WORLD HEALTH ORGANIZATION
Regional Office for the Eastern Mediterranean
ORGANISATION MONDIALE DE LA SANTE
Bureau régional de la Mediterranee orientale

منظمة الصحة العالمية
المكتب الاقليمي لشرق المتوسط

REGIONAL COMMITTEE FOR THE
EASTERN MEDITERRANEAN

EM/RC45/12
June 1998

Forty-fifth Session

Original: Arabic

Agenda item 13

PROGRESS REPORT

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) IN THE EASTERN MEDITERRANEAN REGION

CONTENTS

1. INTRODUCTION

The epidemic of acquired immunodeficiency syndrome (AIDS) continues to spread all over the world. Although the Joint United Nations Programme on HIV/AIDS (UNAIDS) became fully operational on 1 January 1996, replacing WHO's Global Programme on AIDS (GPA), WHO continued to play a leading role in HIV/AIDS prevention and control because of its constitutional mandate in international health and because of its responsibility as one of the cosponsors of UNAIDS. This report is submitted to the Regional Committee in consonance with its resolution EM/RC40/R.6 requesting the Regional Director to inform the Regional Committee regularly about the regional and global AIDS situation as well as about the progress in the implementation of AIDS control activities.

2. GLOBAL AND REGIONAL HIV/AIDS SITUATION

2.1 Global HIV/AIDS situation

Up to the end of 1997, a cumulative total of 1 736 958 AIDS cases had been reported from all over the world (Table 1). However, owing to underdiagnosis, incomplete reporting and delays in reporting, the cumulative total is estimated to have reached 12.9 million. The proportion of AIDS cases that are reported varies widely, from less than 10% in some countries to over 90% in others. Furthermore, complete reports for 1997 have not been received except from a few countries. Reporting for 1996 is also incomplete for a number of countries. Of the estimated cases, 11.7 million have already died, one-fifth of them, i.e. about 2.3 million, in 1997. Of the people who died in 1997, 46% were women and 460 000 were children.

Table 1. Reported AIDS cases by continent

Year	Africa	America	Asia	Europe	Oceania	Total
1979–89	92 577	182 487	739	39 443	2 201	317 447
1990	54 411	67 075	554	17 480	780	140 000
1991	71 724	80 600	959	19 378	915	173 576
1992	70 355	103 928	2 224	21 109	873	198 489
1993	73 377	107 417	7 745	22 713	925	211 177
1994	70 200	100 370	15 020	26 084	1 041	212 715
1995	107 100	93 050	22 226	24 414	880	247 670
1996	56 341	68 372	21 541	20 019	715	166 988
1997	8 361	14 890	3 394	4 888	168	31 701
Total*	617 463	839 189	74 431	197 374	8 501	1 736 958

* Totals include 36 895 cases that could not be shown by year as the year of diagnosis was not reported.

There was a decline in the number of cases and deaths due to AIDS in the industrialized countries as a result of better care, and particularly the use of combination anti-retroviral treatment including the newly available drugs. Use of anti-retroviral drug zidovudine during pregnancy and delivery in these countries has also reduced the transmission of human immunodeficiency virus (HIV) infection from infected pregnant women to their newborn babies. On the other hand, the number of cases and deaths due to AIDS continued to increase in the developing countries, particularly sub-Saharan Africa and some of the countries in south and south-east Asia.

Because of the long interval between infection with HIV and the development of AIDS, the number of AIDS cases gives an indication of the epidemic about 10 years earlier. The number of HIV infections gives a more accurate picture of the current status of the epidemic. According to new estimates, infection with HIV is far more common in the world than previously thought. About 16 000 new HIV infections occurred every day in 1997 in the world, making a total of 5.8 million new infections during that year. Nearly 88% of them were in adults, over 40% in women. Over 50% of the new infections occurred among young people aged 15 to 24 years. About 30.6 million people were estimated to be living with HIV at the end of 1997 (Table 2). In other words, one in every 100 adults in the sexually active ages of 15 to 49 years is infected with HIV, more than 90% of them in the developing countries. Two-thirds of the infected people live in sub-Saharan Africa where 7.4% of all people aged 15 to 49 years are estimated to be infected with HIV. At the current rate of the spread of the epidemic, it is estimated that more than 40 million people will be living with HIV in the world in the year 2000.

