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# PROGRESS REPORT ON

# ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

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## ABBREVIATIONS

| | |
|---|---|
| AIDS | Acquired immunodeficiency syndrome |
| AIEC | The Regional AIDS Information Exchange Centre, EMRO, Alexandria |
| ARC | AIDS-related Complex |
| GPA | Global Programme on AIDS |
| HIV | Human immunodeficiency virus |
| IDUs | Injecting drug users |
| NAP | National AIDS Programme |
| NGOs | Nongovernmental organizations |
| NORAD | Norwegian Agency for International Development |
| STD | Sexually transmitted diseases |
| UNAIDS | United Nations Programme on HIV/AIDS |
| UNDP | United Nations Development Programme |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |
| UNICEF | United Nations Children's Fund |
| UNFPA | United Nations Population Fund |
| UNHCR | Office of the United Nations High Commissioner for Refugees |

# ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

**[Agenda item 4 (ii)]**

## 1. INTRODUCTION

The present report is submitted to the Regional Committee in accordance with its resolutions requesting, among other things, to keep the Committee informed regularly with up-to-date information on the global and regional epidemiological situation with regard to AIDS.

## 2. GLOBAL AND REGIONAL HIV/AIDS SITUATION

### 2.1 Global situation

At the end of 1995, a cumulative total of 1 291 810 AIDS cases was reported to the Global Programme on AIDS (GPA) of WHO since the beginning of the pandemic. This represents a 26% increase in cases since 31 December 1994. The number of cases reported, by continent, is shown in **Table 1.**

**Table 1. AIDS Cases Reported, by Continent and Year**
(as of end-1995)

| Year | Africa | Americas | Asia | Europe | Oceania | Total |
|---|---|---|---|---|---|---|
| Up to 1989 | 92526 | 184162 | 746 | 39658 | 2188 | 319280 |
| 1990 | 54528 | 65041 | 478 | 17311 | 770 | 138128 |
| 1991 | 72756 | 78579 | 838 | 18937 | 897 | 172007 |
| 1992 | 73631 | 99881 | 2039 | 20697 | 866 | 197114 |
| 1993 | 67124 | 100731 | 7368 | 22053 | 879 | 198155 |
| 1994 | 65684 | 83475 | 11707 | 23541 | 906 | 185313 |
| 1995 | 16486 | 47793 | 5454 | 11906 | 174 | 81813 |
| Total | 442735 | 659662 | 28630 | 154103 | 6680 | 1291810 |

Allowing for underdiagnosis, incomplete reporting and delays in reporting and based on the available data on human immunodeficiency virus (HIV) infections around the world, it is estimated that, up to the end of 1995, six million AIDS cases have occurred worldwide since the pandemic began. The major proportion of these cases have occurred in sub-Saharan Africa and the Americas. At a conservative estimate, the cumulative number of AIDS cases is expected to reach 10 to 12 million by the year 2000.

Because of the long interval between the occurrence of HIV infection and the appearance of the disease, the number of HIV infections gives a more accurate picture of the current status of the AIDS pandemic. As of end-1995, it is estimated that around 17 million adults were living with HIV infection. Of them, the majority (66%) were in sub-Saharan Africa (11.2 million), followed by South and South-East Asia (3 million). The cumulative number of HIV infections is estimated to reach 30 to 40 million by the year 2000. In 50

countries, the estimated HIV prevalence rate was less than 5 per 10 000 sexually active adults and in 15 countries, all in sub-Saharan Africa, the prevalence rate was over 500 per 10 000.

## 2.2 Regional situation

Although the AIDS epidemic is at an early stage, the available evidence indicates that it is spreading in the Eastern Mediterranean Region (EMR). Most of the recent HIV infections are occurring as a result of indigenous spread. Heterosexual transmission has continued to be the predominant mode of the transmission.

