger age groups than before. Furthermore young populations represent the core of groups who are more vulnerable to drug addiction and harmful sexual practices.

2. REGIONAL ACTIVITIES IN HIV/AIDS/STD

2.1 National commitment

In most countries of the Region, greater national commitment has been noted, with countries giving greater priority and allocating more national resources to the national AIDS programmes. The participation of the many concerned sectors and nongovernmental organizations in the national response, as well as the private sector, has been encouraged. In many instances, national STD and AIDS programmes have been integrated and also decentralized to provinces and districts. Countries have continued to disseminate information and educational materials to specific groups, such as youth, as well as to the general public but to a lesser extent to groups with high-risk behaviour. HIV hotlines have been established only in a few major cities. HIV school curricula and premarital counselling have been developed in some countries. Religious leaders have been involved in educational activities in many places. The mass media has been activated especially around the World AIDS Campaign. HIV/AIDS and STD surveillance have continued to be strengthened in some countries. However, screening of some groups, such as expatriates, remains the largest HIV testing activity in many places although the benefit of this type of activity in terms of preventing spread of HIV within the country has not been proved. Actions to maintain blood safety are also among the main activities of the programmes.

Countries are increasingly responsive to the pressure to spend more on care and treatment of people living with HIV/AIDS. There have been clear efforts in some countries to introduce antiretroviral therapy and treatment guidelines, establish adequate care set-ups for people living with HIV/AIDS and develop voluntary HIV counselling and testing where possible. Training of health care and other supportive staff on infection control as well as HIV/AIDS and STD management has continued.

From a programmatic point of view, almost all countries will complete their present cycle of planning by the end of 2000. The Islamic Republic of Iran, Morocco and Sudan have started the process of national strategic planning for HIV/AIDS.

2.2 Support to national AIDS programmes, 1998–1999

The Regional Office gave high priority in 1998–1999 to providing technical and financial support to the national AIDS programmes of the countries of the Region.

Technical support

The Regional Office provided technical support to the national AIDS programmes through various channels, including correspondence, meetings and visits of Regional Office staff and short-term consultants. Technical support, covering various major aspects of the national programmes, such as STD control, STD prevalence study, surveillance, prevention interventions, injecting drug use, blood safety, clinical management, laboratory diagnosis, monitoring and evaluation, was provided for nine countries. Two missions were fielded by WHO for epidemiological investigations and containment measures for the AIDS/HIV outbreak among children in the Libyan Arab Jamahiriya.

Fellowships

The Regional Office continued to award fellowships to the national staff in order to strengthen the national capabilities in planning, implementing and evaluating national AIDS programmes. Altogether 13 fellowships were awarded to the Islamic Republic of Iran, Iraq, Jordan, Lebanon, Saudi Arabia, Syrian Arab Republic and Republic of Yemen in the areas of clinical management of AIDS, nursing care, HIV counselling, STD control, programme management and HIV surveillance.

Supplies and equipment

The Regional Office provided supplies and equipment including diagnostic kits for HIV/STD, condoms, audiovisual equipment, data processing equipment and educational materials to 10 countries (Djibouti, Iraq, Jordan, Lebanon, Libyan Arab Jamahiriya, Pakistan, Sudan, Syrian Arab Republic, Tunisia and Republic of Yemen). The Regional Office also procured diagnostic kits for HIV and STD at concessional prices under the WHO bulk purchase system for Pakistan, Sudan and Republic of Yemen. In addition, supplies and equipment for laboratory monitoring of HIV/AIDS for the Libyan Arab Jamahiriya were ordered under funds in trust.

Monitoring and evaluation

The Regional Office continued to monitor the implementation of national AIDS programmes through periodic reports, staff visits and updating of country profiles. Reporting of HIV/AIDS improved considerably during the biennium. In 1998, reports were received from all countries except three. However, reports on STD were received from 12 countries only. An STD prevalence study to find out the prevalence of STD among women attending antenatal and gynaecological clinics was started in Egypt, Jordan, Lebanon, Pakistan, Sudan and Syrian Arab Republic. The study proposal is being finalized in the Islamic Republic of Iran and the Republic of Yemen.

Financial support

The Regional Office continued its efforts at all levels to sustain and enhance the national response to HIV/AIDS. The Regional Office allocated US$ 592 200 to the countries from its regular budget and made available in addition US$ 370 000 to the countries from the WHO headquarters' regular budget for strengthening HIV/AIDS activities. The Regional Office executed projects in Djibouti, Egypt, Jordan, Lebanon, Morocco and Syrian Arab Republic worth US$ 690 500 which were financed by UNAIDS. In addition to mobilization of national resources, the national AIDS programmes received support from various other sources, such as UNAIDS, UNDP, UNICEF, UNFPA, UNHCR and the Norwegian Agency for International Development (NORAD).

Financial support provided to the national AIDS programmes by the Regional Office from its regular budget was used for a wide of variety of activities, including training of health care providers, such as doctors, nurses, counsellors, laboratory staff and auxiliary staff; training of workers belonging to other sectors, such as teachers, media personnel, social workers, youth, women and community workers; production and dissemination of educational materials and messages; HIV/STD surveillance; STD prevalence study; and monitoring and evaluation. Training was organized for various components of the national programmes, such as prevention interventions, surveillance, STD control, STD prevalence study, counselling and care of persons with HIV/AIDS.

