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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 identifies some problems in the national responses to HIV/AIDS and reviews the work of the WHO Regional Office for the Eastern Mediterranean Region in the fields of HIV-related prevention and care for 1999. It highlights some of the challenges ahead, based on what is actually known about the situation and the consensus recommendations of the 10th Intercountry Meeting of National AIDS Programme Managers, 24–27 May 1999, Tunis, Tunisia.

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1. GLOBAL AND REGIONAL HIV/AIDS SITUATION

1.1 The global picture

Twenty years ago, many countries had not even heard of AIDS. Today the AIDS pandemic presents a tragedy that is barely comprehensible, let alone manageable. By the end of 1999, 33.6 million men, women and children were estimated to be living with HIV/AIDS while newly infected persons in 1999 exceeded 5.6 million. It is devastating to note that with every minute that passes, 11 new people are infected with the virus and that since the beginning of the epidemic, 16.3 million have lost their lives. AIDS has become without doubt one of the major infectious killers, with a toll of 2.6 million deaths in 1999 alone (7123 persons every day, 297 every hour, 5 every minute).

The overwhelming danger of AIDS is that it targets young adults. More than 95% of new infections are occurring in developing countries, mainly in sub-Saharan Africa, and about 50% of them are in individuals under 25 years of age. This age factor makes AIDS uniquely threatening to adolescents and children. In 1999, an estimated 570 000 children aged 14 or younger became infected with HIV. Over 90% of them acquired the infection at birth or through breastfeeding.

The infection rate continues to rise mainly in developing countries, where people already struggle with poverty, poor health systems and limited resources for prevention and care. Premature death and disability caused by HIV/AIDS have devastating effects on the economy and social fabric of the affected communities and nations. By the end of 1999, 11.2 million AIDS orphans had lost their mothers before reaching the age of 15. Recent projections suggest that life expectancy in the 10 sub-Saharan African countries most affected by HIV/AIDS will be reduced by more than 20 years by the year 2010 when compared to projections without HIV/AIDS. The financial burden of care for AIDS patients is overwhelming. In several countries, HIV-infected patients occupy 50%–80% of hospital beds in urban areas. One year of basic medical costs for a person with AIDS in some African countries is two to three times their gross domestic product per capita.

While Africa is now the worst affected region, HIV infection is spreading quickly in Asia, particularly south and south-east Asia, where six million people are affected, especially young people who inject drugs. In the Americas, in spite of a decline in mortality due to AIDS, the rate of infection is increasing in minority and underprivileged populations. Between the end of 1997 and the end of 1999 the number of people living with HIV/AIDS doubled in the newly independent states of eastern Europe, which is ripe for increases among drug users and in the incidence of sexually transmitted diseases. Table 1 shows the distribution of HIV/AIDS cases in different regions of the world.

Table 1. Regional HIV/AIDS statistics and features, December 1999

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	23.3 million	3.8 million	8.0	55	Hetero
North Africa and Middle East	Late 80s	220 000	19 000	0.13	20	IDU, Hetero
South and south-east Asia	Late 80s	6 million	1.3 million	0.69	30	Hetero
East Asia and Pacific	Late 80s	530 000	120 000	0.068	15	IDU, Hetero, MSM
Latin America	Late 70s– early 80s	1.3 million	150 000	0.57	20	MSM, IDU, Hetero
Caribbean	Late 70s– early 80s	360 000	57 000	1.96	35	Hetero, MSM
Eastern Europe and central Asia	Early 90s	360 000	95 000	0.14	20	IDU, MSM
Western Europe	Late 70s– early 80s	520 000	30 000	0.25	20	MSM, IDU
North America	Late 70s– early 80s	920 000	44 000	0.56	20	MSM, IDU, Hetero
Australia and New Zealand	Late 70s– early 80s	12 000	500	0.1	10	MSM, IDU
TOTAL		33.6 million	5.6 million	1.1	46	

[a] The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 1999, using 1998 population numbers
[b] Hetero: heterosexual transmission; IDU: transmission through injecting drug use; MSM: sexual transmission among men who have sex with men

HIV primarily affects individuals and groups who become more vulnerable to the infection due to their marginalized situation, social and economical deprivation. Which sub-populations or communities are particularly vulnerable varies from country to country in terms of occupation, migration status, sexual and drug taking behaviour, geographic location and income level. For example, HIV prevalence in drug injectors in one of the southern populated states in China which was virtually zero in 1998, rose to 11% by early 1999.

Around the world some young people are more exposed than adults to HIV infection especially those who live in difficult circumstances, out of school, in the streets, who share needles with other injecting drug users, and who are sexually and physically abused. This is why the 1999 World AIDS Campaign focused on children and young people to protect their rights to information and care and to reduce their vulnerability.