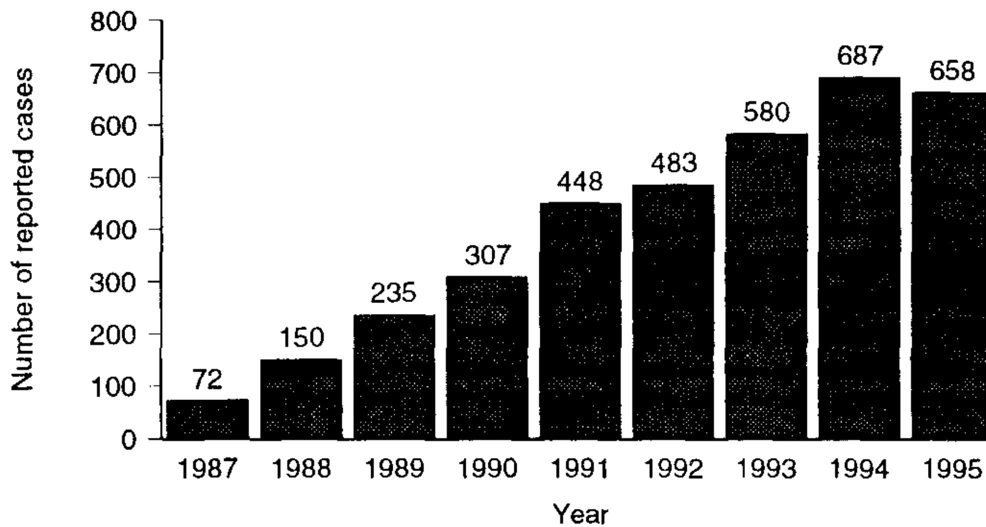
Persistent efforts have been made to obtain reports of HIV/AIDS from the Member States. Based on the reports received up to end-1995, a cumulative total of 3 666 cases has been reported from all countries of the Region, except Afghanistan, which has not reported any case yet. In addition, 531 cases of AIDS-related complex (ARC) have also been reported. However, this is considered to be a gross underestimate and, owing to underrecognition, underreporting and delays in reporting, the actual number of cases that have already occurred in the Region is estimated to be at least three or four times greater, that is between 10 000 and 15 000 cases. Among the countries in the Region, the largest number of cases was reported from Sudan, followed by Djibouti, Morocco and Tunisia **(Table 2).**

**Table 2. Number of AIDS cases reported, from the beginning of the epidemic up to end-1995**

| Country | No. of cases reported |
|---|---|
| Afghanistan | 0 |
| Bahrain | 28 |
| Cyprus | 47 |
| Djibouti | 822 |
| Egypt | 129 |
| Iran, Islamic Republic of | 118 |
| Iraq | 42 |
| Jordan | 39 |
| Kuwait | 19 |
| Lebanon | 91 |
| Libyan Arab Jamahiriya | 17 |
| Morocco | 306 |
| Oman | 55 |
| Palestine | 8 |
| Pakistan | 55 |
| Qatar | 80 |
| Saudi Arabia | 137 |
| Somalia | 13 |
| Sudan | 1341 |
| Syrian Arab Republic | 36 |
| Tunisia | 255 |
| United Arab Emirates | 8 |
| Republic of Yemen | 20 |
| **Total** | **3666** |

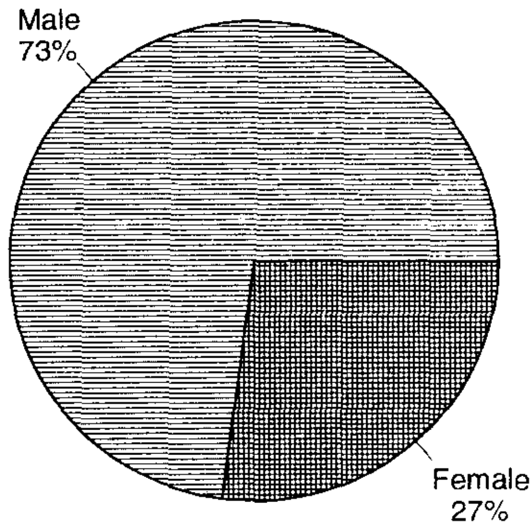
The number of new cases reported continued to show an increasing trend over the years **(Figure 1).** Despite a lack of information from some countries, 551 new cases of AIDS were reported during the first nine months of 1995, representing an increase of 24% over the number of cases reported for the similar period in 1994.

