Economic Analysis of HIV/AIDS in MENA

Introduction

HIV/AIDS has now emerged as one of the world’s worst infectious diseases. Virtually unknown 20 years ago, the epidemic has spread with ferocious speed to become the leading cause of death in Africa. Other regions and countries, which once were thought to be immune to the spread of HIV/AIDS, such as Russia, India, and China, now stand on the brink of widespread epidemics.

Countries in the Middle East and North Africa (MENA) region are at an early stage of the HIV/AIDS epidemic with an average rate of prevalence of about 0.3 percent among the adult population. While these numbers are relatively low compared with Africa and Asia, low prevalence rate does not mean low risk. Recent evidence suggests that the number of adults and children living with HIV/AIDS is rising rapidly (see figure 1.1 in Chapter 1).

Based on the available information, HIV transmission is taking place mainly among high-risk groups such as injecting drug users (IDUs) and commercial sex workers (CSWs). But because of the lack of adequate surveillance data, outbreaks in such groups can easily be overlooked and spread to the general population as has happened elsewhere. Despite specific social and cultural values that have helped prevent the rapid spread of HIV/AIDS in MENA, the region exhibits high risks of vulnerability. The option of waiting to act until the HIV prevalence rate rises further in the general population would be a costly option. By that time, a general epidemic could be on its way and, as shown by the international evidence, it could then be too late to prevent the inevitable increase in human sufferings as well as associated losses in economic growth.
An Invisible but Lethal Disease

Most MENA countries are at an early stage of the HIV infection stage. However, the situation varies considerably across countries (box A1.1). Until recently, most cases of infection in MENA countries were found among IDUs, men who have sex with men (MSM), CSWs and their clients, prisoners (who are frequently drug users), and patients with sexually transmitted diseases (STDs).

As has happened in other countries, MENA countries face a risk that the HIV infection could spread to the general population. In Sub-Saharan Africa, the region hit hardest by HIV/AIDS, the epidemic spread mainly through heterosexual contacts and it has now reached an advanced AIDS stage. In Asia and the Pacific, injecting drug use combined with unprotected sex, rising rates of STDs, and other factors have led to an acceleration of the spread of HIV. While sociocultural factors have helped slow down the initial spread of HIV/AIDS in Asia, they have not prevented its increase. At one point in time, it was thought that an HIV/AIDS epidemic could not occur in India because its conservative values would prevent the spread of HIV. Yet, India now probably has the largest HIV positive population in the world.1 In Eastern Europe and

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**BOX A1.1**

**Epidemiological Profiles in the MENA Region**

Type 1: Repeated testing, consistently low rates, but no consistent testing or reporting of high-risk groups:

- Egypt, Jordan, Syria, and possibly Saudi Arabia and Iraq.

Type 2: Gradually growing accumulation of levels of infection and at least some rapid increases in identified high-risk groups:

- 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.

Type 3: Generalized epidemic levels of HIV:

- Djibouti.

Central Asia, the rapidly growing epidemic is fueled by injecting drug use and secondarily by sexual transmission. What makes the HIV/AIDS epidemic particularly lethal is that it remains invisible for a long period of time. In contrast to most other epidemics, which are of relatively short duration, a long incubation period of five to eight years separates HIV infection from the AIDS stage. In the absence of adequate surveillance systems as is the case in most MENA countries, there are no early warning systems that would alert public health officials to detect outbreaks among high-risk populations. Such a situation allows the HIV infection to spread from high-risk groups to the general population, at which point it is too late to prevent a generalized HIV/AIDS epidemic. The result is to transform a public health issue into a disease that affects the economic and social course of countries for many decades to come.

**Long-Term Erosion of the Process of Economic Growth**

The relationship between HIV/AIDS and economic development is complex. Long-wave events such as HIV/AIDS typically unfold over several decades rather than just a few years. This means that there is a long and uneven lag between the onset of the infection and the moment when the economic and social impacts become visible. At the macro level, the impact of the HIV/AIDS epidemic is felt through three main channels. The first one concerns the labor force. As people fall ill, they are less likely to be able to work and be productive. Because AIDS kills people in the prime of their working lives, the epidemic has a direct impact on output. But this impact depends on the structure of the labor market. In countries where there is a large pool of unemployed labor, the reduction in output would be small as firms could replace lost labor quickly. Over time, however, unemployment would fall and the economic impact of HIV/AIDS would be felt over the medium to long term.

The second economic impact affects human capital. Increased mortality affects not only unskilled labor but also skilled labor, which depletes the stock of human capital. In addition, it reduces the accumulation of human capital. As people live shorter lives, they have fewer incentives to invest in human capital and training. In particular, orphans are found to be less likely to be kept in school.

HIV/AIDS also affects the transmission of knowledge from adults to the younger generation. As the HIV epidemic creates an unprecedented number of orphans, it affects the process whereby the young generation learns its skills from the older generation. These effects were recently analyzed by constructing an overlapping generation model with two family
structures, nuclear and pooled in the case of South Africa and Kenya. In a pooled family structure, children are raised by the extended family. Where this collective responsibility can no longer be assured because of the loss of parents because of HIV/AIDS, the transmission of knowledge from one generation to the next is weakened. When these orphans become adults, their capacity to transmit knowledge are also reduced, which erodes economic and social development.

The third impact of HIV/AIDS is to reduce savings and the accumulation of physical capital. Faced with increased AIDS-related expenditures and lower income caused by the illness of adult family members, households cut down on consumption and savings, which results in less investment and slower economic growth. Until recently, the reduction of savings because of AIDS was probably negligible. But this could be changing with the introduction of antiretroviral therapy (ART), which, even at the current lower prices, results in a large increase in per capita expenditures.

Overall, the economic impact of HIV/AIDS is felt by firms, households, and governments in the form of an “AIDS” tax. The tax is incurred by firms in the form of additional hiring and training cost (to replace lost labor), increased absenteeism, and higher medical claims and pensions. The resulting costs can be substantial as shown by the example of South Africa. Given the high level of the tax, firms have an incentive to shift the burden of the tax either to households or to governments. This is accomplished by pre-employment screening, reducing the medical benefits and pensions paid by firms, outsourcing activities, and increasing the proportion of temporary workers. In the end, however, the AIDS tax still has to be paid by households and it reduces economic growth.

The AIDS tax is also borne by governments. Government revenues tend to decline as the size of the active labor force is reduced and individual productivity falls. In particular, HIV/AIDS reduces the productivity of the civil service, which weakens the capacity of governments to deliver essential services such as education and health. At the same time, AIDS-related expenditures increase. For MENA countries, the financial cost of HIV/AIDS can be substantial, especially when the AIDS stage is reached. As shown by Figure A1.1, the cost of HIV/AIDS prevention, treatment, and care could reach 1.5 percent of GDP on average by 2015. As a result of lower revenues and increased AIDS-related expenditures, fewer resources are available for financing non-health expenditures, particularly investments, which reduces long-term economic growth.

