Regional Bureau for Arab States
HIV/AIDS Regional Program in the Arab States

Saving Lives,
Saving Money

The Private sectors' Response to HIV/AIDS in the Arab Region

UNDP/HARPAS (English original, March 2006)

1191 Corniche El Nil, World Trade Centre
Boulac, Cairo, Egypt
P.O. Box: 982, Post Code: 11599
Tel.: +202 5791 733
Fax: +202 5784 847
www.harpas.org

The analysis and policy recommendations of this Report do not necessarily reflect the views of the United Nations Development Programme, its Executive Board, or its Member States.

The mention of specific companies does not imply that they are endorsed or recommended by UNDP in preference to others of a similar nature that are not mentioned.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of UNDP concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

UNDP does not warrant that the information contained in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use.

The Global Health Initiative's Private Sector Intervention Case Examples have been reproduced with kind permission of the World Economic Forum/Global Health Initiative.

Designed by: Mohamed El Ghamrawy

Saving Lives, Saving Money
The Private sector's Response to HIV/AIDS in the Arab Region

TABLE OF CONTENTS

TABLE OF FIGURES

TABLE OF BOXES

TABLE OF ANNEXES

FOREWORD

Dear Reader,

The AIDS epidemic is haunting the world. Over the past two decades thousands of people have died of HIV/AIDS. Today across the globe, there are millions of women, men and children infected with this disease. No region across the world can claim that it is immune from the attack of AIDS. The Arab region is no exception.

Many in the Arab world feel that AIDS is not an issue to worry about - due to its relatively low prevalence rates in the region. This is a fatal misconception. The high risk factors that fuel the spread of HIV/AIDS have created a threat to development in many parts of the world. This requires a pro-active response. The Arab world, including all sectors, should not hesitate to show resolve in standing up to face this epidemic.

Private companies operating in this region have a unique opportunity to become a pro-active stakeholder, along with the rest of society, in the response to HIV/AIDS**. There are lessons to be learned from the experiences of private companies in other parts of the world in dealing with the spread of the HIV/AIDS epidemic and its negative effect on basic infrastructure, investments and the business environment. To serve their own interest and those of their societies, the best and brightest from the Arab business world must now join hands and exert maximum effort to halt and reverse the spread of HIV/AIDS.**

The **League of Arab States** is committed to combating HIV/AIDS. In partnership with the UNDP/HIV/AIDS Regional Programme in the Arab States (HARPAS), the League of Arab States has placed HIV/AIDS as one of three major health priorities in the Arab world.

The League of Arab States is proud to support efforts aimed at strengthening the regional multi-sectoral response to the threat of HIV/AIDS, on several fronts, including initiatives with Religious Leaders, Legal Experts, Arts and Media experts and all visionary figures in the region. The Arab League is dedicated to policy change, addressing HIV/AIDS as a **development**, **human rights** and **governance** issue. The Private Sector is a crucial player in our joint effort and must be engaged to contain the spread of HIV/AIDS and its devastating impact.

In light of the new UNDP/HARPAS Private Sector initiative, **the League of Arab States strongly encourages private companies operating in the Arab region to join us in our efforts to reverse the spread of the epidemic.** The League of Arab States believes the involvement of the private sector in the regional response to HIV/AIDS could create a truly multi-sectoral and more effective response.

H.E. Ambassador Amre Moussa
Secretary-General
League of Arab States

FOREWORD

HIV/AIDS will kill more people this decade than all of the wars of the past 50 years. The HIVAIDS epidemic has proven that no community, country or continent is immune from its deadly impact. Transcending traditional borders of state, HIV/AIDS shatters the security of societies to reverse development gains, undermine social and economic prosperity, and unravel the very fabric of family life.

Despite still low prevalence rates in the Arab region, one new HIV infection occurs every 20 minutes. Some 540,000 people live with the disease in the Arab region and with 92,000 new HIV infections last year alone, Arab states have one of the fastest growing HIV infection rates in the world. This is combined with six-fold increase in AIDS related deaths since the early 1990s, if this trend continues the effects on economic potential and human development in the region could be devastating.

HIV/AIDS strikes the young, upwardly mobile and most productive members of our society. Therefore, HIV/AIDS not only takes away the present, but it takes away the future. In the Arab region , those most vulnerable to HIV/AIDS infection are between the ages of 15-49, thereby shifting demographics that decimate years of development, investment, talent and intellectual wealth of nations. Moreover, destabilizing forces such as unemployment, mobility and conflict weaken social structure and place people at increased risk for HIV infection. Lack of information, stigma and silence, and false sense of security surrounding HIV/AIDS in the Arab region create a deadly environment for the rapid infection rates witnessed today.

In the addition to the human toll, the impact of HIV/AIDS on economics prosperity and development cannot be ignored. A recent World Bank study on the macro-economics impacts from HIV/AIDS shows that in the 9 Arab countries, GDP losses could total over 35% of today's GDP by the year 2005 if urgent action is not taken immediately. Globally, business leaders are increasingly concerned about HIV/AIDS and its effects on commerce. They understand that HIV/AIDS reduces productivity, resulting in lost revenues and increased business costs. Prudent, forward thinking businesses want to act now, to do their part to stem the further spread of HIV/AIDS epidemic. UNDP's Regional Bureau for the Arab states has recognized business leaders as critical partners in the regional HIV/AIDS response. We believe that the entrepreneurial, spirit that has created business success stories in the region can also be used to turn the tide of the current HIV/AIDS epidemic.

With our growing range of partners, from the league of Arab States to the regions' highest level of Religious Leadership, the business sector also occupies an important place at the decision making table. Firms must ask important questions related to corporate responsibility, requirements, responsiveness and the comparative consequences of action and inaction. This report focuses on the such questions and outlines the benefits and costs of tackling HIV/AIDS with smart interventions that make real business sense.

It is our hope that together we can make a difference in the Arab world. This study is our invitation to you, your business and your employees, to join us in the HIV/AIDS response as responsible citizens and leaders in our society.

Rima Khalaf Hunaidi
Assistant Secretary-General and Director
Regional Bureau for Arab States

LIST OF ACRONYMS

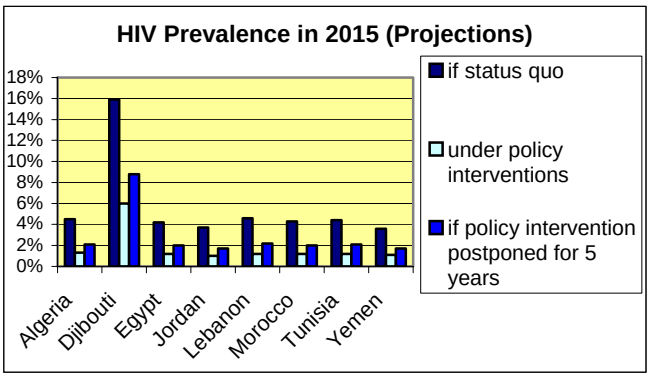
AAA	Awareness Against AIDS
ABC on AIDS	Asian Business Coalition on AIDS
AFTA	Arab Free Trade Area
AIDS	Acquired Immunodeficiency Syndrome
ALCS	Association de Lutte Contre le SIDA
ALO	Arab Labor Organization
AMCHAM	American Chamber of Commerce
AMF	Arab Monetary Fund
AMU	Arab Maghreb Union
ART	Anti-Retroviral Treatment
ARV	Anti-Retrovirals
ASEAN	Association of South East Asian Nations
ATL MST/SIDA	Association Tunisienne de Lutte contre les MST et le Sida
BCM	Billion Cubic Meters
BEAD	Business Exchange on AIDS and Infectious Diseases
BIT	Bilateral Investment Treaties
BRSP	Bureau for Resources and Strategic Partnerships
CCM	Country Coordinating Mechanisms
CDG	Capacity Development Group
CGEM	Confédération Générale des Entreprises Marocaines
CIDA	Canadian International Development Agency
CNRS	Centre National de la Recherche Scientifique
CSW	Commercial Sex Worker
EIRIS	Ethical Investment Research Services
ERF	Economic Research Forum
ESCWA	Economic and Social Commission for Western Asia
ETG	Expanded Theme Group
FAO	Food and Agriculture Organization
FDI	Foreign Direct Investment
FEDA	Federation of Economic Development Associations
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FHI	Family Health International
FSW	Female Sex Worker
FTA	Free Trade Agreements
GAFTA	Greater Arab Free Trade Agreement
GBC	Global Business Coalition
GC	Global Compact
GCC	Gulf Cooperation Council
GDP	Gross Domestic Product
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GHI	Global Health Initiative
GNP	Gross National Product
GTG	Gajah Tunggal Group
HAART	Highly Active Anti-Retroviral Therapy
HARPAS	HIV/AIDS Regional Programme in the Arab States
HCT	Hotel Catering and Tourism
HIV	Human Immunodeficiency Virus
IBRD	International Bank for Reconstruction and Development

IDP	Internally Displaced Person
IDRC	International Development and Research Center
IDU	Injecting Drug User
IFC	International Finance Corporation
IGAD	Intergovernmental Authority on Development
ILO	International Labor Organization
IPR	Intellectual Property Rights
IRD	Institut de Recherche et de Développement
MENA	Middle East & North Africa
MERCOSUR	Southern Common Market (Argentina, Brazil, Uruguay, Paraguay)
MOHP	Ministry of Health and Planning
MSM	Men having Sex with Men
MTCT	Mother to Child transmission
NAFTA	North American Free Trade Agreement
NANASO	Northern African Network of AIDS Service Organizations
NAP	National Aids Program
NBA	National Business Alliance
NBR	National Bureau of Asian Research
NGO	Non-Governmental Organization
OPEC	Organization of Petroleum Exporting Countries
PEP	Post-Exposure Prophylaxsis
PLWHA	People living with HIV/AIDS
RANAA	Regional Arab Network Against Aids
RBAS	Regional Bureau for Arab States
SME	Small and Medium Enterprises
SURF	Sub-Regional Resource Facility
TIFA	Trade and Investment Framework Agreements
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Fund for Population
UNICEF	United Nations Children’s Fund
UNIDO	United Nations Industrial Development Organization
UNODC	United Nations Office on Drugs and Crime
UNRISD	United Nations Research Institute for Social Development
VCCT	Voluntary Confidential Counseling and Testing
WB	World Bank
WEF	World Economic Forum
WFP	World Food Programme
WHO	World Health Organization
WHY	World Hunger Year
WTO	World Trade Organization

EXECUTIVE SUMMARY

Reasons for the Private Sector operating in the Arab region to get involved in the Response to HIV/AIDS

Many studies insist on the necessity to immediately take measures in response to HIV/AIDS, and one better understands this great need when made aware of the projections of the epidemic. Because of the serious lack of data on HIV/AIDS in the MENA region, projections are only available in certain countries, as indicated in the chart below.



HIV/AIDS impacts are likely to concentrate on young adults in their most productive years. Thus, AIDS is projected as having the potential to become the second major cause of death among adults of working age in the world – including the Arab world – posing a serious economic threat.[1]

The epidemic is eroding productivity just at the time when developing countries, including most of the Arab countries, need to become more competitive to cope with rapid globalization. In the private sector, this raises the costs of business and deters investment.[2]

Loss of trade partners & investors

On both a national and regional level, business seeks stability and certainty to support investment in operations and new markets. AIDS is a direct threat to such a foundation. The intensification of the Arab region's trade influx and economic collaboration with other regions of the world could generate, in case of a further epidemic spread, financial complications not only for the Arab countries, but for investors as well. Comparative advantages that allow certain Arab countries to attract foreign investors such as a great availability of skilled and/or unskilled low cost labor could disappear because of HIV/AIDS. According to a recent report of the National Bureau of Asian Research, HIV/AIDS might destabilize the flow of migrants towards labor importing countries, namely the Gulf countries.[3] The decrease of foreign labor would therefore oblige these countries to diversify their economies by using domestic labor, which would generate an increase in the costs of labor, thus jeopardizing the competitiveness of companies operating in the sub-region. Arab countries as well as foreign investors would have to cope with the financial consequences of such an epidemic, and the latter would lose a great number of sources in cheap and profitable investment.

[1] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction,* 2003 The International Bank for Reconstruction and Development / The World Bank, p.53

[2] www.worldbank.org

[3] Laura M. Kelley and Nicholas Eberstadt, *Behind the Veil of a Public Health Crisis: HIV/AIDS in the Muslim World*, National Bureau of Asian Research, June 2005, p. 8

Loss of workforce & customers

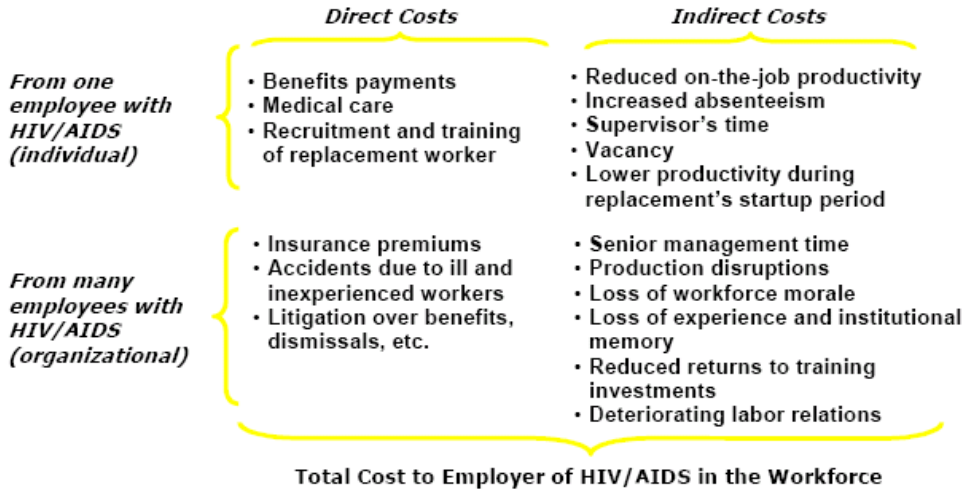
On one hand, HIV/AIDS could have effects on the size and productivity of the current labor force because of higher mortality and morbidity. On the other hand, HIV/AIDS could affect the accumulation of future human capital. The private sector must realize that its best asset, its functionality and working capital – in other words its present and future workforce – are greatly endangered. If nothing is done now, companies might experience difficulties in 15 to 20 years to find skilled or non-skilled workforce in the Arab region.

Another unfortunate but logical consequence of the pandemic is the reduction of consumption. HIV often strikes the breadwinner and his/her family will have no choice but to spend their savings on medicine, treatment and care. In other words, the epidemic is eroding the demand for goods and services in developing markets, meaning that companies are losing or will lose their customers.[4] Companies might therefore experience difficulties in finding customers for their products or services, and will suffer great losses in terms of results and profits.

Example of costs generated by HIV/AIDS on regional companies

The costs of measures and policies to be implemented against HIV/AIDS vary according to the profile of the company. While there is some common ground, the potential impact of the disease will differ from firm to firm.[5] Clearly, the total impact of direct costs on firms will vary depending on factors such as whether firms provide worker protections like in-house medical facilities, ARVs, employment benefits, funeral costs, pension accounts, etc. Many of the more serious costs of the pandemic cannot be measured by traditional cost accounting mechanisms, but some studies show that these indirect costs can represent up to 200 percent of the direct costs.[6]

Thus, the costs of HIV/AIDS on business could be summarized as follows:



Source: Frank Feeley, Paul Bukuluki, Alizanne Collier, Matthew Fox, *The Impact of HIV/AIDS on Productivity and Labor Costs in Two Ugandan Corporations*, October 2004, p.9

[4] Sydney Rosen, Jonathan Simon, William Mac Leod, Matthew Fox, Donald M. Thea, Jeffrey R. Vincent *AIDS is Your Business*, Harvard Business Review, February 2003

[5] *Opportunities for Business in the fight against HIV/AIDS*, GBC, University of Cape Town, Columbia University, January 2005

[6] Neesa Moodley, Business Report, *Absenteeism costs R12bn a year, with up to R2.2bn due to AIDS*, February 2005

Private companies operating in other regions of the world have seriously analyzed the costs presented above. The immediate consequences and the burden generated by HIV/AIDS on their daily business activities encouraged some of them to conduct comprehensive studies on the most appropriate and cost-effective ways to respond to the epidemic. Most of these studies, conducted on companies operating in Sub-Saharan African countries, agree on the fact that "responses that are good for health – prevention and treatment – are good for businesses".[7]

HIV/AIDS Prevention & Treatment measures proven to be profitable investments

Regional companies with different professional activities and operating in different Arab countries agreed to participate in a cost simulation on the implementation versus the non-implementation of measures responding to HIV/AIDS in their own branches across the Arab world. The results of these simulations over the period of 2005-2015 clearly demonstrated that in several Arab countries, the costs generated by HIV/AIDS could be reduced by up to 53 percent if the companies decide to respond to HIV/AIDS through prevention, treatment, and care rather that not responding at all, or by terminating the contract of the employees living with HIV.

The Arab region is not an exception to HIV/AIDS

The countries of the MENA region are increasingly interconnected and are also fostering economic exchanges with other regions of the world as shown in section 1. The developments in section 2 demonstrate that there is no proof today that the MENA region is less vulnerable to HIV/AIDS than other already affected regions of the world, regardless of the size of its population, its religion, its standard of living, or its political situation. As a major and growing segment of society, the private sector operating in the region can expect to have a serious impact of HIV/AIDS on its activities.

Arab society presents many inherent structural factors that have proven to generate a conducive environment for the spread of HIV/AIDS. Structural vulnerabilities include poverty, unemployment, unequal gender relations, poor access to social services and education, mobile populations, armed conflicts, commercial sex work, poverty, and a high number of youth. With this socio-economic structural vulnerability come high-risk behaviors, including certain sexual behaviors (especially among youth) and injected drug use.

Nevertheless, one of the greatest risks comes from the fact that the authorities have not yet implemented appropriate and relevant surveillance methods, and consequently do not have a clear picture of infection rates. Because the epidemic is not appropriately monitored and the risks underestimated, the response is inadequate.

A survey of the World Economic Forum reports that Middle Eastern and North African firms are among the least concerned in the world about the current and future impacts of HIV/AIDS on their activities. Indeed, only 13 percent of firms in the MENA region reported a current impact on their activities, while 74 percent expect none in the next five years.[8] Another survey from the WEF shows that 99 percent of firms that estimate HIV/AIDS infection

[7] Sydney Rosen, Jonathan Simon, William Mac Leod, Matthew Fox, Donald M. Thea, Jeffrey R. Vincent *AIDS is Your Business*, Harvard Business Review, February 2003

[8] *Business & HIV/AIDS: A Healthier Partnership? - A Global Review of the Business Response to HIV/AIDS 2005-2006*, World Economic Forum/ Global Health Initiative, January 2006, p.25

among their workforce (which represents less than 3 percent of all the firms in the region) believe the infection rate is below 1 percent, and fewer than 3 percent believe they have seen any significant impact on costs, productivity, and revenue.[9]

According to a report of the World Bank, these results can be explained not by the absence of consequences from the epidemic on businesses but by the fact that short-term economic impacts are lower in countries with high unemployment rates.[10] In other words, private companies wrongly interpret the lack of visibility of economic consequences – generated by the high unemployment situation – as a lack of risk and potential economic losses by private companies. This prevents companies from adopting appropriate HIV/AIDS policies. If the MENA region would experience full employment, private businesses operating in the region would probably have already felt the impact of the epidemic on their activities, and would have possibly responded. This implies that activities of private businesses operating in the region are already affected by the epidemic while its future or potential employees are being infected. Even though the evolution of the epidemic is unpredictable, tangible costs could appear only in a few years. And these costs will be as high as determined by the rate of the sector's response.

Added value of the private sector's involvement in the response to HIV/AIDS, and a brief look at the current – and limited – regional initiatives aiming at fostering this response

Even though the primary impact of business involvement is generally an immediate influx of resources, it is crucial to be aware of the secondary impact of this involvement, which is an immense level of expertise on outreach.

On one hand, private entities employ an increasing percentage of the Arab population, and an individual will generally be easier to reach as an employee rather than as a citizen. In other words, the fact that a growing number of people are part of private companies makes it easier to get in contact with them and to spread messages and relevant information to prevent the spread of HIV/AIDS. On the other hand, private entities have the ability to extend this outreach to the rest of the community. According to Professor Diana Barrett from the Harvard Business School: "The unique capabilities of businesses give to this sector new responsibilities: the same companies that have distribution network, the skill set and the financial acumen to make certain companies' products available in every minuscule African town, have the ability to apply these capabilities to the problem of HIV/AIDS, with an efficiency, flexibility, and speed that governments can simply not match."[11]

UN agencies

Generally, UN agencies agree that they only recently became involved with AIDS in the Arab region, except the WHO that has been involved for more than 15 years. According to UNAIDS Regional Office for the Middle East and North Africa, the initiatives of the ten UNAIDS cosponsoring organizations[12] whose aim is to involve the private sector operating in the region in the response to HIV/AIDS are very limited in the Arab region.

---

[9] *A Global Review of the Business Response to HIV/AIDS 2004-2005*, World Economic Forum/Global Health Initiative, January 2005, p.23

[10] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, The International Bank for Reconstruction and Development / The World Bank, 2003, p.55

[11] Interview of Professor Diana Barrett by the Harbus Online team, *Corporate partnerships to combat HIV/AIDS*, May 2005

[12] ILO, UNESCO, UNDP, WFP, WB, UNFPA, UNICEF, UNODC, WHO, UNHCR

Currently, the only UN agencies that have initiatives specifically targeting the private sector in the Arab region are the ILO and UNICEF. Other agencies like the WHO, the WB, UNESCO, WFP have a limited collaboration with private companies operating in the region.

We have to clarify the fact that many UN cosponsoring agencies have important and efficient initiatives fostering the private sector's response to HIV/AIDS in other regions of the world, or are working on the response to HIV/AIDS with other stakeholders in the Arab region. However, even though many UNAIDS cosponsors receive financial support from private companies operating in the Arab region, these agencies are currently the only ones with such initiatives when it comes to HIV/AIDS and the private sector in the Arab region.

International Organizations

In addition, CARE, the Global Fund to fight Aids Tuberculosis and Malaria (GFATM), the Global Compact, the Association Tunisienne de Lutte contre le Sida et les Maladies Sexuellement Transmissibles (ATLS MST SIDA), the Association de Lutte Contre le Sida au Maroc (ALCS), and – in a more limited way – Family Health International (FHI), are the only organizations identified with initiatives aiming at fostering the private sector's response to HIV/AIDS in the Arab region.

Corporate initiatives

As stated above, only 3 percent of private companies have a written policy against HIV/AIDS. Not surprisingly, most of these initiatives come from multinational companies, mainly because of the limited financial resources of smaller private entities. It is possible – though doubtful – that some national companies or SMEs operating in the Arab region implement HIV/AIDS policies. However, the lack of documentation from these entities prevents us from accurately reporting these initiatives.

In other regions of the world some very effective responses include the formation of national or international business coalitions or associations. So far, 44 coalitions are operating world-wide[13], like the Global Business Coalition against HIV/AIDS (GBC), the Business Exchange on AIDS and Infectious Diseases (BEAD), or the Asian Business Coalition (ABC on AIDS). These coalitions allow members of the business community to share best practices and to develop a coordinated response within the national strategy. Interestingly, this type of coalition – which does not yet exist in the Arab region – appears to be one of the most effective means to engage an increasing number of companies in the response to HIV/AIDS.

Main challenges and needs to be met in the implementation of HIV/AIDS policies by private companies

As once stated by the Global Business Coalition, "businesses, globally, are doing 5 percent of what they could do."[14] Figures stated in this report among others demonstrate that Arab businesses are doing less than this. However, companies do not always bear the responsibility for this lack of engagement. Due to its culture and traditions, involvement in the response to HIV/AIDS is a very sensitive issue in the MENA region, which requires preliminary conditions and appropriate justifications. Our research demonstrates that many companies throughout the MENA region are willing to get involved in the response to HIV/AIDS, through financial support to organizations, technical expertise or through the implementation

[13] *Guidelines for Building Business Coalitions against HIV/AIDS*, Global Business Coalition, Appendix 1
[14] Trevor Neilson, *Understanding the role of business in the Global AIDS crisis*, Global Business Coalition

of constructive and profitable HIV/AIDS policies. However, their willingness is sometimes diffused due to the need for 'politically correct' strategies that require the preliminary support of the government before tackling such a sensitive issue like HIV/AIDS.

Furthermore, the majority of the Arab workforce is employed in SMEs. Unlike regional or multinational companies, these SMEs generally have very limited funds – if any at all – to be allocated to HIV/AIDS policies. Most of their budgets are allocated to daily priorities, such as production, management, communications, etc. Paradoxically, SMEs in the Arab region will be the first entities to see their activities affected by the epidemic due to their high HIV/AIDS vulnerability. The pendant of the previous hurdle to the response to HIV/AIDS is simple but often-generalized lack of knowledge for companies in terms of HIV/AIDS policies.

Finally, the fact that HIV/AIDS is a strong taboo in the Arab region can make it particularly difficult for private companies to tackle the HIV/AIDS threat. Today, many employers, employees, people from the governments, decision-makers, and an important part of the Arab population in general view HIV/AIDS as a disease related to improper behavior rather than governance, human rights and development. As a consequence of this systematic stigma and discrimination, many private companies consciously decide not to engage themselves in the response to HIV/AIDS, fearing for their products or their image to be associated with the epidemic. Ironically, it is the very attempt of the companies to protect their activities by denying any impact of HIV/AIDS or any HIV/AIDS policy that may speed up the deterioration of their businesses.

One must ask: why would a company, after discovering an employee's HIV+ status, decide to terminate his/her contract? In light of the information mentioned above, the most likely answer appears to be neither an economic justification nor a moralistic one, but a mere lack of appropriate information; since an infected employee receiving a cost effective treatment can be perfectly productive for 15-20+ years, with a non-existent risk of spreading the virus to his/her colleagues since HIV is not contagious but rather, transmissible through sexual contact, shared needles or blood transfusion. A better understanding of the epidemic has already generated a positive response from partners in the multisectoral response to HIV/AIDS, including top-level Arab religious leaders from the Muslim and Christian world. This change of attitude from religious leaders of the Arab world allows us to think that the private sector, if provided with the appropriate information, tools and networks will join the various stakeholders – governments, religious leaders, NGOs, artists and media professionals, People Living with HIV/AIDS and civil society – already engaged in the response to HIV/AIDS.

Examples of possible response to HIV/AIDS from private companies

As a UNDP Resident Representative in the Arab region once stated: "there are no copyrights when it comes to good social engagement." Indeed, the response of Arab companies to HIV/AIDS does not require reinventing the wheel. Basic but efficient policies have already made a real difference and have allowed many countries worldwide to reverse the trend of the epidemic.

Concretely, a company's response can target different groups or populations. A company can decide to implement an internal policy focused on its employees and their families by providing information and raising awareness as well as providing care, support, and treatment to its infected and affected employees. Another possibility for companies is to adopt an external policy, which consists mainly in focusing on the communities where their employees

and consumers live. Of course, these two types of policies are perfectly compatible, and many companies implementing internal policies generally combine them into community outreach policies which also benefit the company. This latter approach involves direct cash or in-kind contributions to the HIV/AIDS prevention activities of governments and NGOs, as well as sponsoring different events (concerts, sports events, etc.). According to FHI, multinational corporations, large local businesses, and private foundations and institutions currently play a limited role in funding HIV/AIDS prevention and care in developing countries.[15] But a number of institutions are leading the way in contributing some of their profits to reduce the burden of HIV/AIDS prevention and care on the communities where their businesses are based.