Intercountry meetings

During 1998 and 1999, the Regional Office organized three intercountry meetings on STD prevalence study, perinatal transmission of HIV and STD case management as well as the tenth intercountry meeting of national AIDS programme managers. In these meetings, the current situation was reviewed, experiences and opinions shared, information on latest developments disseminated and measures for strengthening specific aspects of national AIDS programmes determined. These meetings were held mostly in the form of workshops, allowing active involvement of the participants, and dealt with specific priority areas of the national programmes.

Publications

The Regional Office reprinted a number of WHO documents on HIV/AIDS/STD in Arabic and English, according to demand in the countries. In addition, a number of new documents were prepared. The Regional Office translated into Arabic a number of

UNAIDS best practice documents of regional interest. The Regional Office continued the publication of a quarterly newsletter *EMR AIDSnews* which contains news, reports and articles on important aspects of AIDS and STD at the country, regional and global levels. The newsletter, which is targeted at health care providers as well as the general public, has been well accepted by readers.

WHO collaborating centres on laboratory diagnosis of HIV

NAMRU-3, Cairo, Egypt, one of the three regional WHO collaborating centres on laboratory diagnosis of HIV, continued to carry out virus isolation and characterization of HIV in a few selected countries of the Region. The findings will be useful for understanding the epidemiology of HIV in these countries and for developing potential vaccines in future. It performed confirmatory tests and subtyping for a large number of samples received from the Libyan Arab Jamahiriya. The other two centres are Kuwait University Faculty of Medicine in Kuwait and the Pasteur Institute in Casablanca, Morocco.

3. REGIONAL OFFICE/UNAIDS COLLABORATION IN THE EASTERN MEDITERRANEAN REGION

WHO hosts the office of the UNAIDS Intercountry Programme Adviser in order to improve collaboration and cooperation in the Region.

The joint plan for 1998–1999 between WHO headquarters, the Regional Office and UNAIDS/Geneva proved a successful experience, both in terms of harmonization of United Nations and of the benefit to the countries of the Region. The plan was developed based on the findings of a review of earlier collaborative activities with UNAIDS, as well as of country needs as expressed in the joint programme review missions documents. The plan defines WHO/UNAIDS joint regional action, as well as complementary activities at country level. These activities were described in section 2. The joint planning process resulted in a more comprehensive and country-focused regional approach in three thematic areas, namely STD prevention and care, access to care by people living with HIV/AIDS and other vulnerable groups, and communication and information on HIV/AIDS. UNAIDS also extended support to the AIDS Information and Exchange Centre in the Regional Office with a view to better dissemination of WHO and UNAIDS material in Arabic.

4. TENTH INTERCOUNTRY MEETING OF NATIONAL AIDS PROGRAMME MANAGERS

The tenth intercountry meeting of national AIDS programme managers held in Tunis, Tunisia, 24–27 May 1999, set the tone for the future. The meeting was planned and conducted as a joint activity of the WHO Regional Office and UNAIDS under the collaborative project for 1998–1999. The main aim was to review HIV/AIDS-related issues shared by the countries, with a focus on persistent problems and emerging trends of HIV/AIDS, as well as its control and prevention. Participants stressed the growing evidence of increasing spread of the epidemic in the Region with threatening outbreaks in vulnerable populations. They also discussed country-based needs which would direct the

regional action of WHO, UNAIDS, and other United Nations agencies. Areas of need were summarized as follows:

- evaluation of country programmes and national strategic planning for HIV/AIDS
- strengthening of surveillance systems and information generation including behavioural studies
- capacity-building in areas of counselling and health education
- approaches to vulnerability issues related to HIV/AIDS and special groups such as migrants, refugees, and injecting drug users
- strategies for resource mobilization and better networking between countries
- strengthening of STD control.

5. CONCLUSIONS AND RECOMMENDATIONS

Clearly, the epidemic is progressing in many parts of the eastern Mediterranean Region. Fortunately, there is still great opportunity for countries to keep infection rates at low levels. National AIDS programmes exist in all countries, but the situation now calls for a renewal of national commitment and a fresh look into the nature of the epidemic, its context and the response at country level.

Many of the prevention and care efforts, especially among those who practise the riskiest behaviours, will continue to be politically and socially controversial. Yet, without a focused strategy to changing the behaviour of those most in need, it will be difficult to protect communities as a whole. Certainly, there are no easy solutions to the political and technical problems posed by such a strategy, but working together to find approaches that are appropriate or adaptable to the cultures and beliefs of the Region will make a difference.

Prevention and care go hand in hand. Countries need to consider how best to respond to the care needs of the growing number of people living with HIV/AIDS and the affected families and to ensure better social acceptance for them.

Finally, without adequate financial resources and broad partnership, both at country and regional levels, it will be difficult to halt the expansion of the epidemic.

Thus it is recommended that countries:

1. Renew their commitment to an expanded national response to HIV/AIDS through demonstrated high level political commitment and leadership, with particular focus on advocacy and resource mobilization for effective HIV/AIDS prevention and care.
2. Initiate and support the process of HIV/AIDS situation analysis and response review as a first step in national strategic planning.
3. Strengthen in-country mechanisms for generation of reliable information, such as serological and behavioural surveillance.
4. Develop strategies that are appropriate/adapted to the local situation and targeted at vulnerable groups.
5. Ensure appropriate institutional capacity and broad partnership to support these priority actions.