What confers to HIV/AIDS such a devastating impact on countries is not only the direct effect of HIV/AIDS on economic growth, but also the reverse causality that can arise from development to HIV/AIDS in the absence of HIV prevention programs. Such causality is particularly strong when growth is accompanied by an increased number of migrant
Factors of Vulnerability

Level of income

Vulnerability to HIV/AIDS is likely to be much worse for low-income than high-income countries. High-income countries are in a better position to replace lost skills quickly and to avoid premature AIDS-related death. They can take advantage of a widespread medical infrastructure to dispense the medication that can allow HIV-infected individuals to remain engaged in economic activities. Because of their well-developed education system, high-income countries are also in a better position to replace lost skills than low-income countries. Alternatively, they can import skilled labor. On balance, MENA countries are medium to high income, and because of that they face lower vulnerability than low-income countries. For these countries the loss of human capital entails a high cost be-
cause of the scarcity of skills and the time involved in replacing them. However, medical costs may have a medium to low impact on the domestic savings of low-income countries, especially if they have access to grants to finance them.

**Openness of countries**

For both low- and high-income countries the economic impact of HIV/AIDS is likely to be worse the more open these economies are. In open economies the domestic rate of return to capital is linked to the world interest rate with an adjustment for country risk. As a result, foreign investors will be less inclined to invest in firms whose costs of operation are increased because of the cost of the HIV/AIDS epidemic, and domestic residents will face stronger incentives to invest abroad. Both effects amplify the economic costs of HIV/AIDS compared with a closed economy (Table A1.1). Given the openness of MENA countries and the role of migration and tourism, MENA countries face high vulnerability risks.

**Labor migration**

While migration per se is not a risk factor, it is an important factor of vulnerability for MENA countries. The conditions under which migrants live often increase vulnerability and can trigger an increase in high-risk behavior. Preventing infection in this group is a long-term investment that has substantial benefits given the importance of migration for the region. For example, the Arab Republic of Egypt records some 3 million of migrant workers, most of them working in the Gulf countries. Algeria, the Islamic Republic of Iran, Jordan, Lebanon, Libya, Morocco, Syrian Arab Republic, and Tunisia also report high levels of migration. From the

<table>
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<th>Economic Impact of HIV/AIDS in Rich and Poor Countries</th>
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<td><strong>Economic Impact through the following:</strong></td>
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<td>Labor effects (loss of labor, reduction in productivity)</td>
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<td>Loss of acquisition and transmission of knowledge</td>
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<tr>
<td>Impact on domestic savings and physical capital because of AIDS-related expenditures</td>
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<td>Openness of economies</td>
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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 are foreigners) or Saudi Arabia (850,000 Filipinos).

**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 difficult interaction between governments and civil society are factors that are likely to reduce the effectiveness of HIV/AIDS prevention programs in most countries. Additional factors include political instability and civil conflict in some countries.

**Income inequality**

Overall, there is a strong relationship between income inequality and the spread of HIV/AIDS (figure A1.2). Compared with other developing

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**FIGURE A1.2**

*Income Inequality and HIV Prevalence Rate in Developing Countries*

![Graph showing the relationship between income inequality (GINI coefficient) and HIV prevalence rate (1997)].

*Source: Data from World Development Indicators (World Bank, 2001).*
countries, North African countries would seem to have lower vulnerability because of their lower rates of inequality. Among other MENA countries, the Islamic Republic of Iran would seem to have a relatively high vulnerability risk. However, these indicators hide wide variations among countries. For example, although the total proportion of Moroccans living in poverty is estimated at between 13 percent and 16 percent, some 60 percent of rural Moroccans are estimated to be poor. This disparity fuels high levels of internal migration, which increases the vulnerability of migrant workers to HIV/AIDS. A similar result also characterizes other MENA countries such as Algeria.

**Gender issues**

Economic and social inequalities between men and women are perhaps one of the major factors of vulnerability to HIV/AIDS. As shown by figures A1.3 and A1.4, HIV prevalence rates are lower when women have access to education and significant economic opportunities to remain financially independent, respectively. These are areas that create significant risks of vulnerability for MENA countries. Countries in the region with high gender-related vulnerability risks include Djibouti, Iraq, Morocco, Saudi Arabia, Syria, and the Republic of Yemen.9

**FIGURE A1.3**

**HIV/AIDS and Female Education in Developing Countries**

![Graph showing the relationship between female secondary enrollment rate and HIV prevalence rate](data:image/png;base64,)

*Source: Data from World Development Indicators (World Bank, 2001).*
Access to information

While education increases the incentive to invest in protective measures, their effects are unlikely to materialize unless adequate information on HIV/AIDS is provided. This is an area of substantial shortcoming in MENA countries. Few of the messages and materials provided by AIDS programs are clear, give explicit information about risk, or even mention the use of condoms for prevention. Not surprisingly, the broad lack of understanding of HIV/AIDS reported by various surveys of knowledge about HIV/AIDS is translated into a lack of protective behavior.

Cultural and social values

Values set apart MENA countries. On the one hand, social values and a strong role of the extended family system are reducing the vulnerability of society to HIV/AIDS. Similarly, the widespread practice of circumcision also acts to reduce the spread of HIV/AIDS. On the other hand, the silence surrounding sexual issues is creating a strong risk factor as it limits the possibility of introducing sexual education in schools and setting up prevention measures. It also tends to drive people living with HIV/AIDS and high-risk groups deeper underground, which further
complicates the task of epidemiological surveillance. In addition, the rise of religious extremism may strengthen even more denial that there is an urgent need to implement prevention measures, particularly among high-risk groups. In such an environment, religion tends to be presented as a shield that is strong enough to prevent HIV/AIDS. Yet, as shown by the experience of Senegal in Western Africa, Muslim leaders can be enrolled to help halt the spread of HIV/AIDS.

**Health and education infrastructure**

This is one area where MENA countries are better placed, because most of their population have access to both education and health services. Such coverage makes it possible to reach the youth population—for example, through sexual education in schools—as well as to deliver effective prevention and treatment through the health system.

**What is the net effect of these various risk factors?**

Some evidence of the role of the various socioeconomic risk factors that affect the spread of the epidemic is provided by the analysis of Jenkins and Robalino.¹⁰ Not surprisingly, these macrolevel indicators explain only part of the cross-country variation in the HIV prevalence rate given the poor quality of the available data. Nonetheless, the results provide some useful information on the factors that are likely to influence the diffusion of the epidemic in MENA countries.

When the model¹¹ developed for this analysis is applied to MENA countries, it predicts higher prevalence rates than the official estimates indicate. Based on current levels of output per capita, participation of women in the labor force, the levels of income inequality and rates of female illiteracy, HIV prevalence rates are found to be between 0.2 and 1 percentage point higher than current official estimates. For most countries this implies a near doubling of current HIV prevalence rates. The difference between the predicted rates and the official estimates could be a result of measurement issues (weak surveillance systems) or other sociocultural factors not considered and controlled for by the model. In any case the important conclusion is that prevalence rates are not likely to be lower than the current ones.

