



THE WORLD BANK

Preventing HIV/AIDS in the Middle East and North Africa

A Window of Opportunity to Act



A Synopsis of the World Bank Regional Strategy

Over the past two decades, HIV/AIDS has emerged as one of the worst infectious diseases in modern history. The epidemic spread with devastating effects in Africa and is now threatening to spread with equal force in the Russian Federation, India, China, and many other transition economies around the world, including the countries in the Middle East and North Africa (MENA) region.

HIV/AIDS infection has a number of characteristics that make it a particularly devastating disease for the human population. HIV/AIDS typically strikes people of working age, as well as those of child-bearing and child-rearing age. Consequently, the spread of disease leads to the loss of skilled and unskilled workers, the main breadwinners, and caretakers of the family. The high morbidity and mortality rates among these groups can seriously undermine the social and economic foundation of a nation.

The HIV/AIDS epidemic is also difficult to contain and control because the infection often remains invisible in a population for a long period. HIV (human immunodeficiency virus) infection typically stays hidden over an incubation period of five to eight years before the disease manifests itself in the form of acquired immune-deficiency syndrome (AIDS). Another reason for the difficulty in detecting this disease is that in the early stages of the epidemic, the HIV infection tends to be concentrated in a small number of high-risk groups who frequently face social stigma and are therefore difficult to identify and to provide with prevention, care, and treatment services. These high-risk groups include injecting drug users (IDUs), males who have sex with males (MSM), commercial sex workers and their clients, prisoners (who are often drug users), and patients

Note: In this document, the MENA region refers to the following countries: Algeria, Bahrain, Djibouti, the Arab Republic of Egypt, Iraq, the Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Libya, Oman, Morocco, Qatar, Saudi Arabia, the Syrian Arab Republic, Tunisia, United Arab Emirates, West Bank & Gaza, and the Republic of Yemen.

with sexually transmitted diseases (STDs). In the absence of an effective surveillance system and prevention programs, HIV infection can spread silently from one group to another. Once the infection spreads to the general population, the transmission rates will rise exponentially and an HIV/AIDS epidemic will be difficult to avoid.

ROLE OF THE WORLD BANK IN ADDRESSING HIV/AIDS

The World Bank—in partnership with others—is working to roll back the spread of this global epidemic. Over the years, it has committed some US\$1.8 billion in grants, loans, and credits for HIV/AIDS programs worldwide. As one of the largest long-term investors in the prevention and mitigation of HIV/AIDS in developing countries, the World Bank Group is working with its partners to:

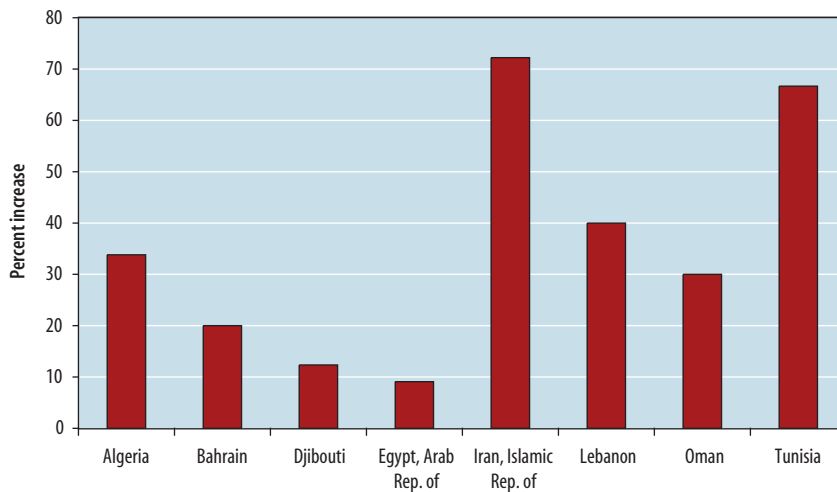
- Prevent the further spread of HIV/AIDS among high-risk and vulnerable groups, as well as in the general population.
- Promote countries' health and multisectoral policies and programs to stop the spread of HIV/AIDS, including education, social safety nets, transport, and other economic areas.
- Expand basic care and treatment activities for those affected by HIV/AIDS and their families, as well as for children whose parents have died of AIDS and other vulnerable children.