Nevertheless, in a number of places, HIV infection rates finally appear to be slowing down, not only in the industrialized world but in the developing countries as well. In Brazil, Senegal, Thailand, Uganda, and now in parts of Tanzania, HIV rates among young women have been cut by 40% as a result of strong prevention programmes. New treatments are now postponing disease and prolonging life for thousands of people living with HIV and AIDS in the industrialized countries. What has been learnt is that successful responses to the epidemic cannot happen without strong political commitment, adequate resources, multisectoral and community involvement including those infected with HIV and their families, effective monitoring of the epidemic and risk behaviours, and positive focus on HIV vulnerable groups.

1.2 Regional HIV/AIDS situation

Around 220 000 people in the Region are estimated to have been infected by the virus by the end of 1999, a little less than 1% of the world figures. As of end of 1999, a cumulative total of 9199 AIDS cases and 25 632 HIV infections had been reported to the Regional office. The gap between reported and estimated cases is clear and points to important shortages in reporting and surveillance as a whole. Although the first reported AIDS cases date back to 1979, most of the cases are clustered in the period from 1990 to 1999, with more than 60% of all new cases being registered in the last 5 years only, which indicates an accelerating pattern of the epidemic.

Table 2 shows the annual distribution of reported new AIDS cases by country. However, it should be noted that the reported figures from the different countries are not to be used on a comparative basis due to reporting differences.

Djibouti remains the most affected country in the Region, with an annual AIDS case rate of more than 31 per 100 000 population. Annual new AIDS cases in Sudan approximately doubled in both 1998 and 1999 compared to 1997. Table 3 compares AIDS case rates per 100 000 population in all countries of the Region for 1998 and 1999.

Table 2. Reported AIDS cases in the Eastern Mediterranean Region 1979–1999

Country	1979–1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	Grand total
Afghanistan[a]															
Bahrain	–	1	–	1	2	–	6	3	6	10	11	14	11	9	74
Cyprus	3	5	6	5	6	7	2	7	11	5	18	10	6	13	104
Djibouti	–	–	1	6	51	107	144	144	196	231	358	434	111	212	1995
Egypt	2	3	6	9	7	12	23	29	22	16	14	25	33	34	235
Iran, Islamic Republic of	–	1	3	5	10	25	16	32	19	16	27	40	21	27	242
Iraq	–	–	–	–	–	7	6	21	37	16	15	2	4	6	114
Jordan	1	3	1	6	1	8	7	8	6	2	4	12	11	3	73
Kuwait	1	–	–	1	1	3	2	2	5	4	5	2	19	4	49
Lebanon	8	–	3	5	10	13	7	22	12	18	5	8	37	32	180
Libyan Arab Jamahiriya	–	–	24	5	11	6	9	2	11	16	21	38	396	72	611
Morocco	1	9	14	20	26	28	30	44	77	57	66	92	93	165	722
Oman	6	11	26	26	22	25	32	37	51	28	24	36	33	45	402
Pakistan	6	2	8	9	5	16	18	16	9	19	20	19	23	17	187
Palestine	–	–	4	1	–	1	6	1	3	3	1	9	3	1	33
Qatar	8	19	11	8	6	10	3	7	6	4	2	4	1	10	99
Saudi Arabia	13	3	6	7	5	10	6	12	38	37	100	112	39	32	420
Somalia	–	1	4	3	5	–	–	–	–	–	–				13
Sudan	2	2	64	122	130	188	184	198	201	250	221	270	511	517	2860
Syrian Arab Republic	1	1	2	8	1	7	3	3	4	6	9	8	8	7	68
Tunisia	6	14	23	19	36	36	38	52	50	65	54	62	44	42	541
United Arab Emirates	–	–	–	–	8	–	–	–	–	–	–	–	–	4	12
Yemen, Republic of	–	–	–	–	1	–	3	4	3	11	60	40	34	7	163
UNRWA	–	–	–	–	–	–	–	–	–	–	1	–	1	–	2
Grand total	58	75	206	266	344	509	545	644	767	814	1036	1237	1439	1259	9199

[a] No data available

– Information not received

Table 3. AIDS case rate in 1999 as compared to 1998 in the Eastern Mediterranean Region