**Economic Costs and Benefits of the HIV/AIDS Program**

To evaluate the economic cost of HIV/AIDS in MENA, we use the results generated by combining a model of economic growth and an
The period of analysis is 2000–25. The impact of the epidemic on the economy is estimated by focusing on the following four channels: size and composition of labor force, productivity growth, health expenditures, and the savings rate of the economy. Three types of labor (skilled, unskilled, and unemployed) are considered. Other channels such as the reduction in human capital are ignored for methodological reasons. To that extent, the model underestimates the economic impact of HIV/AIDS.

The diffusion of HIV/AIDS is formalized by focusing on two channels of transmission: the sharing of infected needles among IDUs and through sexual intercourse. The population is divided into five groups: CSWs, female IDUs, male IDUs, low-risk females, and low-risk males. Given the high levels of uncertainty affecting the transmission parameters, a traditional simulation approach in which outcome variables are projected on the basis of explanatory variables would not be appropriate. Instead, the evolution of the HIV/AIDS epidemic and the economy is simulated by running 100 combinations of the various parameters that determine the course of the epidemic. These include the shares of high-risk population (IDUs and CSWs); the HIV/AIDS prevalence rates among these groups; the frequency and heterogeneity of sexual interactions; the prevalence of STDs; the prevalence of condom use and needle sharing; the distribution

of AIDS-related deaths among the unemployed, skilled, and unskilled workers; and the reduction in total factor productivity growth resulting from HIV/AIDS.

The model is necessarily a simplification of the complex mechanisms through which the economy and the HIV/AIDS epidemic interact. Nonetheless, it captures the main effects of the epidemic on the labor force, productivity growth, health expenditures, and domestic savings rate.

What are the main results? First, the level of uncertainty surrounding the evolution of the HIV/AIDS epidemic is considerable. There are, however, quite a large number of scenarios clustered around an HIV/AIDS prevalence rate of around 4 percent by 2015. This result is important, because it is usually found that once the epidemic reaches such a level, its demographic and economic impacts become quite substantial. In the case of the MENA countries, the model generates a similar outcome. On average, the annual GDP growth rate for the 2000–25 would be reduced by 0.3 to 0.4 percentage points for all countries with the exception of Djibouti (-1.3 percentage points) (table A1.2)\textsuperscript{13}. In total, the accumulated cost of the HIV epidemic for the period 2000–25 would amount to between 25 percent (the United Arab Emirates) and 54 percent (Tunisia) of current GDP and greater than 150 percent in the case of Djibouti. These are substantial costs that are incurred even though most of the economies currently have high unemployment rates. Costs would even be higher if the effect of HIV/AIDS on the accumulation of capital had been counted in the estimates.

\begin{table}[h]
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\caption{Economic Impact of the HIV/AIDS Epidemic}
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\hline
 & Present Value Losses in & Average Reduction in & Average HIV Prevalence \\
 & 2000-25 (% of current GDP) & GDP Growth Rate (%) & Rate in 2015$^a$ \\
\hline
Algeria & 41.2 & -0.40 & 4.5 \\
Djibouti & 150.8 & -1.34 & 15.9 \\
Egypt, Arab Rep. of & 51.3 & -0.42 & 4.2 \\
Iran, Islamic Rep. of & 38.7 & -0.42 & 4.2 \\
Jordan & 33.6 & -0.35 & 3.7 \\
Lebanon & 30.0 & -0.45 & 4.6 \\
Morocco & 39.5 & -0.42 & 4.3 \\
Tunisia & 54.0 & -0.44 & 4.4 \\
Bahrain & 35.6 & -0.38 & 4.2 \\
Kuwait & 35.7 & -0.36 & 4.1 \\
Oman & 35.6 & -0.35 & 4.0 \\
Qatar & 33.2 & -0.38 & 4.3 \\
Saudi Arabia & 35.8 & -0.31 & 3.7 \\
United Arab Emirates & 25.6 & -0.32 & 3.9 \\
\hline
\end{tabular}
\textit{a.} The figures are calculated as averages across the scenarios that are generated.
Policy Implications

In principle, allocating public funds for an epidemic such as HIV involves a decision process quite similar to any other decisions about the use of public funds. It entails comparing the cost today of implementing a program of HIV/AIDS activities with the enhanced economic and social development that would be made possible by the subsequent reduction of the prevalence of HIV/AIDS. In the case of MENA countries, the choice they face is quite straightforward: either pay a small cost now to implement intervention measures or defer action and incur a much higher cost in the future. Because the epidemic is still at an early stage, the intervention measures would consist mainly of improved surveillance activities (to remedy the current shortcomings of the current system), prevention activities targeting specific groups, and information and education campaigns (IEC).

Key high-risk target groups

High-risk groups include the following:

- **IDUs and their sex partners.** Most IDUs in the region are males and nearly one-third are married. Condom use among IDUs is, however, rare, which creates strong risk of spread of HIV/AIDS.

- **Prison inmates.** In the Islamic Republic of Iran, for example, some 10 percent of inmates are reported to inject drugs (UNAIDS 2004) with 90 percent sharing needles with others. By 2001, 12.5 percent of prison inmates were estimated to be HIV positive (UNAIDS 2004, epidemic update; Global HIV Prevention Working Group, 2003).

- **Other social groups.** Although there is a general lack of information concerning the high-risk social groups, various surveys have detected infection rates among MSMs and CSWs and their clients (Jenkins and Robalino 2003; UNAIDS 2004, epidemic update).

For all these high-risk groups there is an urgent need to act now. This need is highlighted by the broad lack of preventive measures among these groups.

- **Harm reduction program for IDUs.** Injection use appears to be a growing problem in MENA, which raises the risk of HIV spread. Yet, access to harm reduction programs is almost nonexistent in the region. Less than 1 percent of the IDU group has access to such activities.

- **Behavioral interventions.** Only 5 percent of sex workers and their clients, 10 percent of MSMs, 2 percent of out-of-school youth, and 27 percent of in-school youth have access to behavioral interventions.
• **Diagnosis and treatment of STDs.** Only about 16 percent of the population who need STD treatment is able to obtain it.

• **Voluntary counseling and testing (VCT).** Compared with other regions, MENA countries have the largest coverage gap with only 6 percent of the target group having access to VCT.

• **HIV/AIDS awareness.** For a variety of reasons (lack of political response and so on) there is a general lack of HIV awareness. Most people believe that they are not at risk of infection. In total, less than 20 percent of the people at risk of infection have access to HIV/AIDS information.

