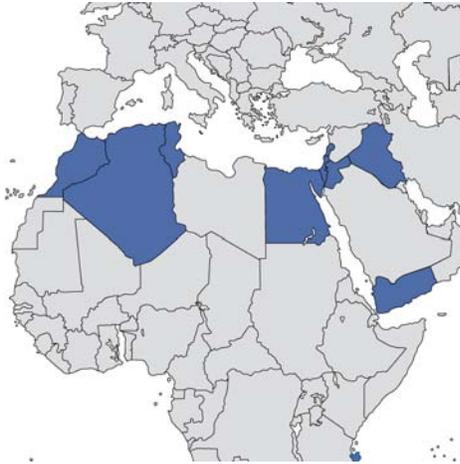




# HIV/AIDS HEALTH PROFILE

## Middle East Region



### Overall HIV Trends

Throughout most of the Middle East region, HIV prevalence remains low, at 0.2 percent, and as of 2008, approximately 310,000 people living in the Middle East and North Africa (MENA) were HIV positive. However, the current trend is toward increasing prevalence. Moreover, even in environments with low prevalence among the general population, there are often discrete populations that are substantially more affected, such as men who have sex with men (MSM), female sex workers (FSWs), and injecting drug users (IDUs) (Joint United Nations Program on HIV/AIDS [UNAIDS], 2009).

While little is known in the Middle East region about HIV prevalence rates among most-at-risk populations (MARPs), a number of risk factors appear to be common among these groups and are reason for concern. Data from available surveys suggest sharing injecting equipment is relatively common; in most countries, IDUs are infected with hepatitis C, an indication of how readily HIV could affect this population. Sexual contact between men is highly stigmatized, and most countries in the region criminalize same-sex activity. As a result, MSM are the most hard-to-reach and stigmatized of the HIV risk groups (World Bank, 2010). Many MSM also have sex with women, and a significant number also inject drugs and/or report sexual relations with a sex worker. For example, in Algeria, Egypt, Lebanon, and Syria, one-third or more of surveyed IDUs reported recently either buying or selling sex (UNAIDS, 2008). Condom use among sex workers during the most recent episode of intercourse with a client has been reported to be low, ranging from 44.4 percent in Jordan to 61.1 percent in Yemen (UNAIDS, 2009). Both the IDU and MSM risk contexts suggest possibilities for an increase in concentrated HIV epidemics over the next decade (World Bank, 2010). However, while there is potential for further spread of HIV among FSWs, near-universal male circumcision and relatively lower levels of risk behaviors may prevent expanded epidemics in many countries. Even so, some FSW subgroups may be at higher risk, such as those who inject drugs and those whose clients inject drugs (World Bank, 2010).

Although male circumcision and engaging in fewer risky behaviors decrease HIV risk, other broad epidemiological trends put the Middle Eastern population at risk of an expanded epidemic: First, HIV is often contracted by people living abroad, with HIV-infected individuals exposing their partners to the infection upon their return to the Middle East (UNAIDS, 2009); second, transmission among specific vulnerable populations may also result in transmission to sexual partners and the general population (UNAIDS, 2009). Because most risk behaviors are practiced by men, women are especially vulnerable. Additional prevention measures are needed for female sexual partners of men who are exposed to HIV during work abroad, drug users, MSM, and men who have sex with sex workers. Females, in particular, are often

underrepresented in surveys and in outreach efforts. In Egypt, for example, while men are far more likely to have HIV than women, this may be due in part to more men being tested than women. In addition,

FSWs and female IDUs in the country are more difficult to reach when collecting data (Shawky, 2009). Other populations that potentially experience an intermediate risk of HIV infection and provide links between MARPs and the general population are truck drivers, fishermen, and military personnel. (World Bank, 2010).

The general population is at the lowest risk of contracting HIV; however, certain subpopulations, such as young people, prison populations, and recipients of blood transfusions, are vulnerable to experiences that may put them at higher risk of HIV infection. Mobile populations are also vulnerable, and in Iraq, Lebanon, and the West Bank and Gaza, complex emergencies often drive population movement. Emergencies can lead to changes in behavior and potentially facilitate the spread of HIV (World Bank, 2010).