HIV/AIDS IN THE MENA REGION

In the MENA region, HIV appears to be transmitted along diverse paths, including injecting drug use, commercial sex, and sex between men. But the social stigma attached to these high-risk groups has meant that there is relatively little information or programs to address their needs, and any major outbreaks in such groups could be easily overlooked. Effective prevention programs depend on systematic and reliable information about the epidemiology of the disease and well-targeted interventions to arrest the transmission of the disease. On both counts—the availability of reliable information and the availability of well-targeted interventions—the MENA countries have been slow to respond.

The HIV prevalence rate remains low in the region, but this is no reason for complacency. The HIV prevalence rate in the MENA region is estimated at just 0.3 percent among the adult population and, with the exception

FIGURE 1.
Percentage Increase in the Numbers of Adults and Children Living with HIV in Selected MENA Countries between 2001 and 2003.



Source: Based on UNAIDS estimates of HIV prevalence rates for 2001 and 2003.

of Djibouti, most of the countries in the region appear to be at an early stage of HIV/AIDS infection. But the low prevalence level does not mean that the risk of an HIV/AIDS epidemic will remain low. Concerns that HIV will increase in prevalence in the MENA region are borne out by the latest trends, which show a significant increase in the number of infected people with HIV (see figure 1). Djibouti is the one country in the region where the HIV infection appears to have spread to the general population. A general population survey conducted in Djibouti in 2002 confirmed the presence of a generalized HIV epidemic.

The current reporting system could be underestimating the actual number of HIV/AIDS cases because of an absence of appropriate surveillance systems. Jenkins and Robalino (2003)¹ estimated the international prevalence of HIV/AIDS using a transmission model based on key socioeconomic determinants. According to this analysis, the HIV prevalence rates for the MENA countries are estimated to be between 0.2 and 1 percentage points higher than current prevalence estimates. The predicted prevalence levels are sensitive to model specification, but in all cases, they predict a prevalence rate higher than those currently reported. For most countries this implies a near doubling of current HIV prevalence rates.

Surveillance of HIV infection is seriously deficient in the MENA region.

The MENA countries fall broadly into two groups in terms of the HIV surveillance system. In the first group, HIV surveillance is systematically conducted only among the general population (e.g., blood donors, pregnant mothers). This form of surveillance is not effective in detecting HIV rates in countries with low prevalence rates, as it likely misses most of the transmissions among the high-risk population. The surveillance data from these countries reveal low transmission levels, but because the data collected are not targeted to the high-risk groups, the reported low transmission rates could be hiding much higher transmission rates among the high-risk groups. The countries in this first group include the Arab Republic of Egypt, Jordan, Syria, and possibly Saudi Arabia and Iraq. A second group of MENA countries has HIV surveillance for some of the high-risk population, and among these population groups there is evidence of steadily increasing levels of HIV infection. However, the surveillance coverage of these high-risk groups remains incomplete. The countries in this second group include Algeria, Bahrain, the Islamic Republic of Iran, Kuwait, Lebanon, Libya, Morocco, Oman, the Republic of Yemen, Tunisia, and possibly Qatar and the United Arab Emirates.

WHY ARE MENA COUNTRIES VULNERABLE?

While sociocultural factors may have helped slow down the initial spread of HIV/AIDS in the MENA region, the region exhibits many characteristics that would make it vulnerable to the spread of HIV/AIDS epidemic. These factors are reviewed below.

Low income levels and income inequalities. Vulnerability to HIV/AIDS is likely to be more pronounced among low-income than high-income countries. High-income countries are better able to mobilize resources toward prevention programs and avert premature AIDS-related death through treatment programs. The MENA region includes a number of countries at a low to lower-middle income range. In an international estimate of HIV prevalence rates, Over (1997) found a strong association between income inequality and the spread of HIV/AIDS.² To the extent that income disparities remain relatively pronounced in a number of MENA countries, they add to the risk of HIV transmission.

Labor migration. The widespread migration both within and out of the MENA region substantially raises the risk of HIV transmission. For example, Egypt records some 3 million migrant workers, most of them working in the Gulf countries. Algeria, the Islamic Republic of Iran, Jordan, Lebanon, Libya,

Morocco, Syria, and Tunisia also report high levels of migration. From the point of view of the receiving countries, migrant workers also form a large population group, such as in Oman (25 percent of the total population) or Saudi Arabia (850,000 Filipinos). Though migration is not a risk in itself, the conditions under which migrants live and work can raise the risk of transmission. Preventing infection in this group is a long-term investment that has substantial benefits given the importance of migration for the region.