**Benefits of interventions**

Substantial benefits would arise from the implementation of the intervention measures. In addition to these monetary gains there would also be additional welfare gains. In total, the population would benefit as follows:

- First, at the macroeconomic level, the projected loss of GDP output would be substantially reduced (Table A1.2), which would increase per capita income. Given the strong impact of GDP growth on poverty, the number of poor people would be much less than in the absence of preventive measures. In aggregate, between 8 and 30 million people

**FIGURE A1.6**

**Percent of Individuals at Risk with Access to Interventions**

Note: CSW, commercial sex workers; STD, sexually transmitted disease; VCT, voluntary counseling and testing.
could escape poverty depending on how sensitive poverty prevalence is to economic growth (Jenkins and Robalino 2003).

- Second, the population at large will benefit directly from avoidance of HIV infection. New infections would be reduced, especially among young people and women. Over time, the reduction in infections would lead to less suffering and premature deaths.

- Third, these interventions would help improve standards of living among disadvantaged groups and reduce income inequality. People living with HIV/AIDS, CSWs, MSM, IDUs, and people in correctional institutions will be able to better protect themselves, and benefit from reduced stigma and improved human rights.

- Fourth, the early implementation of interventions will reduce the future number of HIV/AIDS patients and orphans. As a result, the costs of treatment and care of HIV/AIDS patients would be reduced. This will allow countries to allocate the savings to productive investments and significantly improve long-term per capita income growth.

**Cost effectiveness of interventions**

International experience has demonstrated that prevention interventions to reduce the spread of HIV/AIDS are cost effective, especially when focused on reducing risks in those groups most likely to contact and spread HIV/AIDS. Interventions such as provision of basic prevention packages for high-risk and vulnerable groups, as well as harm reduction for IDUs, have proven highly effective.14

Additional evidence is also available in the case of MENA countries. Expanding condom use by 30 percent and access to safe needles for IDUs by 20 percent was found to have substantial benefits for the period 2000–25. Among MENA countries, the net gains (that is, after subtracting the cost of interventions) would range from 17 to 40 percent of today’s GDP (figure A1.7). On average this translates into an increase of 0.3 percent in GDP growth rate.

However, the benefits decline sharply if these interventions are delayed. As an example, delaying the interventions by five years can cost countries an average of 8 percent of today’s GDP (27 percent in the case of Djibouti) (figure A1.8). Put differently, inaction can make more than half of the economic decline unavoidable for most MENA countries. Historic evidence corroborates the benefits of acting early. For example, the efforts of Senegal to act early have certainly contributed to keeping the HIV prevalence rate at a low level. Thailand’s program is another example that illustrates the benefits of early action.
FIGURE A1.7

Net Benefits from Increasing Access to Condoms and Safe Needles for IDUs in 2000–25


FIGURE A1.8

Losses Incurred by Delaying Interventions by Five Years in 2000–25

Notes

1. Approximately 5.1 million people were estimated to be HIV positive at end-2003.
2. For example, cholera epidemics may last for only a few months in any one location.
3. In the case of most other infectious diseases, the rapid onset of illness and diseases has the benefit of alerting public officials early on. This happened most recently with the Ebola fever. Faced with increased mortality, countries took measures to control the spread of the disease and to immobilize the victims of the disease, thereby reducing their potential to infect other individuals. As a result, the socioeconomic effects of the Ebola fever were limited to the short term.
6. Currently, they are estimated to amount to 1 to 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).
9. Those countries had female school enrollment rates below 40 percent in 1990–95, which created a significant risk of vulnerability.
10. See the reference in note 6 for more details on the econometric model that was used to account for the level of HIV prevalence rates in MENA countries.
11. The model predicts 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 (GDP), and migration.
13. These impacts are estimated by averaging the outcomes of the various scenarios.
14. See, for example, Commission on Macroeconomics and Health, “The Evidence Base for Interventions to prevent HIV infection in Low- and Middle-Income Countries” (Paper No. WG5: 2, 2001).
## Annex 2

### Reported AIDS Cases in the MENA Region, 1990 to Mid-2003

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### Sources:

### Note:
- b. The Libyan daily *ash-Shams* quoted national AIDS program Director Ahmad Mahmoud as saying that about 800 Libyan patients and 175 foreign residents in the country have AIDS (UPI, December 27, 2003).
- c. *Al Jazeera* (October 23, 2003) reported that the Ministry of Health announced that it had registered 1,509 Saudi nationals as AIDS patients.
- d. Figures include both HIV and AIDS.
## Profiles of the HIV/AIDS Epidemics in Countries of the MENA Region