The right question

Experts agree on the fact that private companies will have to sooner or later invest in policies against HIV/AIDS as they cannot separate their own interests from those of the societies in which they function. They will not be able to keep on operating in an economic bubble and will have to accept their responsibility as corporate citizens. The question is not "will private companies have to invest against HIV/AIDS?" but "how much and when will private companies have to invest against HIV/AIDS?" The answer depends on the characteristics of each company, but depends mostly on the ability of companies to react quickly. The longer they wait to implement appropriate measures and policies, the more they will have to invest in their late attempt to balance the situation. In other words, a preventive and proactive response is far less costly than a late response generating reactionary costs.

Private companies and foreign investors operating in the region should realize that MENA is one of the last regions of the world that has a monumental chance to maintain its low rates of HIV/AIDS prevalence, and hence low production costs. Many other regions in the world are experiencing a rapid spread of the epidemic, which has generated or will generate an increase in the costs of business for the coming years. In terms of human life, businessmen operating in the region must accept their prestigious role as corporate citizens and contribute to the health and wealth of future generations. Economically, local and foreign businessmen must act together to maintain low levels of HIV/AIDS infections in the very interest of their economic sustainability in the region.

The Arab region is at a crossroads in regards to the destiny of the HIV/AIDS epidemic, and the position adopted by the private sector will play a crucial role in the spread of HIV/AIDS. Maintaining low prevalence rates means, in less technical words, that business leaders in the region have a chance to offer a better life to future generations. Businessmen can decide to deny the problem, and to wake up in 10 years when – according to projections – many Arab countries will be facing a widespread epidemic affecting many of their employees and population. Or businessmen can begin to realize the urgency and necessity to apply specific measures addressing and tackling the problem of HIV/AIDS in the Arab region, in the interest of both their population and business activities. By working in close collaboration with other stakeholders (government, civil society, etc.), private companies can make a real difference in the response to HIV/AIDS by promoting and implementing the policies described in this report and working towards a collective change.

[15] Peter Lamptey, *Opinion: Expanding the Partnership -- The Private Sector's Role in HIV/AIDS Prevention*, Family Health International, 2005

INTRODUCTION

For more than two decades now, the HIV/AIDS epidemic has been expanding worldwide, leaving no country immune to its human, social, economic, political and cultural impact. Thus, more than 25 million people have already died from HIV/AIDS, and approximately 40.3 million are currently living with the virus worldwide.[16]

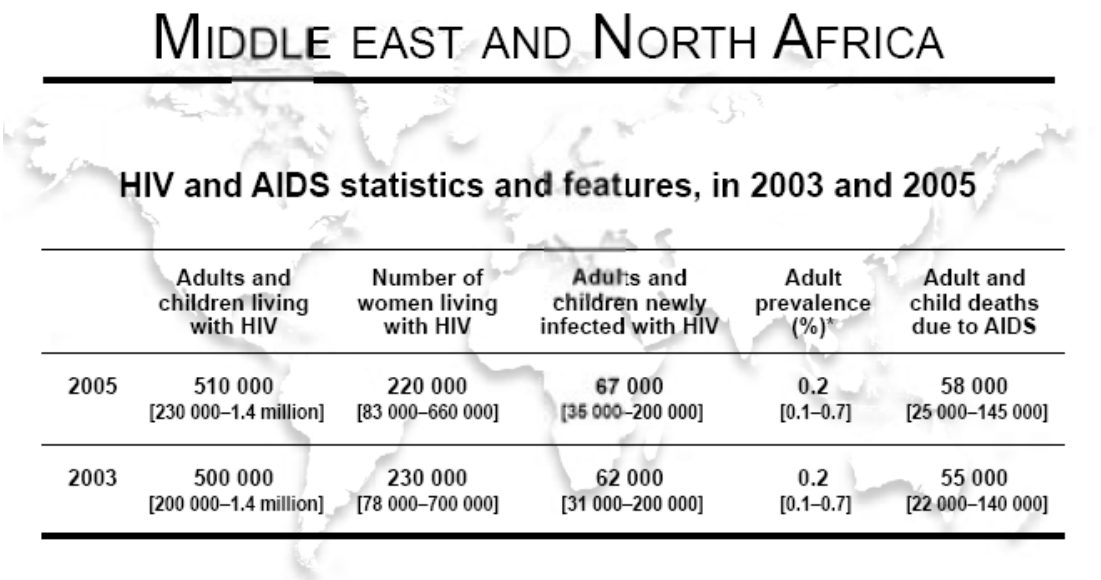
Trevor Neilson, Executive Director of the Global Business Coalition against HIV/AIDS, stated: "just as no country has remained totally untouched by AIDS, so too has no sector remained totally immune. HIV/AIDS is a critical issue for every company in the world today. The disease penetrates borders and threatens the world's emerging economies. Because HIV/AIDS kills so many adults in the prime of their working and parenting lives, it decimates the workforce, fractures and impoverishes families, orphans millions, and shreds the fabric of communities."[17]

Far from controlling the spread of the epidemic, all the regions of the world (except the Caribbean which witnessed no changes) reported an increase of the number of people living with HIV/AIDS in 2005. UNAIDS reports that 3.1 million people died from AIDS in 2005 and nearly five million people became newly infected with HIV during the same year, totaling more people than any previous year.[18] As a result, most of the countries in the world decided to react and to invest more significantly in the response to HIV/AIDS, reaching an amount of US$ 6.1 billion in 2004. This represented a 20-fold increase in investment since 1996. Even though this figure is far from being sufficient for meeting the needs of the countries to respond appropriately to HIV/AIDS – the Kaiser Family Foundation estimated that US$22 billion will be needed annually in 2008[19] – this amount already reflects awareness among the decision makers. Logically, the pace of this shift in mentality varies from one region to another, depending mainly on the impact HIV/AIDS is having on the people's daily life. Despite the increasing costs being generated or that will be generated by HIV/AIDS on businesses activities around the world, the private sector – which includes foundations, international NGOs and the business community – contributes to less than 5 percent of the financial response globally[20]. It should be noted, however, that the corporate sector does sometimes contribute to the HIV/AIDS response through workplace programmes not included in this figure.

In regards to the Arab region, the HIV/AIDS response is still limited. This is because indicators of the epidemic are still relatively low compared to other regions of the world, as seen in the chart below.

[16] *AIDS Epidemic Update*, UNAIDS, December 2005, p. 1-2
[17] *Opportunities for Business in the Fight against HIV/AIDS*, Global Business Coalition, January 2005
[18] *AIDS Epidemic Update*, UNAIDS, December 2005, p.1
[19] Jennifer Kates, *Financing the Response to HIV/AIDS in Low and Middle Income Countries: Funding for HIV/AIDS from the G7 and the European Commission*, Kaiser Family Foundation, July 2005, p.3
[20] *Ibid*, p.13

FIGURE 1: HIV/AIDS UPDATE SITUATION IN THE MENA REGION (END OF 2005)



HIV and AIDS statistics and features, in 2003 and 2005

	Adults and children living with HIV	Number of women living with HIV	Adults and children newly infected with HIV	Adult prevalence (%)*	Adult and child deaths due to AIDS
2005	510 000 [230 000–1.4 million]	220 000 [83 000–660 000]	67 000 [35 000–200 000]	0.2 [0.1–0.7]	58 000 [25 000–145 000]
2003	500 000 [200 000–1.4 million]	230 000 [78 000–700 000]	62 000 [31 000–200 000]	0.2 [0.1–0.7]	55 000 [22 000–140 000]

Source*: AIDS Epidemic Update*, UNAIDS, December 2005

In 2005 in the Arab region, approximately 58,000 people died from AIDS and 67,000 people became newly infected with HIV, bringing the total number of people living with the virus in the Middle East and North Africa region to approximately 510,000.[21] Bearing in mind that the Arab-Israeli conflict caused approximately 75,000 to 105,000 victims to date[22], HIV/AIDS may cause in the next 10 years approximately five times more deaths than the armed conflicts of Arab countries with Israel have over the last 50 years. These figures are alarming but the MENA region is still considered a low prevalence region compared to other regions of the world. It is important to understand that the figures on the number of people infected or affected by the virus in the region might not accurately reflect reality. In addition, low prevalence is not synonymous with low risk. Experts have good reason to believe that there is scope for expansion of the epidemic in the Arab region. One of these reasons is inappropriate surveillance methods implemented in most of the Arab countries, which reinforces the statement of Peter Piot, UNAIDS Executive Director, according to which 95 percent of the people infected by HIV worldwide – and subsequently in the Arab region – do not know it.[23] These practices generate a lack of realistic and appropriate behavioral data on the HIV/AIDS situation and its evolution.

The fact that the Middle East and North Africa (MENA) region is threatened by the epidemic is also reflected in its high infection growth rates – the second highest infection rate after Eastern Europe.[24] Thus the situation can change rapidly, as in other Muslim countries such as Indonesia, where 88 percent of the population is Muslim.[25] Indonesia reported approximately 110,000 people living with HIV/AIDS in 2005[26] and alarming prevalence rates in certain at-risk groups like Injecting Drug Users (IDUs), reaching 48 percent in the capital Jakarta and 53

[21] *AIDS Epidemic Update*, December 2005, UNAIDS, p.70
[22] UNDP/HARPAS's calculations based on http://users.erols.com/mwhite28/warstat4.htm
[23] John S. James, *World Issues Today: Interview with Peter Piot, Executive Director of UNAIDS*, June 2000
[24] UNAIDS/WHO, 2002
[25] U.S. Central Intelligence Agency, http://www.cia.gov/cia/publications/factbook/geos/People
[26] *Indonesia Country Profile*, National Authorities, WHO Country Office for Indonesia and WHO Regional Office for South-East Asia, June 2005, p.1, see http://www.who.int/3by5/support/june2005_idn.pdf

percent in Bali.[27] The spread of HIV/AIDS in the Arab region is even more likely given the undeniable presence of risk factors including: unemployment, illiteracy, armed conflicts, migration, poverty, weak access to information and education, gender inequalities, a majority of young people among the population, weak health systems, and other issues that have an impact and foster the spread of the epidemic.

If the epidemic is not controlled and immediate measures and policies against HIV/AIDS implemented, the consequences for the region could be dramatic. The virus could infect any segment of the population and every sector of the economy could witness great human and financial losses, as will be discussed later in this report. For these reasons and in order to prevent further spread of the epidemic, it is time that an appropriate multisectoral response becomes effective. This must include the increased involvement of the private sector, not only as a source of funds, but as a proactive stakeholder in the response.

The purpose of this report is to provide a comprehensive study of the private sector's response to HIV/AIDS in the Arab region. This report will also present the great potential and the main reasons for the private sector operating in the Arab region to get involved in the response to HIV/AIDS. The information contained in this report will be used to create an informed approach to engaging private entities, and hopefully enhance the private sector's concrete response to HIV/AIDS in the field.

For their own interest as well as the interest of their communities, it is essential that private entities operating in the region become active in the response to HIV/AIDS. Their effective commitment, with governments and civil society, could greatly change current trends towards generalized epidemics. However, if the private sector decides not to take into consideration the unavoidable consequences of HIV/AIDS on their activities as presented in this report, the regional response to HIV/AIDS might not be sufficient to reverse current trends. Many countries in other regions of the world such as Thailand, Uganda, Senegal or Brazil have already succeeded in confronting the epidemic. Today, the Arab region has a great opportunity to turn the tide of the epidemic, but this opportunity has to be seized now.[28]

Parameters of this research

Private sector:

A broad definition of private sector includes formal local, national and international businesses, as well as informal enterprises, non-governmental organizations and communities.

The private sector is the part of a nation's economy that is not controlled by the government.[29] It is characterized as being a for-profit business with capitalistic economic practices.[30] A wider definition of this includes not-for-profit and civil society entities.[31] Although we will mention and indicate some private/not-for-profit entities in this report, the focus will mainly

---

[27] *Indonesia Country Profile*, National Authorities, WHO Country Office for Indonesia and WHO Regional Office for South-East Asia, June 2005, p.1, see http://www.who.int/3by5/support/june2005_idn.pdf

[28] It should be mentioned that many countries in the region lack thorough and accessible information, thus resulting in some inevitable gaps and possible inaccuracies throughout this report

[29] http://www.investorwords.com/3860/private_sector.html

[30] *The American Heritage Dictionary of the English Language*, Fourth Edition 2000

[31] Roy Widdus, *Public-Private Partnerships for Health require thoughtful evaluation*, Bulleting of the WHO, 2003, p. 81

remain on for-profit entities i.e. Small and Medium Enterprises (SMEs)[32], national, regional and international businesses belonging to the formal as well as the informal economic sector.

The Arab region:

The geographical borders of this report follow the scope of action of the United Nations Development Programme/HIV/AIDS Regional Programme (UNDP/HARPAS) in the Middle East and North Africa region, which includes – out of the 22 Arab countries – the following 18 countries: Algeria, Bahrain, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, the Occupied Palestinian Territories, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, UAE, and Yemen. This region covers an area of more than 15 million km², with approximately 313.1 million inhabitants[33] - roughly 5 percent of the world's population. The populations of individual countries vary from about half a million (Bahrain, Djibouti) to some 73.4 million (Egypt)[34]. The four countries not covered by UNDP/HARPAS are Oman and Qatar (where there are no UNDP Country Offices), as well as Mauritania and Comoros Islands which are under the umbrella of the UNDP/RBA (Regional Bureau for Africa). However, UNDP/HARPAS endeavors to involve all 22 Arab countries when appropriate.

Response to HIV/AIDS:

We could define a response as "a process, a reaction or an answer occurring due to the effect of some foregoing agent[35]" - the agent being, in this case, HIV/AIDS. In more specific terms, the definition of the response to HIV/AIDS consists of measures or policies implemented by private entities in order to limit and revert the spread of the epidemic via appropriate treatment, care, and support to the infected or affected members of the very entity or its community.

For purposes of this report, two types of private sector responses are covered: internal responses (focusing on workplace policies and practices and covering the company's employees and their families), and external responses (focusing on the communities outside the company).

Methodology:

For this research, UNDP/HARPAS has conducted a literature review, and conducted meetings with regional business associates in order to gather background information. In addition, 168 persons related to the private sector and/or HIV/AIDS – in the Arab region and in other regions of the world – have been contacted by phone or through e-mail.[36]

---

[32] According to the IFC, there is no single definition of an SME. The definition of small and medium enterprises can change from one country to the other. The classification can be done according to the number of employees and/or according to the level of capital investment: The definition of SMEs according to the Free Trade Association is as follows: Small enterprise: Up to 10 employees; Medium enterprise: from 11-99 employees; Large enterprise: Above 99 employees.

[33] *The State of World Population*, UNFPA, 2004

[34] *Demographic, Social and Economic Indicators*, UNFPA, 2004

[35] *The American Heritage Dictionary of the English Language*, Fourth Edition, 2000

[36] Among them, 51 are affiliated with private companies, 39 are affiliated with NGOs, international NGOs and/or not-for-profit organizations, 66 are affiliated with UN agencies, and 12 are government officials and/or affiliated with governmental agencies. The full list of meetings and/or stakeholders contacted is also available at the end of this document, in addition to an example of a typical interview. The Egyptian bias in the list of meetings is mainly due to the fact that the UNDP/HARPAS is a Cairo-based programme, in addition to the fact that many multinational or regional companies operating in the Arab region have established their headquarters in Cairo, Egypt.

Presentation of the content:

This report will first study the transformations and changes the Arab region has been experiencing lately through the regional and global integration processes and their subsequent economic and social repercussions (section 1). This will provide an understanding of the private sector's growing role in today's Arab society. Within this context, reasons for the Arab private sector to get involved in the response to HIV/AIDS will be examined, including the benefits of such an involvement, and the costs generated in case no immediate measures are being implemented (section 2). This study will further examine closely the extent of the current – and limited – private sector's response to HIV/AIDS, as well as regional initiatives whose aim is to foster the private sector's involvement in this response (section 3). Then, different responses implemented by private entities in other regions of the world will be studied (section 4), and some recommendations on how to improve the private sector's response in the Arab region will be presented (section 5).

UNDP/HARPAS's mandate:

UNDP/HARPAS aims to create heightened awareness and capacity building to build commitment and leadership in breaking the silence through collective action at the regional level. This is achieved by UNDP/HARPAS's advocacy for a multisectoral approach, enrolling leaders from government, civil society including NGOs and Religious Leaders, media and the private sector.[37] Similarly, the UNDP Private Sector Development Guidance Initiatives led by the Capacity Development Group (CDG)/Bureau for Development Policies (BDP) and Bureau for Resources and Strategic Partnerships (BRSP) indicates that "UNDP's role should be facilitating and translating economic development into sustainable development".[38] Experts agree, as explained in this report, that HIV/AIDS is jeopardizing economic – and therefore sustainable – development in the Arab region and globally.

As a co-sponsor of UNAIDS[39], UNDP's global mandate is focused on integrating HIV/AIDS responses into multi-sectoral national strategies, promoting prevention, and facilitating access to care and treatment for people living with HIV/AIDS. In its areas of work, UNDP's response is focused in two axes of intervention:

1. HIV/AIDS, Governance and Development
2. An Enabling Human Rights Environment.

In its response, UNDP is approaching the two axes through a subset of innovative methodologies that the HIV/AIDS Theme Group has developed and that address the underlying causes of the epidemic through:

1. Policy support
2. Capacity development for action at scale
3. Strategic partnerships to generate results.

UNDP's priorities are to develop capacities of leaders at all levels of society to ensure that actions are brought to scale, mitigate the socio-economic impact of the epidemic and promote

---

[37] *Leadership Development Programme Strategy Note*, UNDP, February 2005, p.6.
[38] *E-Discussion on UN/UNDP Role in Private Sector Development, Reference Note,* May 2005
[39] ILO, UNESCO, UNDP, WFP, WB, UNFPA, UNICEF, UNODC, WHO, UNHCR

an enabling human rights environment that promotes and protects the rights of people living with HIV/AIDS. Within the two axis of intervention HARPAS is working on the following initiatives engaging a wide range of partners[40]:

1. *HIV/AIDS, Governance and Development*
   - Civil Society: Regional Arab Network Against Aids
   - Art and Media sector
   - Religious Leaders
   - Sub-Regional Initiatives
   - Private Sector

2. *An Enabling Human Rights Environment*
   - Legal Review
   - Women's Empowerment

As HARPAS scales up its multi-sectoral response to 'break the silence' surrounding HIV/AIDS, the involvement of the private sector becomes more pertinent. Furthermore, from the data available and feedback from partners, there is evidence to show that there is a great need for capacity building in the private sector to respond effectively to HIV/AIDS. This includes the step of mapping the situation of the HIV/AIDS response in the region and researching the internal policies of companies as well as private sector involvement with external clients and communities, including the sharing of best practices. Based on this research, UNDP can then provide necessary support regarding how to best mainstream HIV/AIDS in internal and external business practices via leadership and capacity building.

[40] The Arab League, UNDP Country Offices, Sister UN agencies, civil society, religious leaders, artists and media experts, lawyers, political leaders, and People Living with HIV/AIDS (PLWHA)

1. SOCIO-ECONOMIC TRANSFORMATION OF THE ARAB REGION

In order to understand the importance of the private sector's involvement in the HIV/AIDS response in the Arab region, one must first understand the increasing control of the private sector on Arab national economies. As shown in the following section, private sector stakeholders are more and more interconnected and interdependent within an increasingly globalized world. Decisions taken on one side of the region can have economic and therefore social repercussions on the other side. The Arab region is expanding its trade between countries, as well as multiplying initiatives to foster economic exchange with other regions of the world. As a consequence, the private sector's social and economic initiatives have a greater impact on the Arab population as a whole, hence the importance of its involvement in the HIV/AIDS response in the MENA region (as further discussed in section two).

1.1. Slow but progressive integration of the region's economies

Globalization and regional integration are terms that can be defined in a number of different ways. When used in an economic context, they refer to the reduction and removal of trade barriers between national borders in order to facilitate the flow of goods, capital, services and labor. Further, this economic process has human implications reflected by processes and trends such as growing migration and an increasing interconnection among Arab populations as well as with populations from neighboring regions of the world.

Like most regions of the world, the Arab region has experienced these globalization and regional integration processes during the last decades. Because countries differ widely in their natural resources, economic and geographical size, population, and standard of living, one can expect these processes to result in dissimilar levels of achievements for each country. Still, the countries of the MENA region are moving toward economic and political cooperation and integration as well as implementing economic reforms. This informs the HIV/AIDS response in certain ways which this research examines.

1.1.1. Economies interconnected on a regional level

Before examining inter-regional trade, it is important to briefly review the main sub-regional bodies whose aim is to foster economic cooperation between its members as well as with other sub-regional groups. This is because sub-regional and regional groups can leverage responses and resources in ways that frame the effective HIV/AIDS response in important ways.

An Arab Gulf Cooperation Council was established in 1981 to strengthen the economic relations between Saudi Arabia, Kuwait, Qatar, United Arab Emirates, Oman and Bahrain, with Iraq, Jordan, Yemen and Egypt signing on in 1989. Unfortunately, the Arab Cooperation Council was soon demolished after Iraq invaded Kuwait in 1990.[41] However, this was significant as one of the main regional bodies established in the Arab states.

Today, the three sub-regional economic bodies of the Arab region, most of which have been created in the 1980s, are: the Gulf Cooperation Council (GCC) covering the Gulf countries[42],

[41] *Trade, Market Access and Food Safety in the Near East Region*, FAO-IDB, October 2003
[42] Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates

the Arab Maghreb Union (AMU) for North African countries[43], and the Inter-governmental Authority on Development (IGAD) for countries in the Horn of Africa[44].

The GCC is currently the most successful model of sub-regional integration in the Arab world. The GCC Charter was ratified by Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates in May 1981. Like other sub-regional bodies, the ultimate goal of its members is full economic unity, to be achieved through economic cooperation and integration efforts.[45]

The Arab Maghreb Union (AMU) was established in 1989 between Morocco, Algeria, Tunisia, Libya and Mauritania. Its objectives are the implementation of a common policy in order to insure the industrial, agricultural, commercial and social development of its members, and the long-term establishment of a free-trade zone, a custom union, and a common market between the countries of the Maghreb[46].

The Inter-governmental Authority on Development (IGAD) in Eastern Africa was created in 1996 to supersede the Inter-governmental Authority on Drought and Development (IGADD), which was founded in 1986. Its members are Djibouti, Eritrea, Ethiopia, Kenya, Somalia, Sudan, and Uganda. IGAD is a regional organization whose aim is to achieve peace, prosperity and regional integration in the Horn of Africa sub-region. This is done by assisting and complementing the efforts of the member States to achieve, through increased cooperation food security and environmental protection, the maintenance of peace and security as well as humanitarian affairs, and economic cooperation and integration.[47]

Such sub-regional bodies work in close collaboration with regional institutions like the League of Arab States (LAS), the Arab Monetary Fund (AMF), and the Arab Labor Organization (ALO).

The League of Arab States, informally called the Arab league, is a voluntary association of independent countries whose peoples are mainly Arabic speaking. Established in Egypt in 1945, the Arab league aims to strengthen ties among member states, coordinate policies, and promote common interests. The 22 Arab countries listed in the introduction are members of the League. The Arab League is involved in political, economic, cultural, and social programs designed to promote the interests of member states. It has served as a platform for the drafting and conclusion of almost all landmark documents promoting economic integration among member states, such as the creation of the Joint Arab Economic Action Charter, setting out the principles for economic activities of the League.[48]

Similarly, the 22 Arab countries are members of the AMF, a regional Arab organization founded in 1976. The AMF's objectives address many of the economic challenges facing the Arab states (disparity in the balances of payments, removal of restrictions on current payments, establishing policies and modes of Arab monetary cooperation, development of Arab financial markets, creation of a unified Arab currency, trade among member States, etc).[49]

---

[43] Morocco, Algeria, Tunisia, Libya and Mauritania
[44] Djibouti, Eritrea, Ethiopia, Kenya, Somalia, Sudan, and Uganda
[45] *Annual Review of Developments in Globalization and Regional Integration in the Countries of the ESCWA Region*, ESCWA, p. 11
[46] www.maghrebarabe.org
[47] www.igad.org
[48] http://encarta.msn.com/encyclopedia_761558355_2/Arab_League.html
[49] http://www.amf.org.ae

The ALO – the pendant of the ILO for the Arab region – is also a key organization in the region. Its objectives, as defined in its constitution and in the Arab Labor Charter, are "to strengthen cooperation between its members in achieving social justice, raising workers' living standards and ensuring their material and moral welfare in freedom, dignity and equality of opportunity." [50] All 21 countries listed in the introduction are members (the 22 Arab countries except Comoros Islands).

These organizations contribute to Arab economic integration, which has frequently resulted in creating political barriers. Inter-Arab trade stands at a modest US$40 billion, less than a tenth of overall Arab trade.[51] All the Arab states signed the agreement of the Arab Free Trade Area (AFTA) in 1996 in an attempt to enhance their trade. Unfortunately, most of the arrangements were not actually effective in fostering economic cooperation between the countries in the region due to a range of constraints from poor infrastructure to administrative and political difficulties, which cut across national markets.

FIGURE 2: INTRA-REGIONAL TRADE IN SELECTED TRADE BLOCS (2001) (BILLIONS OF US$)

	2001	
	Intra-regional Trade value	**Intra-regional trade as share of total trade (percentage)**
ASEAN*	166.1	22
EU	2,650	59
NAFTA*	30.54	7.5
GAFTA**	622	9

Source: *Annual Review of Developments in Globalization and Regional Integration in the Countries of the ESCWA Region*, ESCWA, 2002, p.9
* Association of South East Asian Nations
** North American Free Trade Agreement
*** Greater Arab Free Trade Agreement

Even though Arab intra-regional trade remains below its potential and its share of total trade is significantly lower than other regions of the world, as demonstrated by the table above, one must be aware that if oil is excluded from the general trade number, trade increases to 19 percent.[52] Certain experts even provide estimates as high as 29 percent.[53]

Furthermore, according to a report of the AMF[54], trade is strongest among members of Arab sub-groups whose factor endowments are presumably similar. For instance, 75 percent of GCC's intra-Arab trade is with other GCC members, and the corresponding ratio for AMU (or Maghreb) and Mashreq members' trade is 65 percent and 35 percent respectively.[55] In other words, the integration tends to be more important on sub-regional level.

[50] http://www.ilo.org/public/english/bureau/leg/agreements/
[51] Ali A. Bolbol and Ayten M.Fatheldin, *Intra-Arab exports and Direct Investment*, Arab Monetary Fund, June 2005, p.3
[52] *Annual Review of Developments in Globalization and Regional Integration in the Countries of the ESCWA Region*, ESCWA, 2002, p.9
[53] Jumana Al Tamimi, *Arab Common Market: A Dream that Must Come True*, Jordan Times, July 2001
[54] Ali A. Bolbol and Ayten M.Fatheldin, *Intra-Arab exports and Direct Investment*, Arab Monetary Fund, June 2005, p.4
[55] *Ibid*

It should also be noted that the Arab countries are getting closer to a successful regional integration process through the completion of the final phase, in 2005, of the Greater Arab Free Trade Agreement (GAFTA), which effectively abolished tariffs. The agreement binds 17 Arab states, opening a potential market of more than 300 million people. Sudan, Somalia, Yemen, Djibouti and Comoros Islands will be exempt from the scheme and allowed a further five years to realign their economies. Zero tariffs have been implemented since January 2005. Still the presence of many non-tariffs barriers, as well as a relative lack of consensus on common rules have slowed down the expected pace of integration.

Main stakeholders agree on the potential for success of this agreement, like Ahmed El-Goweili, secretary-general of the Arab League's Council for Arab Economic Unity, who considers that "the political will is there to open up.[56]" With a customs union scheduled for 2008 and a common market in 2020, Arab nations will open their markets in an unprecedented manner. Successful integration efforts are more likely to come first among sub-sets of countries in the region, rather than in the region as a whole. As more countries in the MENA region progress in de-regulating and liberalizing their economies, cross-links among these groupings will strengthen social and economic ties within the MENA region as a whole.