Systematic monitoring of the epidemic is far from complete. Surveillance systems remain inadequate in their coverage of at-risk groups and thus fail to reflect risk behaviors or provide incidence and prevalence rates. In addition, the adoption of preventive practices is very limited, and the participation of people living with HIV/AIDS (PLWHA) and civil society in the HIV/AIDS response is still nascent. Despite some progress, general attitudes, institutions, and laws do not facilitate the implementation of an expanded response. The first step in addressing the spread of HIV/AIDS is to recognize the presence of the disease and the sociocultural, political, and economic patterns that fuel and bear the burden of its impact.

An estimated total of 21,000 people in **Algeria**, including 0.1 percent of the adult population, were living with HIV in 2007. Higher prevalence rates have been observed among MARPs: for example, 4 percent of commercial sex workers were infected with HIV in Algiers (UNAIDS, 2009), and 2.4 percent of sexually transmitted infection (STI) clinic patients were infected (United Nations General Assembly Session [UNGASS], 2010). A main mode of HIV transmission in the country is also through exposure to contaminated drug injecting equipment, and a related concern is the overlap of injecting drug use and sex work, which also appears to be facilitating HIV transmission. According to the World Health Organization (WHO)/UNAIDS/UNICEF *Towards Universal Access* report, by the end of 2007, only 20 percent of HIV-infected people were receiving antiretroviral therapy (ART).

With less than 0.1 percent of the population estimated to be HIV positive, **Egypt** is a low-HIV-prevalence country. According to UNGASS, as of the end of 2009, 3,919 cumulative HIV cases have been reported, 2,920 of which are Egyptian. National HIV statistics are expected to be underestimated, however, as they are primarily based on mandatory testing for HIV, voluntary counseling and testing (VCT) reports, and passive surveillance systems (Shawky, 2009). UNAIDS estimates for 2007 were significantly higher, putting the number of HIV-positive Egyptians at 9,200. However, unsafe behaviors among MARPs and limited condom use among the general population place Egypt at risk of a broader epidemic. Egypt's recent U.S. Agency for International Development (USAID)-funded, first-round Biological-Behavioral Surveillance Survey (Bio-BSS), conducted by the Ministry of Health and Population, targeted street children, MSM, FSWs, and IDUs and identified a concentrated epidemic among MSM in Alexandria, with a seroprevalence of 6.2 percent (UNAIDS, 2009). The survey also found HIV infection rates of 0.6 percent among IDUs and 0.8 percent among FSWs (UNAIDS, 2009). The Bio-BSS revealed that most at-risk groups have links with the general population, such as MSM, who are often either married or have multiple opposite sex partners (Shawky, 2009). In 2005, the Government of Egypt started to provide ART for HIV/AIDS patients free of charge. By the end of 2007, only 9 percent of HIV-infected people were receiving ART.

Little is known of the epidemic in **Iraq**. HIV prevalence among the general adult population is estimated at less than 0.2 percent. HIV among IDUs is estimated at 0.3 percent, while rates among FSWs and MSM

are unknown. The rate of prisoners infected with HIV has been estimated at 0 percent, as has the rate of HIV infection among tuberculosis patients. Following the 2003 invasion of Iraq, a major area of concern

has been the abduction of women and girls for prostitution and the violent force used to engage them in sex work for survival or economic necessity. Human rights organizations have reported a thriving industry of Iraqi refugee girls as young as 12 years old working in night clubs in Damascus, Syria. Because refugees are not officially allowed to hold jobs in Syria, aid workers have reported substantial increases in the number of Iraqi women and girls engaged in sex work (World Bank, 2010).

In **Jordan**, the adult prevalence rate remains at about less than 0.2 percent, with fewer than 1,000 people estimated to be living with HIV/AIDS in 2007. The majority of diagnosed HIV/AIDS cases have been among men (81 percent) and foreigners. Of Jordanians diagnosed, 22 percent were infected in Jordan and 74 percent were infected outside Jordan. The capital city of Amman has 57 percent of HIV cases. Little is known about HIV prevalence rates among high-risk populations; however, a Behavioral Surveillance Survey of taxi drivers, FSWs, MSM, and IDUs was completed in 2009, and its findings are pending analysis. While risk behaviors among vulnerable populations are a concern, cultural sensitivities may pose the greatest threat to the country's low prevalence. Stigma and discrimination against PLWHA are widespread, with just 4 percent of ever-married women surveyed in the 2007 Demographic and Health Survey expressing accepting attitudes toward PLWHA on all four measures of tolerance. Just 14 percent of women have comprehensive knowledge about HIV and AIDS – i.e., they know that consistent use of a condom and having just one uninfected partner can reduce the chance of infections, that a healthy-looking person can have HIV, and that