<table>
<thead>
<tr>
<th>Country</th>
<th>Date of First Recorded AIDS Case</th>
<th>Estimated Adult Prevalence Level (Percent)</th>
<th>Estimated Adults and Children Living with HIV/AIDS (Reported [r] and Estimate [e] by UNAIDS/WHO, End 2001)*</th>
<th>Female Reported AIDS Cases or Reported HIV Infections (Percent)</th>
<th>HIV in High-Risk Groups (Percent)</th>
<th>Features of Epidemic Transmission Modes among Reported AIDS Cases, 1997–2001; HIV Prevalence in General Population; Major Risks; Indicators of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Algeria</td>
<td>1985</td>
<td>0.1</td>
<td>1,067 (1/01) [r]; 13,000 (adults) [e]</td>
<td>27 (AIDS, 2001)</td>
<td>1.2 in FSWs (1988); 0.10 in 20 FSWs (2000); 3 in 139 FSWs (2000); STD clinics at 6 sites; 9 (2/22) at Tamanrasset, 1.7 (2/117) at Oran, rest zero (2000); 41% heterosexual, 5% homosexual, 18% IDU, 10% blood, 2% MTCT, &lt;1% other, and 24% unknown; 0.9% HIV prevalence at 4 antenatal sites (2000); 0.3% in 345 TB patients (1998); 0.4 in 1,984 antenatal mothers (2000); high levels of migrants from West and Central Africa transiting through southern area; FSWs from Algeria and elsewhere.</td>
<td></td>
</tr>
<tr>
<td>Bahrain</td>
<td>1985</td>
<td>0.3</td>
<td>216 (December 2000 [r]); &lt;1,000 [e]</td>
<td>7 (AIDS, 2001); 11 (HIV, July 2001)</td>
<td>1.6 in 242 multitransfused children with hemolytic anemias (1995); 0.3 in 291 IDUs (2000); 0.9–2.3 in IDUs (1998); 11% heterosexual, 4% homosexual/bisexual, 72% IDU, 2.4% MTCT, and 10% blood; 67% all cases in IDUs (2001); 0 in 2,079 blood donors (1999); 0.2 in 627 antenatal women (1998); migrant sex trade, opiates.</td>
<td></td>
</tr>
<tr>
<td>Djibouti</td>
<td>1986</td>
<td>2.9 (1.1–4.7, 95% CI, 2002)</td>
<td>3,500–14,500 [e] (1999)</td>
<td>21 (AIDS, 1997–98); 54 among 15- to 29-year-old cohort.</td>
<td>22 in STD patients (1996); 28 in FSWs (1998); &gt;50 in street sex workers and 26 in bar sex workers (1996); 99% heterosexual and 1% MTCT (1997–98); 1.9% in private antenatal clinic (1999); 26% in TB patients (2001); 1.8%–3.1% in blood donors (2000); STDs: 3.2% syphilis in antenatal mothers (1997); in 2002, general population 2.8% (95% CI 1.2% to 4.5%, 1999); high levels of commercial sex; 100,000 refugees sent home; 5,000–10,000 resettled in camps (2003).</td>
<td></td>
</tr>
<tr>
<td>Egypt, Arab Rep.</td>
<td>1986</td>
<td>&lt;0.1</td>
<td>1,711 (1,153 Egyptians; 558 foreigners; 368 with AIDS, May 2003) [r]; 8,000 [e]</td>
<td>11; 17.3 (NAP, end-2001); 19% (HIV, end-2001)</td>
<td>1 in 102 MSM (1999); 0.79 in 382 MSM (2000); 0.86 in 815 MSM (2001); 0 in 129 FSW (2001); 0 in 920 STD patients (2001); 54% heterosexual, 11% homosexual, 24% blood, &lt;1% MTCT, and 9% unknown (end 2001); 0.006% in blood donors (2001); 0 antenatal; 0.6% in TB patients; 75% infections acquired in Egypt; 16% drug users are IDUs, 31% of whom share equipment (2001); 4,897 drug users tested</td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td>Date of First Recorded AIDS Case</td>
<td>Estimated Adult Prevalence Level (Percent) (UNAIDS/WHO)</td>
<td>Estimated Adults and Children Living with HIV/AIDS (Reported ( r ) and Estimate ( e ) by UNAIDS/WHO, End 2001)</td>
<td>Female Reported AIDS Cases or Reported HIV Infections (Percent)</td>
<td>HIV in High-Risk Groups (Percent)</td>
<td>Features of Epidemic Transmission Mode among Reported AIDS Cases, 1997–2001; HIV Prevalence in General Population; Major Risks; Indicators of Change</td>
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<tr>
<td>Egypt, Arab Rep. of</td>
<td>&lt;0.1</td>
<td>626 AIDS ( r ) October 2002; 20,000 ( e )</td>
<td>5.1 (end 2002)</td>
<td>0.72 in 140,277 drug users tested over time; 0.5 in 8,202 IDUs (1998); 2.3% among prisoners, mostly drug users, in 2000; 0 in 5,700 STD patients (1998); 0 in 1,605 FSWs (1998).</td>
<td>15.8% sexual, 52.7% IDU, 19.8% blood, 0.3% MTCT, and 11.3% unknown (2002); 4.2% in TB patients (2002); rapid threefold increase in HIV/AIDS in 2001–02; 4% among VCT center users (2001); sex work, polygamy also risk factors; estimated 30,000 CSWs (2002); 170,000 IDUs; estimated that prevalence remains around 15% among IDUs and &lt;5% among FSWs.</td>
<td></td>
</tr>
<tr>
<td>Iran, Islamic Rep. of 1986</td>
<td>&lt;0.1</td>
<td>180 as of April 2003 ( r ); &lt;1,000 ( e )</td>
<td>9</td>
<td>Mandatory screening for prisoners, STD patients, health and hotel workers; premarital tests, etc.</td>
<td>9.3% heterosexual, 86.1% blood, and 4.6% MTCT (1999); STDs: reported cases increased between 1999 and 2000; 0.1% syphilis and 0 HIV in pregnant women (2000); war zone, sex work.</td>
<td></td>
</tr>
<tr>
<td>Iraq</td>
<td>1986</td>
<td>2,700 ( e )</td>
<td>22% (end-2001)</td>
<td>STD patients-immigrant workers, n=900, 0.6 (2002).</td>
<td>46.8% heterosexual, 24.8% homosexual, 13.2% IDU, and 2.9% MTCT (mid-2003); cumulative HIV detected, 3,802 (mid-2003); between 1999 and 2002: 54.3% heterosexual, 14.4% homosexual, 13.2% IDU, 2.7% MTCT; transmission among homosexuals appears to be decreasing. IDU levels about the same as earlier; large Eastern European migrant sex trade, HIV levels unknown.</td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td>Year</td>
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<td>Cases</td>
<td>HIV/AIDS Information</td>
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</tr>
<tr>
<td>Jordan</td>
<td>1986</td>
<td>&lt;0.1</td>
<td>324 cumulative, 131 (40%) Jordanians as of June 2003; &lt;1,000 [e]</td>
<td>13 (AIDS); 26 (HIV/AIDS)</td>
<td>No surveillance except prisoners; none infected of 945 tested (2000). 40% heterosexual, 3.2% homosexual, 3.2% IDU, 38.9% blood (1997–00), 1.1% MTCT, and 13.7% unknown; only 1 of 281 TB patients infected; 0.03% among blood donors; none among antenatal mothers tested 1992, 1994, 1999; KAP study (1999) of 3,200 people revealed 4%–16% sex outside of marriage in last year, of which 10% MSM; small study of 56 FSWs, 3–5 clients/day; 25% condom use (2003).</td>
<td></td>
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<tr>
<td>Kuwait</td>
<td>1984</td>
<td>0.12</td>
<td>835 (December 2000)</td>
<td>18 HIV/AIDS</td>