**Figure 1. Reported AIDS cases in the Eastern Mediterranean Region by year (up to September 1995)**



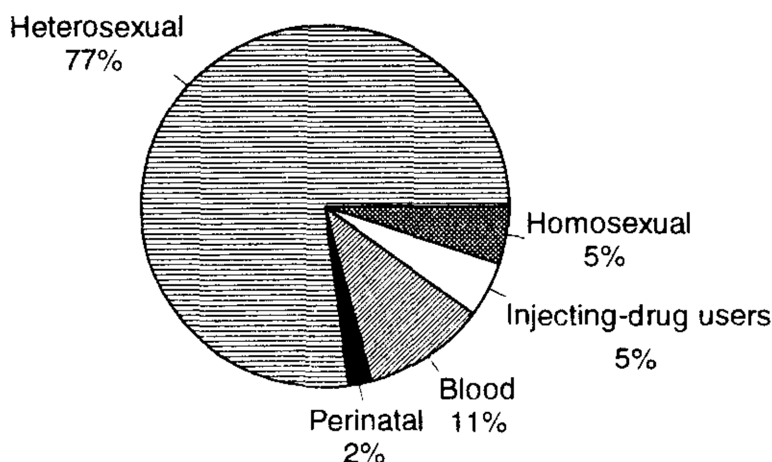

Among the total number of AIDS cases reported since the beginning of the epidemic in the Region, 73% were in males and 27% females **(Figure 2)**. The proportion of female cases has been increasing over the years, from 18% in 1990 to 33% in 1994, indicating an increasing importance of heterosexual transmission. Of the total cases, 89% were among the productive age-group of 15 to 49 years.

**Figure 2. AIDS cases in the Eastern Mediterranean Region by sex (up to 1995)**



Sexual transmission is the predominant mode of transmission, accounting for 82% of the total reported cases (**Figure 3**); 77% through heterosexual transmission and 5% through homosexual transmission. Eleven per cent of the cases were due to transmission through blood and blood products, most of them infected during the early periods of the pandemic, before screening of blood donations against HIV was widely available. The proportion of AIDS cases resulting from sexual transmission has been increasing steadily during the recent years, while the proportion resulting from blood transmission has been decreasing. The proportion of AIDS cases resulting from sexual transmission increased from 70% in 1990 to 88% in 1995, while the proportion resulting from transmission through blood and blood products decreased from 17% to 5% respectively during the same period. Five per cent of cases were among injecting drug users, while perinatal transmission was responsible for only 2% of the cases.

**Figure 3. Mode of transmission of AIDS cases in the Eastern Mediterranean Region (up to 1995)**




As mentioned above, AIDS cases represent a late stage in the total spectrum of HIV infections that occurred 10 or more years ago, and they do not depict the current situation of the epidemic. The number of HIV infections gives a better picture of the current status of the epidemic. Approximately 200 000 persons are estimated to be living with HIV in the Region at the end of 1995.

In order to monitor the trend of HIV infection, surveillance is being carried out in many countries of the Region. The findings of HIV surveillance indicate that the prevalence of the infection is much higher among certain groups of population, particularly those practising high-risk behaviour, such as those afflicted by sexually transmitted diseases (STD), prostitutes and bar girls. For example, between 1990 and 1995, HIV prevalence increased in Djibouti from 2% to 20% among STD patients and from 24% to 45% among prostitutes. In Sudan, the prevalence increased from 1.3% to 5% among STD patients during the same period. HIV infection is also showing an increasing trend among STD patients in Pakistan, the Syrian Arab Republic and Yemen at rates much higher than in the general population. A strong association has been observed between HIV and tuberculosis in Djibouti and Sudan, where 12.8% and 14.2% respectively of tuberculosis patients were found to be positive for

HIV infection. However, HIV infection among recipients of multiple blood transfusions declined considerably in the 1990s, indicating an increased efficiency in the screening of blood donations to ensure safety from HIV infection.

HIV prevalence among blood donors and pregnant women is still very low in the Region, except in Djibouti where it had reached 2.4% and 9.3% respectively in 1995. HIV infections were also reported among blood donors in many other countries, namely Egypt, the Islamic Republic of Iran, Kuwait, Lebanon, Morocco, Oman, Somalia, Sudan, the Syrian Arab Republic, Tunisia and Yemen, but at very low rates.

National protocols for HIV surveillance have been prepared in 14 countries, with emphasis on sentinel surveillance of STD patients. However, the protocols could not be fully implemented in most countries owing to the inadequate collection of blood samples, as most of STD patients seek care from sources other than the public sector facilities.

## 3. REGIONAL ACTIVITIES

### 3.1 Support to national AIDS programmes

Technical and financial support to Member States continued to receive top priority among the activities of the Regional Office.