It is important to understand that this reinforcement of inter-regional trade will probably imply an intensification of labor force migrations. These migrations are already important between the "labor importing countries" – GCC and Libya – and the "population surplus countries" – Morocco, Egypt, Tunisia, Syria, Jordan, and Lebanon.[57] This growing economic interaction, followed by social interaction, explains the need for adopting a regional approach in the response to HIV/AIDS as mobile populations, including migrant workers, are especially vulnerable to HIV infection. The economic and social patterns that are being established and intensified require that Arab countries coordinate their policies and support each other in the response to HIV/AIDS, in the interest of the region's population and business.

1.1.2. Economic potential to optimize on a global level

Common measures of globalization illustrate the MENA region's still relatively weak integration with the world economy, and the share of the Arab countries in world trade remains small. Arab exports, 70 percent of which are in the petroleum sector, are valued at US$ 300 billion. With imports of US$ 200 billion, they account for only 3.5 percent of world trade. This figure is low in comparison to other regions.

The region's poor exportations have been related to the prolonged use of inward-looking strategies based on import-substitution.[58] Such strategies were abandoned by a number of countries in other regions during the 1980s, as part of their process of economic reform. These countries achieved a greater outward orientation, and created a favorable climate for trade and investment, by lowering trade barriers, privatizing many industries, and reforming the foreign-exchange market. The MENA countries are also implementing some of the same reforms, but at a slower pace.

[56] *Full Steam Ahead on Economic Reforms,* Al Ahram, December 2004
[57] Interview of Mr. Diaa Nour-el-Din by UNDP/HARPAS team – Senior Economist, Economic Research Forum, July 2005
[58] Nabli and De Kleine, 2000

Experts agree that the MENA region's integration in the global economy remains below its potential.[59] However, they also agree on the fact that MENA countries have strong potential for expanding trade. Exports other than oil are a third of what they could be given the region's many marketable characteristics, which are favorable to trade. The region's incomes are low, and fall within the bottom half of world income distribution (2 percent of world income). Wages are also fairly low, within the bottom half of world wages, and the region is geographically close to a high-income area, the European Union (EU), which is just across the Mediterranean Sea.

Even so, it is interesting to stress the economic contrast between the 22 countries of the League of Arab States – and more specifically the 18 countries studied in this report. According to UNDP's Regional Bureau for Arab States (RBAS), countries are categorized as follows according to level of income:

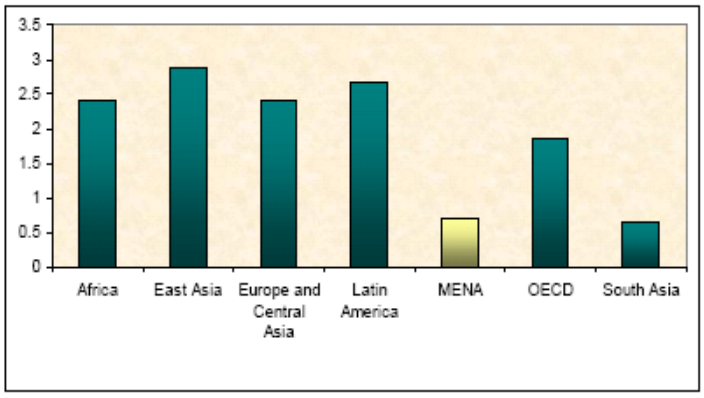
BOX 1: ECONOMIC PROFILE OF THE 22 ARAB COUNTRIES

Net-contributing Countries: Bahrain, Kuwait, Libya, Saudi Arabia and United Arab Emirates, Oman, Qatar

Middle-income countries: Algeria, Egypt, Iraq, Jordan, Lebanon, Morocco, Syria, Tunisia and the Occupied Palestinian Territories

Least Developed Countries: Sudan, Somalia, Djibouti, Yemen, Mauritania, and Comoros Islands

FIGURE 3: FDI INFLOWS AS A SHARE OF GDP (2003*)



Source: *Economic Developments and Prospects, Oil Booms and Revenue Management*, World Bank, 2005, p.47 (* or closest available)

The Arab countries' efforts to attract a higher share of global Foreign Direct Investment (FDI) inflows have not been entirely successful so far.[60] Despite a 50 percent increase in FDI since 1990[61], net FDI inflows to GDP average only a third of the average level achieved worldwide.[62] As illustrated in figure 3, most of FDI inflows are concentrated in a handful of countries.[63]

Though remaining at a low level, many Arab countries reported significant increases in the share of FDI as a percentage of their GDP between 1990 and 2003, namely Jordan (+322.2

[59] George T. Abed and Hamid R. Davoodi, *Challenges of Growth and Globalization in the Middle East and North Africa*, International Monetary Fund, 2003
[60] *Annual Review of Developments in Globalization and Regional Integration in the Countries of the ESCWA Region*, ESCWA, p.1
[61] *Private sector development, World Development Indicators,* International Monetary Fund/World Bank, 2005
[62] *Economic Developments and Prospects, Oil Booms and Revenue Management*, World Bank, 2005, p.47
[63] George T. Abed and Hamid R. Davoodi, *Challenges of Growth and Globalization in the Middle East and North Africa*, International Monetary Fund, 2003, p. 5

percent, thus reaching 3.8 percent of the GDP), Lebanon (+850 percent, 1.9 percent), Mauritania (+2,700 percent, 19.6 percent), Morocco (+766.7 percent, 5.2 percent), Sudan (+7,600 percent, 7.6 percent), and Tunisia (+266.7 percent, 2.2 percent).[64]

MENA countries have a great potential for attracting more investment from abroad and encouraging more private investment at home, both of which are crucial in trade and development and will impact the nature of the HIV/AIDS pandemic in the region related to the many economic and development factors that can fuel or stem its spread. If exports other than oil were higher, and if the investment climate was better, domestic private investment in traded goods and services would obviously be much higher. According to the WB, the FDI inflows that the region could expect would be five to six times what they are today – some 3 percent of GDP, up from an average of 0.5 percent.[65] Decision makers in the region are aware of this potential and know that FDI can contribute to more trade.[66]

Things are changing and Arab countries are making great efforts to better integrate their economies and foster exchanges with other regions of the world through trade agreements with main economic pillars.

In this regard, eight Arab countries joined the World Trade Organization (WTO) since its creation in January 1995, as described in the table below.

FIGURE 4: ARAB MEMBERS OF THE WTO

Members of the WTO	*Date of membership*
Bahrain	1 January 1995
Kuwait	1 January 1995
Morocco	1 January 1995
Tunisia	29 March 1995
Djibouti	31 May 1995
Egypt	30 June 1995
UAE	10 April 1996
Jordan	11 April 2000

Source: http://www.wto.org

Further, Algeria, Iraq, Lebanon, Libya, Saudi Arabia, Sudan and Yemen are part of the WTO but remain as observers.[67]

The WTO's main components are the General Agreement on Tariffs and Trade (GATT), the General Agreement on Trade in Services (GATS) and the Trade-Related Aspects of Intellectual Property Rights (TRIPS). The TRIPS Agreement is actually part of a package to which countries seeking WTO membership have to adhere. It focuses on the protection of copyrights, patents, trademarks, geographical indications, layout-designs, trade secrets and unfair competition.

Despite the apparent will of developed and developing countries to establish a multilateral trade system, issues related to Intellectual Property Rights protection in Arab countries have

[64] *Ibid.*
[65] *Trade, Investment, and Development in the Middle East and North Africa, Engaging the World*, World Bank, August 2003, p.20
[66] Ali A. Bolbol and Ayten M.Fatheldin, *Intra-Arab Exports and Direct Investment*, Arab Monetary Fund, June 2005, p.5
[67] http://www.wto.org

been increasingly addressed or integrated in a growing number of bilateral discussions and treaties, as developed below. Indeed, these bilateral agreements enhance the protection of intellectual property rights beyond the agreed levels of the TRIPS Agreement, hence resulting in a negative effect on Arab countries. Many experts argue "this will circumvent and hinder the efforts of these countries to acquire the desired levels of technology and development".[68]

Because of the negative effects generated by these agreements on the population of developing countries, there continues to be a lack of agreement and controversy over the expected benefits of this TRIPS Agreement, more than a decade after the creation of the WTO.[69]

The European Union

The European Union is the Mediterranean countries' main trading partner for both exports and imports (Syria, Jordan, Lebanon, the Occupied Palestinian Territories, Egypt, Tunisia, Algeria, and Morocco). Over the past decades, the Arab countries and the European Union have developed close and intense relations. The members of the European Union (EU) and 12 Mediterranean countries[70] have implemented and continue to negotiate bilateral Euro-Mediterranean Association Agreements. Among the 12 Mediterranean partners, 8 of them are Arab countries, as listed above. The Mediterranean partner countries combined include approximately 240 million consumers, compared with the EU market of 376 million. The grid of Association Agreements with Mediterranean Partners has been completed with the conclusion of negotiations with Syria in October 2004, as shown in the figure 5.

FIGURE 5: EURO-MED ASSOCIATION AGREEMENTS

Country	*Title of the agreement*	*Status*
Algeria	Euro-Mediterranean Association Agreement	Signed on 22.04.02 / In process of ratification
Egypt	Euro-Mediterranean Association Agreement	Signed on 25.06.01 / In force since 1.06.04
Jordan	Euro-Mediterranean Association Agreement	Signed on 24.11.97 / In force since 01.05.02
Lebanon	Euro-Mediterranean Association Agreement Interim Agreement for Early Implementation of Trade Measures	Signed on 17.06.02 / In process of ratification *In force since 01.03.03*
Morocco	Euro-Mediterranean Association Agreement	Signed on 26.02.96 / In force since 1.03.00
Palestinian Authority	Interim Association Agreement, awaiting a Euro-Mediterranean association agreement	Signed on 24.02.97 / In force since 1.07.97
Syria	Euro-Mediterranean Association Agreement	Negotiations concluded / Initialed 19.10.04 / Council to decide on signature.
Tunisia	Euro-Mediterranean Association Agreement	Signed on 17.07.95 / Entry into force 1.03.98

Source: http://europa.eu.int/comm/external_relations/euromed/med_ass_agreemnts.htm

Also known as the Barcelona Declaration, this agreement sets 2010 as the target date to complete the Euro-Mediterranean Free Trade Area, which will then bring about even greater economic integration between Arab and European economies and foster greater economic openness in the region. The conclusion of this agreement is a major step towards achieving the common objective of a Euro-Mediterranean free trade zone.[71]

[68] http://www.bilaterals.org/article-print.php3?id_article=1790
[69] http://www.bilaterals.org/article-print.php3?id_article=1790
[70] Algeria, Cyprus, Egypt, Israel, Jordan, Lebanon, Malta, Morocco, Palestinian Authority, Syria, Tunisia, and Turkey
[71] Dr. Günter Rexrodt, *Speech at the 38th Conference of the Arab Chambers*, Tunis, May 25th 2004

These bilateral negotiating processes can lead to far-reaching obligations for Arab countries in specific areas like IPR where WTO decisions have not yet been made of seem to be resisted by other southern countries. Through these bilateral agreements, Arab countries could accept high IPR protection levels, which may in turn have drastic consequence on the production of generic drugs, and therefore on the provision of affordable ARVs to People Living With HIV/AIDS (PLWHA).

The United States of America

In addition to that, three countries in the Arab world have engaged in dialogue on bilateral trade liberalization with the United States of America: Egypt, Jordan and Morocco. The United States and Jordan signed a free trade agreement in October 2000 which came into effect in December 2001. The US-Egypt Presidents' Council was established in the spring of 1995 to provide advice and counsel reflecting private sector views, needs and concerns regarding Egypt's business climate, including facilitating private sector development in Egypt and strengthening commercial ties between the United States and Egypt. Further, the US-GCC Economic Dialogue was established in 1985 and is the primary vehicle through which the GCC countries and the United States discuss trade and investment issues. Finally, a US-North Africa Economic Partnership was launched in 1998 to enhance policy dialogue and break down barriers to trade and investment among the countries of North Africa and between each country and the United States.

In the long term, the US president announced in May 2003 plans for a US-Middle East Free Trade Area (MEFTA) by 2013. The US trade agenda for the Middle East is supposedly a "step-by-step pathway" to "deeper trade and economic partnerships" with the US.[72] Thus, the US plans to integrate a series of bilateral free trade agreements (FTAs) into a region-wide free trade area.

The US already has in place Bilateral Investment Treaties (BITs) and Trade and Investment Framework Agreements (TIFAs) with several Arab countries, as shown in figure 6. [73]

FIGURE 6: ECONOMIC AGREEMENTS BETWEEN THE US AND ARAB COUNTRIES

Country	*Title & Status of the agreement*
Algeria	TIFA in force (July 2001)
Bahrain	BIT in force / TIFA in force (June 2002)
Egypt	BIT in force / TIFA in force (July 1999)
Jordan	BIT in force / TIFA in force
Kuwait	BIT under negotiations / TIFA in force (February 2004)
Morocco	BIT in force
Oman	BIT under negotiations
Qatar	BIT under negotiations / TIFA in force (March 2004)
Saudi Arabia	BIT under negotiations / TIFA in force (July 2003)
Tunisia	BIT in force / TIFA in force (October 2002)
UAE	TIFA in force (March 2004)
Yemen	TIFA in force (February 2004)

Source: http://www.bilaterals.org/

[72] http://www.bilaterals.org/article.php3?id_article=109&var_recherche=ARVs+AIDS
[73] *Ibid.*

Consequences generated by these FTAs and BITs for the local population could be far-reaching, and with more dramatic consequences for PLWHA. With intellectual property standards even stricter than those of the WTO (hence called TRIPS-plus), some of these agreements threaten access to ARVs medicines. Indeed, agreements with TRIPS-plus provisions reduce implementation flexibility left by the TRIPS agreement and reaffirmed in the 2001 Doha Declaration. During the WTO Ministerial conference in November 2001, WTO members recognized the importance of "an implementation and interpretation of the Agreement on TRIPS in a manner supportive of public health, by promoting both access to existing medicines and research and development into new medicines.[74]" However it can be argued that the implementation of these bilateral agreements eventually produces the opposite effect by raising prices of drugs, and therefore reducing their affordability. According to some experts, "this web of bilateral agreements is part of a global strategy to by-pass WTO multilateral negotiations and to continuously raise international standards on intellectual property.[75]"

For example, the FTA signed in March 2004 between Morocco and the US violates the WTO agreement by increasing the duration of patent protection from 20 to 30 years, directly threatening the survival of Morocco's generic industry which provides not only thousands of jobs, but also maintains affordable prices for those who need HIV/AIDS treatment. Bearing in mind the low purchasing power of most of the populations in Arab countries, by raising the prices of ARV drugs these agreements are simply condemning thousands of people to death.

In June 2005, only 5 percent of the PLWHA living in the Arab region had access to ARV treatment.[76] It can be rigorously argued that these agreements with the US and the EU will not improve the current situation for the PLWHA and their region.

South America

As far as Latin America is concerned, one can expect that the common determination of the Arab and South American political leaders for a closer political collaboration, reflected by the recent first South American-Arab Summit held in Brazil in May 2005, will be followed by an intensification of trade exchanges, thus boosting business and investments between the two regions. A positive sign in this sense is the approval, during this summit, of an agreement between the GCC and the Southern Common Market (MERCOSUR), a key South American economic bloc (Argentina, Brazil, Paraguay and Uruguay), pledging negotiations for a free-trade area linking the two groups.[77] Certain figures such as the 50 percent increase (between 2003 and 2004) of bilateral exchanges between the Arab region and countries like Brazil (which, with Mexico, accounts for 81 percent of the total GDP of the continent and 50 percent of the population) allow us to think the economic interaction between South America and the Arab region represent a very promising opportunity for businesses.[78]

Even though the Middle East and North African countries' economic share represented only 2.3 percent of the South American countries' exports in 2003[79], the economic structure of each region favors a strengthening of their economic cooperation. Indeed, the economic complementary relationship of the two regions is reflected by the very nature of the Arab

[74] http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_e.htm
[75] Julien Reinhard, *Deprive Doha of All Substances*, August 2004, http://www.evb.ch/cm_data/Deprive_Doha.pdf
[76] *Progress on Global Access to HIV Antiretroviral Therapy, An Update on 3x5*, UNAIDS/WHO, June 2005, p.7
[77] http://www.mapsofworld.com/world-news/brasilia-summit.html
[78] *Arab Countries & South America – Economic Cooperation Perspectives*, http://www.dcci.gov.ae
[79] *Arab Countries & South America – Economic Cooperation Perspectives*, http://www.dcci.gov.ae

countries' exports such as oil, gas, petrochemicals, agricultural and animal products, garments and other exports, which find receptive markets in highly populated South American countries importing also oil, fertilizers, chemicals, gas, pharmaceuticals, cereals, fodder, iron, oils, etc.

Furthermore, some Arab countries like Egypt, Lebanon, Tunisia and Saudi Arabia have signed trade and economic agreements with countries in South America, as indicated in figure 7.

FIGURE 7: AGREEMENTS SIGNED BETWEEN ARAB AND LATIN AMERICAN COUNTRIES (2004)

The Agreement	*Arab Countries*	*South American Countries*
Investment Promotion	*Egypt*	*Chile*
Economic Cooperation	*Morocco - Kuwait*	*Mexico - Peru*
	KSA – UAE	
Trade	*Egypt, Morocco, UAE*	*Peru - Brazil*
	Tunisia, Lebanon	

Source: *Study by the Arab League "Arab countries and Latin America", 2004*

Asia

Similarly, Arab countries are trying to foster their economic cooperation with Asia, as reflected by initiatives including the first Arab-Asian Summit held in Malaysia in February 2004 and the Middle Eastern-Asian Summit held in Singapore at the end of June 2005. The goals of these initiatives are to enhance economic relation between the Arab and Asian worlds and to develop forums for economic and social cooperation and integration, among other objectives. Interestingly, Asian and Arab political leaders are urging their respective business sectors to take the lead and to become the driving forces of this push for economic cooperation.[80]

[80] *Abdullah and Goh urge closer Asia-Middle East business ties*, The Daily Star, AFP, April 2005

FIGURE 8: SHARE OF ASIAN COUNTRIES IN ARAB IMPORTS/EXPORTS (2004)

Country	*Asian Export partners*	*Asian Import Partners*
Algeria	-	China 5.3%
Bahrain	South Korea 2.3%, Japan 2%	Japan 7.6%
Djibouti	-	India 8.2%, China 7.8%,
Egypt	-	China 5.5%
Iraq	Japan 7.3%	Vietnam 7.7%
Jordan	India 6.4%	China 8.4%
Kuwait	Japan 22.6%, Singapore 12.4%, Taiwan 8.4%,	Japan 8.2%, China 5.9%
Lebanon	-	China 6.3%
Libya	-	-
Mauritania	Japan 13%, China 5.8%	China 7.4%
Morocco	-	China 4.8%
Oman	China 27.6%, South Korea 17.8%, Japan 12.7%, Thailand 11.7%	Japan 16.6%, India 4.3%
Qatar	Japan 43.8%, South Korea 16.1%, Singapore 10.8%	Japan 8.7%
Saudi Arabia	Japan 16.4%, South Korea 8.7%, China 5.8%, Singapore 4.5%	Japan 6.7%, China 5%
Somalia	Thailand 31.3%, India 8.5%, China 4.1%	India 9.3%
Sudan	China 64.3%,	China 10.7%, India 4.6%
Syria	-	China 7.6%
Tunisia	-	-
UAE	Japan 28.5%, South Korea 9.5%, Thailand 5.9%	China 10.4%, India 8.3%, Japan 7.2%
Yemen	China 33.5%, Thailand 31.4%, Singapore 7.2%, South Korea 6.1%	China 9%, India 4.3%

Source: http://www.cia.gov

The table above shows the significant role of Asian countries – especially China, Japan and India – as business partners for Arab countries, especially for the GCC members.

In summary, the economic preconditions for increasing integration of the MENA region in the world economy are improving for an important number of countries. The key to this greater integration now lies at the country level. Some MENA countries have made considerable headway in stabilizing, reforming, and opening up their economies.

Governments and decision makers in the region are aware of the fact that economic policies need to be centered on regional cooperation, foreign and local investment facilitation and job creation.[81] For this reason, one can expect Arab countries to intensify their regional cooperation and global economic interaction with international partners, with the subsequent social and human implications one can expect.

1.2. Growing privatization process and the increased role of the private sector

According to the World Bank, while a number of countries in the region have low tariffs, research suggests that openness to trade tends to have little impact on growth in economies that are excessively regulated. The impact of tariff liberalization will be constrained if the regulatory environment dissuades investment. Meeting the development challenges in the MENA region requires sustainable and productivity driven economic development, and job

[81] *Survey of Economic and Social Developments in the ESCWA Region*, ESCWA, 2005, p.2

growth. Global trends suggest the most important engine for rapid and sustainable economic growth is a dynamic and competitive private sector, free from excessive regulation.[82]

Beginning in the late 1980s, many Arab countries committed themselves to far-reaching economic reforms and promoted private sector-led development[83] in an effort to create jobs, diversify and nurture their economies.

Algeria, Kuwait and Saudi Arabia are moving toward opening the development of their oil and gas fields to foreign companies. Qatar and UAE are continuing to use foreign companies as partners in the expansion and development of their oil and gas industries. In recent years, Egypt, Morocco, Tunisia and UAE have undertaken one or more new independent power projects. Most Arab countries have now implemented new investment laws that allow 100 percent foreign ownership of domestic enterprises. Better laws and stricter enforcement of intellectual property protection in many of the Arab countries have led to increased investment in the pharmaceutical industry in Jordan and in the high-tech industries in UAE.[84]

Resource-rich countries in the Gulf region are leading the way in trade and structural reforms. They have a US$355 billion Gulf Cooperation Council (GCC) customs union; they are liberalizing private entry in power, water, real estate, and other previously protected sectors; and they are reforming banking and financial regulations.

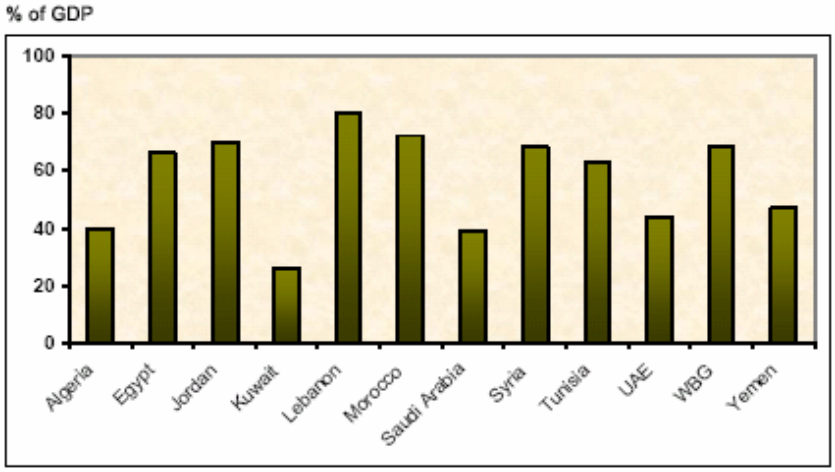
Most Arab countries have increased their efforts to attract FDI, as well as Arab inter-regional private investment. Prudent monetary and fiscal policies have generally been pursued in most countries and new laws and regulations that attract foreign and Arab investment have been passed.[85] Since the beginning of the 90s, many Arab countries have witnessed a significant increase of their domestic credit to private sector – which refers to financial resources provided to the private sector such as loans, non-equity securities, trade credits, etc. Regionally, this domestic credit to private sector rose from 39.5 percent to 46.4 percent of the GDP between 1990 and 2003, which demonstrates an increased support to private initiatives (+101.3 percent in Egypt, +4.6 percent in Lebanon, +64 percent in Morocco, +68.5 percent in Oman, +1.28 percent in Saudi Arabia, and +34.6 percent in Syria).[86]

Nowadays, countries in the MENA region are showing increased commitment to supporting private investment and exports by implementing structural reforms and stabilization efforts aimed at improving the business environment. With contrasting results depending on the country, governments are becoming less involved in the direct provision of goods and services and more active in developing market mechanisms, creating supporting institutions and providing safeguards to endure equitable distribution. They are directly reducing government involvement in the economy through privatization, encouraging private sector participation in infrastructure and reforming their institutions to make them more hospitable to private investment.[87]

---

[82] *Middle East and North Africa, Economic Developments and Prospects,* World Bank, 2005
[83] *Middle East and North Africa – Overview*, www.web.worldbank.org
[84] http://www.export.gov/exportamerica/NewOpportunities
[85] *Annual Review of Developments in Globalization and Regional Integration in the Countries of the ESCWA Region*, ESCWA, p.10
[86] *Private Sector Development, World Development Indicators,* International Monetary Fund/World Bank, 2005
[87] *Macro-economic Trends in the ME and Africa*, Economic Research Forum, 2000

FIGURE 9: PRIVATE SECTOR CONTRIBUTION TO GDP (EARLY 2000S)



Source: *Economic Developments and Prospects, Oil Booms and Revenue Management*, World Bank, 2005, p.54

In Tunisia for example, private enterprises account for about 60 percent of total investment by non-financial enterprises, a figure that remained more or less steady throughout the 1990s. Total private investment was 51 percent of total investment in 1999, accounting for 14 percent of GDP. In recent years, the Tunisian government has decreased tariff rates as part of its partnership agreement with the European Union, simplified customs procedures, improved its infrastructure, and offered investment and export incentives to the private sector, particularly small and medium enterprises (SMEs), which now dominate manufacturing. The government has given SMEs tax exemptions and established a fund to encourage small information technology firms.

In Morocco, the government has reduced price controls, enacted a new investment code, reformed customs and taxes, worked to adapt training programs to the needs of the market and sold many of its enterprises to private buyers. As a result, the private sector's contribution to GDP increased to 73 percent in 1997, up from 64 percent in 1985. Its share in total exports increased to 75 percent in 1995, up from 60 percent in 1985.

In the Occupied Palestinian Territories, the private sector is concentrated in small family run businesses, services, commerce and construction, and agricultural products such as olive oil and fruit. Industry, especially related to technology, was growing in the two years up to the outbreak of the latest Intifada. The SME sector also holds promise, given the right incentives, and FDI could be forthcoming from the Palestinian diaspora.[88] However, we can reasonably state that the private sector will not be able to grow efficiently unless all restrictions are lifted and the military occupation ends. In this regard the transfer of powers and authority on the Gaza strip to the Palestinian Authority in August 2005 could represent a glimmer of hope provided that it includes the lifting of Israeli measures such as internal closure both in Gaza and in the West Bank, as well as free movement of people and goods across the borders from Gaza. Unfortunately, this scenario appears quite unlikely given that the World Bank predicted in December 2004 that poverty and unemployment will rise following the "Disengagement" even under the best of circumstances because Israel will retain full control over the movement of goods in and out of Gaza, as well as an enforced separation of the West Bank and Gaza. This will prevent the residents of each area from visiting one another, and will draw up separate customs agreements with each zone severing their already shattered economies.[89]

[88] *Macroeconomics Trends in the ME and Africa*, Economic Research Forum, 2002, p.18
[89] Jennifer Loewenstein, *Watching the Gazan Fiasco, the Shame of It All*, http://counterpunch.com, August 2005

Jordan has opened to trade and created a more hospitable investment environment, with encouraging outcomes. During the last decade, the country adopted ambitious economic reform and structural adjustment programs aimed at transforming the economic structure of the country to one that generates internal and self-sustaining activity. The country's economic and legal environment has been adjusted, and continues to undergo reforms. Jordan embarked on a privatization program in the second half of 1996 in order to create a more open market-oriented economy that is friendly to foreign investments and to activate the market forces. Such economic measures aimed at liberalizing and expanding the participation of the private sector in the economy, make it more competitive at the regional and international levels and further integrate it with the world economy.[90]

In Egypt, economic growth and reforms have been slow in recent years due to external shocks. However, the government has recently adopted a proactive stance to developing a more attractive business environment for foreign investment. If reform momentum continues without being undermined by exogenous shocks, the prospect of a modest economic turnaround is expected.