Youth and unemployment. Youth, especially unemployed and out-of-school youth, are generally more vulnerable to risky behaviors associated with HIV/AIDS. MENA countries have a large and growing youth population who face a high rate of unemployment. This combination of demographic and economic factors makes the MENA countries highly vulnerable to the spread of HIV/AIDS.

Openness of countries. As MENA countries pursue liberalization policies and restrictions on trade and capital flows are reduced, migration and tourism are expected to grow, thereby bringing economic benefits. But open borders also raise new public health risks as migration and tourism potentially increase commercial sex or drug use (e.g., when migrants gain access to, or act as, sex workers).

Security and conflict. An effective response to prevent the spread of HIV/AIDS depends very much on the presence of a strong political commitment and a stable policy environment. Civil conflicts and security problems in the region limit governments' ability to respond effectively to the threat of HIV/AIDS and increase many of the risk factors associated with the spread of HIV/AIDS, such as migration and unemployment.

Cultural and social values. The extended family system and conservative social values in the MENA countries tend to reduce the vulnerability of the society to HIV/AIDS. On the other hand, the silence on the cause and consequences of HIV/AIDS creates a strong risk factor, as it severely limits the scope for introducing public discourse and education programs or for mobilizing communities and resources for preventive measures. The stigma associated with AIDS tends to drive the high-risk groups and people living with HIV/AIDS underground, which complicates the task of epidemiological surveillance and provision of targeted intervention.

Access to information. Though education increases the incentives to invest in protective measures, these effects are unlikely to materialize unless adequate information on HIV/AIDS is provided. This is an area of substantial shortcomings in MENA countries. Few of the messages and materials disseminated by

AIDS programs provide a clear explanation about the risks or even mention the use of condoms for prevention. Not surprisingly, the general lack of knowledge of HIV/AIDS reported by various surveys translates into a lack of protective behavior.

Gender gap. Economic and social inequalities between men and women are a potential contributing factor of vulnerability to HIV/AIDS.³ HIV prevalence rates tend to be lower when women have access to education and significant economic opportunities for remaining financially independent. While gender inequalities have been reduced over time in terms of access to education and labor markets, significant gender gaps still exist in the region. These conditions significantly raise the risk of HIV transmission in those MENA countries that have very low female school enrollment rates and other gender-related vulnerabilities.

Governance factors. A key factor explaining why some countries have been able to mount an effective response to the HIV/AIDS epidemic early on is whether governments are accountable to the broad majority of the population. From this perspective, both the limited role of nongovernmental organizations (NGOs) and the limited interaction between governments and civil society are factors likely to reduce the effectiveness of HIV/AIDS prevention programs in the region.

WHAT IS THE LONG-TERM ECONOMIC AND SOCIAL IMPACT OF HIV/AIDS?

*HIV/AIDS, through its impact on mortality and morbidity and the resulting demographic changes, affects all levels of an economy and society, from individuals and households to small and large businesses to the different levels and activities of government.*⁴

The financial and economic costs of HIV/AIDS can be substantial, especially when it reaches the full AIDS epidemic stage. A recent World Bank study estimated that an AIDS epidemic could reduce the average economic growth rate in the MENA region by 1.5 percent per year for the period 2000–25.⁵ Cumulatively, this would translate into a potential loss in production of about 35 percent of the current gross domestic product value by 2025.

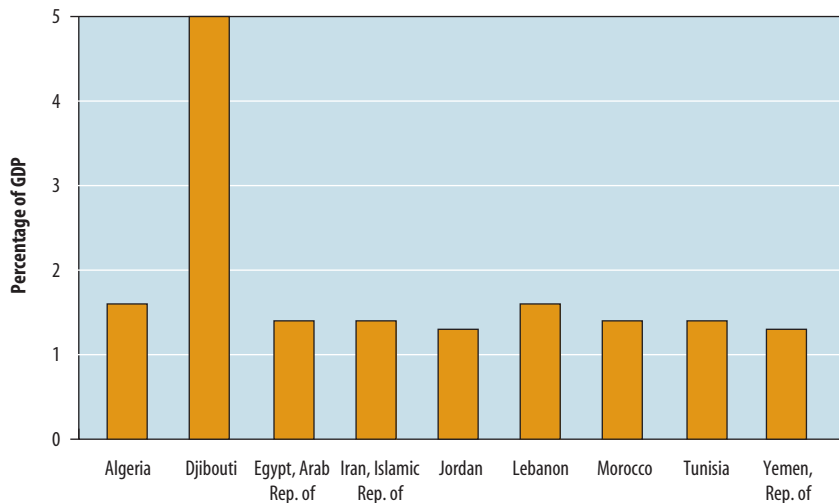
The most visible consequences of HIV/AIDS are the increased spending on prevention, care, and treatment. For MENA countries, the financial cost of an HIV/AIDS epidemic could be substantial. An estimate by Jenkins and Robalino (2003) projects the direct cost of HIV/AIDS to be on average around 1.5 percent of GDP by 2015 for most MENA countries, and as high as 5 percent in Djibouti (see figure 2).