<b>HIV Estimates in the Middle East Region</b>	
<b>Algeria</b>	
Total Population*	34.6 million
Estimated People Living with HIV/AIDS**	21,000
Adult HIV Prevalence**	0.1%
<b>HIV in Most-at-Risk Populations</b>	
Commercial Sex Workers in Algiers, 2007**	4%
STI Clinic Patients, National, 2007***	2.4%
<b>Egypt</b>	
Total Population*	80.5 million
Estimated People Living with HIV/AIDS**	9,200
Adult HIV Prevalence**	<0.1%
<b>HIV in Most-at-Risk Populations</b>	
Commercial Sex Workers in Alexandria, 2007**	0.8%
IDUs in Alexandria, 2007**	0.6%
MSM in Alexandria, 2007**	6.2%
<b>Jordan</b>	
Total Population*	6.4 million
Estimated People Living with HIV/AIDS**	<1,000
Adult HIV Prevalence**	<0.2%
<b>Lebanon</b>	
Total Population*	4.1 million
Estimated People Living with HIV/AIDS**	3,000
Adult HIV Prevalence**	0.1%
<b>HIV in Most-at-Risk Populations</b>	
MSM, National, 2009 ***	1%
<b>Morocco</b>	
Total Population*	31.6 million
Estimated People Living with HIV/AIDS**	21,000
Adult HIV Prevalence**	0.1%
<b>HIV in Most-at-Risk Populations</b>	
Commercial Sex Workers in Rabat, 2007**	2.6%
Commercial Sex Workers, National, 2007**	2.1%
Prison Population, National, 2007**	0.6%
IDUs, National, 2008**	6.5%
<b>Tunisia</b>	
Total Population*	10.6 million
Estimated People Living with HIV/AIDS**	3,700
Adult HIV Prevalence**	<0.1%
<b>Yemen</b>	
Total Population*	23.5 million
Estimated People Living with HIV/AIDS***	318
Adult HIV Prevalence**	<0.2 % <sup>1</sup>
<b>HIV in Most-at-Risk Populations</b>	
Prison Population, National, 2007**	>10%
FSWs, National, 2006**	1.6%
*U.S. Census Bureau 2010 **UNAIDS 2008 ***UNGASS	
Note: <sup>1</sup> This number reflects the confidence interval reported.	

HIV cannot be transmitted by mosquito bites or by sharing food. At the end of 2007, there was no available estimate of Jordan's ART coverage for HIV-infected people.

At 0.1 percent, **Lebanon** also has a low HIV prevalence rate among the general adult population; approximately 3,000 individuals are estimated to be living with HIV/AIDS. HIV prevalence is estimated to be 1 percent among MSM; estimates for other vulnerable groups are not available (UNGASS, 2010). Recent biobehavioral surveys reveal that despite high knowledge of HIV transmission, MARPs still engage in high-risk behavior. For example, a major concern is the overlap of injecting drug use and sex work, which appears to be facilitating the spread of HIV. By the end of 2007, 26 percent of HIV-infected people were receiving ART.

An estimated 21,000 people are living with HIV/AIDS in **Morocco**, where the adult prevalence among the general population is 0.1 percent. Estimates of commercial sex workers have been higher, with 2.6 percent infected with HIV in the capital, Rabat, and an estimated 2.1 percent infected nationally. Another main mode of HIV transmission in the country is through IDU exposure to contaminated drug-injecting equipment; nearly 7 percent of IDUs are estimated to be HIV infected. In a recent survey, 53 percent of IDUs reported using sterile equipment the last time they injected; however, just 13 percent reported using a condom during their most recent episode of sexual intercourse. Some declines in HIV prevalence have appeared among at least one vulnerable population: Between 2002 and 2007, HIV prevalence among prisoners declined from 1.2 percent in 2002 to 0.6 percent in 2007 (UNAIDS, 2009). By the end of 2007, 31 percent of HIV-infected people were receiving ART.

**Tunisia's** smaller epidemic is concentrated among IDUs, with the primary route of HIV transmission in the country being through IDU exposure to contaminated drug-injecting equipment. An estimated 3,700 people are living with HIV, and prevalence among the general adult population is estimated at less than 0.1 percent. By the end of 2007, 29 percent of HIV-infected people were receiving ART.