In the Gulf, smaller countries accelerated reforms in trade, investment, and development. The UAE, especially Dubai, have followed an impressive outward-oriented and private investment-led growth strategy that has been successful so far.

Policy-makers elsewhere in the region are beginning to re-examine their strategies. For instance, Algeria has started to significantly re-open its trade regime and encourage private investment. Syria's earlier hesitant steps towards economic opening are being re-examined with a view of strengthening trade and investment. Lebanon is beginning to consider ways of addressing the massive economic dis-incentives of the difficult public debt and macroeconomic situation. Even in larger, oil-based countries such as the Republic of Yemen and Saudi Arabia, non-oil trade and private investment have become central issues, because oil contributes little to job creation.[91]

As demonstrated in figure 10, the role and the potential of the private sector’s place in the Arab economies is reflected in the share of total employment it represents, a main source of job creation in countries of the Maghreb like Morocco, Tunisia and Algeria, or still relatively limited – especially in countries such as Kuwait, Saudi Arabia and Libya.

[90] http://www.epc.gov.jo/programs

[91] *Trade, Investment, and Development in the Middle East and North Africa, Engaging the World*, World Bank, August 2003, p.23

FIGURE 10: PRIVATE SECTOR EMPLOYMENT IN MENA (2000)

	Private sector as a share of total employment, 2000*
MENA	71%
Algeria	71%
Bahrain	72%
Egypt	71%
Jordan	56%
Kuwait	7%
Libya	34%
Morocco	90%
Saudi Arabia	21%
Tunisia	78%

Source: UNDP/HARPAS's calculations based on *Economic Developments and Prospects, Oil Booms and Revenue Management*, World Bank, 2005

From these figures, ranging from 90 percent in Morocco to 7 percent in Kuwait, we can understand better where the privatization process stands. It is important to notice than even in countries with a low share of private sector employment, plans to encourage private sector and sell off state-owned enterprises are pending, because governments realized they would not be able to create as many jobs for their employees than private entities.[92]

Despite the uneven pace of this privatization process, Arab governments have understood that the private sector is great source of job creation, generating a relationship with a very high level of inter-dependency between private entities and governments. Without the government's commitment and capacity to provide pro-growth economic policies and institutional arrangements, the private sector will not invest up to its potential. On the other hand, without private investment, government policies will not create new jobs, more goods, and services.[93]

All these examples of the growing privatization processes taking place in the Arab region show the growing economic – and consequently social – role the private sector bears. All the information provided above demonstrates that this role will be increased along with the reinforcement of the governments' privatization policies, and that the implication against HIV/AIDS of the private sector operating in the Arab region is becoming an indispensable component of a multisectoral response.

1.3. The Private Sector's Profile in the Arab region

1.3.1. A majority of Small & Medium Enterprises…

Now that the increasing role of the private sector in the Arab region is established, it is important to better understand the profile and the specificities of the private sector operating in the Arab region, with its economic and human assets, its level of vulnerability to HIV/AIDS, and its varied potential means of response to the epidemic.

In terms of employment, the pillars of the Arab private sector are the Small and Medium Enterprises (SMEs). In Algeria for example, the SME sector represents 97 percent of all

[92] *Economic Trends in the MENA Region*, Economic Research Forum, 2002, p. 94
[93] *Economic Trends in the MENA Region*, Economic Research Forum, 2000

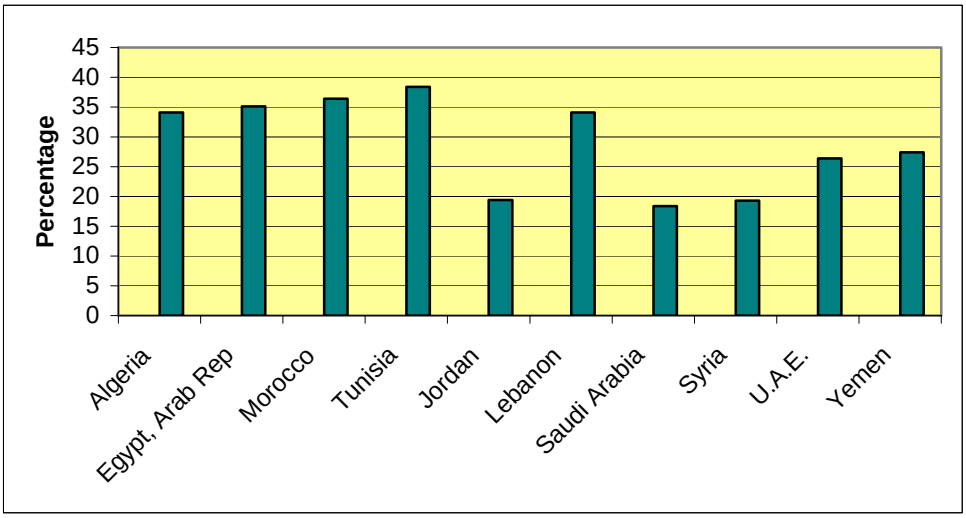
businesses, which is nearly half of the workforce and 45 percent of the GDP. Similarly in Egypt, SMEs represent 98 percent of the country's private non-agricultural businesses, while in Morocco, more than 92 percent of businesses are SMEs that employ nearly 48 percent of the country's total workforce.[94]

However, because of inadequate supplies of skilled labor, complex legal and institutional systems for commercial lending and little access to formal finance, markets, or government support programs[95], the private sector activity is often concentrated in a small number of national, regional and multinational large firms that might have benefited from protective policies.

1.3.2. …working in the informal sector

The formal private sector remains relatively under-developed in MENA, as it is still emerging from the culture of decades of state-led growth and industrialization. On average, the formal private sector accounts for less than 50 percent of GDP in the region.[96]

FIGURE 11: PERCENTAGE OF INFORMAL SECTOR IN GNP (2000)



Source: Friedrich Schneider, *Size and Measurement of the Informal Economy in 110 Countries around the World*, July 2002

The definition of the informal sector presents some difficulties because the activities included in the definition of the very concept evolve constantly. As stated in a 2002 report of Friedrich Schneider, "the informal economy develops all the time according to the principle of running water: it adjusts to change in taxes, to sanctions from the tax authorities and to general moral attitudes, etc."[97] Still, the same report indicates that the informal sector could be understood as "market-based production of goods and services, whether legal or illegal that escapes detection in the official estimates of GDP."[98]

---

[94] Definition of SME in Algeria: less than 250 employees, total assets less than USD6.25 million, turnover up to USD25 million; Definition of SME in Egypt: less than 100 employees, turnover less than USD2 million; Definition of SME in Morocco: less than 200 employees, turnover up to USD5 million, total assets up to USD7.7 million; see *North Africa Enterprise Development, Supporting the SME Sector in Algeria, Egypt and Morocco*, International Finance Corporation, 2003-2004, p.5

[95] *Middle East and North Africa, Economic Developments and Prospects*, World Bank, 2005

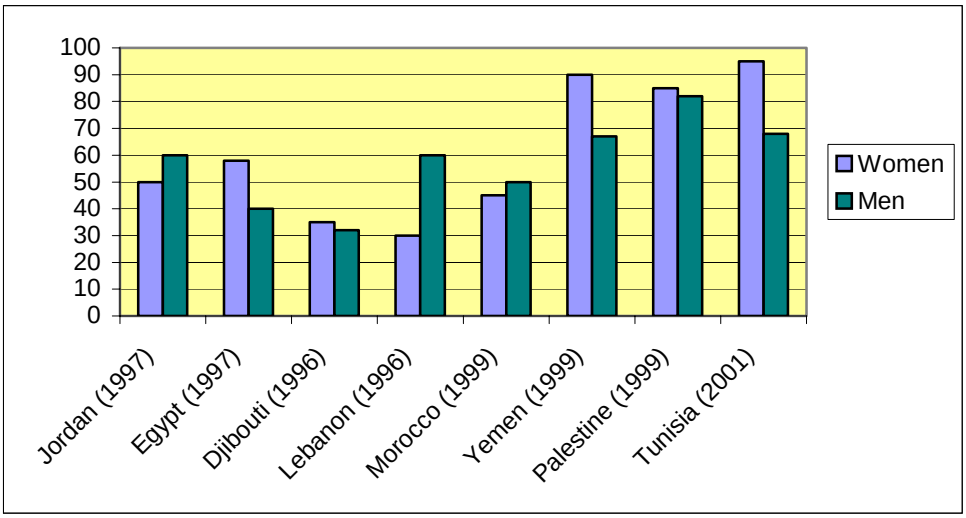
[96] *Ibid.*

[97] Friedrich Schneider, *Size and Measurement of the Informal Economy in 110 Countries around the World*, July 2002, p.3

[98] *Ibid.*

As many Arab countries committed themselves to privatization programs and restructuring their economies, the labor absorption rate became negative in some governments and public sectors during the nineties (-3 percent over the period 1995-2000 in Egypt for example). Moreover, statistics indicate that the formal private sector's ability to absorb labor was limited and even negative during the nineties (-50 percent in Egypt). "As a consequence of limited labor absorption rates in the formal sector, a tremendous increase in employment occurred in the informal sector which started to emerge in the 1970's and its share mounted to the degree that it employed 61 percent of Arab workforces on average (this figure reached 80 percent in countries like Egypt)", stated a survey of the American University of Cairo in 2002.[99] This informal sector is characterized by small-scale establishments, moderate investments, and capital and household production. It normally operates outside legislations and state supervision as mentioned above.

FIGURE 12: PERCENTAGE OF LABOR FORCE PARTICIPATION IN THE INFORMAL SECTOR



Source: The World Bank, *Gender and Development in the Middle East and North Africa, Women in the Public sphere, MENA Development report*, 2004, p.82

Depending on the market, new SMEs amounting to some 5 to 15 percent of all firms enter the market each year.[100] New entrants are absorbed mainly in the informal private sector, due to the shrinking labor absorptive capacity in the formal private sector.[101] The crucial importance of this informal sector in many Arab economies is reflected in countries such as Egypt where a large and vibrant extra-legal economy employs today over 8 million people (about 40 percent of the workforce) and has assets of almost US$250 billion, 30 times the market value of all companies registered on the Cairo Stock Exchange.[102]

According to the ILO, the informal sector is highly vulnerable to HIV/AIDS since the informal economy enjoys no social protection coverage nor does it benefit from any financial security.[103]

[99] *Youth Unemployment and Macroeconomic Policies*, American University of Cairo, 2002
[100] *Small Business Activities, Annual Review*, International Finance Corporation, 2004, p.6
[101] *Youth Unemployment and Macroeconomic Policies*, American University of Cairo, 2002
[102] *Unleashing Entrepreneurship – Making Business for the Poor*, Commission on the Private Sector and Development, March 2004, p.9
[103] *HIV/AIDS and the World of Work, Regional Strategy and Plan of Action for the Arab States*, International Labour Organization, Regional Office for the Arab States, June 2003, p.61

1.3.3. … employing more and more women

The role of women in the development of the private sector – whether formal or informal – has to be highlighted. In 2004, women represented approximately 32 percent of the total labor force in the Arab region (public and private sector)[104], with differences in each country indicated in the figure 13.

FIGURE 13: PERCENTAGE OF WOMEN AND MEN IN THE TOTAL LABOR FORCE (2000)

Country	*Women*	*Men*	*Country*	*Women*	*Men*
Algeria	28	72	***Oman***	17	83
Bahrain	21	79	***Occupied Palestinian Territories***	n.a.	n.a.
Djibouti	n.a.	n.a.	***Qatar***	16	84
Egypt	30	70	***Saudi Arabia***	18	82
Iraq	20	80	***Somalia***	43	57
Jordan	24	76	***Sudan***	30	70
Kuwait	23	77	***Syria***	27	73
Lebanon	30	70	***Tunisia***	32	68
Libya	23	77	***UAE***	13	87
Morocco	35	65	***Yemen***	28	72

Source: *League of Arab States*, 2000

Even though the number of girls enrolled in school is still relatively low (especially in higher education – only 14 percent of the girls go to university, against 20 percent for the boys)[105], Arab countries have achieved noticeable successes in girls' education as many Arab states aim to meet the UN Millennium Development Goals (MDGs) including providing access to education for girls.[106] For example, the MENA's average literacy rate for women rose from 16.6 percent in 1970 to 52.5 percent in 2000; the average number of years of schooling for women (15 years old and older) increased from 0.5 in 1960 to 4.5 years in 1999, and in many countries, women represent a sizable share of the university population (in the UAE, they represent more than 70 percent of all the university students).[107]

This improved – with still much more potential for progress – access to education increases the chances of educated girls and women to have access to employment, and therefore to the private sector (even though the majority of women work in the public sector).[108] This employment/education link is reflected by the slow but undeniable increase of women among the total labor force[109] as demonstrated in the following countries between 1999 and 2002: Bahrain (+3.46 percent), Kuwait (+14.15), Lebanon (+4.73 percent), Morocco (+0.79 percent), Somalia (+0.94 percent), U.A.E. (+2.83 percent), and Egypt (where the female labor force is estimated to have grown at nearly twice the rate as the male labor force between 1998 and 2005).[110] It is also interesting to notice that around the world, women-owned businesses are among the fastest growing segment of the private sector and in the MENA region, there is

[104] Nadereh Chamlou, *Speech at the Arab Women International Forum*, June 2004
[105] Ibid.
[106] *Arab Human Development Report*, UNDP/Arab Fund for Economic and Social Development, 2002, p. 28
[107] Nadereh Chamlou, *Speech at the Arab Women International Forum*, June 2004
[108] *Ibid.*
[109] *World Development Indicators*, The World Bank, 2004
[110] *Egypt Country Profile, The Road Ahead for Egypt*, Economic Research Forum & Institut de la Méditerranée, December 2004, p.153

increasing evidence of the beginning of such a trend, where educated women are setting up their own businesses.[111]

In light of this data, it must be mentioned that low female participation rates in the labor force (less than 30 percent, which is the case in most of the Arab countries) are correlated with high HIV/AIDS prevalence.[112] Empowered women are less likely to adopt at-risk behaviors and thus less vulnerable to HIV/AIDS. Bearing in mind the increasing consistency of women in the workplace (meaning that in certain countries women are more likely to hold on to their jobs)[113] and the increasing awareness of companies about the benefit of having a diverse work force[114], the best investment for private companies – depending on their field of activities – is a well-informed and empowered female employee. Therefore, the current trend of the female labor force in the region represents an asset in the response to HIV/AIDS, provided that they are given adequate information about HIV/AIDS including ways to protect themselves from infection and discrimination. As a senior advisor for the World Bank MENA region stated: "The private sector can be a powerful agent for change on issues of gender equality. And women can be powerful agents for the growth of a robust private sector".[115]

1.3.4. SMEs: a higher vulnerability to HIV/AIDS

As far as the workforce in the Arab region is concerned, data and figures available on HIV/AIDS are mainly disclosed by multinational companies, which are the only entities having the human and financial means to implement measures for prevention, treatment, and care. It is already a positive step that some multinational companies operating in the region are aware of the human and economic imperative for responding to HIV/AIDS, but they are still far from reversing the trend of the epidemic.

However, according to the Global Business Coalition's guidelines, SMEs are particularly vulnerable to the HIV/AIDS threat due to their limited financial, clinical, and human resource capacity to proactively manage HIV/AIDS prevention and care interventions.[116] In other words, despite documented effects of HIV/AIDS on SMEs, SMEs in the region have made little progress towards developing comprehensive strategies to combat the epidemic, which is reinforced by the fact that most SMEs have little capacity to deal with the problem and lack sufficient financial resources. This vulnerability is compounded by the increased viability risk facing SMEs. Often, the loss of a key employee due to AIDS can prove catastrophic for a SME in a situation where larger firms might have access to multiple employees capable of performing comparable work. Besides, SMEs also tend to have more difficulties adopting long-term policies, unlike multinational companies.

In this regard, a study conducted by the University of Port Elizabeth surveyed 209 small businesses in South Africa. The study identified AIDS as one of three main factors that cause nearly 80 percent of South African start-up SMEs to fail each year.[117] Further, the ILO adds

---

[111] Nadereh Chamlou, *Speech at the Arab Women International Forum*, June 2004
[112] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, 2003 The International Bank for Reconstruction and Development / The World Bank, p.50
[113] *Egypt Country Profile, The Road Ahead for Egypt*, Economic Research Forum & Institut de la Méditerranée, December 2004, p.149
[114] Nadereh Chamlou, *Speech at the Arab Women International Forum*, June 2004
[115] *Ibid.*
[116] *Guidelines for Building Business Coalitions against HIV/AIDS*, Global Business Coalition, p. 71
[117] http://www.ifc.org/ifcagainstaids

that the nature of the transitory and seasonal workforce in many SMEs aggravates the loss in productivity even further.[118]

In summary, the Arab private sector is a fertile ground for the spread of the epidemic and reinforces of the countries' vulnerability to HIV/AIDS. Multinational companies can be powerful partners for the implementation of HIV/AIDS policies, but a strategy excluding the participation of SMEs would neglect more than half of the Arab workforce.

1.4. What are the main sectors of the Arab economies?

A few sectors in the region represent the pillars of Arab economies. These sectors employ generally a high percentage of the national labor force, and should represent privileged targets for sector-oriented HIV/AIDS policies.

According to the experts interviewed for the purpose of this research[119], services are one of the main pillars of the Arab economies and the main employers of labor force, more specifically the tourism sector and the transport sector. In addition, the oil and gas sector as well as the agriculture sector and the textile industry, especially in North Africa, play a crucial role in the MENA economies.

1.4.1. Tourism

Countries in the MENA region, given world heritage sites, climatic advantages, natural attractions, and proximity to a high-income region, are well placed to benefit from tourism. Tourism receipt averages in recent years have been more than US$4 billion a year in Egypt (27 percent of total exports), US$2 billion in Morocco (20 percent of total export earnings), about US$1.5 billion in Tunisia (17 percent of total export earnings), and some US$0.7 billion each in Jordan and Lebanon (20 percent and 35 percent of total export earnings, respectively). These levels are among the highest in the world relative to total exports. Yet Algeria, the Republic of Yemen, Saudi Arabia, and Syria receive flows of tourism far below their potential. Even in the current high-tourism countries, the numbers of arrivals and their spending are below potential. For example, the Czech Republic, Hungary, and Poland together receive some US$12.5 billion annually in tourism receipts. As everywhere, tourism is vulnerable to safety and security issues, followed by the quality of services. In the next 10 years, if conflict in the region can be reduced sharply, the prospects for tourism remain good and will boost employment. The reforms in trade and investment will benefit tourism both directly and indirectly.[120] In other words, the workforce in the tourism sector has the potential to increase significantly.

World Tourism Organization statistics indicate that the number of incoming tourists to the Arab countries amounted to some 33.2 million in 2001, representing approximately 4.8 percent of the total number of tourists worldwide and a slight increase of 0.4 percent in comparison with 2000. The number of incoming tourists to the Arab countries was less than half that of France. Revenues from tourism to the Arab countries amounted to some US$16 billion, registering an increase of 1 percent in comparison with 2000 and representing some

[118] *HIV/AIDS and the World of Work, Regional Strategy and plan of Action for the Arab States*, International Labour Organization, Regional Office for the Arab States, June 2003, p.61
[119] cf. annexes "List of Contacts and Meetings"
[120] *Ibid.*

3.55 percent of gross tourism revenue worldwide. Revenues from tourism in the Arab countries were equal to half those of Spain.[121]

In the last decade, a great majority of the Arab countries have seen the number of people working for the travel & tourism sector increase significantly, as shown in figure 14. It must be mentioned that these figures represent the travel and tourism total employment, which includes direct and indirect employment (i.e. the total number of people employed in the travel and tourism industry as well as the jobs associated with this industry: industry suppliers, food suppliers, wholesalers, laundry services, etc.).

FIGURE 14: TRAVEL AND TOURISM TOTAL EMPLOYMENT (PERCENTAGE OF THE LABOR FORCE, 2004)

Country	*1990*	*1995*	*2000*	*2004*
Algeria	4.9	5.2	5.9	5.8
Bahrain	7.5	15.9	37.4	24.2
Egypt	7.6	8.8	10.0	12.9
Jordan	23.6	19.2	15.4	16.0
Kuwait	11.4	9.6	8.6	9.0
Lebanon	27.8	9.2	8.9	12.0
Libya	6.2	8.9	10.3	9.4
Mauritania	25.6	25.8	27.6	33.1
Morocco	9.1	9.2	11.7	13.8
Oman	8.0	10.1	10.9	11.0
Qatar	10.6	30.6	19.6	17.6
Saudi Arabia	10.9	9.2	8.0	8.4
Sudan	2.9	5.2	6.7	7.9
Syria	6.3	7.8	5.7	6.0
Tunisia	15.2	15.9	16.1	18.3
UAE	8.9	9.7	10.4	9.9
Yemen	3.2	5.0	7.7	6.2

Source: *The Impact of Travel & Tourism on Jobs and Economy*, World Travel & Tourism Council, 2004

These figures demonstrate the un-met potential of the tourism sector in this region, and allow us to presume that this sector will be significantly developed in the future despite the current security issues certain countries of the region face. Many governments have counted on the growing success of tourism and have invested significantly to attract investors and thus create employment. In other words, the expected growing number of employees in the tourism sector should be seriously considered as an important population-target in case of sectorial oriented HIV/AIDS policies. This point has been understood by the ILO, which plans to launch a project whose aim is to foster the response to HIV/AIDS in the Hotel Catering and Tourism (HCT) industry of 7 Arab States (as further mentioned in section 3).

1.4.2. Oil & Gas

The MENA region has abundant oil and gas resources. Of the 1,050 billion barrels of proven world crude oil reserves at the end of 2001, the MENA region accounted for about 69

[121] *Annual Review of Developments in Globalization and Regional Integration in the Countries of the ESCWA Region*, ESCWA, 2002, p.5

percent.[122] In contrast, the region accounted for just about 31 percent of total world production, and about 50 percent of exports. As for gas, the Middle East accounted for about 40 percent of the total gas world reserves of 155 trillion cubic meters in 2003.[123]

Consequently, MENA's industry is still dominated by extractive activities, which account for the bulk of industrial value added, ranging between 13.5 percent in Bahrain and 36.8 percent in Qatar.[124]

Six countries – Saudi Arabia, Iran, Iraq, UAE, Kuwait, and Qatar, known as the Middle East Six – are considered the major regional oil producers and dominate the regional production by originating approximately 80 percent of the total MENA production. Libya, Oman, Algeria and Egypt follow the six key regional producers with small contributions from Syria and Yemen. Saudi Arabia's production makes it the largest Organization of the Petroleum Countries (OPEC) member producer, representing 30 percent of total OPEC production. Oil exports remain a dominant share of merchandise exports for the region, accounting for 80 percent of merchandise exports among oil economies, and 72 percent for MENA countries as a whole.

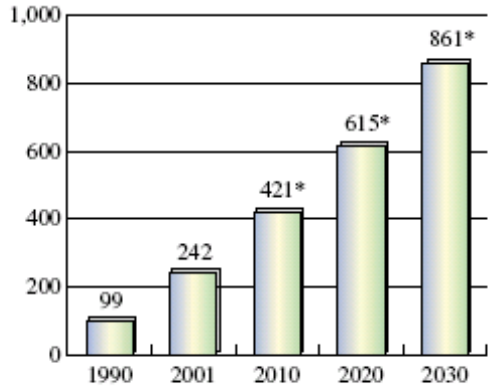
However, the large oil resources have also meant excessive dependence on a single sector, with the attendant downside risks from oil price fluctuations. Over the years, most of the oil-exporting MENA countries have focused their efforts on diversifying their economies away from the hydrocarbon sector[125]. The results have been relatively irregular. The diversification into the petrochemical industry has been quite successful for some countries (Saudi Arabia and Kuwait, for example) but the price of petrochemical products tends to be positively correlated with that of oil, which reduces the protection it provides from the vicissitudes of the oil market. In general, the non-hydrocarbon sector has largely been weak in oil-dependent MENA countries, and the policy thrust has been focused on how to expand the role of the private sector through appropriate structural reforms.[126]

Thus, the oil sector is extremely important to the economies of Arab countries – especially for the GCC countries since it provides more than one third of their total GDP, and because Middle Eastern members of OPEC are expected to supply some 40.5 percent of world demand by 2020.[127] However, despite its economic importance, it surprisingly provides fewer than 2 percent of the jobs in the GCC countries.[128] Still, one has to bear in mind that the employees of this sector represent a highly vulnerable population to HIV/AIDS, due to several factors such as their high mobility and the fact they are usually located in geographically isolated environments with limited social interaction, with might lead to risk behaviors such as unprotected sexual relations with Commercial Sex Workers (CSWs).

---

[122] Bright E. Okogu, *The Middle East and North Africa in a Changing Oil Market*, International Monetary Fund, 2003
[123] *Ibid.*
[124] *Ibid.*
[125] *Economic Developments and Prospects, Oil Booms and Revenue Management*, World Bank, 2005
[126] *Ibid.*
[127] *Impact of the World Oil Market on the Economies of GCC States: Quantitative Assessment and Forecast*, ESCWA, 2001, p.3
[128] http://www.un.org/Depts/rcnyo/no61999/ESCWAactivities.htm

FIGURE 15: NATURAL GAS PRODUCTION IN THE MIDDLE EAST (BILLION CUBIC METERS)



Source: *Natural Gas Survey, Middle East and North Africa,* Arab Petroleum Research Centre, 2005

Unlike oil, natural gas reserves are more widely dispersed around the world. In 2002, gas production from the region accounted for about 14 percent of total world output[129], in part reflecting the relative under-investment in the gas sector of the region. However, things are changing. The US$25 billion Saudi Gas Initiative, ongoing or planned production expansion by Algeria, Oman and Qatar, and expected developments in Iran, Libya, and Yemen should substantially raise Middle Eastern gas output in the coming years. Hence gas will definitely play an important role in shaping the region's economy in the future, as reflected in figure 15.

1.4.3. Transport

Transport is considered to be one of the most important sectors that require regional integration because of the major role it plays in developing intra-regional trade[130]. However, it must also be considered as a high-priority sector in the response to HIV/AIDS due to the vulnerability of its workforce, as further explained in the last chapter of this section.

The transport infrastructure and services provide access to jobs, markets, health, education, and other social services. It typically accounts for between 5 and 8 percent of a country's total paid employment, and generates 4 to 7 percent of GDP.[131] Transportation plays a fundamental role in connecting countries with external trading partners, and employs an increasing number of people throughout the MENA region. The greater integration of the region's economies through trading blocs described previously in section 1.1.1 holds promise for increasing trade among members, thus increasing the exchange of goods and people, which will generate a greater need for transportation services.

Land, maritime, and air transport networks in the MENA region have developed substantially. However, emphasis has been placed on providing national linkages in land transport networks, to the expense of the regional linkages that arguably did not receive the attention they deserve.[132]

Still, improving the efficiency of trade logistics is a top priority for most countries of the Arab region since efficient trade logistics serve as a catalyst for economic competitiveness and consequently deeper integration with the global market. In turn, this promotes economic activity, encourages investment, and generates opportunities for employment. This point allows us to assume that governments, in collaboration with private investors, will

[129] Bright E. Okogu, *The Middle East and North Africa in a Changing Oil Market*, International Monetary Fund, 2003
[130] *Annual Review of Developments in Globalization and Regional Integration in the Countries of the ESCWA Region*, ESCWA, 2002, p.12
[131] *Sector Brief,* World Bank Group, September 2004
[132] *Ibid.*

significantly foster the development of this sector. Indeed, although private participation in infrastructure has declined precipitously in recent years[133], the need to build additional capacity at ports and airports, and to extend and maintain road networks has continued to grow.