But an HIV/AIDS epidemic would have far-reaching fiscal and economic effects that go beyond the direct cost of prevention, care, and treatment. These consequences are considered below.

Impact on the labor force. As people fall ill, they are less likely to be able to work and to be productive. Because AIDS affects the prime working age population, the epidemic has a direct impact on output, but this impact depends on the structure of the labor market. In countries like those of the MENA region, where there is a large pool of unemployed labor, the reduction in economic output could be relatively small, as the firms are able to replace lost labor quickly, at least in the short run. However, if the AIDS infection strikes the relatively scarce skilled-labor force, the impact on economic growth and productivity could be more pronounced.

Impact on the private sector. The private sector will be affected through the decreased productivity of its employees and increased labor costs, arising from early retirement or death of employees, which disrupts companies' operations, raises medical and death-related benefits including pensions, and increases recruitment and training costs. The resulting costs can be substantial, as demonstrated by a study conducted in South Africa.⁶

FIGURE 2.
Projected HIV/AIDS-Related Health Expenditures in 2015



Source: C. Jenkins and D. A. Robalino. 2003. *HIV/AIDS in the Middle East and North Africa: The Costs of Inaction*. Washington, DC: World Bank.

Impact on human capital. In the long run, increased mortality through HIV/AIDS affects both skilled and unskilled labor, thereby depleting the stock of human capital and reducing the accumulation of knowledge, skills, and other important human capital assets. As people live shorter lives and as opportunities for highly skilled labor declines, they would have fewer incentives to invest in education and training. HIV/AIDS also affects the transmission of knowledge from adults to the younger generation. In many countries, the HIV epidemic has created an unprecedented number of orphans and disrupted the normal process by which the young generation learns from the older generation.

Impact on the public sector. An HIV/AIDS epidemic sharply raises the cost of certain public services, particularly in health care and social assistance, while reducing the government's tax base. This would contribute to an erosion of government financial resources. As a result of lower revenues and increased AIDS-related expenditures, fewer resources will be available for financing non-health expenditures, possibly reducing long-term economic growth. Government revenues tend to decline as the size of the active labor force is reduced and individual productivity falls.

Impact on poverty. Households are directly affected through loss of income, especially when the breadwinner falls ill, and significantly increased expenditures on health care, funerals, and other associated costs. Affected households are forced to cut down on savings and consumption, which in turn leads to reduced investment opportunities and poorer health, nutrition, and educational attainments of the household members. Consequently, many families on the edge of poverty could be forced below the poverty line. Even among poor households that are not directly affected by the epidemic, the associated slowdown in economic growth will reduce their opportunities to escape poverty.

WHAT IS THE STATUS OF HIV/AIDS PROGRAMS IN THE MENA REGION?

While many governments in the MENA region have begun to take steps toward the prevention of HIV/AIDS, overall the response to HIV/AIDS in the region has been slow. The HIV/AIDS activities have been concentrated on medical issues, such as blood supply safety, mandatory testing, and, increasingly, treatment of AIDS patients. The social and economic factors that drive an HIV epidemic have not been adequately addressed, either with research or with interventions. Basic steps such as condom promotion are largely absent in the region; programs to defuse social stigma and institutional discrimination experienced by

vulnerable groups, and education and communication strategies to expand public awareness and knowledge of the epidemic remain limited.