Data are sparse regarding the epidemic in the **West Bank and Gaza**, with prevalence among the general population and MARPs largely unknown. It is estimated that 52 percent of HIV transmission occurs via heterosexual sex, 1 percent via homosexual sex, 4.7 percent via injecting drug use, and 17.6 percent via blood and blood products transfusion. Similar to other countries in the region, most women are infected by their husbands, and women are vulnerable to infection earlier in life, with the average age at HIV infection among women nearly a decade younger than that among men. Key areas of concern include rising drug use since 1994 and a large youth population with low levels of comprehensive knowledge of HIV and high levels of misinformation.

Official UNAIDS estimates indicate HIV prevalence is less than 0.2 percent among the general adult population in **Yemen**, and the latest UNGASS report indicates there were 318 cases in 2009 (UNGASS, 2010). HIV prevalence reportedly exceeds 10 percent among the general prison population (UNAIDS, 2009, citing Dolan et al., 2007). About 1.6 percent of the national population of FSWs are infected with HIV (UNAIDS, 2009), and estimates from multiple studies have ranged from 1.3 percent to 7 percent (UNAIDS, 2009, citing Abu-Raddad et al., 2008). By the end of 2007, there was no UNAIDS estimate available of Yemen's ART coverage for HIV-infected people.

### **Economic and Social Impact of HIV/AIDS in the Middle East**

Illness, disability, and death associated with the HIV/AIDS epidemic have harmful economic and social effects. The vast majority of people who have the disease are between the ages of 15 and 49, and young people ages 15 to 24 make up half of all new cases. The prevalence of the disease among young, otherwise healthy adults poses challenges to the systems for supporting dependent populations, such as children and the elderly. At most, the region may face an increase in prevalence of a few percentage

points in several countries. However, this represents a significant disease and economic burden in a region that is largely unprepared for such an epidemic. For example, the World Bank (2010) estimates that if unchecked, the prevalence rate in Jordan could reach 3.7 percent by 2015. If the epidemic were to reach this level, the economic and social effects would ultimately have an impact on the country's capacity to achieve Millennium Development Goal 6: to reduce the spread of HIV/AIDS (UNGASS Report on Jordan, 2010).

### **National/Regional Response**

All nine USAID priority Middle East countries have approved national strategies and programs to address HIV/AIDS. However, in the majority of the region, the AIDS response is inadequate. Primarily, monitoring efforts in the region must be strengthened. Biobehavioral surveys need to be regularly conducted among most vulnerable populations, and survey results should be monitored over time. Additional research on the size and distribution of priority populations should be implemented as well. Particular attention is needed for studies on vulnerable populations, such as young people between the ages of 15 and 24, who represent one-fifth of the population in the region. Finally, mathematical modeling and cost-effectiveness studies are needed to explore HIV dynamics and predict intervention impacts.

The region also needs to strengthen civil society contributions to HIV efforts, including contributions from nongovernmental organizations (NGOs), community-based organizations, and PLWHA. Their outreach is particularly important given the reality that HIV exists largely in MARPs that are highly stigmatized and hidden.

Particular attention is needed in increasing ART coverage. Just 14 percent of people in need of treatment were receiving ART in 2008 in the Middle East and North Africa, which is less than half the global average for low- and middle-income countries. Women and children are particularly vulnerable. Less than 1 percent of pregnant women in MENA received an HIV test during pregnancy in 2008. These low HIV testing rates may be due in part to the lack of policies promoting the routine offer of an HIV test to women in low-prevalence epidemics. Of all regions in the world, coverage rates among women and children were lowest in MENA, where about 1 percent of pregnant women living with HIV, 1 percent of infants born to women with HIV, and 6 percent of children living with HIV received ART (WHO/UNAIDS/UNICEF *Towards Universal Access*, 2009). ART service coverage expansion is also slower in MENA compared with other regions: Coverage rose from 11 percent to 14 percent between 2004 and 2008, compared with the more than fourfold increase globally during the same time period.

However, because they are financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria, the USAID focus countries in MENA — with the exception of Lebanon, which does not receive Global Fund financing — have higher rates of ART coverage compared with the overall rate of coverage throughout MENA (including both Global Fund- and non- Global Fund-financed countries). With the exception of Lebanon, the USAID focus countries are the only countries in the MENA region to receive Global Fund support.