<td>0 in 2,600 STD patients; mandatory testing for sexual offense prisoners, IDUs in treatment/custody; 0 in 193 IDUs (2000). 73% heterosexual, 6% homosexual, 6% IDUs; 2% MTCT; 6% blood, and 8% unknown; 275,307 people screened in 2000, 1.7% HIV positive; 0 in pregnant women; STDs: increased from 1,002 in 1991 to 6,043 in 1997; 30% gonorrhea, 1.6% syphilis; HIV types B &amp; C, via India; migrants/sex/heroin.</td>
<td></td>
</tr>
<tr>
<td>Lebanon</td>
<td>1984</td>
<td>0.09</td>
<td>700 (October 2003)</td>
<td>16 (AIDS); 21 (HIV/AIDS, December 1999)</td>
<td>In 1999, 0 infected of 205 select FSWs; 0.2 in prisoners; 6.3% of all reported HIV cases are IDUs, all males. 47% heterosexual, 28% homosexual, 3% IDUs, 15.6% blood, and 6.7% MTCT (cumulative); &gt;50% recent cases local origin; rising percentage of women; general population behavioral surveys in 1991 and 1996 show drop in use of condom from 40% to 33%; NSP reports 68% of 15–24 year olds sexually active, 33% with multiple partners, 76% never used condoms; 33% IDUs had commercial sex in last month.</td>
<td></td>
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<tr>
<td>Libya</td>
<td>1990</td>
<td>0.2</td>
<td>800 +175 foreigners (December 2003); 7,000 [e]</td>
<td>—</td>
<td>571 new infections in 2000, 98% among IDUs; 319 in 2001. 56% heterosexual, 22% blood, and 22% MTCT (cumulative), but not currently accurate; outbreaks in hospitals from lack of infection control, 370 children in 1998; 0.3% in 296 TB patients (1998).</td>
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<tr>
<td>Morocco</td>
<td>1986</td>
<td>0.1</td>
<td>963 (94% Moroccan, December 2001)</td>
<td>36 AIDS; 50 HIV (among new cases)</td>
<td>0.1 in 7402 STD patients (2001); 2.3% in CSWs (2001). 70% heterosexual, 9% homosexual, 6% IDUs, 3% blood, 2% MTCT, 6% other, and 4% unknown; &lt;1% in antenatal women (2001); rising rates in some areas, Tangiers higher in IDUs, Marrakech higher in MSM.</td>
<td></td>
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<tr>
<td>Country</td>
<td>Date of First Recorded AIDS Case</td>
<td>Estimated Adult Prevalence Level (Percent)</td>
<td>Estimated Adults and Children Living with HIV/AIDS (UNAIDS/WHO)</td>
<td>Female Reported AIDS Cases or Reported HIV Infections (Percent)</td>
<td>HIV in High-Risk Groups (Percent)</td>
<td>Features of Epidemic Transmission Mode among Reported AIDS Cases, 1997–2001; HIV Prevalence in General Population; Major Risks; Indicators of Change</td>
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<tr>
<td>Oman</td>
<td>1987</td>
<td>0.1</td>
<td>833 (November 2003) [r]; 1,300 [e]</td>
<td>32 HIV/AIDS</td>
<td>In 1999, 5 in 135 arrested IDUs; 8.3 among 60 IDUs.</td>
<td>41% heterosexual, 11% homosexual, 2% IDUs, 22% blood, 6% MTCT, 2% other, and (2000); 0 HIV in 337 STD patients (2001). 17% unknown; 2% in TB patients (2000); STDs: incidence rate of reported cases dropped from 92 to 48.6 per 100,000 between 1996 and 2000; among 245 men in social clubs, 13% nonmarital sex in past year (1995).</td>
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<td>Qatar</td>
<td>—</td>
<td>0.09</td>
<td>300 [e]</td>
<td>29 (cumulative AIDS)</td>
<td>In 1999, 5 in 2,249 STD patients.</td>
<td>20% heterosexual, 4.8% homosexual, 58% blood, 8% MTCT, and 9.6% unknown; 0 in 2,464 blood donors (1999).</td>
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<tr>
<td>Saudi Arabia</td>
<td>1984</td>
<td>—</td>
<td>- 6,787 [r, cumulative, 23/10/03]; 22% Saudi nationals</td>
<td>20 (AIDS, 2003)</td>
<td>2.3 in multitransfused children (1989); 0.14 in 2,102 IDUs (1997).</td>
<td>72% heterosexual, 6% homosexual, 2% IDUs, 15% blood, and 4% MTCT (1997–98); 8/10/02 report of 452 AIDS, additional 833 HIV=1,285 HIV/AIDS; 436 cumulative by 2000, 350 cases reported 2001, 200 in 2002, rose to 800 in 2003; 450 died (as of 9/03); rise due to suspected improvement in reporting.</td>
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<tr>
<td>Syrian Arab Rep.</td>
<td>1987</td>
<td>0.01</td>
<td>145 (July 1999) [r]; 800 [e]</td>
<td>19 (NAP, 2001)</td>
<td>As of 1998, STD patients 0.12; FSWs 0.12; bar girls 0.04; MSM 0.59; 0 in IDUs.</td>
<td>73% heterosexual, 8% homosexual, 8% IDUs, 8% blood, and 4% MTCT (1997–2000); 250,000 people tested yearly, almost all mandatory; 0.0015% in blood donors, 0.005% in Syrian travelers before departure; few cases detected; STDs: April–June 1999, 2,342 cases reported at four centers according to syndromic method.</td>
</tr>
<tr>
<td>Tunisia (includes expatriates)</td>
<td>1985</td>
<td>0.06 (March 2001)</td>
<td>1,125, 738 alive (December 2002) [r]; 2,200 [e]</td>
<td>40 (AIDS, 1998–99)</td>
<td>0 to &lt;1 in registered FSWs throughout 1990s; 0 in 570 FSWs (1999), 0.22 in 458 FSWs (2001).</td>
<td>51% heterosexual, 10% homosexual, 27% IDUs, 8% blood, 4% MTCT (1998–99); 0 in 108 anental mothers (1999); &gt;50% detected as AIDS; all infected females and 30% males acquired infection in Tunisia; high proportion among expatriates; 0.25% in TB patients (1996); 0.003% in blood donors; by 2002, all new HIV cases among women through sexual transmission; among males 10% IDU, 6% heterosexual, 3% homosexual.</td>
</tr>
<tr>
<td>Country</td>
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<td>First Detection</td>
<td>Latest Data</td>
<td>AIDS Count</td>
<td>Transmission Modes</td>
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<tr>
<td>United Arab Emirates</td>
<td>2000</td>
<td>2,300 (January)</td>
<td>2,300 (2003)</td>
<td>19 AIDS</td>
<td>54.7% heterosexual, 18.9% blood, 5.7% homosexual/bisexual, 3.8% IDU, 1.9% MTCT, and 15% unknown (HIV/AIDS, 2002).</td>
<td></td>
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<tr>
<td>West Bank and Gaza</td>
<td>1988</td>
<td>1.6</td>
<td>72 (December)</td>
<td>19 AIDS</td>
<td>54.7% heterosexual, 18.9% blood, 5.7% homosexual/bisexual, 3.8% IDU, 1.9% MTCT, and 15% unknown (HIV/AIDS, 2002).</td>
<td></td>
</tr>
<tr>
<td>Yemen, Republic of</td>
<td>1990</td>
<td>0.01 (1999)</td>
<td>1,077 (June)</td>
<td>33 (2000)</td>
<td>77.3% heterosexual, 15.9% homosexual, and 6.8% blood (1998); more than 50% infections acquired in Yemen; gender ratio changed from 4:1 (male to female) in 1995 to 2:1 in 1999 and 1:1 in 2000; 0.7% in 11,070 low-risk people (1998); 0.04% in 19,813 blood donors (1998) rose to 0.28% in 2000; 6.9% in TB patients (1999); 45% HIV infections among Yemenis.</td>
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<td>approx.</td>
<td>5 HIV (2000)</td>
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</table>