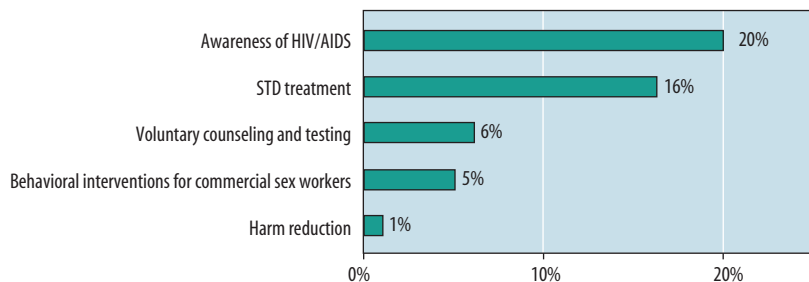
HIV/AIDS awareness. For a variety of reasons, such as lack of political response, there is a general lack of HIV awareness in the MENA countries. According to the Global HIV Prevention Working Group, less than 20 percent of the people at risk of infection had access to HIV/AIDS information in 2003 (see figure 3), and most people believe that they are not at risk of infection.

Limited coverage of prevention programs of high-risk groups. Table 1, summarizes the coverage of high-risk groups by various interventions in selected MENA countries. It illustrates the limited extent of coverage in the region. Injecting drug use is a growing problem in the MENA region, yet access to harm-reduction programs is almost nonexistent in the region, with the possible exception of the Islamic Republic of Iran.

Limited access to diagnostic services for the high-risk groups. Another important intervention is the diagnosis and treatment of STDs. The Global HIV Prevention Working Group estimates that only 16 percent of the population who need STD treatment are able to obtain it. The MENA region is also one of the most underserved regions with respect to voluntary counseling and testing, with only 6 percent of the target groups having access in 2003.

Growing awareness and political commitments to HIV/AIDS programs. Political leaders in Djibouti, Libya, the Islamic Republic of Iran, and most recently Algeria have publicly acknowledged the HIV/AIDS problems in their countries. To date, the Islamic Republic of Iran, Lebanon, and Morocco are

FIGURE 3.
Percentage of Individuals at Risk with Access to Interventions in UNAIDS-MENA⁷ Region



Source: "Access to HIV Prevention: Closing the Gap." Report by the Global HIV Prevention Working Group convened by the Bill and Melinda Gates Foundation and the Henry J. Kaiser Family Foundation, May 2003.

TABLE 1.
Program Coverage of High-Risk Groups in Selected MENA Countries

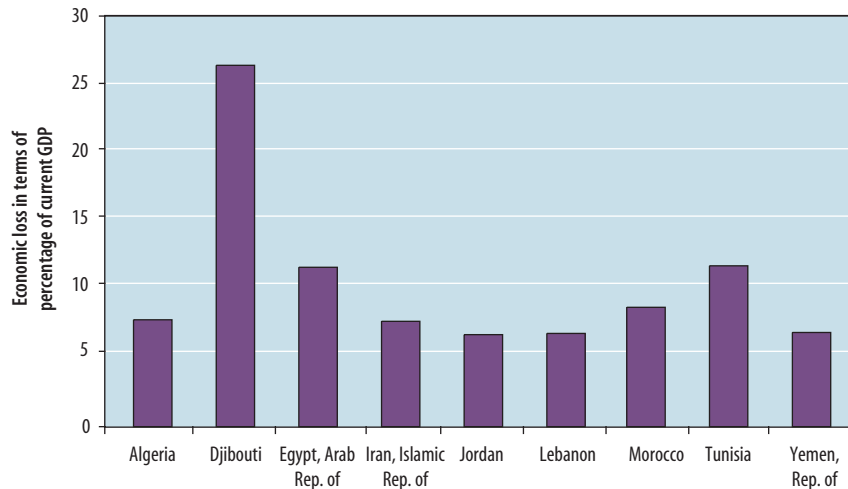
<p>Programs for Intravenous Drug Users Islamic Republic of Iran: 150,000 IDUs, 23% covered by harm reduction program through 72 sites Egypt: only one center for 17,000 IDUs</p>
<p>Programs for Sex Workers Islamic Republic of Iran: Estimated number: 60,000. Estimated coverage by outreach prevention programs: 0% Oman: Estimated number: 3,500. Estimated coverage: 0%</p>
<p>Males Having Sex with Other Males Islamic Republic of Iran: estimated number: 10,000. Coverage by services: 0% Oman: estimated number: 12,500. Coverage: 0%.</p>
<p>Prevention Services for Prisoners Islamic Republic of Iran: 150,000 prisoners. Coverage: 3% Morocco: 50,000 prisoners. Coverage: data not available Oman: 3,203 prisoners; Coverage: 3%</p>
<p>Outreach Program for Children Living in the Street Islamic Republic of Iran: 25,000 children. Coverage: 3%</p>
<p>HIV/AIDS Education—Is it part of the primary education curriculum? Egypt: No Iran: No Morocco: Yes (3,658 students covered) Oman: No</p>
<p>HIV/AIDS Education—Is it part of the secondary education curriculum? Egypt: No Islamic Republic of Iran: Yes Morocco: Yes (1,068 students covered) Oman: Yes</p>