Country	Population (1000s)[a]	AIDS case rate (per 100 000 population)	
		1999	1998
Djibouti	670	31.64	16.56
Oman	2 302	1.95	1.43
Sudan	30 326	1.70	1.68
Libyan Arab Jamahiriya	4 664	1.54	8.49
Cyprus	855	1.52	0.7
Bahrain	620	1.45	1.77
Qatar	693	1.44	0.14
Lebanon	3 700	0.86	1
Morocco	27 775	0.59	0.33
Tunisia	9 333	0.45	0.47
Kuwait	1 809	0.22	1.05
Saudi Arabia	18 855	0.17	0.2
United Arab Emirates	2 624	0.15	–
Jordan	4 732	0.06	0.23
Egypt	61 880	0.05	0.05
Syrian Arab Republic	15 597	0.04	0.05
Islamic Republic of Iran	61 505	0.04	0.03
Republic of Yemen	16 333	0.04	0.2
Palestine	2 893	0.03	0.1
Iraq	21 847	0.01	0.02
Pakistan	139 020	0.01	0.02
Afghanistan	20 452	NA	NA
Somalia	6 602	NA	NA

[a] Source: WHO EMRO, 1998

NA = Information not available

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, with a predominance of heterosexual transmission. Transmission through contaminated blood or blood products has decreased markedly in recent years and was reported as the cause of 1.4% of all known reasons for AIDS cases in 1999 compared to 4% in the previous year. These figures indicate progress in blood safety measures, yet in a few countries poor infection control and blood safety practice and coverage seem to persist. On the other hand, injecting drug use has been the mode of transmission in 4% of all reported AIDS cases since 1990. Perinatal transmission was reported in 2.5% of AIDS cases in 1999.

In 1999, HIV prevalence among specific groups remained low in most of the countries, except for Djibouti, which already exhibits the features of a generalized[1] epidemic. The rates of HIV infection in Djibouti have reached as high as 38.1% in prostitutes, 11% in tuberculosis patients and 1.32% in blood donors as reported in 1999.

Among blood donors in the same year, reported rates of HIV were 1% in Somalia and 1.5% in Sudan.

1.3 Alarming patterns of HIV spread emerging in the Region

The epidemic in the Region is more complex still. What is observed in AIDS is not the uniform expression of spreading infection, but a series of epidemics, each with its own structure and dynamics. While HIV presence remains low in the general population, those groups who are already disadvantaged economically, politically and socially are most vulnerable to HIV. In particular, patients with sexually transmitted diseases and tuberculosis, prisoners, female prostitutes, migrants and drug injectors show increased levels of the infection. If left unchecked, the epidemic among these vulnerable populations has the potential to develop into serious situations, which will affect the community as a whole.

Most alarming is the emerging and threatening alliance between tuberculosis and HIV. Among tuberculosis patients, a strikingly high level of HIV infection was registered in 1999. For example, in Somalia it was 6.9%, in Sudan 7.2%, and in Republic of Yemen 6.9%. In Egypt and Oman, the rate of HIV infection was 0.3% and 1.05% respectively.

Injecting drug use in particular threatens to fuel the next wave of the HIV epidemic in the Region. In 1999, it was reported to be frequently associated with HIV/AIDS in Bahrain, Egypt, Islamic Republic of Iran, Morocco, Oman, Pakistan and Tunisia. By most conservative estimates, the numbers of addicts are counted in millions in this part of the world. A high proportion of them injects drugs. Sharing and using unclean needles are very common practices among these injectors. Even in places where HIV has not yet visibly affected these groups, there is clear evidence of a threatening potential for explosive spread. For example, among 200 respondents[2] of a study of drug injectors in Lahore, Pakistan, who tested negative for HIV, 89% tested positive for HCV. This extremely high HCV infection rate combined with a high rate of needle sharing (64%) and low awareness, shows that there is a serious potential for epidemic rates of HIV infection once the virus enters this vulnerable group. The HIV prevalence rate of 5% found in 1999 among drug injectors in Oman is also alarming. More efforts are needed to understand better the dynamics of this HIV sub-epidemic among drug users. This includes consideration of the extent of HIV risk bridging to the general population,

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[1] HIV epidemic stages are defined as:

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

[2] Baseline study of the relationship between injecting drug use, HIV and hepatitis C among male injecting drug users in Lahore; UNDCP and UNAIDS in Pakistan, December 1999

especially since injecting drug use seems to be intimately linked to other vulnerable situations such as migration, youth and prisons.

Sexually transmitted diseases (STD) are common in the Region. It is estimated that around 10 million cases occur in the Region every year, but less than 6% of that estimate are reported annually. STD 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.