--- Not available.  

Note: CI, confidence interval; FSW, female sex worker; IDU, injecting drug user; KAP, knowledge, attitude, practice; MTCT, mother-to-child transmission; MSM, men who have sex with men; NAP, National AIDS Program; STD, sexually transmitted disease; TB, tuberculosis; VCT, voluntary counseling and testing.  

a. Unless otherwise indicated.
References for Annex 3

Abdelmajid, B.H. 1999. Situation épidémiologique des maladies sexuellement transmissibles. Chapitre 1 in Les 7èmes (JNSP/DSSB/99). Department of Preventive Medicine, Faculty of Medicine, Tunis. Mimeo.


Spratt, K. February 2000. HIV/AIDS and Sexually Transmitted Infections (STIs) in the West Bank and Gaza. USAID.


Algeria has finalized her multisectoral National Strategic Plan (NSP) for HIV/AIDS for the period of 2003–06, in collaboration with nongovernmental organizations (NGOs) and international partners. The government has been approved to receive $8.8 million designated for the next two years from the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM) to implement its multisectoral Action Plan to fight HIV/AIDS, with the participation of communities and the civil society. Additionally, for a number of years, an association of people living with HIV/AIDS (PLWHA) has been established and a network of NGOs working on HIV/AIDS is now in place. Specific preventive activities have been supported among religious leaders, prisons, and police forces. Currently, plans are proceeding to strengthen surveillance and to undertake a study on drug use and HIV/AIDS.

The increased political level of commitment to fight HIV/AIDS is apparent in the president’s speech on December 1, 2003, to commemorate the World AIDS Day in Algeria (see box A4.1 below).

Djibouti has the most advanced epidemic among MENA countries (2.9% among adults). With the help of the Bank, it has developed a multisectoral strategy and has obtained a $12 million International Development Association (IDA) grant to implement a joint HIV/AIDS, tuberculosis, and malaria strategic plan. In addition, the International Road Corridor Rehabilitation in Djibouti is a Bank-funded project (loan) that has an HIV/AIDS component aimed at diminishing the potential for increased transmission of HIV in the trucking industry and at construction sites. Djibouti is also one of the six countries of the Horn of Africa that are benefitting from an Institutional Development Grant from the Bank to their Inter-Governmental Authority on Development. The grant mainly focuses on building the HIV/AIDS monitoring and evaluation (M&E) capacity of member states. The French government had been funding STD treatment programs in the past, but it is not clear whether it is continuing to do so.
In the Arab Republic of Egypt, the government program has been largely dependent on outside funding sources. Recently, a situational assessment was completed, and there are plans to develop an NSP. The Ford Foundation has contributed by establishing a hotline, which has been important even if slowly used. Caritas, an NGO, operates a hotline in Alexandria. The Swiss government funds the improvement of blood banks. Small efforts at research into men who have sex with men (MSM) and injecting drug users (IDUs) have been mounted, but neither real outreach programs nor behavioral surveillance has been developed. Through

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**BOX A4.1**

**President Bouteflika’s Speech on the World AIDS Day 2003**

The Algerian President gave a speech on December 1, 2003, to commemorate the World AIDS Day in Algeria. This was the first time the President extensively addressed the issue in Algeria. In his speech, he expressed the country’s commitment to tackle HIV/AIDS in a socially and culturally appropriate manner by breaking the silence around the epidemic, raising awareness among the community, mobilizing key stakeholders to fight against HIV/AIDS, and reducing the discrimination and stigma associated with the epidemic. The President underlined that:

(i) Breaking the silence around HIV/AIDS and taboos of talking about the epidemic in Algeria and other parts of the world is a crucial step to address the epidemic in an adequate manner;

(ii) Raising awareness and HIV-related education, especially among the youth, are important preventive methods in the fight against the spread of HIV/AIDS;

(iii) Women’s physiological and social vulnerability to HIV/AIDS is a challenge that needs to be tackled to stem the increasing spread of the epidemic among women;

(iv) Confidentiality must be guaranteed/reinforced in medical centers for voluntary testing to reduce/mitigate people’s fear of discrimination and stigma of being exposed as HIV-positive and avoiding testing and treatment;

(v) HIV/AIDS has to be addressed in a socially and culturally appropriate manner, with consideration of local beliefs, values, and traditions to have effective programs to prevent the spread of the epidemic; and

(vi) Collaboration and partnership of different stakeholders, including civil society, the private sector and international agencies is crucial in the fight against HIV/AIDS.

Family Health International’s (FHI) IMPACT program, the United States Agency for International Development (USAID) has begun a local program funded at approximately $1 million yearly. Its first accomplishment was a sexually transmitted infection (STI) study among high-risk groups, carried out in 2000–01. Since then it has helped to develop a voluntary counseling and training (VCT) service; conducted training for health workers on sexually transmitted diseases (STDs), HIV treatment, and blood safety; and is planning to work on improved surveillance, building capacity in community-based organizations (CBOs) that work with IDUs, and reducing stigma. The Ford Foundation, USAID, and the World Health Organization (WHO) contribute to an infectious disease surveillance system and education program through the U.S. Naval Medical Research Unit-3 (NAMRU-3) for HIV, hepatitis C, and hepatitis B. USAID also funds the Center for Development and Population Activities (CEDPA) to work on HIV and STDs with young women in Upper Egypt. The potential for HIV to spread through a significant number of refugees from the Horn of Africa as well as the large number of migrating Egyptians has not yet been addressed. Programs to reduce risk among the most vulnerable groups have not been established.

The Islamic Republic of Iran appears to have the most focused prevention activities composed of a continuum of harm reduction and care for IDUs, including those in prison, with options for treatment of addiction, including methadone maintenance. The interventions being implemented in prisons are innovative and could provide a model for the region (see box A4.2). Plans are under way to provide outreach prevention services to sex workers as well. Public campaigns have begun to alert the general population. The Red Crescent of the Islamic Republic of Iran has mobilized 1 million volunteers to help disseminate its HIV/AIDS anti-stigma message. The programming was launched across all 28 branches of the national organization. Local television advertisements advise the use of condoms and campaign against the isolation of and discrimination against AIDS victims. Couples engaged to be married are required by law to attend HIV/AIDS awareness classes before their marriage. Free (government-financed) needles are distributed at pharmacies to prevent transmission through needle sharing among IDUs. The Islamic Republic of Iran has been approved to receive grants from the GFATM in the last two application rounds of 2002 and 2003. The first two-year grant for $9,698,000 is to improve HIV/AIDS surveillance, raise awareness about the epidemic, and improve access to and quality of HIV/AIDS treatment and care, while the second grant for $5,698,000 is to build the capacity of civil societies in the Islamic Republic of Iran to confront the epidemic.
Jordan has also been successful at receiving approval for a grant from the GFATM for $2,483,900 to conduct a wide range of activities, including targeted interventions with high-risk groups, STI/HIV/AIDS education in schools, establishing VCT centers and promoting their use, providing home-based care and antiretroviral therapy (ART) for all those in need, developing improved surveillance, conducting safe injecting and blood safety assessments, and improving capacity among staff. In addition, FHI has a program in Jordan funded by USAID, at approximately $400,000 per year that has conducted research, designed and implemented an STI prevalence study in the general population, and developed a hotline and counseling center. Peer education activities with out-of-school youth have been developed through UNAIDS Program Acceleration Funds (PAF). Few local NGOs have yet to become involved and capacity to reach and work with vulnerable groups remains limited.