Table 2. Estimated HIV infections in the world by geographic region

Geographic region	Number of persons living with HIV/AIDS (million)	Adult prevalence rate (%)	Women among HIV positive adults (%)
Sub-Saharan Africa	20.8	7.4	50
North Africa and Middle East	0.21	0.13	20
South and south-east Asia	6.0	0.6	25
East Asia and Pacific	0.44	0.05	11
Latin America	1.3	0.5	19
Caribbean	0.31	1.9	33
Eastern Europe and central Asia	0.15	0.07	25
Western Europe	0.53	0.3	20
North America	0.86	0.6	20
Australia and New Zealand	0.012	0.1	5
Total	30.6	1.0	41

2.2 Regional HIV/AIDS situation

The spread of the AIDS epidemic continued to be slow in the Eastern Mediterranean Region (EMR), owing largely to the social and cultural factors prevailing in the Region. However, there is no doubt that HIV infection is spreading indigenously within the individual countries and is not limited to importation from other countries.

AIDS cases have been reported from all countries of the Region except Afghanistan. Up to the end of 1997, a cumulative total of 6000 cases had been reported to WHO from these countries (Table 3). Allowing for underdiagnosis, underreporting and delays in reporting, the actual number of cases that have already occurred are estimated to be over 16 000. The largest number of cases was reported from Sudan, followed by Djibouti, Morocco, Tunisia, Saudi Arabia and other countries. However, the AIDS case rate was highest in Djibouti in 1997 (67.95 per 100 000 population) which was far above the next highest of 0.87 and 0.77 per 100 000 population respectively in Bahrain and Sudan and which was comparable to the case rates in the countries of sub-Saharan Africa.

Table 3. Reported AIDS cases in EMR up to end of 1997

Country	Up to 1990	1991	1992	1993	1994	1995	1996	1997	Total	Report up to
Afghanistan	0	0	...	...	...	...	...	...	0	31.12.91
Bahrain	4	3	4	4	5	8	5	15	48	31.12.97
Cyprus	27	4	2	4	9	3	4	5	58	30.9.97
Djibouti	58	107	144	144	196	231	358	434	1672	31.12.97
Egypt	27	12	23	29	22	16	14	25	168	31.12.97
Iran, Islamic Republic of	19	25	16	32	19	16	27	40	194	31.12.97
Iraq	0	7	6	21	37	16	15	2	104	31.12.97
Jordan	12	8	7	8	6	2	4	12	59	31.12.97
Kuwait	3	3	2	2	5	4	5	2	26	31.12.97
Lebanon	24	7	6	32	14	8	6	1	98	31.12.97
Libyan Arab Jamahiriya	5	2	3	2	3	2	...	...	17	31.12.95
Morocco	70	28	30	44	77	57	66	92	464	31.12.97
Oman	37	12	11	16	28	12	12	23	151	31.12.97
Pakistan	30	16	18	16	9	20	19	19	147	31.12.97
Qatar	52	10	3	7	6	4	2	4	88	31.12.97
Saudi Arabia	34	10	6	12	38	37	100	112	349	31.12.97
Somalia	13	...	...	...	...	...	...	...	13	31.12.90
Sudan	320	188	184	191	201	257	221	270	1832	31.12.97
Syrian Arab Republic	13	7	3	3	4	6	9	8	53	31.12.97
Tunisia	77	28	25	36	43	61	55	15	340	30.6.97
United Arab Emirates	8	...	...	...	...	...	...	...	8	31.12.90
Yemen, Republic of	1	0	3	4	3	11	60	...	82	31.12.96
Palestine	5	1	6	1	3	3	1	9	29	31.12.97
Total	839	478	502	608	728	774	983	1088	6000	