The Regional Office provided technical assistance in planning, implementation, monitoring and evaluation of national AIDS programmes (NAPs). Funds for priority activities, such as increasing national technical capabilities, health education, surveillance, blood safety, care of persons with HIV/AIDS, STD control, and support to nongovernmental organizations (NGOs) mainly in their work with groups practising high-risk behaviours, were provided to countries of the Region.

Technical support

Assignment of advisers, including Regional Office staff and short-term consultants, comprised an important part of the technical support. The Regional Office fielded a total of 40 missions in 12 countries in 1995 **(Table 3)**, which included four planning missions in three countries, 35 implementation missions in 12 countries, and a review mission.

**Table 3.**
**Missions to Countries in the Region in 1995**

| Types of missions | No. of missions | No. of countries covered | No. of advisers involved |
|---|---|---|---|
| Planning | 4 | 3 | 9 |
| Implementation | 35 | 12 | 35 |
| Review and Evaluation | 1 | 1 | 3 |
| **Total** | **40** | **12*** | **47** |

* more than 1 mission in some countries

Planning missions included visits to assist national programmes in the formulation of medium-term plans and in the preparation of workplans for AIDS prevention and control.

The implementation missions included missions in surveillance (6), information, education and communication (6), evaluation (5), injecting drug use (3), clinical management (3), sexually transmitted diseases control (3), HIV counselling (3), NGO collaboration (3), blood safety (2) and condom logistics (1).

In addition to the above short-term missions, WHO provided four long-term staff members (one each in Djibouti and Pakistan, and two in Sudan). In addition, WHO supported the recruitment and funding of a number of national staff in Djibouti, Lebanon, Pakistan and Sudan.

Fellowships

With the aim of increasing the national capabilities, the Regional Office awarded 17 fellowships in 1995 for national staff from five countries (Egypt, the Islamic Republic of Iran, Iraq, Sudan and the Syrian Arab Republic). They included one each in the field of HIV epidemiology, IEC and programme management; three in counselling; four in nursing care; and seven in clinical management.

Supplies and equipment

WHO provided, in 1995, supplies and equipment, including diagnostic kits for HIV/STD, audiovisual equipment, educational materials, office and data processing equipment and condoms to 14 Member States. The value of these supplies and equipment was more than US$556,000.

Support to national and local activities

Financial support to national and local activities represented a major portion of the WHO support to AIDS programmes. During 1995, WHO provided financial support to all countries for a wide variety of activities that included training of health care workers, such as doctors, nurses, health educators, counsellors, laboratory staff and paramedical staff; training of others such as teachers, media personnel, social workers, youth, women and community workers; and orientation of religious leaders, decision-makers and opinion leaders. Support was also extended to activities aimed at educating the general public as well as those at increased risk of HIV infection; and production of information, educational and training materials, such as pamphlets, posters, radio and TV spots, manuals and guidelines. The Regional Office also provided support for the conduct of sociobehavioural studies, HIV surveillance and evaluation; and planning and review exercises.

Activities aimed at promoting collaboration of NGOs in AIDS prevention and control were continued. The Regional Office provided financial support amounting to US$220 000 to 61 NGO projects in 12 countries.

Monitoring and evaluation

The Regional Office continued to monitor the implementation of national AIDS programmes through reports, staff visits and by updating its country profiles. A comprehensive external review of the national AIDS programme was carried out in Yemen with WHO's technical assistance. The first evaluation survey in the Region to measure the effectiveness of the programme, using global indicators was carried out in Sudan. Similar surveys started in Djibouti, Egypt, Lebanon and Pakistan.

Financial resources

Member States are implementing their national plans with funds from various sources: some countries use solely their own national resources, while others receive external support to varying degrees. A few countries depend mostly on external support for implementation of their plans. In 1995, the WHO's Global Programme on AIDS remained the principal source of such external support, the extent of which for any individual country depended on the epidemiological situation and the needs for external support. Other sources included UNDP, UNICEF, UNFPA, UNHCR and NORAD and other bilateral agencies.

WHO's Global Programme on AIDS ceased to exist on 31 December 1995 and has been replaced by the joint and cosponsored United Nations Programme on HIV/AIDS (UNAIDS) (see Section 4). The funds allocated for support to national programmes by UNAIDS are significantly smaller than those provided through the WHO's former Global Programme on AIDS. Joint government/WHO programme review missions have allocated funds under Regular Budget in a number of countries in 1996-1997 biennium for the prevention and control of STDs, including AIDS, and a professional staff member has been assigned, under the Regular Budget, to the newly established STD unit in the Regional Office.