Source: "Coverage of Selected Services for HIV/AIDS Prevention, Care & Support in Low & Middle Income Countries in 2003." Washington, DC: Policy Project of the Futures Group, June 2004.

implementing some programs for at-risk groups, and Algeria and Djibouti are just beginning. Algeria, Djibouti, Egypt, the Islamic Republic of Iran, Lebanon, Morocco, and the Republic of Yemen have developed or are currently developing a National HIV/AIDS Strategic Plan. Bahrain, Jordan, Libya, Oman, Syria, and Tunisia have expressed an interest in doing the same. Algeria, Djibouti, the Islamic Republic of Iran, Jordan, Morocco, and the Republic of Yemen have all been approved to receive grants of varying amounts to address HIV/AIDS from Global Fund to Fight AIDS, TB and Malaria (GFATM) in the first three funding rounds.

Innovative interventions by NGOs. A number of innovative interventions by NGOs are also showing some positive results in the prevention of HIV/AIDS

FIGURE 4.
Economic Losses Incurred by Delaying Interventions by Five Years in 2000–25



Source: C. Jenkins and D. A. Robalino. 2003. *HIV/AIDS in the Middle East and North Africa: The Costs of Inaction*. Washington, DC: World Bank.

among the high-risk groups. Examples of successful programs include an integrated prevention approach for HIV and STDs implemented by AMSED, a Moroccan NGO; behavioral interventions for IDUs in the Kermanshah Province in the Islamic Republic of Iran; and HIV prevention programs among MSMs by ALCS, a Moroccan NGO operating in the Maghreb region. These programs form a good basis for future expansion of behavioral interventions in the region.

WHY ACT NOW?

If HIV/AIDS is left unchecked, its potential economic impact in the MENA countries could be substantial. To illustrate this point, Jenkins and Robalino (2003) carried out a simulation model in which the impact of a five-year delay in preventive interventions was measured over the course of a 25-year period (see figure 4). The results predict an average loss of 8 percent of current GDP, ranging up to 27 percent in the case of Djibouti.

Governments can play a critical role in implementing policies and programs to fight the spread of an HIV/AIDS epidemic. By taking action now, while the epidemic is in its early stage of transmission, it is possible to prevent the spread of human suffering and misery to the millions of people in the MENA

region, as well as avert the significant drag on economic growth. International experience has demonstrated that interventions to reduce the spread of HIV/AIDS are cost effective, especially when focused on the high-risk groups, such as IDUs. Priority actions are highlighted below.

- ***Establish a reliable surveillance system to identify and target support to the most vulnerable groups.*** The expansion of the second-generation surveillance could greatly enhance a country's ability to design and direct appropriate interventions toward the most vulnerable groups and thereby arrest the spread of HIV/AIDS in a more cost-effective manner.
- ***Vigorously pursue the implementation of cost-effective interventions to stem the spread of HIV/AIDS in its very early stages.*** In low-prevalence settings, prevention measures targeted at populations at risk are most effective. The following high-risk groups will need special attention: IDUs and their sex partners, commercial sex workers, prison inmates, MSM, and youth.
- ***Expand public information programs and education, and encourage greater public discussion of HIV/AIDS.*** This can be achieved through media and advocacy programs targeted to vulnerable groups such as youth and migrant workers as well as the general population.

Promote cooperation between governments and civil society to mobilize the participation of all levels of the society in the prevention of HIV/AIDS. Full cooperation among key stakeholders and communities will help to improve the effectiveness of HIV/AIDS prevention, care, and treatment programs.

HOW CAN THE WORLD BANK ASSIST?

The following strategic directions have been identified as areas where the World Bank could support the MENA countries in the design, evaluation, and implementation of the HIV/AIDS programs.

1. **Engage political leaders, policy makers, and key stakeholders to raise awareness and give greater priority to HIV/AIDS programs within the national development agenda, with particular focus on prevention and expanding access to information.**

A major challenge to a successful HIV/AIDS prevention program is to raise awareness and mobilize local leaders to respond proactively while the infection is in the early stages of an epidemic. The Bank could assist the governments and key stakeholders through the following actions:

- Support media, advocacy, and analytical activities to expand access to information and raise awareness among political leaders, other key stakeholders, and the general public.
- Undertake analytical work to justify investments in HIV/AIDS programs and identify cost-effective interventions.
- Mobilize additional resources to support the design and implementation of priority HIV/AIDS programs.