1.4.4. Textile Industry

During the last decade, in the context of a quota dominated regime for successful exporters in the world market, MENA countries, which had mostly remained quota free, had managed to improve their world market share in clothing from 2.5 percent in mid-1980s to 4 percent by 1995.[134] This increase has come mainly from the market gains made by Morocco, Tunisia, United Arab Emirates and Egypt. However, a rising concern discernible from analysis of market share trends is the recent weakening of competitiveness of MENA exporters in world markets, mainly due to competition coming from Asia and the consequences caused by the delay in modernizing this industry.

The geographic orientation of the MENA country textile and clothing exports remains biased to Europe, which is understandable given its proximity. The countries that relied mostly on the European Union or the United States for exports have either continued to be focused on the same market, or further intensified their dependence. Gulf countries and more recently Jordan tended to trade more with the United States; Egypt and United Arab Emirates have more or less balanced orientation to the US and EU markets, though neither is an important supplier in those markets. As mentioned previously, Jordan has special free-trade agreements that have helped the country to orient clothing exports to the US market.

Experts agree on the critical role of textile and clothing in sustaining MENA manufacturing jobs and exports. Between textile and clothing exports, clothing exports were of greater importance to the MENA region in 2000 with receipts at US$8.3 billion compared to textile exports of US$2.4 billon. This has not always been the case. In 1974 for example, textile exports were twice as great as clothing exports for MENA.

The increasing world market share of MENA countries in global trade in textiles and clothing implies that the dependence of these countries for non-traditional exports, jobs, and income generation has increased. On average, between 10 percent (Jordan) to 41 percent (Tunisia) of employment in manufactures use to originate in the textiles and clothing sectors, and up to 50 percent (Tunisia) of merchandise exports was earned by this sector in 2000.[135] In manufacturing value added 23 percent (Tunisia) is derived from textiles and clothing. In Tunisia, Morocco, and Jordan the textile and clothing sector has grown in importance over time. In Egypt however, the share of employment has remained almost unchanged even as export share increased and value added share declined. Despite the difficulties it is currently facing, the textile and clothing industries in the MENA region remain very important sources of employment. Furthermore, because a great majority of their employees are unskilled and/or semi-skilled, they should also be considered as a high-priority population-target for sector oriented HIV/AIDS policies.

---

[133] *Ibid.*
[134] Dipak Dasgupta, Mustapha Kamel Nabli, T.G. Srinivasan, Aristomene Varoudakis, *Current World Trade Agenda: Issues and Implications for the MENA Region*, May 2004
[135] Dipak Dasgupta, Mustapha Kamel Nabli, T.G. Srinivasan, Aristomene Varoudakis, *Current World Trade Agenda: Issues and Implications for the MENA Region*, May 2004

1.4.5. Agriculture

Before the peak of the oil boom in the 1970's, agriculture was the main economic activity in the region and it still remains an important pillar of several national economies in the MENA region, as shown in figure 16.[136] Apart from some of the Gulf countries, this share varies from 2.2 percent for Jordan to 37.2 percent for Sudan. In addition the agriculture sector employs a significant share of the labor force in many the countries in the region. The share of agriculture in total labor force in 2000 varied greatly between countries, with the highest percentage reached in Djibouti (79 percent) followed by Somalia (71 percent), Sudan (61 percent), and Yemen (51 percent).

FIGURE 16: AGRICULTURAL GDP AND AGRICULTURAL LABOR FORCE (2000)

Country	*Agricultural GDP as Share of Total GDP*	*Agricultural Labor Force / Total Labor Force*
Algeria	8.6%	24%
Bahrain	0.9%	1%
Djibouti	3.7%	79%
Egypt	16.6%	33%
Iraq	33.2%	10%
Jordan	2.2%	11%
Kuwait	0.4%	1%
Lebanon	11.9%	4%
Libya	N.A.	6%
Morocco	13.5%	36%
Oman	2.8%	36%
Qatar	0.5%	1%
Saudi Arabia	6.6%	10%
Somalia	N.A.	71%
Sudan	37.2%	61%
Syria	24.1%	28%
Tunisia	12.3%	25%
UAE	3.3%	5%
Yemen	15.3%	51%

Source: FAOSTAT, 2002

According to the Food and Agriculture Organization (FAO), many of the MENA countries are opening up and liberalizing their agricultural markets at on the unilateral, regional and global level. These changes result in important implications for intra and extra-regional trade, use of agricultural resources, and sustainability of agricultural development in the region. This sector has been liberalized through the elimination or reduction of input subsidies, the removal or reduction of guaranteed producer prices, the reduction of the number of subsidized commodities, and the liberalization of exchange rates and of the trade regime. Still, some of the MENA countries continued supporting agriculture, mainly for food security reasons.

Agricultural trade liberalization is also taking place in the context of several regional trading agreements, most important among which are the AFTA, the GCC, the AMU and the EU Mediterranean Agreements described previously in section 1.1.1. Regional integration continues to be an issue of great concern in the MENA and promotion of intra-regional agricultural trade remains a key objective in all regional trading agreements.

[136] *Trade, Market Access and Food Safety in the Near East Region*, FAO-IDB, October 2003

The most remarkable development in the agricultural trade liberalization process is 15 MENA countries' access to the WTO (observers included, as explained in section 1.1.2) and the commitments they made under its various agreements. Many countries in the region agreed to a set of principles to reduce trade distortions caused by agricultural policies. However, despite progress achieved in the implementation of this agreement, many experts agree that the international trade system remains unbalanced. Geographic proximity plays an important role in establishing intra-trade patterns in the region. Syrian agricultural exports account for the largest percentage of total inter-Arab agricultural exports, amounting approximately to 29 percent, out of which Saudi Arabia imports about 50 percent, while the other Arab states import 35 percent, and the rest goes to Algeria 7 percent, Jordan 6 percent, and Egypt 4 percent. Second in exportation is Saudi Arabia, which exports about 90 percent of its total agricultural exports to the Arab countries of the neighboring Gulf States. Sudan, Libya and Saudi Arabia absorb about 60 percent of Egypt's intra-Arab agricultural exports. Morocco's major agricultural exports go to Saudi Arabia, which accounts for 49 percent of its inter-Arab agricultural exports, whereas 21 percent go to Algeria, 5 percent to Tunisia and 3 percent to Egypt. Similarly, most of Algeria's agricultural exports go to Morocco, Tunisia and Egypt. As for Jordan, 30.5 percent of its agricultural exports go to Saudi Arabia.[137] As one can notice, most of the Arab intra-trade is generally conducted between two or three countries in the region. This economic interdependency between Arab countries reinforces the need for a regional response to threats like HIV/AIDS.

As a consequence, given the high number of people employed in the economic sectors presented above – tourism, transport, oil and gas, textile industry, and agriculture – it makes sense to consider them as privileged sources of outreach in the response to HIV/AIDS and to elaborate specific policies targeting these economic sectors and their subsequent workforce.

1.5. Focus on groups of employees particularly vulnerable to HIV/AIDS

It is also important to stress the vulnerability of certain at-risk groups of employees of the private sector, relative to their behavior, living and working conditions, as well as accompanying and underlying diseases. And because of the transformations presented above, there is an increase of these at-risk groups throughout the region. Certain types of work are more susceptible to the risk of infection with HIV than others, although the main issue is one of behavior, not of occupation.

[137] *Trade, Market Access and Food Safety in the Near East Region*, FAO-IDB, October 2003

BOX 2: FACTORS THAT INCREASE THE RISK OF INFECTION FOR CERTAIN GROUPS OF WORKERS – ILO CODE OF PRACTICE

According to the International Labor Organization Code of Practice, the factors that increase the risk of HIV infection for certain groups of workers are summarized as follows[1]:

- *Work involving mobility, in particular the obligation to travel regularly and to live away from spouses and partners.*
- *Work in geographically isolated environments with limited social interaction and limited health facilities.*
- *Single-sex working and living arrangements among men.*
- *Situations where the worker cannot control protection against infection.*
- *Work that is dominated by men, where women are in a small minority.*
- *Work involving occupational risks such as contact with human blood, blood products and other body fluids, needle-stick injury and infected blood exposure, where Universal Precautions are not followed and/or equipment is inadequate.*

Source: *HIV/AIDS and the World of Work, Regional Strategy and plan of Action for the Arab States*, International Labour Organization, Regional Office for the Arab States, June 2003, p.35

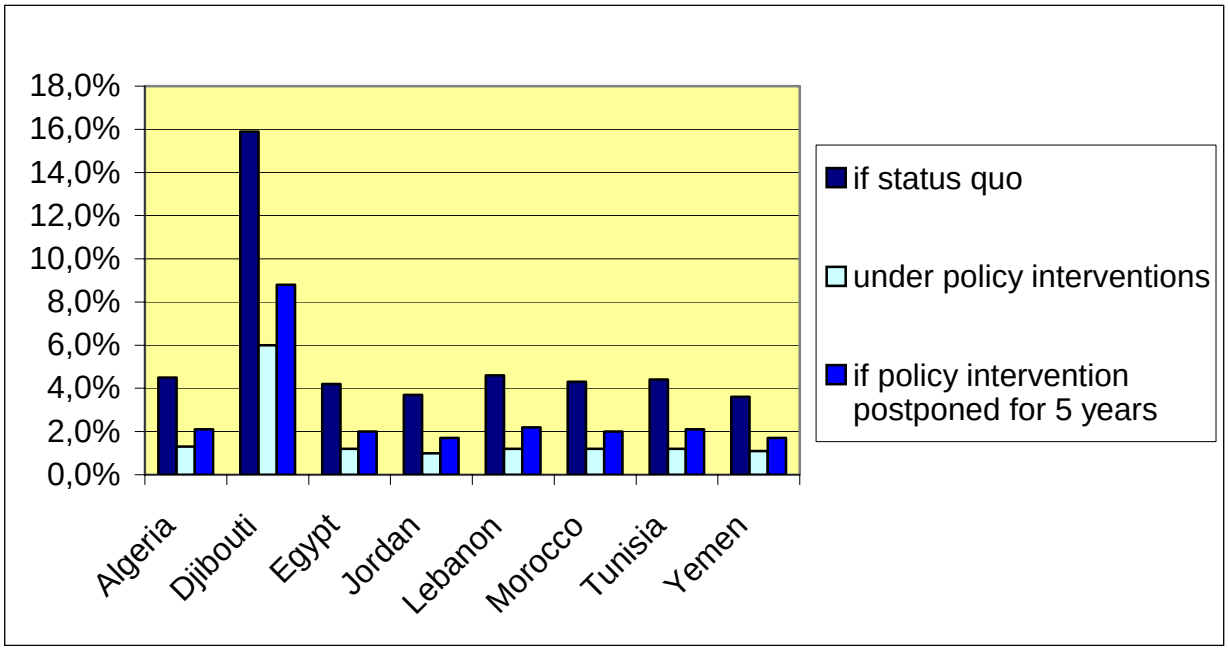
We can understand from these descriptions that the most vulnerable segments of the Arab workforce are the ones working in sectors such as transportation, industry (especially manufacturing), oil and gas, building and construction, among other sectors. This statement is reinforced by the fact that a large proportion of the workforce mentioned above falls within the high-risk semi/unskilled categories. It must be noticed that the sectors that represent the pillars of the many Arab economies are also some of the most vulnerable sectors to HIV/AIDS.

2. WHY SHOULD THE PRIVATE SECTOR GET INVOLVED IN THE RESPONSE TO HIV/AIDS IN THE ARAB REGION?

2.1. How will the epidemic spread in the Arab region?

Many studies insist on the necessity to immediately take measures in response to HIV/AIDS, and one better understands this great need when made aware of the projections of the epidemic. Because of the serious lack of data on HIV/AIDS in MENA, projections are only available in certain countries, as indicated in the chart below (full data is available in the appendix). However, because of the significant economic and social interaction between Arab countries, as previously demonstrated, and the numerous cultural similarities, one can logically expect other Arab countries to have quite similar growth rates in the prevalence of HIV/AIDS.

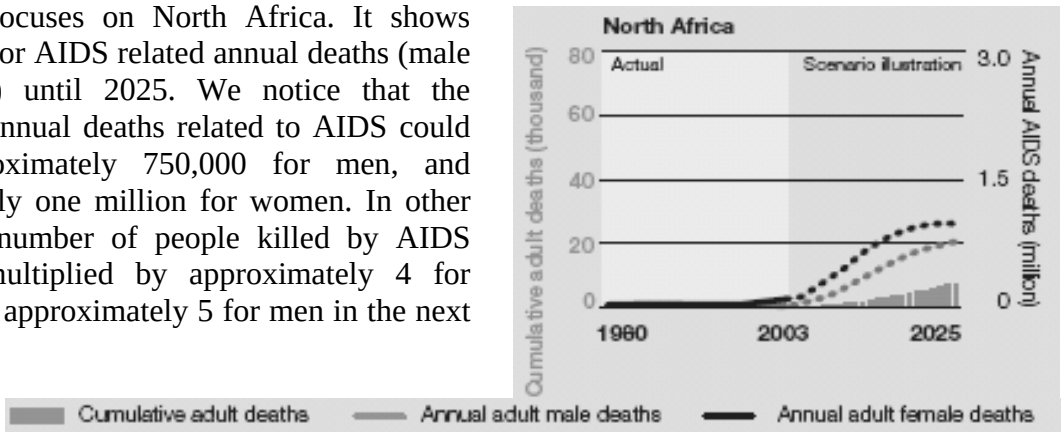
FIGURE 17: HIV PREVALENCE IN 2015 (PROJECTIONS)



Source: Figure based on data from "Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction,* The International Bank for Reconstruction and Development / The World Bank, 2003", p.109, 127, 128

FIGURE 18: ANNUAL AIDS DEATHS IN NORTH AFRICA (PROJECTIONS)

Figure 18 focuses on North Africa. It shows projections for AIDS related annual deaths (male and female) until 2025. We notice that the number of annual deaths related to AIDS could reach approximately 750,000 for men, and approximately one million for women. In other words, the number of people killed by AIDS could be multiplied by approximately 4 for women, and approximately 5 for men in the next 20 years.



Source: *AIDS in Africa – Three Scenarios to 2025*, UNAIDS, January 2005

Without any serious intervention, the high-risk behaviors and the structural vulnerability of the Arab region make it impossible that the epidemic will ever be eradicated or stabilized on its own. Only concrete and effective HIV/AIDS campaigns, measures, and policies taken by all stakeholders of Arab society – including corporate citizens – will reverse the epidemic's current trend.

2.2. HIV/AIDS policies: a necessary investment for private companies

HIV/AIDS impacts young adults in their most productive ages. Thus, AIDS could become the second major cause of death among adults of working age in the world – including the Arab world – posing a serious economic threat.[138]

The epidemic is eroding productivity just at the time that developing countries, such as most of the Arab countries, need to become more competitive to cope with rapid globalization. In the private sector, this raises the costs of business and deters investment.[139]

2.2.1. Losing trade partners and investors

Today, countries facing a widespread epidemic do not have the capacity to be as economically dynamic and productive as in the past when HIV infection rates were low. Therefore, their ability to maintain their level of exports is jeopardized.[140] Even countries with dynamic economies like South Africa are experiencing great economic losses generated directly or indirectly by HIV/AIDS. Experts are skeptical about the solidity of the newly found South African prosperity that has been announced[141], partly due to the domestic exports that have not reached the expected level (possibly because of the loss of competitiveness generated by HIV/AIDS, among other reasons), and the direct fixed investment that remains at disappointing low levels (possibly because of the increasing production costs generated by

[138] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, 2003 The International Bank for Reconstruction and Development / The World Bank, p.53
[139] www.worldbank.org
[140] Robert Greener, *AIDS and Macroeconomic Impact*, Botswana Institute for Development Policy Analysis, 2001, p.52
[141] Helmo Preuss, *South Africa Economic Growth as Good as it Gets*, Mail & Guardian, April 2005

HIV/AIDS, among other reasons). These trends contributed to South Africa's first trade deficit in 22 years at the end of 2004.[142]

The HIV/AIDS crisis has actually increased the risk profile for investment in the Southern African region[143]. Certain countries badly affected by the epidemic, like South Africa, are experiencing significant declines in FDI[144] because of decreasing productivity and increasing production costs. A Business Map investor survey released at the end of January 2002 found that the spread of HIV/AIDS in South Africa has significantly contributed to decreased FDI levels[145], in addition to disruptions in agricultural production, food security, and an expected 17 percent decrease of its GDP by 2010. Because AIDS is destroying the twin rationales of globalization strategy – cheap labor and fast-growing markets – the pandemic is forcing executives to think twice before investing in countries affected by HIV/AIDS.

In the Arab region, overall losses in GDP have been difficult to project. As described in a survey of the World Bank[146], estimates reveal losses of up to 2-3 percent in nations with HIV infections of over 10 percent. If no measures are implemented immediately in the HIV/AIDS response in the region, 8 Arab countries (namely Algeria, Egypt, Djibouti, Jordan, Lebanon, Morocco, Yemen, and Tunisia) could lose up to 30 percent of their GDP in the next 20 years. Calculations for a broad range of diffusion scenarios indicate that the average growth rate of potential GDP could be reduced by 0.2 to 1.5 percent per year for the period 2002–25. The consequences for their national economies would be dramatic, not to mention the repercussions on the regional level. The impact would be even stronger because of the interdependency of certain Arab economies.

Furthermore, on both a national and regional level, businesses seek stability and certainty to support investment in operations and new markets. AIDS is a direct threat to such a foundation. It threatens the stability and security of a nation, with preliminary evidence suggesting that the pandemic can deter foreign investment and disrupt other flows of goods and capital, as stated in a report of the Global Business Coalition against HIV/AIDS.[147] The intensification of the Arab region's trade influx and economic collaboration with other regions of the world such as the European Union and the United States could generate, in case of a further epidemic spread, financial complications not only for the Arab countries, but for investors as well. Comparative advantages that allow certain Arab countries to attract foreign investors such as a great availability of skilled and/or unskilled low cost labor could disappear because of HIV/AIDS. Arab countries as well as foreign investors would have to cope with the financial consequences of such an epidemic. Investors would have to bear the costs of delocalization and thus would lose a great number of sources in safe, cheap, and profitable investment.

2.2.2. Losing workforce & customers

As stated above, AIDS strikes individuals in their most productive years. Today, 35 million people living with HIV are between the ages of 15-49. The greatest number of new infections

[142] Mariette Le Roux, *First South African Trade Deficit in 22 years*, Mail & Guardian, September 2004
[143] Nawaal Deane, *HIV/AIDS Raises the Risk Premium On Foreign Investment in SA*, Mail & Guardian, February 2002
[144] *Opportunities for Business in the Fight Against HIV/AIDS*, Global Business Coalition, January 2005, p. 7
[145] Nawaal Deane, *HIV/AIDS Raises the Risk Premium On Foreign Investment in SA*, Mail & Guardian, February 2002
[146] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, The International Bank for Reconstruction and Development / The World Bank, 2003, p.XVIII
[147] *Opportunities for Business in the Fight Against HIV/AIDS*, Global Business Coalition, January 2005

targets the future workforce, young adults between the ages of 15 to 24 years of age.[148] On a national level, the human capital of a country is given by the size and quality of its labor force. HIV/AIDS is likely to affect both.

On one hand, there are effects in the size and productivity of the current labor force because of higher mortality and morbidity. Premature deaths represent not only losses in a production, but also losses of knowledge and experience associated with this.[149] Countries highly affected by the epidemic experience great losses of teachers, researchers, doctors, engineers, etc. The loss of human capital and shifting demographics threaten to decimate decades of development, skill, and intellectual resource.

On the other hand, HIV/AIDS can affect the accumulation of future human capital. Indeed, premature deaths tend to increase the number of orphans who are less likely to fully develop their physical and intellectual capacities.[150] A recent report by Heidelberg University and the World Bank[151] argues that many estimations are modest, failing to account for loss in human capital, the increasing numbers of AIDS orphans worldwide, and the loss of skills and education over generations. By 2001, 13.4 million children under 15 years of age lost parents to the disease, a number that is expected to almost double to 25 million by 2010.

The National Bureau of Asian Research raises another point specifically concerning the Gulf countries. According to a recent report, HIV/AIDS might destabilize the flow of migrants towards these countries and impact remittances home.[152] The decrease of foreign labor would therefore oblige the Gulf countries to diversify their economies by using domestic labor. One of the direct consequences would be an increase in the costs of labor, thus jeopardizing the competitiveness of companies operating in the sub-region.

In light of this information, the private sector must realize that its best asset, its functionality and working capital, its present and future workforce, are greatly endangered. If nothing is done now, companies might experience difficulties in 15 to 20 years to find skilled or non-skilled workforce in the Arab region.

Another unfortunate but logical consequence of the pandemic is the reduction of consumption. Since HIV often strikes the breadwinner, his/her family will have no choice but to spend their savings on medicines, which will prevent them from consuming, and could lead to impoverishment. In other words, the epidemic is eroding the demand for goods and services in developing markets, meaning that companies are losing or will lose their customers.[153] As described in a report of the World Bank[154], "using the most recently published estimates of HIV prevalence, losses in gross domestic product and consumption resulting from the diffusion of HIV/AIDS could be significant in many MENA/Eastern Mediterranean countries. The future losses of potential output and consumption during that

[148] *Opportunities for Business in the Fight Against HIV/AIDS*, Global Business Coalition, January 2005
[149] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, The International Bank for Reconstruction and Development / The World Bank, 2003, p. 53
[150] *Ibid.*
[151] Belle, Devarajan, Gersbach, *Long Run Economic Costs of AIDS: Theory and an Application to South Africa*, World Bank, 2002.
[152] Laura M. Kelley and Nicholas Eberstadt, *Behind the Veil of a Public Health Crisis: HIV/AIDS in the Muslim World*, National Bureau of Asian Research, June 2005, p. 8
[153] Sydney Rosen, Jonathan Simon, William Mac Leod, Matthew Fox, Donald M. Thea, Jeffrey R. Vincent *AIDS is Your Business*, Harvard Business Review, February 2003
[154] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, The International Bank for Reconstruction and Development / The World Bank, 2003, p.XVIII

period could be equivalent to 35 percent of today's GDP, even under conservative assumptions. These losses occur as rising mortality and morbidity reduce labor productivity, capital investments are reduced, and the labor force shrinks."

In some countries of the region, calculations suggest that by 2010, around 8 to 30 million who would have escaped poverty in the absence of the epidemic will instead continue to have consumption levels below the poverty line because of expected losses in output and consumption.[155]

Companies might therefore experience difficulties in finding customers for their products or services, and will suffer great losses in terms of results and profits.

2.3. What is the day-to-day impact of HIV/AIDS on business?

2.3.1. An expensive equation generated by the spread of the epidemic

Costs of measures and policies to be implemented against HIV/AIDS vary according to the profile of the company. That is to say a company's organizational structure, size, field of activities, operating locations, risks and vulnerability factors will determine the costs and benefits of HIV/AIDS measures and policies. There are a diverse range of industries operating in regions where the epidemic is most severe, each with unique characteristics that determine the impact of HIV/AIDS on productivity and profitability. While there is some common ground, the potential impact of HIV/AIDS will very likely differ dramatically from business to business.[156]

It is true that calculating the economic and business costs of the pandemic has proven elusive, which is not surprising given its magnitude, breadth, and duration. Many of the more serious costs of the pandemic cannot be measured by traditional cost accounting mechanisms, but some studies show that these indirect costs can represent up to 200 percent of the direct costs.[157] However, it is relevant to have a global view of the total costs and a closer look at the ones that can be calculated. Even though this section is focusing on the economic impact of HIV/AIDS reflected by mere and impersonal figures, one has to bear in mind that we are talking about human lives. Practices mentioned in the following section such as the termination of an employee's contract justified by his/her HIV status or the disclosure of his/her identity and HIV status to other entities are unethical. These kinds of measures foster stigma and discrimination towards PLWHA and dramatically slow down the creation of an enabling environment, which is one of the keys for an appropriate and effective response to HIV/AIDS in this region. It is also important to understand that such measures do not prevent the company from the economic impact of the epidemic.

Clearly, the total impact of direct costs on firms will vary depending on factors such as whether firms provide worker protections like in-house medical facilities, employment benefits, funeral costs, and pension accounts. Still, the simple equation of the costs of HIV/AIDS on business would be:

Total costs = measurable costs + non-measurable costs

---

[155] *HIV/AIDS and the World of Work, Regional Strategy and Plan of Action for the Arab States*, International Labour Organization, Regional Office for the Arab States, June 2003, p.64

[156] *Opportunities for Business in the Fight against HIV/AIDS*, Global Business Coalition, University of Cape Town, Columbia University, January 2005

[157] *Ibid.*

In this equation, **measurable costs** would be factors such as:

1) Recruitment and Training process

The high turnover of the labor force generated by the loss of employees affected by AIDS obliges companies to constantly hire new employees and to provide them adequate training in order to retain the necessary number of employees and maintain its level of activities. This process generates important costs that vary depending on the size of the company.

2) Health insurance of workers and medical care

The cost of health insurance for employees is usually divided between the company and the employee. Theoretically, the price of the health insurance should not vary whether an employee is sick or not. However, in certain cases, some companies even refuse to insure PLWHA. The treatment and care of the infected and affected employees with HIV/AIDS could represent a significant cost if many employees are infected with the virus. The treatment is sometimes extended to the employee's family members.

3) Funeral provisions

Some companies operating in countries highly affected by the epidemic have to bear the costs of several funerals per week.[158]

4) Absenteeism

Absenteeism from sickness, caring for ill family members, and preparing for and attending funerals of people who died from AIDS-related diseases is one of the components that create a loss of productivity. A study of the American Insurance Company (AIC) in South Africa showed that the absenteeism rate for people living with HIV/AIDS who did not have access to appropriate ART was three times higher than that of people not infected with the virus. In this study, PLWHA who did not have access to appropriate ART were absent 32 days a year on average, in four stints of 7 to 8 days.[159]

The **non-measurable costs** (which can represent, as already mentioned, up to 200 percent of the direct costs, according to the AIC survey)[160] would be represented by factors such as:

1) Loss of productivity

Production lines, management structures, and cohesion in the workplace are directly undermined by increased absenteeism, among other things.

2) Loss of efficiency

It has been proven that on an individual level, infected and affected employees who do not receive appropriate treatment might not be as efficient as other employees, which generates a direct loss of productivity.[161]

---

[158] Interview of Professor Diana Barrett by the Harbus Online team – Senior Lecturer at Harvard Business School, *Corporate Partnerships to Combat HIV/AIDS,* May 2005

[159] Neesa Moodley, Business Report, *Absenteeism costs R12bn a year, with up to R2.2bn due to AIDS*, February 2005

[160] *Ibid.*

3) Loss of skilled employees

Greater staff turnover generally leads to knowledge and skill loss among employees. As stated above, this repetition of this phenomenon could make it difficult for companies to find skilled employees in 15 to 20 years in the Arab region.

4) Loss of business opportunities

As explained in details above, the loss of trade partners and customers represent a great loss of business opportunities for companies and are translated in direct financial losses.

5) Loss of morale and workplace cohesion

Lower morale due to illness and loss of co-workers threatens the stable environment and the workplace cohesion needed to sustain operations. Companies with aggressive AIDS strategies enjoy a surge in employee morale.[162]

6) Public relations risks of inaction

According to the Global Business Coalition's Guidelines for business, "reputational risk" is also a key motivator for businesses with high profile brands and for companies in certain sectors to take action against HIV/AIDS. Strong evidence has emerged revealing significant public relations and government relations benefits to companies who become involved, regardless of where their company operates. Companies like Viacom, Daimler-Chrysler, Anglo-American, MAC Cosmetics and others have found that their involvement in the issue brings them worldwide recognition - routinely referred to in the media as models for corporate citizenship.[163] Finally, an additional benefit of corporate involvement in the fight against AIDS relates to corporate government relations efforts.