### 3.2 National commitment

The prevalence of HIV is fortunately still at a low level in most of the countries of this Region. However, this is no excuse for complacency, if a serious situation is to be avoided. Concerted efforts should be made continuously to keep this level low. Such efforts require continued and strengthened commitment and a greater mobilization of resources, particularly since the AIDS pandemic is spreading rapidly. Countries that have so far been depending significantly on external support should recognize that such support can only be a supplement to national inputs and they should mobilize national resources in implementing their national plans.

There is still a tendency in many countries to limit the national AIDS programme to the health sector. Because of the wide implications of the disease, it should be recognized by all that the AIDS problem cannot be tackled by the health sector alone and there is a need to actively involve other sectors and NGOs.

### 3.3 Sexually transmitted diseases

Available information is too meagre to assess the true magnitude of sexually transmitted diseases (STDs) in the Region, but the extent of the problem is considered to be not insignificant. STDs not only cause high morbidity, but also result in serious complications and long-lasting sequelae. In addition, those with genital lesions increase the risk and efficiency of HIV transmission by many times. Therefore, the Regional Office emphasized the need to establish and develop an effective programme to control STDs. As a reflection of this emphasis, effective January 1996, the Regional Office established, an STD unit, which would deal with AIDS as well.

During 1995, technical assistance in STD control was provided to Egypt, Sudan and the Syrian Arab Republic for implementing national STD control activities and in preparing national operational guidelines. In addition, financial assistance was provided for the training of health care workers, production of educational material and supply of condoms and diagnostic kits. In order to enhance cost-effectiveness and efficiency, the emphasis was laid on a syndromic approach to STD case-management.

### 3.4 Intercountry meetings

A number of intercountry meetings were organized to review the current situation, to exchange experiences and to provide participants with an update on the developments related to various aspects of AIDS and STD control, as well as to increase the capabilities of the national staff in planning, implementation, monitoring and evaluation of AIDS and STD control programmes. These meetings were mostly in the form of workshops directed towards priority areas in national programmes and aimed at preparing draft national plans for consideration by national authorities.

Brief reviews of the intercountry meetings held in 1995 are given below.

1. Annual meeting of national AIDS programme managers, Amman, 10-13 April 1995

This meeting covered all important aspects of the national AIDS programmes, particularly challenges in planning and management, HIV/AIDS/STD surveillance, studies on high-risk behaviour, STD control, AIDS among youth, evaluation through the use of indicators, mobilization of resources, care of persons with HIV/AIDS and involvement of other sectors and NGOs. The participants exchanged their experiences in the implementation of national programmes and were updated on recent developments in this field.

2. Workshop on AIDS education in schools, Alexandria, 11-15 September 1995

This workshop was attended by participants from ministries of health and education. It highlighted the role of AIDS education in schools in view of the vulnerability of youth to HIV infection. Some of the existing educational packages were reviewed, and the design of curricula and planning of extracurricular activities, training of teachers and development of support services were discussed. Participants from both ministries of health and of education prepared national plans of action for AIDS education in schools in their countries in line with local responsibilities and cultural aspects.

3. Workshop on AIDS education at the workplace, Lahore, 25-27 September 1995

As the vast majority of HIV-infected individuals are in the working age-group, this workshop was organized to highlight the importance of AIDS education at the workplace. The participants reviewed current AIDS education activities at the workplace and discussed strategies and approaches for such education. Participants from each country prepared a plan of action for AIDS education at the workplace.

4. Workshop on prevention of HIV transmission through injecting drug use, Cairo, 16-18 October 1995

The participants in this workshop reviewed drug abuse in general and the HIV situation among injecting drug users (IDUs), in particular in the Region. The strategies and interventions for prevention of HIV among IDUs as well as situation analysis, planning and evaluation for such interventions were discussed. Plans of action were prepared by the participants in collaboration with WHO secretariat members.

5. Workshop on HIV counselling, Beirut, 25-28 April 1995

Various aspects of HIV counselling were discussed, using participatory approach. The areas covered included values and attitude clarification, psychosocial aspects of counselling, nature, purpose and type of counselling, including pre- and post-test counselling and voluntary counselling and testing. The participants were assisted in preparing national plans of action for HIV counselling in their countries.