2. Help countries to upgrade their surveillance systems and strengthen research and evaluation of epidemiological, economic, and behavioral aspects of HIV/AIDS.

In partnership with other bilateral and international agencies such as Joint United Nations Programme on HIV/AIDS (UNAIDS) and WHO, the Bank could help mobilize resources to strengthen and upgrade the surveillance systems and support research activities to monitor the epidemic and target resources effectively:

- Institute second-generation surveillance, including surveys on STDs and high-risk behaviors.
- Conduct research on vulnerable groups, such as migrants, youth, IDUs, and commercial sex workers, and identify constraints such as social stigma and behavioral factors that affect the mode of transmission.
- Undertake analysis of gender-specific vulnerabilities to HIV infection and the impact of HIV/AIDS on women and their families, and identify appropriate policies and adjustments in existing laws and regulations to address these constraints.

3. Support the development of national HIV/AIDS strategy and programs with priority focus on prevention and expansion of access to information.

In close partnership with national HIV/AIDS partners, the Bank could support the following activities:

- Integrate the national HIV/AIDS strategy within national development plans and budget frameworks, including intersectoral programs and activities.
- Support national AIDS programs to mainstream HIV/AIDS activities in relevant key sectors.
- Support systematic monitoring and evaluation of national HIV/AIDS programs to measure impact and improve effectiveness.

4. Support capacity building and knowledge sharing for comprehensive management of HIV/AIDS programs.

Working in active partnership with other development agencies in the region, the Bank could provide technical and financial resources to support priority capacity-building activities identified under the national and regional HIV/AIDS programs. These activities may include the following:

- Develop multisectoral planning capacity to identify and design appropriate, cost-effective interventions that will reduce vulnerability among high-risk groups, such as youth and migrant workers, by affecting sexual behaviors, employment, education, and other interventions.
- Mobilize resources at different levels to support capacity building in the region in close cooperation with UN agencies, NGOs, and representatives of the civil society.
- Support the development of Centers of Excellence among key research institutions in the region in order to sustain training and capacity-building activities over a longer term.

Table 2 provides more details of the MENA HIV/AIDS strategy.

CONCLUSION

Low prevalence of HIV/AIDS in the MENA region does not equate to low risk, and action now can prevent a probable epidemic. The region is lagging in its defense against this devastating epidemic, but it may also have the advantage of time. Timing is crucial and the window of opportunity that exists now must not be wasted if the mistakes of other regions with more advanced stages of the epidemic are to be avoided in MENA.