... Information not received

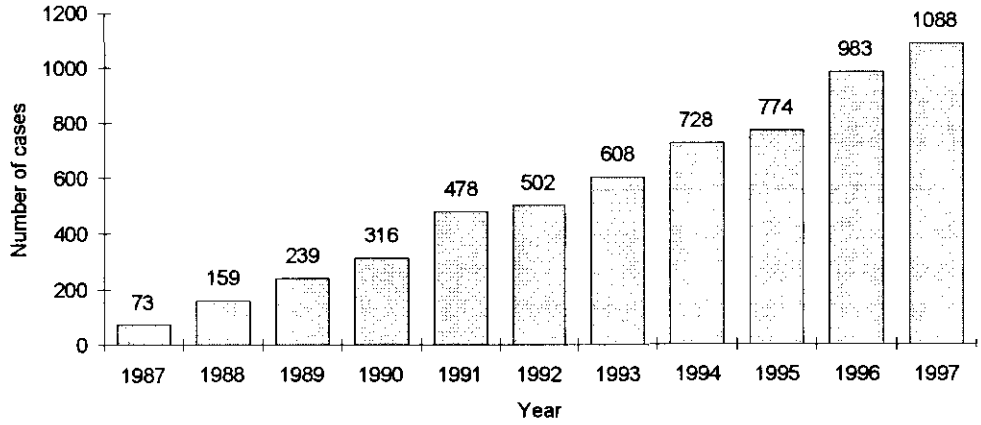

Figure 1. Reported AIDS cases in EMR by year

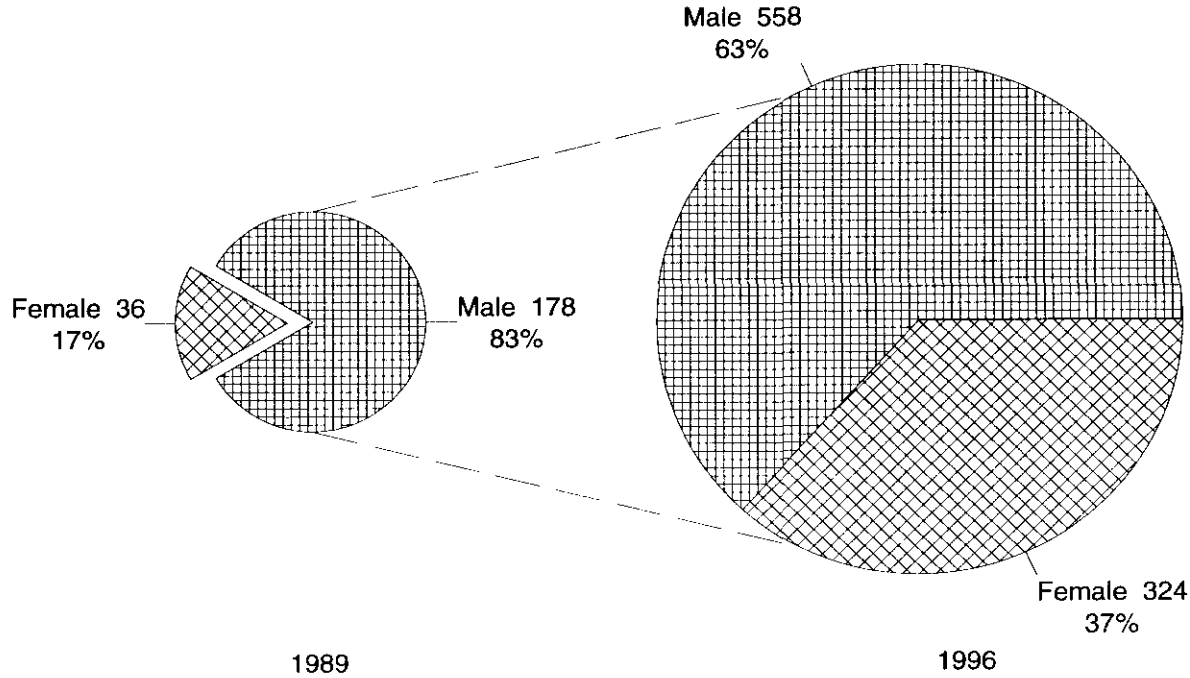

Figure 2. Reported AIDS cases in EMR by sex in 1989 and 1996

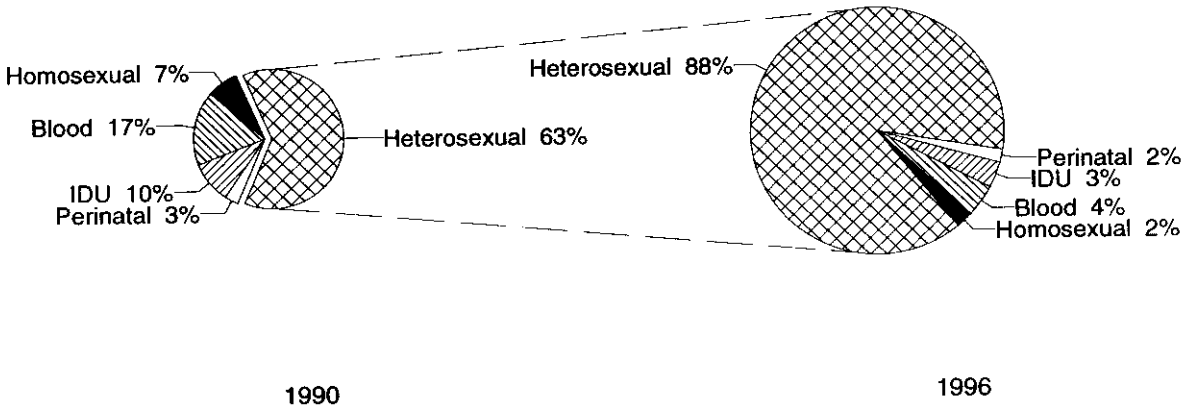

Figure 3. Reported AIDS cases in EMR by mode of transmission in 1990 and 1996

As a result of persistent efforts of the Regional Office, regular and complete reports were received from most of the countries. However, incomplete reports are still being received from a few countries and a few others are not reporting. The available reports show a consistently increasing number of new cases over the years indicating a continued spread of the epidemic during the last decade (Figure 1).

Among the total reported cases, 71% were males and 29% females. However, the sex ratio has been undergoing a gradual change over the years. The proportion of female cases has more than doubled from 17% in 1989 to 37% in 1996, indicating an increasing heterosexual transmission of HIV infection (Figure 2). Among the total reported cases, 89% belonged to the productive age group of 15 to 49 years.

The predominant mode of HIV transmission in the Region is sexual transmission which is responsible for 83% of the reported AIDS cases, 79% through heterosexual transmission and 4% through homosexual transmission. Other modes of transmission included use of contaminated blood or blood products (10%), injecting drug use (4%) and perinatal (mother to child) transmission (3%). Most of the cases due to contaminated blood or blood products occurred before screening against HIV became widely available. The proportion of AIDS cases due to this mode of transmission decreased from 17% in 1990 to 4% in 1996 (Figure 3). AIDS cases due to blood or blood products are still being reported from a few countries, partly due to the long interval between the beginning of HIV infection and the development of AIDS and partly due to incomplete coverage of screening. On the other hand, the proportion of reported AIDS cases due to sexual transmission increased from 70% in 1990 to 90% in 1996.

As stated earlier, AIDS represents a very late stage in the total spectrum of HIV infection. It is, therefore, essential to estimate the prevalence of HIV infection in order to understand the current status of the epidemic. This is being done in the countries through HIV surveillance of selected groups of people including patients with sexually transmitted diseases (STD), prostitutes, homosexuals, injecting drug users, recipients of frequent blood transfusions or blood products and pregnant women. However, the goals of surveillance protocols could not be achieved in most of the countries because of the inadequate collection of blood samples. A few other groups such as tuberculosis (TB) patients, blood donors, prisoners and migrant workers are also being tested. With a few exceptions, prevalence of HIV among these groups remained low in most of the countries. Examples of these exceptions follow.