7) Decreased reliability of supply chain and distribution channels

Because companies operating in the region logically rely on other companies to make business, the weakening of one part of the economic chain could jeopardize the rest of the chain. In other words, HIV/AIDS threatens the economic activities of a company by targeting its employees, as well as its suppliers and distributors.

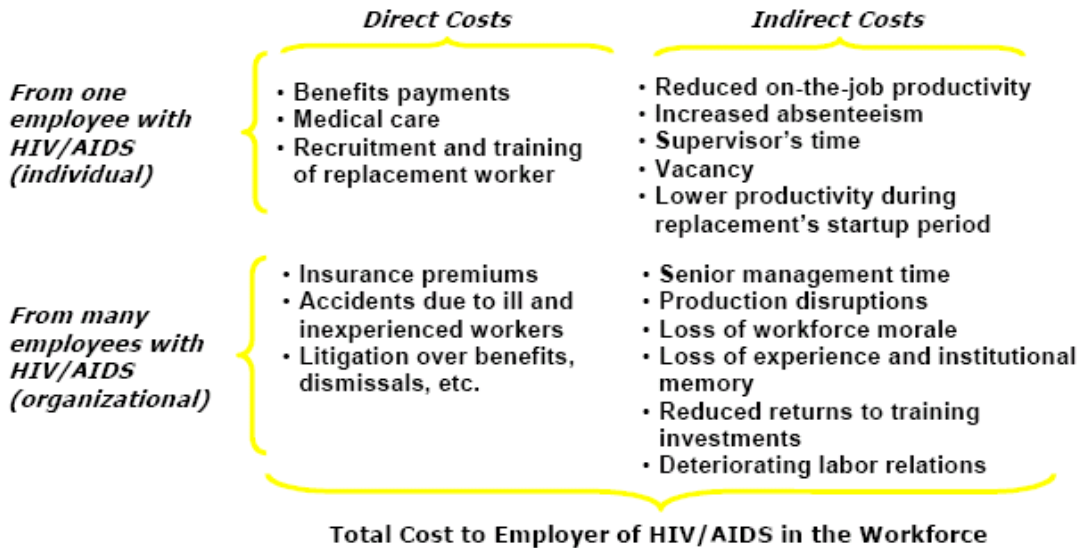
8) Risk of viability (especially for small companies)

As seen above, the loss of a key employee due to AIDS can prove to be catastrophic for a SME in a situation where larger firms might have access to multiple employees capable of performing comparable work.

---

[161] *Opportunities for Business in the Fight against HIV/AIDS*, Global Business Coalition, January 2005, p. 3
[162] *Ibid*, p.7
[163] *Ibid*, p. 6

FIGURE 19: TOTAL COST OF HIV/AIDS IN THE WORKFORCE



Source: Frank Feeley, Paul Bukuluki, Alizanne Collier, Matthew Fox, *The Impact of HIV/AIDS on Productivity and Labor Costs in Two Ugandan Corporations*, October 2004, p.9

Private companies will have to sooner or later invest in policies to respond to HIV/AIDS as they cannot separate their own interests from those of the societies in which they function. They will not be able to keep on operating in an economic bubble and will have to accept their responsibility as corporate citizens. The question is not "will private companies have to invest to respond to HIV/AIDS?" but "how much will private companies have to invest to respond to HIV/AIDS?" The answer, as explained in details above, depends on the characteristics of each company, but mostly on the ability of companies to react quickly. The longer they wait to implement appropriate measures and policies, the more they will have to invest in their late attempt to balance the situation. In other words, a preventive and proactive response is far less costly than a late response generating reactionary costs.

2.3.2. Concrete examples on private companies operating in the Arab region and other regions of the world

The costs presented in the previous section have been seriously taken into consideration and analyzed by private companies operating in other regions of the world. The immediate consequences and the burden generated by HIV/AIDS on their daily business activities encouraged some of them to conduct comprehensive studies on the most appropriate and cost-effective ways to respond to the epidemic. Most of these studies, conducted on companies operating in Sub-Saharan African countries, agree on the fact that "responses that are good for health – prevention and treatment – are good for businesses".[164] Indeed it appears that with the burden of disease raised by the prevalence of HIV, investments of companies in interventions responding to HIV/AIDS may reduce the costs of chronic illness in the labor force to such an extent that the firms are actually starting to notice savings.

The findings of a study[165] conducted in 2004 by the Center for International Health and Development at Boston University on the financial impact of HIV/AIDS on private companies, also called "AIDS tax", confirm these statements. It has been found that the cost

[164] Sydney Rosen, Jonathan Simon, William Mac Leod, Matthew Fox, Donald M. Thea, Jeffrey R. Vincent, *AIDS is Your Business*, Harvard Business Review, February 2003
[165] Sydney Rosen, Jonathan Simon, William Mac Leod, Matthew Fox, Donald M. Thea, Jeffrey R. Vincent, *AIDS is Your Business*, Harvard Business Review, February 2003

of one HIV infection in the absence of appropriate response on the part of the company could reach, in some cases, 3.5 times the employee yearly pay. Furthermore, this annual "AIDS tax" on businesses, depending on the workforce structure, HIV seroprevalence, and employee benefits, turned out to vary from 0.4 percent to 5.9 percent of the total labor costs of the companies studied, which represented in absolute terms up to US$11.9 million per year for some companies.

HIV/AIDS Prevention and Treatment Measures Proven to be Profitable Investments

As a logical consequence, companies with higher business costs realized that low-cost prevention measures would generate a positive return on investment. These measures would have been profitable to companies with lower cost business if they had taken into account all the organizational costs generated by the epidemic. Even though the returns were not large, it is crucial to realize they were positive. Similarly, the same study showed that all the studied companies would have earned positive returns on investment had they provided Highly Active Anti-Retroviral Treatment (HAART) at no cost to their employees. In this case, the costs generated by the epidemic could have been reduced by more than 40 percent per year. Even for less significant positive returns on investment, "providing free anti-retroviral therapy at every level of the workforce made eminent financial sense for all studied companies".[166] Other surveys in African countries showed that for companies studied, providing HAART for a year represented only 2.9 to 9.2 percent of the cost of losing an employee. These figures do not even include non-measurable but significant benefits mentioned previously, such as the cohesion of the workplace, the preservation of efficiency and productivity, or the recognition by employees and communities of the company's concern for its employees.

The results of these studies conducted in Sub-Saharan Africa have been obtained empirically (i.e. after several years of observation). Because of low HIV prevalence, general lack of data on employees' HIV status, as well as a very limited number of HIV/AIDS policies implemented by companies operating in the Arab region, such an empirical methodology is difficult to apply in this region currently. However, projections based on current trends in the Arab region provide important data for a simulation of costs generated by the epidemic in companies operating in the region, as detailed in the appendix.

Two regional companies operating in several Arab countries agreed to participate in a cost simulation on the implementation vs. the non-implementation of internal and external company policies implemented to respond to HIV/AIDS in their own branches across the Arab world. The main results are disclosed in the figure 20.

[166] [166] Sydney Rosen et al, *AIDS is Your Business*, Harvard Business Review, February 2003

FIGURE 20: FINANCIAL IMPACT OF HIV/AIDS IN THE ABSENCE OF APPROPRIATE HIV/AIDS POLICY

Company Studied	***A***	***B***
Industry	Professional Services	Public Health Services
Workforce size *(on average for 2005-2015)*	100	80
Total direct costs of HIV/AIDS for 2005-2015 *(in the absence of appropriate HIV/AIDS policy)*	US$ 18,535	US$ 9192
Total Annual direct costs of HIV/AIDS *(in the absence of appropriate HIV/AIDS policy)*	US$ 1,685	US$ 835
Potential reduction in cost of HIV/AIDS due to prevention and treatment programs	up to 27.6%	up to 53.4%
Total annual cost of HIV/AIDS as a percentage of yearly pay of an average employee *(in the absence of appropriate HIV/AIDS policy)*	97%	89%

According to the calculations realized in close collaboration with the HR department and the financial department of the company's branch in Egypt, the company could save approximately US$ 18,535 by 2015 (up to US$ 44,000, depending on the employee's experience) if its management decided to start implementing effective measures to respond to the epidemic today, like the ones presented in section 4. Indeed, the total annual costs generated by the absence of an appropriate HIV/AIDS policy are almost equivalent to the yearly pay of an average employee.

As a consequence, it is up to 4 times more cost effective for this private company to respond to the HIV/AIDS epidemic through effective policy including employee prevention, treatment, and care rather than not responding, or refusing to face the epidemic by terminating the contract of its employees living with HIV/AIDS. In other words, the benefits are up to 4 times greater than the costs, excluding the numerous indirect benefits generated by HIV/AIDS prevention, treatment and care. These indirect benefits include sustainable productivity, steady efficiency, good worker morale, durable presence of experienced and skilled employees, awareness and full enjoyment of present business opportunities, etc.

Further, certain costs generated by the epidemic, such as the costs generated by the termination of employment, could be much more significant, since the departure of an employee – especially a senior employee with many years of experience – could result in a general decrease of the profits, among other things. The loss of such employees, although consequential for companies, is often impossible to fully quantify accurately. This point demonstrates the benefits of implementing prevention, care and treatment measures to respond to HIV/AIDS in the workplace.

Similarly, the cost simulation conducted in close collaboration with the management of the Lebanese branch of the other company showed that over the period 2005-2015, the implementation of HIV/AIDS policies turns out to be slightly more cost-effective that the absence of response, considering that the indirect costs mentioned above are not included. The realistic inclusion of these costs makes the response to HIV/AIDS from the company twice as cost-effective as the absence of response to the epidemic.

Financially speaking, if the company decides to terminate the contract of its employees living with HIV/AIDS between 2005-2015, its management will have to bear direct yearly costs comprised between approximately US$ 621 to US$ 1,228 per year, i.e. on average approximately US$ 835. This figure reaches approximately US$ 1,718 per year if the indirect costs are included. If the company decides to implement HIV/AIDS measures between 2005-2015, its management will have to bear direct yearly costs equivalent to US$800.

Indeed, the costs generated by the implementation of HIV/AIDS measures are 35 percent lower than the costs generated by the termination of the employees living with HIV/AIDS. However, despite the fact that the direct costs generated by the implementation of HIV/AIDS measures turn out to be superior to the direct costs generated by the termination of HIV+ employees' contract in case of employees with lower experience and qualifications (based on the assumption that the constant turn over of employees does not affect the company's productivity), the realistic inclusion of the indirect costs changes the results significantly. Not only the implementation of HIV/AIDS measures becomes almost 3 times cheaper (-67 percent) for department heads, but it also makes this scenario cheaper for middle and unskilled employees, respectively by 1,9 times (-48 percent) and 1,4 times (-29,2 percent).

Furthermore, one can notice that on average, the implementation of HIV/AIDS measures turns out to be slightly more cost-effective if the indirect costs are not included (-4,2 percent), and significantly more cost-effective if the indirect costs are included (-53,4 percent).

2.4. Why the Arab region is not an exception for the spread of HIV/AIDS

As shown above, the countries of the MENA region are increasingly interconnected and are also fostering economic exchanges with other regions of the world. In addition to this fact, the developments that follow demonstrate that there is no proof today that the MENA region is less vulnerable to HIV/AIDS than other regions of the world which are heavily affected, regardless of the size of its population, its religion, its standard of living or its political situation. As a major and growing segment of society, the private sector operating in the region can expect to have a serious impact of HIV/AIDS on its activities.

The HIV/AIDS epidemic in the Arab countries varies according to many factors.[167] It is noticeable that the countries facing a widespread epidemic are the least developed ones as well as the countries suffering from complex emergencies.

[167] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, The International Bank for Reconstruction and Development / The World Bank, 2003, p.19

BOX 3: HIV EPIDEMIC PROFILES IN THE MENA REGION

Type 1: Consistently low rates but no consistent testing of high-risk groups:
=> *Egypt, Syria, Jordan, possibly Saudi Arabia and Iraq*

Type 2: Rising infection rates; some rapid increase in identified high-risk groups:
=> *Algeria, Iran, Libya, Morocco, Tunisia, Lebanon, Oman, Bahrain, Kuwait, Yemen, and possibly UAE and Qatar*

Type 3: High levels of HIV in general population, although more epidemiological data is needed:
=> *Djibouti, Sudan, possibly Somalia and Mauritania*

Source: Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, The International Bank for Reconstruction and Development / The World Bank, 2003, p.19 with recent input from WHO/EMRO and UNDP/HARPAS

Even though the level of HIV/AIDS varies from one country to the next, every country in the MENA region have many factors that create structural vulnerability. This combination generates a great risk in increasing the spread of the epidemic in the near future.

2.4.1. Structural vulnerability

Wherever overall social and economic conditions are poor, not only is there a greater risk of HIV/AIDS transmission, there is also less capacity to handle both prevention and care. Social and economic inequalities affect especially those who are systematically marginalized from power and access to goods, services and opportunities. Vulnerability is far greater when people cannot access reliable information, afford basic health services, or negotiate safety in their sexual relationships.[168]

Arab society presents many inherent structural factors that have proven to generate a environment conducive for the spread of HIV/AIDS. Structural vulnerabilities include: Poverty, unemployment, unequal gender relations, poor access to social services, migration, commercial sex work and a high number of youth. Poverty is the key factor in vulnerability to the spread of HIV/AIDS. It both creates and exacerbates other conditions of susceptibility such as unemployment, poor access to health care, and gender inequality. Furthermore, structural vulnerability creates conditions for high-risk behavior. These include drug use and sex work.[169]

Weak access to education and health services

Poor access to social services, including health and education due to structural vulnerabilities like poverty and gender inequality exacerbate the spread of STDs, and especially HIV/AIDS throughout the Arab region. Illiteracy prevents populations from acquiring basic information about means of transmission and prevention of HIV/AIDS, thus generating misconceptions and risk behaviour. Basic education is essential for individuals to process and evaluate health information. Therefore, the provision of basic education, especially among women, is a critical factor in stemming the tide of HIV/AIDS in the Arab world.

[168] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction,* The International Bank for Reconstruction and Development / The World Bank, 2003, p.7
[169] Joseph Collins and Bill Rau, *AIDS in the Context of Development*, UNAIDS, 2000, p.15

Despite some progress in access to education, approximately 70 million people in the Arab world are still illiterate[170] (about one third of Arab men and half of Arab women were illiterate in 2002).[171] "Some Arab children, albeit only a small percentage, are still denied their fundamental right to basic education", stated the Arab Human Development Report in 2004. Once again, the percentage of the illiterate adult population (15 and above) varies greatly from country to country, ranging from a high 51 percent in Yemen to 9.1 percent in Jordan, with important rates in Morocco (49.3 percent), Egypt (44.4 percent) and Sudan (40.1 percent).[172]

In 2001, net enrolment in primary education in Arab countries was 77 percent and adult literacy 60.8 percent. When disaggregated for women, the risk of low levels of education and illiteracy become of even more acute concern. For instance, the net primary enrolment for girls was just 28 percent in Djibouti, 42 percent in Sudan, 49 percent in Yemen, 56 percent in Saudi Arabia and 64 percent in Oman.[173] In Egypt, a nationally representative survey of adolescents found that of girls 10 to 19, 45.5 percent had never attended school and of those surveyed at the age of 17 years old, 12 percent had dropped out at age 11.[174]

Furthermore, while educational opportunities have expanded rapidly over the last several decades, there is evidence of declining quality and overcrowding. For instance, there were 40 students for every teacher in Yemen primary schools in 2001.[175] Similarly, in Egypt, 80 percent of schools are overcrowded. In an effort to reduce class size, 30 percent of schools implemented double shifts.[176] The drop out rate for girls shot up rapidly and their drop out rate was five to six times higher in double shift schools.[177]

While lack of basic education especially among the poor undermines awareness and understanding of health and disease, there have been few formal attempts at national education programs that introduce health education with reproductive health components into the school curriculum. Where those do exist, they are usually classified as biological studies and there is some evidence that teachers skip the sensitive sections about sex. Only Tunisia, Morocco, Algeria, Jordan, and Bahrain have a module about reproductive health in their national school curriculum.[178]

The sparse availability of sex education in schools coupled with inadequate reproductive health resources in national clinics and hospitals, create an environment conducive to the spread of HIV/AIDS. Public health services are of varying quality throughout the region, though in many countries there is a generalized shortage of state funding for health services. With the largest population in the region, Egypt's public spending on healthcare is given a

[170] www.unicef.org/media
[171] *Arab Human Development Report*, United Nations Development Programme/Arab Fund for Economic and Social Development /Arab Gulf Programme for United Nations Development Organizations, 2004, p.10
[172] *Arab Human Development Report*, United Nations Development Programme/Arab Fund for Economic and Social Development /Arab Gulf Programme for United Nations Development Organizations, 2004, p.236
[173] *Arab Human Development Report 2003*, UNDP, p.318
[174] Bonnie L. Shepard, Jocelyn L. DeJong, *Review of Young People's Sexual and Reproductive Health and Rights In the Arab States and Iran*, September 2004, p.44
[175] SESRTCIC (Statistical, Economic and Social Research and Training Centre for Islamic Countries), *statistical database*, http://www.sesrtcic.org/statistics/byindicators.php
[176] Bonnie L. Shepard, Jocelyn L. DeJong, *Review of Young People's Sexual and Reproductive Health and Rights In the Arab States and Iran*, September 2004, p.44
[177] *Ibid*
[178] *Ibid*

low priority with only 1.8 percent of the total GDP devoted to public expenditure on health.[179] Similarly low rates are found in Libya (1.6 percent), Syria (1.6 percent) and Sudan (1.0 percent). In the Republic of Yemen, only 30 percent of the rural population has access to health care. Health expenditure is US$2.58 per day, compared to the benchmark ideal of 12 US$ per day.[180] Exemplifying regional economic diversity however, Saudi Arabia and Jordan devotes 4.2 percent of their respective GDPs to health expenditures.[181]

While health services are of varying quality, medicalization of healthcare throughout the Arab world reduces resource provision addressing reproductive and sexual health and increases the risk of HIV/AIDS even further. Health service workers demonstrate a serious lack of knowledge about STD prevention. STD patients are rarely provided with condoms because public health officials fear condoms' promotion.[182] Public health policies and programs lack comprehensive user services and do not cater to the specific needs of women, youth and the poor. Cultural barriers block these groups' access to health care and significantly reduce their level of sexual health. Government services are not equipped to answer or counsel questions about sexual and reproductive health nor provide services and resources regarding HIV/AIDS. When it comes to requesting such services, users have additional and legitimate concerns about confidentiality.[183]

Furthermore, enormous stigma and rights issues within national health care systems surround the HIV/AIDS epidemic in the region. These issues particularly effect youth and other vulnerable populations including PLWHA. Recent reports from Saudi Arabia revealed that an HIV/AIDS patient was expelled from a private hospital in Jeddah. Furthermore, 4,200 foreigners who tested positive for HIV were denied ART.[184] Similar stigmas are found in health care systems throughout the region. As mentioned previously, only 7 percent of the PLWHA living in the Arab region had access to ART in 2004.[185] In Yemen a survey of health care workers found that the majority of respondents believed that people living with AIDS should be isolated.

Poverty

Poverty heightens susceptibility to HIV/AIDS in the Arab region by creating health and other risk factors. Although data is scarce, researchers estimate that income distribution is more unequal than evidenced by existing statistics. A defining feature of the Arab region is the coexistence of extreme affluence and extreme poverty. However, in light of available indicators for the region as a whole, economic growth is declining and poverty is on the rise. Because poverty levels are growing, the conditions for HIV/AIDS vulnerability in the Arab world are quickly being created. Income distribution, a particularly important factor in Arab countries, is becoming increasingly unequal. Egypt has become one of the 47 poorest countries in the world with 43,9 percent of the population living beneath the poverty line.[186] However, this figure does not exceed 14.4 percent according to the Egyptian Minister of Planning.[187] Income inequality is also widespread and in 2004 Jordan scored 36.4 on the Gini

[179] *Arab Human Development report 2003*, UNDP, p.297
[180] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, The International Bank for Reconstruction and Development / The World Bank, 2003, p.72
[181] *Ibid.*
[182] *Ibid*
[183] *Ibid.*
[184] Mark McKinnen, *Saudis jail, deport foreigners with HIV*, the Globe & Mail, August 2005
[185] *3x5 Progress Report*, UNAIDS/WHO, December 2004, p.11
[186] http://hdr.undp.org/statistics/data/
[187] *Al Missa*, UNDP Egypt's Press Review, September 2005, p.10

index, Tunisia 39.8 and Morocco 39.5[188], thus indicating that disparities in levels of wealth are on the rise.[189] Meantime, it is estimated that overall, 62 million people in the Arab world currently live below the poverty line, on less than US$1per day, and 145 million people live on under US$2 per day.[190]

Globalization processes, economic adjustment programmes and the short-term effects of economic reforms are affecting employment. Economic stakeholders did not succeed in creating enough jobs and in adequately distributing wealth to balance the population growth. This problem is reinforced by rapid urbanization, changing migration patterns, and dwindling financial resources for population programmes. Poverty is directly connected to AIDS because it creates a chain reaction of negative effects, increasing people's susceptibility to sexually transmitted diseases. These include the numerous factors listed above including a lack of access to education, health care, unemployment and labour migration. Of considerable importance however, is poverty's direct link to poor health conditions. Poverty's effect on health clearly reflects current realities experienced in the MENA region. Impoverishment everywhere results in under-nourishment and the lack of hygienic living conditions, including clean water. In Yemen, where poverty rates are over 50 percent[191], 31 percent of the population did not have sustainable access to an improved water source in 2000. Malnourishment, including the lack of clean water, makes people susceptible to a range of illness and infectious disease, especially sexually transmitted diseases (STDs) such as HIV/AIDS. This is explained by the fact that these conditions slow the healing process and depress the immune system. Similarly, once infected with HIV, the onset of AIDS is likely to be quickened by malnutrition, repeated infection and unsanitary living conditions.[192] In 2003, 13 percent of the total population in the MENA region was undernourished. In Iraq, the rate of under-nourishment has increased nearly fourfold, from 7 to 27 percent, over the past ten years. In Somalia, 71 percent of people were malnourished in 2003.[193] Because poverty creates under-nourishment and susceptibility to disease, countries in the Arab world are particularly vulnerable to AIDS. Furthermore, researchers have found that women are even more susceptible to poverty and disease. Poverty and gender are inextricably intertwined, and poor women are most susceptible to HIV infection.[194]

Poverty exacerbates social and economic factors that heighten risk of HIV and AIDS related illnesses. UNAIDS has described the relationship between poverty and HIV/AIDS as "bi-directional".[195] Therefore poverty not only raises vulnerability to HIV/AIDS in Arab countries but also worsens its impact on individuals and groups. The experience of HIV/AIDS intensifies poverty and has the potential to increase the epidemic itself. Although reporting of HIV/AIDS in the Arab world is deficient, it is clear that because poverty is on the rise. Arab countries are at high risk, especially if institutional frameworks for dealing with the spread of disease are not created. Without access to health, education or other preventive services a downward spiral is being created, in which women and the poor will be particularly affected

[188] *Arab Human Development Report 2003,* UNDP, p. 139
[189] The Gini Index measures inequality over the entire distribution of income or consumption. A value of 0 represents perfect equality and a value of 100 perfect inequality see: UNDP, *Arab Human Development Report 2003*, p. 139; UNDP, *Human Development Report 2004, Cultural Liberty in Today's Diverse World*, p.188
[190] UNDP, *Arab Human Development Report 2003,* p. 139
[191] UNDP, *Arab Human Development Report 2003*
[192] Joseph Collins and Bill Rau, *AIDS in the Context of Development*, UNAIDS, 2000, p.6 from UNDP, 1992, p.4, see also UNAIDS, 2000c
[193] *Human Development Report, 2003 Millenium Development Goals: A Compact Among Nations to End Human Poverty*, UNDP, 2003
[194] Joseph Collins and Bill Rau, *AIDS in the Context of Development*, UNAIDS, 2000, p.6
[195] *Ibid*

by HIV/AIDS. Economic growth remains elusive and poverty continues to grow in the MENA region. Therefore, unless action is taken, conditions that foster the spread of HIV are falling into place.[196]

Unemployment

The decline in economic growth experienced throughout the MENA region has created a sharp increase in unemployment rates, heightening the threat of HIV/AIDS by increasing risk behaviors such as drug use and commercial sex work. The acute vulnerability created by growing unemployment in Arab countries can be attributed to numerous economic factors. With the highest number of youth in history, there has been a rapid rise in new entrants to the labor market while job creation has slowed with declining economic growth rates. Opportunities in domestic job markets are therefore falling, giving way to high unemployment rates. Regional unemployment rose to 15 percent in 2003. In fact, regional unemployment was more than double the rate found in other middle-income countries, where unemployment has slowed in recent years.[197]

Approximately 35 percent of the total Arab population is in the labor market and the figure is set to grow to 123 million in 2010, given the high number of people older than 15 years old who are about to join the workforce.[198] This means the Arab market should have the capacity of accommodating an average of three million workers every year to avert a worsening unemployment situation, which appears to be a challenging task given the current real growth rates in the Arab GDP, political turbulence in some states, slackening capital flow into the region, and economic reforms which require massive job layoffs in the short term. The problem Arab countries are facing today is that the workforce is growing faster than their economies, and this combined with low levels of investments and layoffs in privatization programmes will aggravate the situation.

The rapid increase of unemployment, especially among youth in the Arab world is expected to persist. According to the Arab Labor Organization, unemployment could grow by at least one percent every year in the next decade, costing Arab states nearly US$ 115 billion, excluding the political and domestic costs generated by possible upheavals.[199] Unemployment widely varies in individual Arab states, with countries such as Algeria (29.8 percent)[200], the Occupied Palestinian Territories (31.3 percent)[201], Yemen (more than 30 percent)[202] and Sudan suffering from much higher joblessness rates than other countries. Also, it must be noticed that women and young people are more affected by unemployment than the rest of the population, with certain countries reflecting jobless rates as twice the regional average.

These high jobless rates among already vulnerable populations – like youth and women – only reinforce the risk of infection to HIV/AIDS. Unemployed people are more likely to adopt high-risk behaviors and therefore may become infected, with the possibility to transmit

[196] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction,* The International Bank for Reconstruction and Development / The World Bank, 2003, p.50
[197] World Bank, *Trade, Investment and Development in the Middle East and North Africa*, 2004
[198] Nadim Kawach, *Unemployment in Arab States set to get worse*, Gulf News, August 2002
[199] Nadim Kawach, *Unemployment in Arab States set to get worse*, Gulf News, August 2002
[200] *Arab Human Development Report*, United Nations Development Programme/Arab Fund for Economic and Social Development /Arab Gulf Programme for United Nation Development Organizations, 2004, p.243
[201] *Ibid.*
[202] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction,* The International Bank for Reconstruction and Development / The World Bank, 2003, p.56

the virus to several partners and ultimately to their spouse/husband when they finally get married.

Gender inequalities

The increased risk of HIV/AIDS infection borne by women in the MENA region is caused by conditions of subordination, discrimination and inequality under the law. In many societies both the discussion of and education about sex is frowned upon. A culture of silence surrounds sexual and reproductive health issues. Many girls and women in Arab countries know very little about their bodies, their sexual and reproductive health or HIV/AIDS. Quality of health services for women is poor, and financial constraints due to competing priorities perpetuate gender inequalities. As a result, millions of people, especially girls and women remain ignorant about HIV/AIDS, without access to education, information or services that would help them learn how to avoid HIV infection.