6. Workshop on STD case-management, Cairo, 20-23 March 1995

The epidemiological situation of STD, policies and principles of STD control, including health promotion, case-management, diagnosis, surveillance, monitoring and evaluation were discussed during the workshop. Case-management, particularly using the syndromic approach, was the main focus. Participants prepared frameworks for plans of action for STD control in their own country.

7. Workshop on laboratory diagnosis in the management of AIDS/HIV infection, Kuwait, 10-14 December 1995

Participants were trained in laboratory diagnosis and management of HIV and major opportunistic infections, including viral, bacterial, parasitic and fungal infections. Methods of diagnosing HIV infection included ELISA and supplemental tests for antibodies, the polymerase chain reaction (PCR) and flow cytometry for quantitation of different lymphocyte subsets. The workshop included lectures as well as practical demonstration. The participants presented details of laboratory facilities available in their countries.

8. Workshop on social marketing and logistics of condoms, Rabat, 13-17 November 1995

In this workshop the role of condom programming, including social marketing, in AIDS prevention and control was clarified, the fundamentals of condom logistics management discussed and the status of supplies in the countries reviewed. The participants identified the barriers to condom programming and the policy implications and covered related areas such as inventory systems, quality assurance and training.

9. Workshop on evaluation of national AIDS programmes, Nicosia, 22-25 August 1995

The participants reviewed the monitoring and evaluation of national AIDS programmes (NAPs) in the Region, focusing on evaluation methods using indicators. Protocols for repeated surveys of general population, estimating condom availability, assessment of STD case-management and HIV/syphilis seroprevalence surveys were presented and discussed. The participants were taught about evaluation instruments, data collection, analysis and management, and were given a demonstration of suitable PC software. The participants were assisted in preparing national plans of action for evaluation, selecting the relevant global indicators and adding other indicators appropriate for the situation in their countries.

### 3.5 AIDS Information Exchange Centre

The Regional AIDS Information Exchange Centre (AIEC) continued to provide information and educational materials to national AIDS programmes, nongovernmental organizations, institutions and individuals. A large amount of audiovisual materials was distributed in 1995.

AIEC assisted countries in the production of printed material; this assistance included the technical clearance of manuscripts and prototypes submitted by the NAPs; provision of culturally sensitive prototypes to be adapted or adopted by the NAPs; and printing of material for a few NAPs. The Centre was responsible for coordinating World AIDS Day activities.

AIEC distributed catalogues of books, journals, slides and video films to NAPs and assisted them in the procurement of these materials. AIEC also provided background material to intercountry meetings and workshops.

### 3.6 World AIDS Day

World AIDS Day was observed on 1 December of each year in all countries of the Region in various forms such as lectures, seminars, debates, games, fairs, exhibitions and competitions. The theme in 1995 was "Shared Rights, Shared Responsibilities". A large number of sectors, NGOs and individuals were involved on this occasion and a large amount of material was distributed in Arabic, English and French. For the occasion, the Regional Office provided NAPs and the sectors concerned with relevant material for distribution or reproduction.

The Regional Director delivered a message on the World AIDS Day theme highlighting the rights of all individuals to have information on AIDS, to be able to avoid infection, to receive health care if afflicted with AIDS and to be treated with dignity and without discrimination. The Regional Director also elaborated on the responsibilities of

individuals, families, governments and international communities for prevention of HIV infection and care of persons with HIV/AIDS.

### 3.7 WHO Collaborating Centres on Laboratory Diagnosis of HIV

There are three regional collaborating centres on the laboratory diagnosis of HIV: NAMRU-3 in Cairo; Kuwait University's Faculty of Medicine in Kuwait; and the Pasteur Institute in Casablanca. These laboratories are providing support to the countries in the Region in HIV testing, including supplemental testing, to confirm the results of HIV tests, and in the training of laboratory staff. NAMRU-3 is also carrying out virus isolation and characterization of HIV in a few selected countries. This activity is considered to be essential to monitor the types of HIV circulating in the Region, and is being carried out in preparation for the development of potential vaccine(s), with the consequent need to identify the prevailing strains. The collaborating centre in Kuwait organized a workshop on the laboratory diagnosis in management of persons with AIDS/HIV infection, mentioned earlier.