In 1996, HIV prevalence was 22.2% among STD patients and 32.7% among prostitutes in Djibouti. In Tunisia, 1% of injecting drug users were found to be positive for HIV in 1996. In the Islamic Republic of Iran, outbreaks of HIV infection among injecting drug users were reported in 1996 and 1997 and prevalence as high as 50% was reported among this group in some prisons. HIV prevalence among prisoners in 1996 was 1.3% in Bahrain, 1.5% in Oman and 1.7% in the Republic of Yemen. Prevalence among TB patients was 1% in Bahrain, 16.7% in Djibouti and 2.1% in the Republic of Yemen. In Egypt, cases of HIV infection among patients undergoing kidney dialysis were reported in 1997. HIV prevalence among pregnant women was 2.9% in both Djibouti and Sudan. HIV prevalence among blood donors continued to be low in all countries except in Djibouti (2.4%) and in Sudan (0.5%) in 1997. Other countries reporting small numbers of HIV positive blood donors in 1997 included Egypt, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Morocco, Oman, Pakistan and Tunisia.

After consideration of available information, it is estimated that 210 000 people were living with HIV at the end of 1997 in the EMR. This constitutes a mere 0.69% of the world total, thus substantiating the slow spread of the epidemic in the Region.

3. STD SITUATION

Although the exact magnitude of STD in the world is not known, they are quite common and are responsible for high morbidity, complications and sequelae. On the basis of various reports and studies, it is estimated by WHO that about 333 million new cases of four curable STD occur every year in the world, 10 million of them in the Eastern Mediterranean Region.

Epidemiological trends of STD vary in different parts of the world. STD control including STD reporting did not receive full attention until recently. However, with the rapid spread of the epidemic of AIDS, which is essentially a sexually transmitted disease, STD control has now started receiving some attention. Various studies have documented the close association between AIDS and other STD. The presence of STD increases the risk of HIV transmission by many times. The modes of transmission of HIV infection and other STD are similar and so also are the target groups and interventions for primary prevention. Hence, STD control is one of the important strategies for prevention of HIV infection.

4. REGIONAL ACTIVITIES

4.1 National commitment

Although the AIDS epidemic is spreading slowly in the Region and the HIV prevalence is still low in most of the countries, there is no place for complacency if a rapid spread of the infection among vulnerable groups of people is to be avoided. Concerted efforts for prevention should be continued and further strengthened for this purpose, along with measures for providing care to people with HIV/AIDS. This requires the active participation of many sectors other than health and participation of nongovernmental organizations.

WHO's GPA was the main provider of external support for those countries which depended heavily on such support for implementation of national AIDS plans. With the disestablishment of GPA, these countries have experienced a gap in financial resources as the amount of support received from UNAIDS is much smaller than the amount they were receiving from GPA. To fill this gap, these countries need to mobilize more national resources as well as other sources of support.

The Regional Office continued its efforts with the countries at all levels to sustain and enhance the national commitment by giving high priority and allocating more national resources to the national AIDS programmes. The Regional Office allocated more than US$ 730 000 in 1996–97 to the countries from its regular budget. The Regional Office also encouraged the participation of all concerned sectors and nongovernmental organizations in the national AIDS programmes.

4.2 Support to national AIDS programmes

The main focus of the Regional Office in allocating its resources was the country level where the action occurs. With this guiding principle, the Regional Office gave high priority to providing technical and financial support to the national AIDS programmes of the countries.

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. During 1996–97, technical support, covering various major aspects of the national programmes, such as planning, surveillance, prevention interventions, injecting drug use, blood safety, care, monitoring and evaluation, was provided through staff visits to ten countries, a WHO consultant to one country and a national temporary adviser to one country.

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 during 1996–97 to Egypt, Iraq,

Morocco, Pakistan, Palestine, Syrian Arab Republic and Republic of Yemen in the areas of clinical management of AIDS, STD control, health education, HIV surveillance and laboratory diagnosis of HIV.

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, Egypt, Iraq, Lebanon, Morocco, 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's bulk purchase system for Pakistan, Sudan and Republic of Yemen, using their national funds and thus bringing a considerable reduction in the cost of purchase.

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. In addition to reporting on HIV/AIDS, reporting on STD was introduced. The Regional Office designed simple tally sheets for recording of STD cases in the health care facilities of the countries and simple forms for reporting to higher levels and is continuing its efforts to receive complete and regular reports on HIV/AIDS as well as on STD, as stated earlier. Evaluation surveys using the global indicators to measure the effectiveness of prevention interventions of national AIDS programmes were completed in Djibouti, Lebanon and Pakistan, in addition to Sudan which had completed a survey earlier. A health facility survey to evaluate STD case management was carried out in Morocco. An evaluation survey protocol was pretested in Egypt but could not be continued owing to operational difficulties. Preliminary work for evaluation was started in the Islamic Republic of Iran and Tunisia.