TABLE 2.
Synopsis of MENA Regional HIV/AIDS Strategy

Strategic Direction	Objective	Approach	Key Expected Benefits
<p>SD#1: Engage political leaders, policy makers, and key stakeholders to raise awareness and raise priority given to HIV/AIDS programs within the national and regional development agenda.</p>	<ul style="list-style-type: none"> • To raise awareness to the threat posed by the epidemic and support the creation of an enabling environment for HIV/AIDS programming. • To mobilize political/social commitment and action toward proactively responding to the epidemic at an early stage. 	<ul style="list-style-type: none"> • Support analytical work, media, and advocacy activities to raise awareness among political leaders and other key stakeholders. • Undertake analytical work to evaluate the cost-effectiveness of different HIV/AIDS interventions and justify investments in HIV/AIDS programs. • Mobilize additional resources to support the design and implementation of priority HIV/AIDS programs. • Policy dialogue with client counterparts during Country Assistance Strategies (CAS), Public Expenditure Reviews (PER), and Poverty Reduction Strategy Papers (PRSP) preparation and inclusion of HIV/AIDS in relevant seminars/conferences. • Awareness raising among Bank staff on the importance of HIV/AIDS issues. 	<ul style="list-style-type: none"> • Increased commitment of governments to HIV/AIDS programming. • Inclusion of HIV/AIDS in policy dialogue tools (CAS, PER, PRSP, etc). • Enabling environment and government policies to support scaling up of HIV/AIDS activities.
<p>SD#2: Support the upgrading of the surveillance systems and strengthen research and evaluation of epidemiological, economic, and behavioral aspects of HIV/AIDS to enhance the effectiveness of HIV/AIDS policies and programs.</p>	<ul style="list-style-type: none"> • To support institutional and local capacity development in the generation and utilization of essential data/information for planning and implementation of HIV/AIDS programs. • To support the development of comprehensive monitoring and evaluation plans and the capacity to implement them. • To support and encourage collaboration and sharing of information. 	<ul style="list-style-type: none"> • Institute second-generation surveillance, including STD and behavioral surveys. • Conduct research on vulnerable groups and identify constraints such as social stigma and behavioral factors that affect the mode of transmission. • Undertake analysis of gender-specific vulnerabilities to HIV infection and the impact of HIV/AIDS on women and their families, and identify appropriate policies and adjustments in existing laws and regulations to address these constraints. 	<ul style="list-style-type: none"> • Improved quality of HIV/AIDS surveillance systems and data leading to informed policy decisions. • HIV/AIDS programs incorporating key gender concerns. • Vulnerability, risky behaviors, and at-risk groups identified for targeted outreach HIV/AIDS programs.
<p>SD#3: Support the development of national HIV/AIDS strategies and programs, based on the specific epidemiological, social, and economic conditions and context of each country.</p>	<ul style="list-style-type: none"> • To raise awareness of the multi-sectoral nature of the epidemic and strengthen intersectoral actions required to address the epidemic. • To ensure all relevant Bank projects in the region are HIV/AIDS responsive. 	<ul style="list-style-type: none"> • Integrate the national HIV/AIDS strategy within national development plans and the budget framework, including intersectoral programs and activities. • Support the national AIDS programs to mainstream HIV/AIDS activities in relevant key sectors. • Undertake systematic monitoring and evaluation of national HIV/AIDS programs to measure impact and improve effectiveness. • Within the Bank, include HIV/AIDS activities in the project preparation process for new projects and retrofit relevant ongoing projects with HIV/AIDS activities. 	<ul style="list-style-type: none"> • National and regional HIV/AIDS plans and actions involving all key development sectors. • Monitoring and evaluation systems for HIV/AIDS developed in countries. • HIV/AIDS mainstreamed in relevant projects and tasks.

continued

TABLE 2, continued

Strategic Direction	Objective	Approach	Key Expected Benefits
SD#4: Support capacity building and knowledge sharing for comprehensive management of HIV/AIDS programs.	<ul style="list-style-type: none"> To raise awareness and develop capacity of Bank staff and relevant client country staff for better management of HIV/AIDS programs. 	<ul style="list-style-type: none"> Develop multisectoral planning capacity to identify and design appropriate, cost-effective interventions that will reduce vulnerability among high-risk groups. Mobilize resources at different levels to support capacity building in the region in close cooperation with UN partners. Support the development of Centers of Excellence among key research institutions in the region in order to sustain training and capacity-building activities over a longer term. Within the Bank, collaborate with World Bank Institute (WBI) and the Bank's Global HIV/AIDS Unit on capacity-building efforts for staff and client countries. 	<ul style="list-style-type: none"> Bank and key government staff enabled to plan and implement HIV/AIDS programs. Local NGOs enabled to implement effective HIV/AIDS programs. Capacity of regional research institutions strengthened in the area of HIV/AIDS research and training.

Notes

1. C. Jenkins and D. A. Robalino. 2003. *HIV/AIDS in the Middle East and North Africa: The Costs of Inaction*. Washington, DC: World Bank. The analysis by Jenkins and Robalino predicted the international variations in HIV/AIDS prevalence levels as a function of income per capita, female participation in labor force, female literacy, the Gini index of inequality, the share of tourism-related activities in gross domestic product, and migration.
2. Over, M. 1997. *The Effects of Societal Variables on Urban Rates of HIV Infection in Developing Countries: An Exploratory Analysis*. European Commission.
3. For example, international comparative analysis by Mead Over (1997) finds significant correlation between HIV/AIDS prevalence levels and female literacy rates.
4. M. Haacker. *The Macroeconomics of HIV/AIDS*. 2004. Washington, DC: International Monetary Fund.
5. Jenkins and Robalino, 2003.
6. Currently, they are estimated to amount to 1–6 percent of the wage bill for South African firms, but they are projected to rise to 15 percent of the wage bill by 2015 (Metropolitan Insurance).
7. It should be pointed out that the UNAIDS includes Sudan and Turkey but excludes Djibouti in its definition of the MENA region. The percentage figures should therefore be interpreted with caution, but the general trends remain valid.

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