2. REGIONAL RESPONSE TO HIV/AIDS/STD

2.1 National commitment

National AIDS programmes exist in almost all countries of the Region however much remains to be done for effective national response to the epidemic. Almost all countries will have completed their present cycle of planning by the end of 2000 but only two countries in the Region have initiated a strategic planning process based on situation analysis and multisectoral participation. In general, the national human and financial resources allocated to HIV prevention and care as well as the political support remain inadequate, while the problem is getting bigger and more complex in some places.

Efforts of the national AIDS programmes are usually concentrated on activities such as raising awareness among the general public, including production and distribution of information material, mostly based around the World AIDS Day campaign. While similar activities need to be maintained, there should be a more realistic vision and better efforts for sustainability and long-term commitment in the national fight against AIDS. There have been many training activities but in most instances there is a clear lack of follow-up, monitoring and appropriate use of the trainees. The participation of the many concerned sectors and nongovernmental organizations in the national response, as well as the private sector, has been encouraged for years. However, only a few countries have succeeded in effective community and multisectoral mobilization. Also, in only a few countries have national STD and AIDS programmes been effectively integrated and decentralized to provinces and districts. Countries have continued to disseminate information and educational materials to young people but far fewer efforts have been focused on targeted interventions for those who are at greatest risk and vulnerability to HIV, such as drug users, and men and women engaging in harmful and risky sexual behaviour. HIV hotlines have been established in only a few major cities. The very few experiences of developing and implementing HIV school curricula have faced important operational and political obstacles, and while religious leaders have been involved in educational activities in some places, the contribution of mass media has not reached the required level.

HIV/AIDS and STD surveillance have continued to be strengthened in some countries. In most cases, national surveillance of HIV/AIDS/STD still suffers from incompleteness and shortages in instituting sound and effective surveillance techniques such as sentinel

surveillance, a fact which renders difficult any attempts at appropriate interpretation of the epidemic situation. The screening of specific 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 the spread of HIV within the country has not been proved. Determinants of the epidemic including behavioural aspects are seldom studied or addressed. The existing problems in the surveillance system for HIV/AIDS need to be addressed both at the country and regional levels.

Actions to maintain blood safety are also among the main activities of the programmes.

A growing number of countries are faced with the pressure to spend more on care and treatment of people living with HIV/AIDS. There have been some efforts in a few 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. However, action still does not meet actual needs in this area.

All this clearly indicates that countries need to revisit their current strategies and develop both more informed knowledge about the situation of HIV/AIDS/STD at the national level and more focused approaches to facing the epidemic.

2.2 WHO support to national AIDS programmes

In the absence of clearly stated national strategies on HIV/AIDS/STD in many instances, the WHO joint AIDS activities with countries are based on the plans of the Joint Government/WHO Planning Review Mission and on needs identified through country visits and national reports. The WHO regional HIV/AIDS and sexually transmitted diseases programme, in its collaborative action at country level, provides support mainly to complement, enhance and expand already existing efforts at country level by government, nongovernmental organizations and other United Nations agencies. The main focus remains advocacy, capacity-building and system development in areas of HIV programme planning and management, surveillance and monitoring, targeted educational interventions, STD care and prevention, care and management of people living with AIDS and blood safety.

In 1999, the Regional Office organized seven specific technical visits to the national AIDS programmes, covering HIV testing, clinical management of AIDS, HIV counselling and nursing care, programme management, and monitoring and evaluation. Seventeen fellowships were awarded during 1999 to Islamic Republic of Iran, Iraq, Jordan, Lebanon, Saudi Arabia, Syrian Arab Republic and Republic of Yemen in the areas of clinical management of AIDS, communication, nursing care, HIV counselling, STD control, programme management and HIV surveillance. Training in STD case management was provided as well in an intercountry workshop for selected countries of the Region. The Regional Office provided supplies and equipment, including diagnostic kits and laboratory equipment for HIV/STD, condoms, audiovisual equipment, data processing equipment and educational material to eight countries of the Region: Djibouti, Egypt, Jordan, Lebanon, Pakistan, Syrian Arab Republic, Tunisia and

Republic of Yemen. On the occasion of World AIDS Day for 1999, the Regional Office prepared and distributed an information and briefing package about the occasion. Various technical guidelines and documents in Arabic and English were translated and printed.

WHO has provided such support to countries within the available resources, which have diminished tremendously in the past few years. This calls for increased efforts to mobilize resources at regional level in support of an expanded response to HIV/AIDS/STD at country level.

3. ROLE OF THE WHO REGIONAL OFFICE IN UNAIDS

As one of the co-sponsors of UNAIDS, WHO continues to play an important role at regional and country levels. The Regional Office hosts the office of the UNAIDS Intercountry Programme Adviser in order to improve collaboration and cooperation in the Region. The Regional Office is also the executing agency of 10 UNAIDS-supported projects in Djibouti, Egypt, Jordan, Lebanon, Morocco, Syrian Arab Republic and Republic of Yemen. WHO representatives in almost all countries of the Region chair the United Nations theme groups at country level.