Financial support

Financial support provided to the national AIDS programmes by the Regional Office from its regular budget was used for a wide 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 material and messages; HIV/STD surveillance; and monitoring and evaluation. Training was organized for various components of the national programmes, such as prevention interventions, surveillance, STD control, counselling and care of persons with HIV/AIDS. Funds were also provided to five nongovernmental organizations—three in Lebanon and two in Pakistan.

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 Norwegian Agency for Development (NORAD).

4.3 Intercountry meetings

The Regional Office organized eight intercountry meetings on the following subjects during 1996 and 1997 in which the current situation was reviewed, experiences and opinions shared, information on latest developments disseminated and measures for strengthening the 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.

- HIV/AIDS/STD surveillance
- Control of STD
- Prevention of HIV transmission through blood
- Role of nurses and auxiliary staff in care of persons with HIV/AIDS/STD
- Programme management in AIDS/STD
- Clinical management of AIDS
- Evaluation of national AIDS programmes
- Meeting of national AIDS programme managers

4.4 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. These included guidelines on HIV/AIDS/STD surveillance, guidelines for carrying out studies of case load and of prevalence of STD, guidelines for STD case management and adaptation of guidelines for evaluation of national AIDS programmes using global indicators. The Regional Office also prepared a brochure on STD for the general public and brochures on AIDS for drug users and long distance drivers. The Regional Office started 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. Four issues were brought out in 1997. The newsletter is targeted at health care providers as well as the general public.

The above documents were distributed by the AIDS Information Exchange Centre which is now technically under the Office of the Deputy Regional Director and administratively under the Health Information Support Unit of the Regional Office in consonance with the policy of distributing all regional documents from one unit of the Regional Office.

4.5 WHO collaborating centres on laboratory diagnosis of HIV

NAMRU-3, Cairo, 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. The other two centres are Kuwait University Faculty of Medicine, Kuwait, and the Pasteur Institute in Casablanca, Morocco. The representatives of the three centres participated in the intercountry meeting of national AIDS programme managers and reiterated their keen interest in collaborating with the national programmes in laboratory diagnosis of HIV.

5. JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS)

UNAIDS became fully operational from 1 January 1996, thus replacing GPA which was disestablished on that date. At the country level, UNAIDS works through the UN Resident Coordinator System and the UN Theme Group on HIV/AIDS. The Theme Group comprises representatives from the cosponsors of UNAIDS and other major interested parties and is chaired by the WHO Representative in most of the countries of the Region. In the beginning, UNAIDS provided core funds to the national AIDS programmes. It now provides project development funds for individual projects.

At the global level, UNAIDS carries out global activities in the areas of advocacy, strategic and policy guidance, best practice and research through various divisions and units. It has no regional structures but collaborates with the regional offices of its cosponsors for carrying out regional and intercountry activities. Under such collaboration, UNAIDS provided funds to the Regional Office to organize five of the intercountry meetings mentioned above, printing of documents and recruitment of consultants to develop the guidelines. Collaboration between the Regional Office and UNAIDS for implementation of country level activities in a few countries of the Region also began in late 1997.

6. CONCLUSIONS

The AIDS epidemic has continued to spread and there is no place for complacency. The national AIDS prevention and control efforts should not only be sustained but should also be enhanced in this Region with greater commitment, higher priority and allocation of more national resources in order to check the spread of the epidemic before it becomes unmanageable. As the health sector alone will not be able to tackle the AIDS problem because of its multifaceted nature, other sectors as well as nongovernmental organizations should also be involved in these efforts.

The source of the epidemiological information in this report is mainly reports from the countries, the quality of which varies from country to country. Complete and regular reports from the countries are required in order to submit a complete report to the Regional Committee.

Thus, it is recommended that the countries should:

- ensure high level commitment to national AIDS and STD programmes by allocating adequate national resources;
- involve all concerned sectors and nongovernmental organizations;
- implement effectively all components of the national programmes; and
- provide the Regional Office with complete and regular reports.