Despite the crucial need to improve response to the HIV/AIDS epidemic throughout the region, it is evident that the USAID focus countries in MENA have made progress toward addressing the epidemic in their strategies and programs, including the development of standardized protocols for conducting behavioral surveys. For example, the Government of Algeria adopted its National Strategic Plan against STI and HIV/AIDS (2008–2012), which focuses on a nationally coordinated response and on strengthening prevention interventions for HIV/AIDS and STIs, promoting VCT, and enhancing overall care of people living with HIV. Other specific examples are listed below.

- Egypt developed a national HIV surveillance plan in 2004, and during 2008, a national disease surveillance system was created in 13 governorates to collect and analyze data on 26 priority infectious diseases, including HIV. These databases are still under development.
- Recently in Jordan, the Ministry of Education included an HIV/ AIDS curriculum in the middle school and secondary school systems. The country has also integrated an HIV/AIDS strategy into its general development plans, including the National Development Plan. In 2008, Jordan's National Center for Human Rights conducted three workshops to review the country's general legislation and examine its capacity to protect the rights of PLWHA.
- In Lebanon, the National AIDS Control Program — in collaboration with civil society, PLWHA, government, and donors — has developed National Operational Plans for Youth and PLWHA and is in the process of developing a national policy to prevent mother-to-child transmission. To strengthen strategic information, Lebanon recently conducted various studies, research, and assessments, including a 2008 biobehavioral survey among MARPs, a 2008 national prison assessment on HIV and drug use, case studies among MARPs, and an impact assessment on behavior change among sex workers.
- Morocco made progress in increasing the number of people receiving HIV counseling and testing between 2001 and 2007 (from 1,500 to 35,458) (UNAIDS, 2009). In addition, Morocco is one of at least two countries in the region to offer needle and syringe programs for IDUs.
- Tunisia's National Strategic Plan (2006–2010) aims to intensify prevention and treatment programs through increasing political engagement, collaborating with civil society, and improving monitoring and evaluation efforts.
- In 2002, Yemen further revised its National Strategic Framework in 2009 to incorporate emerging challenges, including inadequacy of official and religious speech on HIV and AIDS; weak financial support; inadequacy of communications with the media; and the lack of a national plan and mechanisms to fully implement the country's HIV/AIDS strategy. A national prevention of mother-to-child transmission program was launched in early 2009. In addition, Yemen has also made progress in promoting knowledge of HIV serostatus, with the number of people receiving HIV counseling and testing increasing 18-fold between 2007 and 2008, from 121 to 2,176 (UNAIDS, 2009).

Other international donors addressing the epidemic in the Middle East include the Global Fund, which has approved more than \$506.9 million to the MENA region. The U.S. Government (USG) provides nearly 30 percent of the Global Fund's contributions worldwide.

### **USAID Regional Support**

Through USAID, the Middle East has received \$1.3 million in fiscal year (FY) 2009 for essential HIV/AIDS programs and services. The Agency's HIV/AIDS programs in the Middle East are implemented as part of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Launched in 2003, PEPFAR is the USG initiative to support partner nations around the world in responding to HIV/AIDS. Through PEPFAR, the USG has committed approximately \$32 billion to bilateral HIV/AIDS programs and the Global Fund through FY 2010. PEPFAR is the cornerstone of the President's Global Health Initiative (GHI), which commits \$63 billion over six years to support partner countries in improving and expanding access to health services. Building on the successes of PEPFAR, GHI supports partner countries in improving health outcomes through strengthened health systems, with a particular focus on improving the health of women, newborns, and children.

The International HIV/AIDS Alliance's **MENA Men Who Have Sex with Men and Most-at-Risk Populations Project** responds to the sexual health needs of MSM and MARPs by working directly with civil society organizations and local stakeholders. The Project has been funded continuously by the

Middle East Bureau for the past six years. As the implementing partner, the Alliance provides technical assistance to local, indigenous NGOs on the implementation of HIV prevention- and advocacy-focused programs for MARPs. The implementing NGOs have strong connections with the appropriate health and HIV departments of the national governments and with regional and international HIV advocacy and support organizations. All activities for the project are planned with the Regional Resource Group and conducted collaboratively with local, national, and international HIV organizations, including the USAID-supported MENA People Living With HIV network, the Regional Arab Network Against AIDS, UNAIDS, and the United Nations Development Program.