The joint UNAIDS/WHO plan for 1998–1999 proved a successful experience, both in terms of harmonization of United Nations efforts and of the benefit to the countries of the Region. The joint planning process resulted in a more comprehensive and country-focused regional approach in three thematic areas; STD prevention and care, access to care by people living with HIV/AIDS and other vulnerable population groups, and communication and information on HIV/AIDS.

UNAIDS also extended support to the AIDS Information Exchange Centre in the Regional Office with a view to development of adapted strategies for the Region and improved access of stakeholders at country level to information and exchange of experiences.

4. SETTING THE AGENDA FOR RENEWING COMMITMENT AND ACTION

Two important regional meetings took place in 1999 and have set the tone for future actions to face the epidemic of HIV/AIDS in the Region.

During the tenth intercountry meeting of national AIDS programme managers, held in Tunis in May 1999, the current situation of HIV/AIDS and the different responses of the countries were reviewed. Programme managers clearly expressed concerns about the growing evidence of increasing spread of the epidemic in the Region and of threatening outbreaks among vulnerable populations. They also discussed country-based needs, which would direct the regional action of WHO and other UN agencies as well as UNAIDS. 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;
- developing adapted approaches and methodologies to vulnerability issues related to HIV/AIDS and special groups such as migrants, refugees and injecting drug users;
- developing strategies for resource mobilization and better networking between countries;
- strengthening of STD control.

A WHO intercountry consultation on demand reduction in substance abuse, held in Beirut in November 1999, recognized the growing problem of injecting drug use in some countries of the Region. It clearly emphasized the need to balance resources and efforts between demand and supply reduction on one hand and on the other, prevention of harmful consequences of injecting drugs including HIV/AIDS. It recommended that countries intensify their efforts with regard to information, education and communication on HIV prevention and injecting drug use, by exploring ways to adapt known methodologies of outreach and harm reduction for drug users to the regional context, based on appropriate situation assessment and analysis. It also stressed the need to consider integrated HIV counselling services for drug users more closely.

5. CONCLUSIONS AND RECOMMENDATIONS

AIDS challenges our Region in an unprecedented manner. What we observe from the situation is that HIV does not affect all countries and all groups equally and that it targets those who are already disadvantaged economically and socially. Therefore, we need to understand how the epidemic affects groups differently and be conscious of local norms and realities and take them into consideration. Applied research, including situation analysis, should be at the basis of the development of the national strategies.

Moreover, we have in this Region the opportunity to build on what has been learned globally about what is effective and what is not. We have learned, for example, that central to the success of the prevention and care strategies in HIV/AIDS/STD are not only political will and appropriate resources, but also approaches that are tailored to specific needs of particular groups in specific situations. In low HIV prevalence areas, such as in many countries of this Region, targeted preventive actions remain the most cost–effective approaches. This means for example addressing vulnerability among migrants and the displaced, men and women engaging in risky sexual behaviour, drug users, and special groups of the young, both in and out of school. Without a focused strategy to change behaviour among those most in need, it will be difficult to protect the community as a whole. We need also to widen our preventive options and make use of new approaches that have proved to be effective, such as peer education, community outreach work and harm reduction strategies among drug injectors, and to adapt them to our context, culture and beliefs.

We have to face also the emerging needs in care and treatment of the hundreds of thousands of people living with HIV/AIDS in our Region and to consider how best to ensure for them social acceptance and appropriate support.

There is also an urgent need to meet the resources required to make a difference in terms of preventing the spread of the infection and reducing its impact, and to ensure the sustainability of action.

This is why countries are requested to endorse and support the actions of the Regional Office in:

1. Intensifying HIV/AIDS/STD prevention efforts, especially among those who practise the riskiest behaviour and to find strategic approaches and methods that are appropriate or adaptable to the cultures and beliefs of the Region. This is to be fulfilled through initiating and supporting the process of HIV/AIDS national strategic planning including situation analysis and response review.

2. Helping countries to find the best ways to respond to the care needs of the growing number of people living with HIV/AIDS and the affected families in the Region and to ensure better social acceptance for them.

3. Ensuring high level political commitment and leadership, with particular focus on advocacy and resource mobilization for effective HIV/AIDS/STD prevention and care.

4. Strengthening regional and in-country mechanisms for generation of reliable information, through serological and behavioural surveillance.

5. Building appropriate institutional capacity and broad partnership to support the above-mentioned priority actions.