Aggravating this problem, women have unequal access to basic education. Studies have shown that a primary education is the minimum requirement needed to benefit from health information programmes. Not only is a basic education essential for individuals to process and evaluate information, it also gives women the status and confidence they need to act on information and refuse unsafe sexual relations.[203] A 32-country study found that women with post-primary education were five times more likely than illiterate women to know facts about HIV/AIDS.[204] In the Arab region, approximately 40 percent of women are illiterate, preventing women and girls from acquiring an adequate understanding of and information about HIV/AIDS.[205] In some Arab countries, women's literacy rates are as low as 37.2 and 44.8 percent such as in Morocco and Egypt.[206] Unequal access to education, with fewer girls attending school than boys, correlates with higher HIV infection rates among both men and women.

Because women have unequal access to social and economic resources, they are more vulnerable to sexual coercion. Economic dependence on men means that women are less likely to be able to negotiate methods of protection against disease. This is especially true in Arab countries where women's dependency is the norm. In 2001, women's economic activity rate in the Arab region was the lowest in the world.[207] Women have less power than men and therefore less ability to decide with whom, how and when they have sex.

Given unequal power within relationships, it is frequently difficult for women, especially young women with older husbands, to refuse sexual relations. The threat of violence limits women's ability to protect themselves against HIV/AIDS. Though violence against women is not well documented in the Arab region, many types of violence are known to exist. These include female genital mutilation or cutting (FGM/C), "honour killings" and other forms of domestic violence including incest, and sexual abuse.[208] Between 1996 and 1998, over 36 honor killings took place in Lebanon, and in Egypt, 35 percent of women reported being

[203] UNFPA, *Women and HIV/AIDS: confronting the crisis*, 2004, p.39
[204] *Ibid*
[205] UNDP, *Human Development Report, 2003 Millenium Development Goals: A Compact Among Nations to End Human Poverty*, 2003 p. 320
[206] *Ibid*
[207] *Ibid*, p.325
[208] "Honor Killing" refers to the practice of murdering girls and women who transgress sexual mores, and therefore dishonour families and society see Bonnie L. Shepard, Jocelyn L. DeJong, *Review of Young People's Sexual and Reproductive Health and Rights In the Arab States and Iran*, September 2004, p.38-40

beaten by their husband at some point in their marriage.[209] The cultural acceptance of violence is still being debated and attitudes seem to condone domestic abuse. For instance, up to 69 percent of Palestinian women agreed that wife beating is justified under certain circumstances, such as if the wife has been sexually unfaithful.

According to statistics, rates of infection are higher among young women who are oppressed by violence and unequal power relations. HIV rates are lower among married women's sexually active unwed peers, probably because cultural expectations have encouraged men to have multiple partners, while women are expected to abstain or be faithful.[210] In Arab countries, where 1.6 million girls are married before the age of 20[211], women are less empowered and therefore have less control over sexual encounters. In fact, young uninfected wives married to unfaithful HIV infected husbands are the highest risk group in all societies.

Furthermore, "traditional" practices such as FGM, found in five Arab countries including Egypt, Sudan, Yemen, Djibouti and Somalia, not only indicates women's lack of education and decision making over their reproductive health, but may also increase the likelihood of girls and women becoming infected with HIV/AIDS. The possibility of unclean instruments being used during cutting, as well as the increased likelihood of tearing and scarring during sexual intercourse or childbirth, increase the risk of HIV/AIDS infection. In cases of infibulation, sexual intercourse leads to bleeding, which in turn makes sexual transmission of the virus from an HIV-positive partner much more likely.[212] In Egypt, a national survey conducted in 1997 indicated that 86 percent of unmarried girls continued to be subject to FGM.[213] In western Sudan, thousands of women who had undergone FGM were raped during the Darfur conflict, escalating the spread of HIV/AIDS.[214]

While conditions for women are poor, with the MENA region ranking next to last on the UNDP's gender empowerment measure, the situation is improving. For instance, the gender gap in primary education has narrowed in some MENA countries and the average number of years of schooling increased from 0.5 to 4.5 from 1960 to 1999.[215] However, a vicious cycle of oppression is created as the increased presence of women in the labour force and education strains traditional gender norms and prompts defensive reactions. Conservative forces attempt to quell change by exerting greater control over women, restricting their access to public life including education and other services even further.[216] The AIDS epidemic is increasingly affecting women in the Arab world. In 2002, 32 percent of AIDS cases were found in women.[217] In 2004, half of all 460,000 people living with HIV were women.[218] Heterosexual intercourse is the primary mode of infection and the virus is effecting women more rapidly

[209] *Making Violence Against Women Count - Facts and Figures*, Amnesty International, 2004
[210] Ibid; Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, The International Bank for Reconstruction and Development / The World Bank, 2003, p.45
[211] Bonnie L. Shepard, Jocelyn L. DeJong, *Review of Young People's Sexual and Reproductive Health and Rights In the Arab States and Iran*, September 2004, p.20
[212] Infibulation refers to the form of FGM in which the entrance to the vagina is sewn up see Amnesty International, *Women, HIV and Human Rights*, 2004, http://web.amnesty.org/library/Index/ENGACT770842004
[213] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, The International Bank for Reconstruction and Development / The World Bank, 2003, p.39
[214] Amnesty International, *Women, HIV and Human Rights*, 2004, http://web.amnesty.org/library/Index/ENGACT770842004
[215] The World Bank, *Gender Development in the Middle East and North Africa; Women in the Public Sphere*, 2004, p.29
[216] Bonnie L. Shepard, Jocelyn L. DeJong, *Review of Young People's Sexual and Reproductive Health and Rights In the Arab States and Iran*, September 2004, p. 16
[217] *Ibid.*
[218] *2004 Report on the Global AIDS Epidemic*, UNAIDS, 2004, p.203-204, Geneva

than men. Breaking the silence on sensitive issues such as sexuality and reproductive health builds awareness and effective action. Greater dialogue and partnerships are especially needed in the MENA region where limited health resources, unequal access to education and cultural practices such as FGM contribute to gender inequality and thus create the conditions for HIV/AIDS risk.

Youth & Sexual Relations at an earlier age

Today, the Arab region counts more young people than it ever did. Indeed, 57.4 percent of the Arab population is less than 24 years old,[219] which represents almost 180 million people. This high vulnerability can be explained by a weak access to information on HIV/AIDS, a much higher unemployment rate than the rest of the population (35.5 percent of the 15-24 years old population in Morocco, 31.1 percent in Tunisia, 30 percent in Algeria – jobless rates among youth are twice the regional average in some countries)[220], a high level of illiteracy (7.5 million Arab children are out-of-school and 70 million people in the Arab world are still illiterate)[221], and other factors that affect youth such as armed conflicts, migrations, child labor, and gender inequalities.

Concerns have been widely acknowledged about HIV vulnerability among the region's youth[222]. Most youth in the Arab region lack access to information and knowledge about reproductive health issues, including HIV/AIDS. Youth from across the region reported that they had insufficient access to information about their own development, including their sexual and reproductive health, whether from parents, teachers or health services[223]. Furthermore, due to economic and social factors, average age at marriage has increased rapidly in several Arab countries.[224] Arab youth are therefore becoming increasingly sexually active and do not have adequate information about protecting themselves from STDs. Certain common practices like early marriages and temporary marriages[225] or summer marriages contribute also to increasing the risk of HIV transmission among the population.

Among areas of high HIV rates in Arab countries, youth figure most prominently**.** In 2003, 50 percent of the 75,000 people newly infected with HIV/AIDS, were youth aged 10 to 24. Because heterosexual sex remains the dominant mode of transmission, both young men and young women are clearly engaging in earlier sexual relations.[226] While rates of infection vary from country to country there is evidence that youth are therefore at particularly high risk. In Lebanon, 52.6 percent of the men sampled were found to be sexually active before the age of 20 (2002). In Djibouti, 71 percent of young people between 15 and 19 years old admitted having sexual relations (2001); and in Egypt, 26 percent of males in universities reported having sexual intercourse at least once (1996).[227] Furthermore, in all studies under-reporting

[219] *Gender based Statistical overview*, ESCWA, 2003
[220] *MENA, World Bank Regional Brief*, September 2004
[221] www.unicef.org/media
[222] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, The International Bank for Reconstruction and Development / The World Bank, 2003, p.37
[223] Bonnie L. Shepard, Jocelyn L. DeJong, *Review of Young People's Sexual and Reproductive Health and Rights In the Arab States and Iran*, September 2004, p. 10
[224] *Ibid*, p. 11
[225] Temporary marriage is also known as "Urfi/Muta3" marriage
[226] Bonnie L. Shepard, Jocelyn L. DeJong, *Review of Young People's Sexual and Reproductive Health and Rights In the Arab States and Iran*, September 2004, p.30
[227] El Zanaty and Abdalla, 1996, quoted from Bonnie L. Shepard, Jocelyn L. DeJong, *Review of Young People's Sexual and Reproductive Health and Rights In the Arab States and Iran*, September 2004, p. 31

is characteristic due to sexual taboos, and rates of sexual activity among youth are likely higher than rates recorded.

Heightening the threat of HIV/AIDS among youth, earlier sexual relations are coupled with a striking lack of information and services. Evidence from different countries shows that while young people have heard of AIDS they do not have information on how to prevent HIV infection. Indeed, a national survey of adolescents from 16 to 19 years old in Egypt revealed that 65.8 percent of girls and 76 percent of boys had heard of HIV/AIDS but most could not identify methods of protection.[228] For instance, only 5.1 percent of girls and 14.3 percent of boys reported knowledge of condoms.[229] This is not surprising given the lack of training and information in schools where sexual education is confined to biology and teachers are usually too uncomfortable to discuss topics related to sex.[230]

Marginalized children and youth, such as migrants and street children are at even greater risk. This group is unable to access information, resources, or services regarding their sexual health, and are more vulnerable to sex and drug abuse. In Morocco, qualitative studies demonstrate not only an increasing acceptance of premarital sex, but also a tolerance of sex work as a means of improving economic status.[231] In Egypt there are an estimated 200,000 street children and increasingly large numbers working or begging on the streets in Yemen. In Sudan, there are an estimated 32,000 street children in Khartoum alone. Street children are likely to be extremely vulnerable to sexual abuse much of which is undetected. Intravenous drug use is of particular concern in Libya where higher HIV rates were seen among young drug users.

As with all areas of research on HIV/AIDS in MENA countries, data and information is scarce. Existing surveillance systems in most countries have a number of limitations including the fact that they are less likely to include women and young people. Given current trends of high numbers of youth and changing sexual behaviour, there is increasing cause for concern, and rates of HIV/AIDS infection are likely higher than currently reported.

Mobility

HIV risk in the MENA region is strongly linked to migration and mobility.[232] Varying forces drive migration and human mobility in the Arab region, including poverty, unemployment, political conflict, and gender inequality. For instance, unemployment in North Africa has spurred temporary labor migration based on seasonal activity and cyclical needs.[233] Though migration and mobility do not themselves increase the risk of HIV/AIDS, the reasons people migrate and the conditions under which they live during and after migration often increase vulnerability and trigger high-risk behaviors such as drug use and the solicitation of sex workers. The key link between human mobility and the AIDS epidemic is thus not the origin of the migrants but the conditions of life during the journey and at the site of destination. Risky living conditions encompass: absence from social control of the home environment, housing in single sex hostels, lack of access to medical care for STDs, drug abuse, and

[228] Bonnie L. Shepard, Jocelyn L. DeJong, *Review of Young People's Sexual and Reproductive Health and Rights In the Arab States and Iran*, September 2004, p.31
[229] *Ibid*
[230] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, The International Bank for Reconstruction and Development / The World Bank, 2003, p.39
[231] *Ibid*, p.38
[232] UNAIDS, *2004 Report on the Global AIDS Epidemic, 2004*, p. 33
[233] International Organization for Migration, *Arab migration in a globalized world*, 2004, p.21-23

obtaining sexual services from sex workers.[234] In the Arab region, four types of migrant or mobile groups typify categories of HIV/AIDS risk including internally displaced persons, refugees, tourists and labor migrants. The World Bank indicates that HIV-related issues concerning migrants, Internally Displaced Persons (IDP), and refugees are especially significant in the MENA region.[235]

Growing unemployment in Arab countries has led to ever increasing poverty driven labor migration, which is increasingly temporary.[236] Migration is a key livelihood strategy of millions of young men who face the prospect of unending poverty in their country. Current trends indicate that young male laborers migrate towards Europe, transiting through North Africa. At the same time, workforces of low and middle income Arab and non-Arab countries seek employment in high-income areas such as the Gulf countries. Oman's total population includes 25 percent migrants from South and Southeast Asia. Saudi Arabia hosts 850,000 Filipinos.[237] Because migrants generally come from poor countries, they are more likely to be infected and transmit the virus during their migration. With migration to Europe, infection is associated with drug use while migration to the Gulf countries means that sexual activities lead to higher rates of HIV.

Egypt has the largest number of migrant workers with an estimated three million men working in the Gulf countries.[238] Algeria, Jordan, Lebanon, Libya, Morocco, Syria and Tunisia also report high levels of labor migration.[239] Returning labor migrants were among the first men registered with HIV or AIDS in numerous Arab countries. After transmitting infection to their wives, HIV infection was passed to children. High rates of HIV resulted in Algeria, with an alarming one percent of antenatal women who were found to be HIV positive.[240] Infection was not only associated with labor migration, but also refugees, sex work and drug use in the region. In Algerian border areas, registered migrants numbered 61,444 in 1994. There were an additional 263,322 migrants from Morocco and 851,601 from Libya.[241] These groups have created a large commercial sex market in border areas while sex workers from elsewhere in Algeria migrate to the area, which has seen marked rises in reported STD rates and AIDS cases in recent years.[242]

Meantime, HIV/AIDS concerns are particularly acute among internally displaced persons and refugees who are at particularly high risk in the MENA region. Population mobility has been linked to armed conflicts in Lebanon, Iraq, Palestine, Somalia, Sudan, the Gulf and Yemen. In 2003 alone there were 183,625 refugees in North Africa.[243] In the Republic of Yemen 70,000 refugees, mostly from Somalia and Ethiopia, have entered over the past decade and in 2004 alone there was a net increase of 2100 Somalian refugees. Countries recording high numbers of refugees in 2001 included Saudi Arabia (245,000), Sudan (349,000) and Algeria (169,000).

---

[234] Joseph Collins and Bill Rau, *AIDS in the context of development,* UNAIDS, 2000, p. 9
[235] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction,* The International Bank for Reconstruction and Development / The World Bank, 2003, p. XVII
[236] *Arab migration in a Globalized World,* International Organization for Migration, 2004, p.21-23
[237] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction,* The International Bank for Reconstruction and Development / The World Bank, 2003, p.34
[238] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction,* The International Bank for Reconstruction and Development / The World Bank, 2003, p.33
[239] *Ibid*
[240] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction,* The International Bank for Reconstruction and Development / The World Bank, 2003, p.34
[241] *Ibid*
[242] *Ibid*
[243] UNHCR, *UNHCR Global Report 2004; North Africa Regional Overview*, p. 1

Together, refugees numbered over one million throughout the Arab states.[244] Because such groups face poverty, marginalization and an associated lack of access to education or health services, they are particularly susceptible to HIV. In Sudan for instance, 4.3 percent of a sample of 470 refugees were infected with HIV.[245]

Statistics show that, discounting HIV prevalence at the site of departure, migrants and other groups with increased levels of mobility have higher infection rates than those who do not migrate. Because labor migration, and mobility attributed to factors as widely varying as political conflict or tourism lead to widespread human movement throughout the Arab region, general populations of MENA countries, including wives and children of migrants are at significant HIV risk.

Conflict Situations

The MENA region has long been marked by conflict including civil war in Sudan starting in 1983, political unrest and civil war in Lebanon, as well as continuing unrest and lack of political resolution in the Occupied Palestinian Territories and Iraq. Political circumstances create conditions for people and groups that underpin the risk of HIV/AIDS. Conflict situations spur numerous HIV/AIDS risk factors including poverty, unemployment, and migration. They further destabilize and disrupt the provision of health and education services, lead to a breakdown in social networks and solidarity, undermining main mechanisms protective of young people's health and development, including their sexual and reproductive health.

In Sudan, the AIDS epidemic has been largely driven by civil war. Risk factors associated with the conflict have been the principle catalysts for the transmission of STDs, especially HIV/AIDS. Political unrest has caused widespread poverty, spurring migration and leading to the emergence of the largest commercial sex industry in the region. Soldiers from the north of the country have become infected and in turn infect their wives. Sexual abuse of female prisoners by government troops has also been commonplace. Thousands of women have been systemically raped by the government backed armed militia. In 2004, up to 16 women were raped every day in western Darfur.[246] Most women have previously undergone FGM, further escalating the rapid spread of HIV. Moreover, many cases of assault were unreported due to the shame associated with rape.

Similarly, in Iraq, a sharp rise in the incidence of sexual violence against women and girls has been documented in Baghdad after the fall of the Ba'athist regime.[247] Over 400 women have been raped in Baghdad, during or after the war, since 2003.[248] Given the collapse of the legal system since the military invasion of the country, it is likely that many other cases of sexual assault have not been documented. Furthermore, victims of rape often do not report such violence due to stigma and fear. No health services and little international assistance have been provided in Iraq. Poverty and unemployment are widespread, with a 48 percent unemployment rate among Iraqi youth. Such conditions will likely propel the rapid spread of

[244] *Human Development Report, 2003*
[245] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, The International Bank for Reconstruction and Development / The World Bank, 2003, p.35
[246] Amnesty International Press Release, *Sudan: systemic rape of women and girls*, April 2004 http://web.amnesty.org/library/Index/ENGAFR540382004?open&of=ENG-373
[247] Bonnie L. Shepard, Jocelyn L. DeJong, *Review of Young People's Sexual and Reproductive Health and Rights In the Arab States and Iran*, September 2004, p.14
[248] *Making Violence Against Women Count- Facts and Figures*, Amnesty International, 2004

HIV as unemployment has given way to a mushrooming sex industry with sex rings including men, boys and underage girls numbering at least 4000[249].

Ongoing conflict not only increases poverty and undermines access to education, and health services, it also weakens and disrupts surveillance capacity, further masking the AIDS risk in MENA countries where political unrest has continued. Indeed, the effects of conflict are often subtle and difficult to discern. In a Palestinian study the *Intifada* was associated with a declining age at marriage for girls because uncertainty and anxiety motivated parents to have their children get married earlier.[250] Under such conditions of violence, community services and access to information are widely unavailable because of the threat of violence, disruption to education and health services, and people's inability to move from place to place.

2.4.2. Growing presence of risk behaviors

With this socio-economic structural vulnerability come high-risk behaviors, including certain sexual behaviors (especially among youth), and injected drug use among others. We need to clarify the fact that the risk of transmission of HIV is only related to the behavior, and not to the social group. Sexual relations – whether they are referring to youth, men having sex with men, or any other so-called "at-risk group" – do not represent any threat for a potential HIV transmission provided that they are perfectly safe and protected relations. Following the same logic, injecting drug use does not imply any risk of HIV transmission as long as contaminated needles are not being exchanged with other drug users.

However, these groups are generally considered as vulnerable groups because the reality is very different from theory. Sharing needles is a common practice among drug users in the region, so much that it has become the primary mode for HIV transmission in several Arab countries. Furthermore, surveys demonstrate that young people initiating early sexual relations have very limited knowledge about how to protect themselves and their partner against a HIV/AIDS, as explained previously in section 2.4.1.

Injecting drug use

Injecting drug use (IDU) has become the primary means if HIV/AIDS transmission in several Arab countries. Populations located in areas along new drug-trafficking routes are increasingly at risk. The United Nations Office on Drugs and Crimes (UNODC) has reported that the drug trade has recently shifted and a major transit route through Turkey and neighbouring countries provide heroin and stimulants to the markets of the Gulf States. [251] As a consequence, localized changes in patterns of drug consumption along those routes have been reported. Most countries in the MENA region are witnessing increased drug use, including injecting drug use such as heroin. As a result HIV rates among injecting drug users will continue to grow, especially without harm reduction programs, reproductive health education, or other resources and services.

---

[249] "*Iraq: Focus on boys trapped in commercial sex trade*", UN office for the coordination of humanitarian affairs, see http://www.irinnews.org/report.asp?ReportID=48485&SelectRegion=Middle_East&SelectCountry=IRAQ

[250] Bonnie L. Shepard, Jocelyn L. DeJong, *Review of Young People's Sexual and Reproductive Health and Rights In the Arab States and Iran*, September 2004, p.14

[251] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, The International Bank for Reconstruction and Development / The World Bank, 2003, p.26

Reflecting new transit routes, drug users represent the greatest share of HIV cases in several Arab countries including Libya, Egypt, Algeria, Bahrain, Kuwait and Oman.[252] In Libya, 98 percent of 571 newly recorded HIV cases in 2000 were found among injecting drug users. Among arrested injecting drug users in Oman, 5 percent were found to be HIV positive in 1999, and the rate grew to 8.3 percent only one year later.[253]

Because of its illicit nature, there is insufficient behavioral surveillance among injecting drug users, resulting in an incomplete picture of HIV spread. However, currently increasing rates of HIV/AIDS where they are monitored indicate that infection is rapidly spreading. A study was conducted in Egypt among problem drug users (IDUs and heroine users) in the community in Greater Cairo revealing alarming risk behaviors such as very low rates of HIV testing and condom use, coupled with high rates of needle sharing.[254] Young injecting drug users are particularly at risk because they do not have the knowledge or skills to protect themselves from infection via contaminated injecting equipment.[255]

Men having Sex with Men (MSM)

Man-to-man transmission of HIV has been recorded in numerous MENA countries including: Algeria, Egypt, Jordan, Kuwait, Lebanon, Morocco, Oman, Qatar, Yemen, Syria and Tunisia. However information about the transmission of HIV between MSM is scarce, with some exceptions such as in Morocco where studies and programs are in place. This shortfall is largely due to the stigma attached to sex between men, especially in the Arab region. MSM is a practice often socially condemned and treated as illegal in most of the Arab and Muslim countries. Being highly stigmatized, MSM remain isolated, underground, with limited access to services or information, which reinforces their vulnerability to HIV/AIDS.[256]

However, some existing studies in Tunisia, Egypt and Morocco have demonstrated that MSM is not only frequent, but also clearly linked to HIV transmission and that a connection is present between MSM activities and CSW in some locations. In 2001, MSM were representing 5 percent of the reported cases in Algeria, 4 percent in Bahrain, 21 percent in Egypt, 3.2 percent in Jordan, 6 percent in Kuwait, 28 percent in Lebanon, 9 percent in Morocco, 11 percent in Oman, 6 percent in Saudi Arabia, 8 percent in Syria, 10 percent in Tunisia, and 15.8 percent in Yemen.[257]

In a study of 500 Tunisian men aged 20 to 69, 12.1 percent reported that their first sexual relationship was with another man. Such relations usually began in adolescence, but an overall 30.9 percent reported male-to-male sexual experiences at some point in their lifetime.[258] Egypt is one of the few countries that specifically monitored the transmission of HIV among MSM groups, where prevalence was 1 percent in 2000. More recently, the proportion of AIDS cases attributed to MSM was reported at 32 percent. Finally, an

[252] Ibid
[253] George Ionita, *UNDP Youth Policies and Studies and Strategies in the Context of the MDG's*, UNICEF, 2005
[254] Elshimi et al, *HIV risk behaviors of problem drug users in Greater Cairo*, UNODC, UNAIDS, 2004
[255] UNAIDS, *2004 Report on the Global AIDS Epidemic, 2004,* p. 33
[256] George Ionita, Jamsheeda Parveen, *Iraq Social Sector Watching Briefs, HIV Prevention*, August 2003
[257] Carol Jenkins, David A. Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction,* The International Bank for Reconstruction and Development / The World Bank, 2003, p.21-24
[258] Bonnie L. Shepard, Jocelyn L. DeJong, *Review of Young People's Sexual and Reproductive Health and Rights In the Arab States and Iran*, September 2004, p.32

epidemiological review of HIV in Morocco similarly found that sexual transmission between MSM accounted for more than 9 percent of cumulative HIV cases over the last decade.[259]

Commercial Sex Workers (CSWs)

Rising levels of HIV among sex workers has been identified by UNAIDS as an early warning sign of the increasing probability that the epidemic will expand exponentially, from sex workers to clients, their wives and eventually their children.[260] Though the various types of sex trade are well hidden, they contribute greatly to the spread of HIV/AIDS in the MENA region. Sex workers both exist and are at greater risk due to the lack of services and information about STDs offered in Arab countries. As long as sex workers are not reached with prevention education and STD services the national risk will grow. Though few in depth studies have been conducted on commercial sex work, evidence of the Arab commercial sex industry and HIV/AIDS prevalence among sex workers indicate that HIV will spread to the general population if action is not soon taken.

Types of sex work vary widely throughout the region and are often well hidden through conformity to cultural norms. For instance, summer marriage is a documented pattern in which Arab tourists from elsewhere in the region, especially the Gulf area, become engaged to and marry young Egyptian girls over the summer in return for a significant bride price.[261] In most cases, these unions end in divorce at summer's end. Young women who are forced into such relations because of social and economic inequalities lack education and information about HIV/AIDS. As never married youth, these girls face a greater risk of infection by older men who likely have multiple sexual partners.[262]

Specific data documenting the prevalence of HIV among female sex workers is scarce due to lack of services and surveillance, however some statistics are available in countries where the sex trade is less hidden. Where research is being conducted, data indicate that HIV will spread quickly in Tunisia, Algeria, Morocco, Yemen, Syria, Djibouti, Sudan, and Iraq if the risk of HIV transmission continues to be ignored. In Tunisia for instance, 300 women were registered as sex workers though many more were thought to be involved in the clandestine trade. In the Republic of Yemen, 7 percent of arrested sex workers were found to be HIV positive.[263] In Djibouti, the rate of HIV infection for female CSWs jumped from 39.5 percent in 1990 to 55.8 percent in 1993.[264] Categories of commercial sex work vary from highly paid women dealing usually with wealthy foreigners, and bar and restaurant workers who provide "quick" sex to Djibouti men. The rate of HIV prevalence within this hierarchy varies according to social and economic scale, however the highest rates of infection were found among female CSWs. In Morocco, where official HIV/AIDS surveillance has been extended to include commercial sex workers, a 2.27 percent HIV prevalence rate was found among those surveyed. Prevalence rates were up to 9 percent in Algeria and 12 percent in Syria.[265]

---

[259] Carol Jenkins, David A. Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction,* The International Bank for Reconstruction and Development / The World Bank, 2003, p.21-24
[260] UNAIDS, *2004 Report on the Global AIDS Epidemic, 2004,* p. 33
[261] Bonnie L. Shepard, Jocelyn L. DeJong, *Review of Young People's Sexual and Reproductive Health and Rights In the Arab States and Iran*, September 2004, p.24
[262] *Ibid*
[263] Carol Jenkins, David A. Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction,* The International Bank for Reconstruction and Development / The World Bank, 2003, p.29-30
[264] *Ibid*
[265] George Ionita, *UNDP Youth Policies and MDG*, May 2005.

Sex tourism promulgated by wealthy Arab men in the MENA region also contributes to the overall risk of HIV. Young men are more likely to engage in risky sexual behaviour when away from home since they have less risk of being discovered. In Egypt alone, over a million Gulf tourists who regularly engage in extra-marital sexual relations visit the country yearly. In a 1995 survey of male members in Oman social clubs, it was estimated that 13 percent had engaged in extra-marital sex over the past year.[266] Data from the republic of Yemen showed that HIV prevalence was three times higher among those who had toured outside the country than those who had not.[267]

Furthermore, commercial sex work involves both men and women. A 2002 analysis of HIV/AIDS by the WHO and UNDP in Yemen found that young boys from poor backgrounds were reported to be lured into the sex trade by older men who offered them gifts and money.[268] In Iraq, following the 2003 conflict, there was an increase in the number of commercial sex workers especially among teenagers. According to official estimates as many as 4 000 male commercial sex workers were involved in the sex trade in Iraq alone. Economic downturn, with a 48 percent unemployment rate among Iraqi youth, compounded by protracted political conflict has led to the increasing involvement of young men and women in the commercial sex trade.[269]

It is difficult if not impossible to conduct research on socially marginalized group such as drug users or commercial sex workers given the illicit nature of their activity across the region. But although it remains clandestine and difficult to research, a commercial sex industry has been documented in many Arab countries. Moreover, data that does exist show that increasing rates of STD patients among sex workers mean the potential for the spread of HIV first to sex workers, their clients and on to clients' wives and children will grow exponentially.