The project continues to support six civil society implementing partners in the ongoing implementation of STI/HIV prevention activities, which address the specific vulnerabilities of MSM in the four countries in the region (Algeria, Morocco, Tunisia, and Lebanon). In 2010, the program's reach expanded in Tunisia and Lebanon, with volunteers being trained in new sites to work with MSM. The partners in Algeria and Morocco have strengthened activities in existing sites and conducted capacity building of local organizations to lead prevention work with MSM in what remains a very challenging context.

The Alliance held discussions with other organizations with a view of building new partnerships that could potentially expand the prevention response to other vulnerable groups in the region. In addition, it continued to strengthen existing activities and emphasize advocacy work at the national and regional levels to influence institutional and organizational environments, while working to develop best practice models that can be shared across the MENA region. This will contribute to a stronger and more sustainable response to HIV programming for MARPs (including MSM) at the local, national, and regional levels. To date, the Project has reached more than 12,000 MSM, health providers, community members, leaders, and social workers through health promotion and outreach activities.

The International HIV/AIDS Alliance provides technical support to local partners on the design, planning, monitoring, and implementation of their programs, including guidance on inclusion of MARPs and PLWHA in their program staff and development. This support may include advice, orientation to other experts, and the sharing and reviewing of tools and other locally produced documents. The Alliance also works with local partners to develop and sustain prevention programs that consist of peer education activities, outreach work, the establishment of safe spaces to enable MARPs to meet, group discussions, condom and lubricant distribution, the sensitization and training of health providers, behavior change communication activities, and advocacy activities.

The MENA MSM and MARPs Project conducts regional workshops and supportive supervision activities to build capacity among partners. Old and new project volunteers and staff are trained in participatory prevention methodology and peer education techniques. Distributions of condoms and lubricants (when available) have continued as part of the Project's outreach and peer education work. Partners have negotiated donations from local sources, such as National AIDS Programs and other multilateral partners; in addition, lubricants are being procured on an ongoing basis. Mobile prevention and/or VCT activities are in operation in several countries, ensuring a wider reach of VCT services for MSM and other MARPs. Telephone hotline and Web-based information sharing and support services were also implemented in Tunisia and Lebanon. Furthermore, many of the first-ever MSM-focused health information and human rights materials for the Middle East have been developed by the project partners and shared throughout the region.

The Health Policy Initiative (HPI) continued to provide support to PLWHA in the MENA region through its **Investing in People Living with HIV Leadership Project**, which has been supported by the Asia (A) and Middle East (ME) Bureaus for the past five years. There have been few PLWHA in the Middle East engaged in the policy and programmatic decision-making processes and able to act as advocates for the right to health, social services, and protection from stigma and discrimination. With funding from previous

years, however, the A/ME Bureaus supported the POLICY Project, and subsequently HPI, in creating a cadre of PLWHA leaders at the national and regional levels who were effectively trained and supported in becoming advocates in the response to HIV/AIDS in the region.

One objective of the Project is to ensure that those directly affected by HIV have a leadership role in policy dialogue, program implementation, and the building of a supportive environment in their communities, countries, and regions. To this end, the Project has supported the development of PLWHA leaders at the country and regional levels in MENA by (1) building the capacity and skills of PLWHA in areas, such as advocacy, stigma and discrimination reduction, care and treatment, and organizational management (2) fostering national and regional support networks; (3) increasing the number of people in the region who have accurate and culturally appropriate HIV-related information; (4) strengthening participants' ability to address challenges in their countries; and (5) developing training curricula that specifically address knowledge and leadership capacity needs of PLWHA in the MENA region, while promoting knowledge transfer by and for PLWHA for implementation and support of country-level activities.

Throughout the life of the Project, HPI has supported the development of national and regional PLWHA support groups and networks. The Project has engaged more than 100 PLWHA from 15 countries in MENA through regional workshops and training activities, peer-to-peer education and counseling support, and the development and promotion of an Arabic-language PLWHA Web site. Additionally, PLWHA groups have received technical support in the form of training and workshops, many of which were the first services ever implemented by and for PLWHA in MENA. Support groups and networks also received financial and capacity building support via small-grant training and implementation mechanisms.

#### **Important Links and Contacts**

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