Lebanon has recently been supported by UNAIDS and the Bank in preparing their comprehensive National AIDS Action Plan for 2004–09 to guide leaders and stakeholders in the organization of appropriate interventions.

BOX A4.2

Islam and Harm Reduction in the Islamic Republic of Iran

With exposure to the issues surrounding HIV among IDUs, the religious leaders in Iran have come to believe that harm reduction is necessary and acceptable in Islam to protect society from the even greater consequence of HIV. Based on their opinions, implementing agencies can carry out such activities as condom distribution and methadone maintenance therapy. Recently, the Islamic Republic of Iran’s Prison Organization has obtained permission to start pilot projects on the effectiveness of needle exchanges in prisons to reduce the transmission of HIV. Condoms are already available in prisons because of the establishment of “private meetings” for married couples. There are suites constructed in all prisons for married couples to meet in private, where condoms are provided. HIV prevention training is also provided to all prisoners and their families several times during the period of their imprisonment. The “private meetings” have been very effective in reducing violence and all antisocial behavior. These are considered to be the right of the prisoner and not just a privilege.

Sources: F. Soltani, United Nations Office on Drugs and Crime, Iran and Dr. Ashfar, Prison Organization, personal communication.
that would lead to a coherent and coordinated HIV/AIDS response at the national level. Additional funds from UNAIDS and funds provided by the United Nations Population Fund (UNFPA) through the Organization of the Petroleum Exporting Companies (OPEC) fund, has enabled selected NGOs to undertake behavior surveys and outreach among high-risk groups, such as CSWs, IDUs, and MSM. The action plan has four major priorities: (1) advocacy, human rights, and coordination; (2) prevention; (3) treatment, care, and support; and (4) surveillance and M&E. An operational manual to guide the implementation of the National Plan has recently been completed. The World Bank has also recently approved an Institutional Development Fund Grant of US$350,000 to the Government of Lebanon to support the strengthening of the National HIV/AIDS M&E and Surveillance Systems.

**Morocco** developed, with technical assistance supported by the Bank, a situational assessment and National AIDS Action Plan, the formulation of which was funded by UNAIDS. This plan was finalized in September 2001 and the government organized a national workshop for its presentation to main stakeholders. The response analysis showed a substantial gap between available and required financial resources. Of the $20 million budget for 2002–04, only 25 percent was available from government resources. With this plan, Morocco developed a successful GFATM proposal and was the first MENA country to receive approval in 2002 for a GFATM grant of $4,738,806 over two years. The proposal targets vulnerable at-risk groups; implements a social communication program aimed at young people, women, and the general population; and provides diagnosis, support, and treatment for people living with HIV/AIDS. There is strong political commitment, evidenced by the financial participation of the government, the help of a few donors such as the European Union and Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), and collaboration with NGOs.

In **the West Bank and Gaza** there is a small STD/HIV/AIDS program with links to the National Five-Year Health Program. Cases of HIV/AIDS have been detected in Palestinian refugees in Jordan, Lebanon, and Syria, as well as the West Bank and Gaza, and specially designed prevention and care programs are needed, but as yet none have been designed or funded.

In 2002–03, the **Republic of Yemen** developed a strategic framework on HIV/AIDS, and a multisectorial task force has been established to coordinate and oversee the implementation of the NSP. Currently, operational plans are being finalized. In addition, resources have been obtained
through the GFATM, bilateral funding, and UN agencies. Despite the challenges that remain in all areas of prevention, care, and support, some attempts now are being made to undertake research and develop programs for risk groups, such as CSWs.

Other nations in the region also have HIV-related activities. For example, Oman is implementing a project with a hotline, Web site, and VCT services for young people; Syria is developing approaches to target youth in slum areas through community-based HIV/AIDS education and communication activities and has received PAF funds from UNAIDS to conduct assessments with the more vulnerable groups in those slums; Tunisia has engaged in HIV/AIDS/STD information, education, and communication campaigns for young people. Libya has begun to address the high risk among IDUs. A rapid assessment and response study is under way and there are plans to improve addiction treatment services.
Twelve countries in MENA have received Program Acceleration Funds (PAF) for a total amount of $791,000. The funds earmarked per country range between a minimum of $30,000 and a maximum of $180,000.

Three-fourths of the total funds allocated for the MENA region have now been obligated to specific activities, while proposals have been formulated by the countries for the use of the remaining fourth. Because many of these activities were developed in 2003, implementation is ongoing. In 2004, new PAF became available for 2004–05.

The activities submitted for PAF funding in MENA for 2002–03 were quite wide-ranging and can be regrouped under the following headlines according to those most frequently requested: (1) reinforcing HIV/AIDS prevention work in diverse non-health sectors, including with religious leaders, interior and defense sectors, prisons, and in the workplace; (2) working with specific vulnerable populations, including young people, drug users, sex workers, and so on; (3) support to the National Strategic Planning (NSP) process; (4) capacity building among NGOs and persons living with HIV/AIDS; (5) strengthening information systems, documentation, and best practices; and (6) supporting specific interventions, such as sexually transmitted infections (STI) and epidemiological surveillance. It should be noted that requests from the last category (6) are, and should increasingly become, less frequent as more funds become available to support such key HIV/AIDS interventions through resources available to the UN agencies themselves.

The following cosponsors have been involved in the implementation of PAF proposals in countries with national counterparts: the World Health Organization, United Nations Children’s Fund, United Nations Development Programme, United Nations Office on Drugs and Crime, United Nations Population Fund, and the International Labour Organization.

## Candidate Countries for the Bank’s Support

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<td>Y</td>
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<td>Y</td>
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Note: IDA, International Development Association; IDF, Institutional Development Fund; N, no; NSP, National Strategic Plan; UNAIDS, Joint United Nations Program on HIV/AIDS; Y, yes.

a. Countries listed according to their adult HIV prevalence rates (2003). Countries selected for support have a score of at least 3 and are highlighted in bold-face type.
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As one of the shocks that can drive households into abject poverty, HIV/AIDS has the potential to impede and even reverse development if not addressed early enough. Prevalence levels in the MENA region are low compared to other areas, but recent evidence indicates that infection rates are increasing.

Greater investments to improve HIV/AIDS advocacy, develop an information base, and implement prevention strategies among high-risk groups are needed now, before prevalence levels reach epidemic proportions. Through investments in these areas, the region can avoid the increase in human suffering a widespread epidemic could bring and preserve the benefits of national and regional development investments put in place by governments and development partners, including the World Bank.

Preventing HIV/AIDS in the Middle East and North Africa presents the rationale for addressing HIV/AIDS in the region and the World Bank’s strategic choices in supporting countries as they try to prevent the spread of the disease. This regional strategy clarifies the role of the World Bank in confronting the epidemic, based on a review of regional and national needs and responses to those needs, as well as the areas in which the World Bank is best positioned to support countries’ efforts. It will be of interest to health care professionals, policy makers, and government members, as well as to those in the development community.