## 4. JOINT AND COSPONSORED UNITED NATIONS PROGRAMME ON HIV/AIDS

The objective behind the establishment of this programme was the fact that the AIDS pandemic affects all sectors of society. It was therefore considered that only a special United Nations programme would be able to fight the pandemic on all fronts, and thus, the joint, cosponsored United Nations Programme on HIV/AIDS, or UNAIDS, was established. UNAIDS draws on the experience, expertise and resources of six cosponsors, namely UNDP, UNESCO, UNFPA, UNICEF, WHO and the World Bank.

UNAIDS is to address the major strategic and policy issues of HIV/AIDS, advocate a strong global response to the pandemic, ensure coordinated support by the cosponsoring organizations to NAPs, and promote and support research of relevance to the developing countries. It would act in partnership with other United Nations agencies, bilateral organizations, community-based groups, NGOs, the private sector and academic institutions and would involve those with HIV infection and AIDS in all areas of work.

At the global level, UNAIDS carries out global-level activities in the areas of advocacy, strategic and policy guidance, research, support to country-level coordination, technical support to NAPs, and monitoring of the epidemic and of national and international responses to it. At country level, the mandate of UNAIDS is to strengthen the national capacity to respond to HIV/AIDS. UNAIDS would work primarily through the Theme Group on HIV/AIDS established in each country. It should be noted that the WHO Representatives in the Region have been designated as chairpersons of the theme groups in their countries of assignment.

UNAIDS also provides technical support to NAPs in the form of staff assignments or consultancies, funds for the "core needs" of the NAPs (in selected countries), and funds for intercountry projects. UNAIDS does not have a regional structure of its own, although there will be regional and intercountry activities, which would be supported by utilizing the existing regional structures of the cosponsors.

The budget of UNAIDS includes resources to be used at global level as well as those intended to support country and intercountry activities. At country level, funding for HIV/AIDS-related activities of the United Nations System in support of NAPs is expected to come essentially from the cosponsors and other United Nations system organizations—not from UNAIDS alone.

In order to maintain strong regional support to national programmes, the Regional Director took the initiative to begin meetings with other cosponsors of UNAIDS. He organized a meeting in Amman on 9 April 1995 with the Regional Directors of other cosponsors and the Executive Director of UNAIDS. The meeting identified areas of collaboration and the comparative strengths of the cosponsors.

## 5. CONCLUSIONS

The AIDS pandemic continues to spread in the Region, mostly indigenously, and hence there is no excuse for complacency. Concerted efforts must be made to check the spread of AIDS before the pandemic becomes unmanageable, as is being experienced in other regions. This calls for a greater commitment to national AIDS programmes, increased mobilization of national resources and the active involvement of all sectors and NGOs in all aspects of the programme, including planning, implementation, monitoring and evaluation.

It is recommended that Member States should continue to:

- ensure a high level of commitment to national AIDS programmes;
- provide adequate national human and financial resources for implementing national AIDS programmes effectively and efficiently;
- enlist and ensure the active involvement of sectors and NGOs concerned in all stages of the programme;
- implement effectively all components of national AIDS programmes, including education of the general population and of specific priority target groups, blood safety, care of persons with HIV/AIDS, HIV surveillance, monitoring and evaluation;
- develop and strengthen STD control programmes; and
- regularly exchange information with WHO, UNAIDS and other countries on HIV/AIDS and programme activities.

**Table 2. Number of AIDS cases reported, from the beginning of the epidemic up to end-1995**

| Country | No. of cases reported |
|---|---|
| Afghanistan | 0 |
| Bahrain | 28 |
| Cyprus | 50 |
| Djibouti | 880 |
| Egypt | 129 |
| Iran, Islamic Republic of | 120 |
| Iraq | 42 |
| Jordan | 40 |
| Kuwait | 19 |
| Lebanon | 91 |
| Libyan Arab Jamahiriya | 17 |
| Morocco | 306 |
| Oman | 55 |
| Palestine | 8 |
| Pakistan | 55 |
| Qatar | 80 |
| Saudi Arabia | 137 |
| Somalia | 13 |
| Sudan | 1341 |
| Syria Arab Republic | 36 |
| Tunisia | 270 |
| United Arab Emirates | 8 |
| Republic of Yemen | 22 |
| **Total** | **3747** |

**Figure 5.1 Reported AIDS cases in the Eastern Mediterranean Region by year (up to end-1995)**