Furthermore, illegal practices including the sexual abuse of children perpetrated by sex tourists, a plague fostered by poverty and affecting especially certain North African countries, is increasing the vulnerability to HIV/AIDS of certain segments of the Arab youth. As stated in the Rabat Declaration of the Arab-African Forum against Sexual Exploitation of Children: "the sexual exploitation of children is one of the vectors of the spread of HIV/AIDS and sexually transmitted infections, as well as other physical and psychological pathologies."[270]

A changing social and economic environment

In addition to the structural vulnerability and the at-risk behaviors, decision-makers have to understand that HIV/AIDS is highly sensitive to the changing social and economic environment. The Arab region is precisely undergoing a significant number of those types of changes. Economic changes are mainly reflected, as presented in section 1, by the ongoing privatization process and the intensification of intra and extra regional trade. On the other hand, social changes – deeply interconnected with the economic changes – are reflected,

---

[266] Carol Jenkins, David A. Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction,* The International Bank for Reconstruction and Development / The World Bank, 2003, 36

[267] *Ibid*

[268] Bonnie L. Shepard, Jocelyn L. DeJong, *Review of Young People's Sexual and Reproductive Health and Rights In the Arab States and Iran*, September 2004, p.28

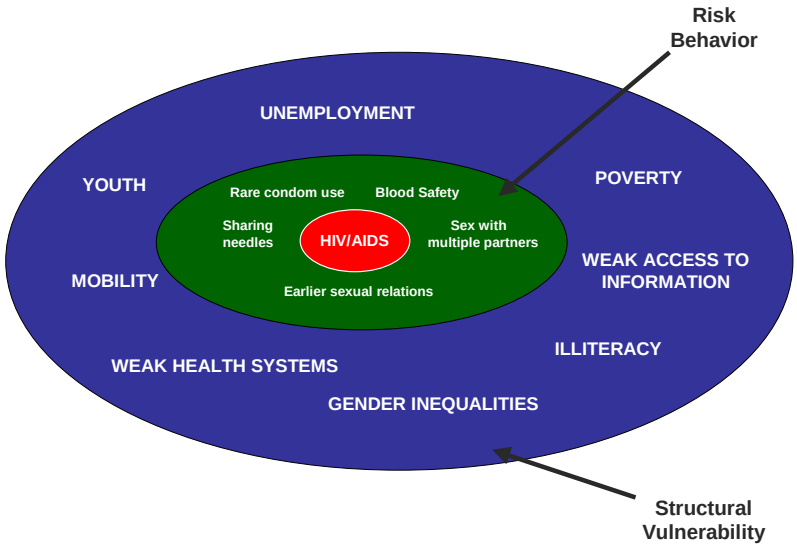
[269] "Iraq: Focus on Boys Trapped in Commercial Sex Trade", UN Office for the Coordination of Humanitarian Affairs, see http://www.irinnews.org/report.asp?ReportID=48485&SelectRegion=Middle_East&SelectCountry=IRAQ

[270] *Declaration of the Arab-African Forum Against Sexual Exploitation of Children,* Rabat, Morocco, October 2001, p.2

according to a report of the Harvard School of Public Health[271], by a breakdown of social network, a recent booming of urbanization exposure to global media, important flux of migrations, rising educational levels, widening generation gaps, and changing gender roles, among other things.

The figure 21 illustrates the structural vulnerability and the risk behaviors present in the Arab region:

FIGURE 21: STRUCTURAL VULNERABILITY & RISK BEHAVIORS IN THE ARAB REGION



Source: UNDP/HARPAS presentation at the League of Arab States, March 2005

Nevertheless, one of the greatest risks comes from the fact that the authorities have not yet implemented appropriate and relevant surveillance methods, and consequently do not have a clear picture of infection rates. As a World Bank report indicates, inadequate surveillance techniques can overlook outbreaks in marginalized social groups. As stated previously, the World Bank insists on the fact that no Arab country systematically samples and surveys vulnerable groups; instead, the general population represented by less vulnerable groups such as antenatal mothers and blood donors is extensively screened.[272] Given the low prevalence rates in the Arab region presented above, these practices turn out to be irrelevant, implying that the epidemic is not appropriately monitored, and therefore the response is inadequate. Hidden epidemics in marginalized social groups pose a real threat of an expanded epidemic even when repeated testing indicates low prevalence in the general population.[273] And because the groups mentioned above usually have partners (wife, husband, sexual partner), one must be aware of the probability that they may transmit the virus to other segments of the population which are initially not considered vulnerable. For example, an IDU, after exposing himself/herself to the virus by sharing needles, will expose his/her partner by having unprotected sexual intercourse; or a migrant worker or an MSM, who is married but still having unsafe sexual intercourse with others, can directly expose his wife. The epidemic has followed this development pattern in other regions of the world, and based on the information

[271] Bonnie L. Shepard, Jocelyn L. DeJong, *Review of Young People's Sexual and Reproductive Health and Rights In the Arab States and Iran*, September 2004
[272] Carol Jenkins, David A. Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, The International Bank for Reconstruction and Development / The World Bank, 2003, p. XV
[273] Family Health International, 2001

available on risk factors, it is projected to increasingly occur in the MENA region if no measures are taken to addressing behaviors that place people most at risk.

2.4.3. Why has the private sector in the Arab region not yet perceived the impact of HIV/AIDS?

A 2006 survey of the World Economic Forum reports that Middle Eastern and North African firms are among the least concerned in the world about the current and future impacts of HIV/AIDS on their activities. Indeed, only 13 percent of firms in the MENA region reported a current impact on their activities, while 74 percent expect none in the next five years.[274] Another survey from the WEF shows that 99 percent of firms that estimate HIV/AIDS infection among their workforce (which represents less than 3 percent of all the firms in the region) believe the infection rate is below 1 percent, and fewer than 3 percent believe they have seen any significant impact on costs, productivity, and revenue.[275]

According to a report of the World Bank, these results can be explained not by the absence of consequences from the epidemic on businesses but by the fact that short-term economic impacts are lower in countries with high unemployment rates.[276] Even if the economic performance in the region improved in the 1990s, the region achieved an annual average growth rate of only 1.3 percent, compared with an annual average of 4 percent for all developing countries. Experts from the World Bank predict that growth among developing nations will be 5.7 percent in 2005, while the MENA region will continue its downward trend to 4.9 percent this year and 4.3 percent in 2006. Last year, the MENA region and South Asia were the only developing regions to record a slowdown in growth. A major consequence of this poor record is persistent high unemployment, which has been perpetuated by years of high growth rates of population and labor force. Employment in the MENA region did grow, at times faster than in other developing countries, but rapid population growth inflated the ranks of the young and fed the labor market with a rising tide of job seekers that exceeded the economies' capacity to absorb them.[277]

In other words, private companies wrongly interpret the lack of visibility of economic consequences – generated by the high unemployment situation – as a lack of risk and potential economic loss by private companies. This prevents companies from adopting appropriate HIV/AIDS policies. If the MENA region would experience full employment, private businesses operating in the region would probably have already felt the impact of the epidemic on their activities, and would have possibly responded. This implies that activities of private businesses operating in the region are already affected by the epidemic while its future or potential employees are being infected. Even though the evolution of the epidemic is unpredictable, tangible costs might appear only in a few years. And these costs will be as high as the response of private companies will be slow.

2.4.4. Political stability: a pre-requisite for investors threatened by the epidemic

---

[274] *Business & HIV/AIDS: A Healthier Partnership? - A Global Review of the Business Response to HIV/AIDS 2005-2006*, World Economic Forum/ Global Health Initiative, January 2006, p.25

[275] *A Global Review of the Business Response to HIV/AIDS 2004-2005*, World Economic Forum/Global Health Initiative, January 2005, p.23

[276] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, The International Bank for Reconstruction and Development / The World Bank, 2003, p.55

[277] George T. Abed and Hamid R. Davoodi, *Challenges of Growth and Globalization in the Middle East and North Africa*, International Monetary Fund, 2003

A common strategy rational investors adopt to minimize the level of risk in their investment portfolio is to avoid investments associated with highly volatile return. Most studies suggest that the macroeconomic environment has an important affect on the level of a country's productivity. Maintaining macroeconomic stability has been a challenge for many MENA countries.[278] Other studies explored the implications of volatile productivity on a multinational company's production patterns in emerging markets.[279] The results showed that higher volatility in productivity would have adverse consequences for the profitability of multinationals, as well as for their expected levels of employment in the relevant emerging market. Consequently, the multinational would opt to invest in more stable emerging markets – thus affecting the level of inward Foreign Direct Investment. As a matter of fact, one main reason many multinational companies continue to produce in high-cost developed countries is because these countries are considered to be politically stable.[280] Investments in many "low-cost" countries, like most of the Arab countries are exposed to large political risks.[281]

Stability in investment risk allows investors to incorporate risk more accurately in estimating rate of return. The need to account for stability in investment risk is particularly important for countries in the MENA region, which historically have a higher level of instability associated with investment risk than developed countries. The empirical results presented in an IMF report[282] indicate that the degree of instability associated with investment risk is a much more critical determinant of foreign investment in the MENA countries than it is for developing countries, which have lower level investment risk.

We have mentioned above that HIV/AIDS embarks populations in a vicious circle of poverty, and is already threatening food security in highly affected countries like South Africa. It has been proven that food security and political stability are often linked, although the relationship is complicated and not necessarily direct or causal. However, evidence suggests the lack of food security resulting from a sudden jolt (i.e. international embargo, poor climate) can lead to political instability[283]. Similarly, poor economic conditions threaten political stability and increase the probability of political coups.[284]

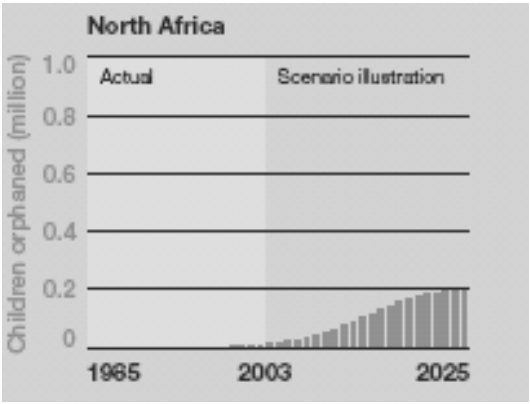
As the International Crisis Group explains in a report[285], "HIV/AIDS destroys the very fiber of what constitutes a nation: individuals, families and communities, economic and political institutions, military and political forces. It is likely then to have broader security consequences, both for the nation and its neighbors, trading partners and allies."[286]

It must also be mentioned that poor economic conditions generated by HIV/AIDS foster the spread of insecurity and create a fertile environment for terrorism, likely to target any country, including developed ones. In this regard, it is important to recognize the number of orphans generated by the epidemic. HIV/AIDS generates premature adult deaths that tend to increase

[278] Iqbal, 2001
[279] Aizenman, 2002
[280] Lucas, 1990
[281] Kitty K. Chan and Edward R. Gemayel, *Risk Instability and the Pattern of Foreign Direct Investment in the Middle East and North Africa Region*, International Monetary Fund, August 2004, p. 5
[282] *Ibid.*
[283] *Food security and Political Stability in the Asia-Pacific Region,* Asia-Pacific Centre for Security Studies, September 1998
[284] Alberto Abadie, *Poverty, Political Freedom, and the Roots of Terrorism*, Harvard University and NBER, October 2004, p.1
[285] *HIV/AIDS as a Security Issue*, International Crisis Group, June 2001
[286] www.intl-crisis-group.org

the number of orphans who are less likely to fully develop their physical and intellectual capacities.[287]

FIGURE 22: CHILDREN ORPHANED IN NORTH AFRICA (PROJECTIONS)



Source: *AIDS in Africa – Three Scenarios to 2025*, UNAIDS, January 2005

By 2003, 15 million children under 18 had been orphaned by HIV/AIDS worldwide.[288] These children generally fall into deep poverty and thus become targets for violent or extremist groups. Deprived of everything, they are easily recruited and trained. In countries widely affected by the epidemic, these children have become a great source of insecurity. As an orphan from Somalia said in an article: "Now I do not know what to do. If you give me food, just bread, I will follow you."[289] For this reason, HIV/AIDS could fuel radical groups and terrorism in the Arab region, with possible implications on a regional and global level. The number of orphans in the MENA region is not available. However, experts forecast that the number of orphans only in North Africa could reach 200,000 in 2025, as indicated in figure 22.

HIV/AIDS and armed conflicts jeopardizing political stability are linked. The epidemic creates a fertile ground for political instability and possible conflicts, and similarly, armed conflicts contribute to the spread of the virus, thus creating another vicious circle. Arab countries such as Sudan, Iraq or The Occupied Palestinian Territories are currently experiencing conflicts that generate, among other devastating consequences, a situation conducive to HIV/AIDS due to the movements of migration, the impoverishment of the population, the rise of insecurity, etc. As an example, a report shows that after the military invasion of Iraq by the USA and the subsequent fall of Saddam Hussein, there has been a sharp rise in the incidence of sexual assault against women and young girls in Baghdad.[290] Similarly, the epidemic in Sudan has largely been driven by the civil war as mentioned previously, with soldiers increasingly infected, and in turn infecting their wives. And in the Palestinian Occupied Territories, surveys have shown that the threat of violence, disruption of health and education services and other negative effects generated by the conflict have encouraged parents to have their children married earlier[291], which increases their vulnerability to HIV/AIDS.

In other words, the consequences of HIV/AIDS on the region's stability compound and complicate the already existing high risks for investment in the MENA region. Indeed, the MENA region could face significant difficulties to maintain its level of FDI if the HIV/AIDS epidemic increases, thus having a direct and negative impact on the private sector's activities.

---

[287] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction,* The International Bank for Reconstruction and Development / The World Bank, 2003, p.53
[288] *2004 report on global trends in the HIV/AIDS epidemic*, UNAIDS, 2004, p.4
[289] Adrian Blomfield, *Orphans of Somali Lose their Home in War on Terrorism*, Telegraph.co.uk, February 2004
[290] Bonnie L. Shepard, Jocelyn L. DeJong, *Review of Young People's Sexual and Reproductive Health and Rights In the Arab States and Iran*, September 2004, p. 14
[291] *Ibid.*

2.4.5. An over-confidence in the socio-cultural HIV/AIDS shield

Several surveys – as well as the limited involvement of many stakeholders – have shown that Arab populations do not yet feel concerned about the HIV/AIDS epidemic, arguing mainly that it is a "foreign – and sometimes occidental – problem."[292] Because reported prevalence levels remain low – and will remain low as long as decision makers turn a blind eye to vulnerable populations – HIV/AIDS will not be considered a priority in the MENA region, thus increasing the population's vulnerability to HIV/AIDS and jeopardizing the region's future. This lack of engagement is reinforced by an over-confidence by the governments in the "protective effects of social and cultural conservatism."[293] It is true that the Arab family unit is known for its integrity and strength. However, the family, the institution in which human beings receive their greatest nurturing, can also create the greatest vulnerabilities in the spread of HIV/AIDS, especially for women and children. The great values that are being taught by parents to the next generation should be considered beneficial to the prevention of HIV/AIDS. Yet, the avoidance of certain subjects such as sexual relations contributes to putting young populations at risk. And while decision makers want to believe in their population's invulnerability, the epidemic is constantly and increasingly affecting crucial segments of the Arab population.

Similarly, Islam is playing a significant role in shaping the response to HIV/AIDS, given that 92.7 percent of the population living in the MENA region is Muslim.[294] It is true that spiritual beliefs and regular religious attendance have been identified by the World Health Organization as a protective factor, especially for young people's health and development.[295] Certain Muslim organizations, like Positive Muslims, have been created to raise awareness about AIDS and offer support to Muslims living with HIV/AIDS. On their website's homepage, they state that: "the idea that AIDS should not be there just because we are Muslims has been overtaken by the hard reality."[296] This reflects the increasing awareness among Muslim populations that AIDS is affecting all populations regardless of religious creed. However, according to other experts like Makhlouf-Obermeyer, "Islam has been used, like other religious doctrines, to legitimate conflicting positions on gender and reproductive choice."[297] Also, young people's health and development issues are far from covering the scope of action of the virus, and according to certain Muslim scholars, the common presumption that HIV/AIDS can be directly linked to an un-Islamic level of moral behavior undermines the efficacy of other factors in determining the actual spread or safety and protection from its fatalities. In regards to the mainstream reaction and response amongst Muslim leaders, Islam may be used as a chance or a deterrent to prevent and proactively respond to HIV/AIDS. According to a report by the National Bureau of Asian Research, one major reason for the lack of action in this region has been assumptions that premarital sex, adultery, CSW, MSM, and IDU do not occur in the Muslim world – or happen so infrequently that the risk of the disease to spread is low.[298] Precious time has already been lost in debating the vulnerability of "good Muslims", who are proven to be just as much at risk as the rest of

[292] Davis 1992, Farza 2001
[293] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction,* The International Bank for Reconstruction and Development / The World Bank, 2003, p. XV
[294] UNDP/HARPAS calculations
[295] *Broadening the Horizon*, World Health Organization, 2003
[296] http://www.positivemuslims.org.za
[297] Bonnie L. Shepard, Jocelyn L. DeJong, *Review of Young People's Sexual and Reproductive Health and Rights In the Arab States and Iran*, September 2004, p.18
[298] Laura M. Kelley and Nicholas Eberstadt, *Behind the Veil of a Public Health Crisis: HIV/AIDS in the Muslim World*, National Bureau of Asian Research, June 2005, p.4

the population; since in certain countries, 80 percent of the heterosexual women with AIDS are monogamous and have only had sex with their husbands.[299]

A Muslim scholar that prefers not to be quoted provides an interesting analysis of Faisal Abdul Rauf's book: "*Islam: A Sacred Law: What Every Muslim Should Know about Shari'ah*". In his book, the author refers to the three responses of Muslims to modern dilemmas: the first one is the "ostrich approach": bury our heads in the sand and quoting ahâdîth and Qur'an, especially those that imply Muslims are on a moral high ground and thus unaffected by these new dilemmas. The second is to build a Muslim society by establishing standards adhering to divinely ordained values. The third is to develop a methodology to integrate the population at large without losing any religious integrity and identity. Clearly this third option will be the most affirmative in a response to HIV/AIDS. Fortunately and thanks to a better understanding of the epidemic, Arab religious leaders from the Muslim and Christian communities – a population few people believed would get involved – have recently chosen the third option and to respond positively to the epidemic. Their commitment has been solidified with the Cairo Declaration signed in December 2004 during a Colloquium organized by UNDP/HARPAS[300] in collaboration with UNAIDS and FHI, and held under the auspices of the League of Arab States.[301] The box 4 displays some selected excerpts from the Cairo Declaration.

[299] Steven W. Sinding, "*Does 'CNN' (Condoms, Needles and Negotiation) Work Better Than 'ABC' (Abstinence, Being Faithful and Condom Use) in Attacking the AIDS Epidemic*?", March 2005
[300] http://www.harpas.org
[301] *Regional Report on HIV/AIDS 2004, Together We Can Break the Silence*, UNDP/HARPAS, 2005, p.17

BOX 4: SELECTED EXCERPTS FROM THE CAIRO DECLARATION

The Cairo Declaration of Religious Leaders in the Arab States in response to the HIV/AIDS Epidemic

We, the Muslim and Christian leaders, working in the field of HIV/AIDS in the Arab world, meeting in Cairo, Egypt from the 28-30 Shawal 1425 H, 11-13 December 2004 AD, in an initiative of the United Nations Development Programme's (UNDP) HIV/AIDS Regional Programme in the Arab States (HARPAS), under the auspices of the General Secretariat of the League of Arab States, and in collaboration with UNAIDS and FHI/Impact, have agreed upon the following […]:

On Prevention

- We emphasize the need to break the silence, doing so from pulpits of our mosques, churches, educational institutions, and all the venues in which we may be called to speak. We need to address the ways to deal with the HIV/AIDS epidemic based upon our genuine spiritual principles an our creativity, and armed with scientific knowledge, aiming at the innovation of new approaches to deal with this dangerous challenge […]
- We view as impious anything that may cause infection through intention or negligence - as a result of not using all possible preventive means available, in accordance with heavenly laws […]

On Treatment and Care

- People living with HIV/AIDS and their families deserve care, support, treatment, and education, whether or not they are responsible for their illness. We call for our religious institutions, in cooperation with other institutions, to provide spiritual, psychological, and economic guidance and support to those in need. We also encourage them not to lose faith in God's mercy, and aspire to a rewarding and productive life, embracing fate with courage and faith […]
- We reject and emphasize the necessity to abolish all forms of discrimination, isolation, marginalization, and stigmatization of people living with HIV/AIDS, we insist on defending their basic freedoms and human rights […]

Addressing other leaders

- As religious leaders we need to reach out to our governments, civil society institutions, NGOs, and the private sector, to seek closer cooperation and greater action in the response to this epidemic […]
- We promote the setting up of guidance and awareness raising centers and facilitate the establishment of charitable organizations to provide care, and support for people living with HIV/AIDS

Some Muslim countries in other regions had adopted the "ostrich approach" in the past, feeling safe from the HIV/AIDS epidemic for social, cultural, and religious reasons. Today, these countries are unfortunately paying the price for their late response to HIV/AIDS. One of them is Indonesia, the largest Muslim country in the world, which is currently facing a rapid and unexpected spread of the epidemic. Indonesia, where 88 percent of the population is reported to be Muslim[302], had low HIV prevalence until the late 1990s, when the situation began to change rapidly. Massive economic and political disruption in recent years has produced dramatic changes in Indonesia's national-risk environment.[303] The country is experiencing new, rapidly developing sub-epidemics in several provinces and communities. Indonesia now perceives HIV/AIDS as a serious threat to its national development and

[302] http://www.cia.gov/cia/publications/factbook/geos/People, U.S. Central Intelligence Agency
[303] *Indonesia's Country Profile*, US Agency for International Development, December 2003, p.1

prosperity. Some vulnerable groups like Indonesian injecting drug users – a growing concern in the Arab countries as well – are reported to have alarming prevalence rates as high as 53 percent.[304] It must be mentioned that most of these drug users are young, relatively well educated and live with their families.[305] In just a few years, Indonesia's HIV/AIDS classification has moved from "low level" to "concentrated epidemic" according to UNAIDS.[306]

The Indonesian private sector thus realized it had no option but to step forward and to actively support the response to the epidemic. Therefore, the business community – in collaboration with other stakeholders like the Indonesian Chamber of Commerce, the Indonesian Employers Organization, local NGOs, UNAIDS and the ILO – created the National Business Alliance in HIV/AIDS in August 2003[307], which has since been a very active agent in building the private sector's capacity to respond to the epidemic.

In light of other regions' experiences, companies operating in Arab countries must realize the human and economic cost that HIV/AIDS represents. Unless the private sector takes appropriate measures to respond to HIV/AIDS today, the epidemic will deprive companies operating in the Arab region from their trade partners, workforce, and customers. Logically, making profitable business and operating in the region will become much more difficult. In this case, companies have a great interest – if not a great need – in investing in the HIV/AIDS response in the region. It is true that some companies are showing a great sense of corporate responsibility, but it is still fair to argue for a pro-active response to HIV/AIDS based merely on corporate self-interest and profitable long-term investment. In other regions, companies have already realized the economic and public relations benefits delivered through the implementation of HIV/AIDS policies.

[304] *Indonesia Country Profile*, National Authorities, WHO Country Office for Indonesia and WHO Regional Office for South-East Asia, June 2005, p.1, see http://www.who.int/3by5/support/june2005_idn.pdf
[305] Riono and Jazant, 2004, quoted from *AIDS Epidemic Update,* UNAIDS, December 2005, p.36
[306] Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction,* The International Bank for Reconstruction and Development / The World Bank, 2003, p.7
[307] *Building Partnerships with the Private Sector,* UNAIDS, March 2005

3. TO WHAT EXTENT IS THE PRIVATE SECTOR CURRENTLY INVOLVED IN THE ARAB REGION'S RESPONSE TO HIV/AIDS ?

Globally, businesses are increasingly responding to the epidemic. Worldwide, 46 percent of firms report some current or future impact from the disease, and few believe they or their workforces will be immune if the epidemic hits their community.[308] Some respond from a sense of enlightened self-interest and corporate social responsibility. Others respond because of the direct effects that HIV/AIDS has or could have on their own business operations, including increased costs, weakened business environment, and threats to consumer base.

When it comes to the Arab region, the HIV/AIDS response of private companies is still relatively weak. According to a 2006 World Economic Forum survey, only two percent of companies operating in the MENA region have a specific written policy on HIV/AIDS, and 7 percent have informal policies.[309] Few firms prohibit discrimination against HIV-positive individuals in promotion, pay and recruitment policies, and only five percent prohibit disclosure of HIV status.[310] The same survey reports that the few policies implemented are also less comprehensive than in other regions of the world (only 27 percent of the policies provide information on the risks of infection, against 54 percent on average in other regions), which doesn't affect the confidence of the companies implementing them. Indeed, 75 percent of those implementing policies are confident that their policies will be sufficient to tackle HIV/AIDS in the next five years.[311]

The main reason for this lack of investment is the fact that 74 percent of the companies operating in the MENA region do not expect any impact of HIV/AIDS on their activities in the next five years, despite the fact that the share of companies expecting a serious impact in the future has doubled to 10 percent since 2004.[312] As stated previously in section two, 99 percent of firms that estimate infection rates among their workforce believe this rate to be below 1 percent, and fewer than 3 percent have seen any significant impacts on costs, productivity and revenue.[313]

Also, businesses in the region believe their local communities are largely unaffected by AIDS. Only 15 percent of businesses report negative effects on their localities.[314] These figures obviously contrast with forecasts by experts that predict an expansion of the epidemic with the consequences presented previously; thus reflecting a lack of access to relevant information which in turn prevents a great number of private entities from adopting appropriate measures and policies against HIV/AIDS.

---

[308] *Business & HIV/AIDS: A Healthier Partnership? - A Global Review of the Business Response to HIV/AIDS 2005-2006*, World Economic Forum/ Global Health Initiative, January 2006, p.11
[309] *Ibid*, p.46
[310] *A Global Review of the Business Response to HIV/AIDS 2004-2005*, World Economic Forum/Global Health Initiative, January 2005, p.23
[311] *Business & HIV/AIDS: A Healthier Partnership? - A Global Review of the Business Response to HIV/AIDS 2005-2006*, World Economic Forum/ Global Health Initiative, January 2006, p.25
[312] *Ibid*, p.25, p.42
[313] *A Global Review of the Business Response to HIV/AIDS 2004-2005*, World Economic Forum/Global Health Initiative, January 2005, p.23
[314] Ibid, p.23

According to the World Bank, it is more likely that private companies decide not to involve themselves unless governments lead the way and include the private sector in a truly multisectoral approach.[315]

In light of this data, it is important to first examine the private sector's added value, specificities and special abilities in the response to HIV/AIDS. Secondly, the successful policies and measures implemented in the region must be considered, along with initiatives whose aim is to foster the private sector's involvement.

3.1. Private sector's added value in the response to HIV/AIDS

At first sight, many stakeholders see the private sector's role responding to HIV/AIDS as a mere source of resources. However, the latter's ability to contribute to the response to HIV/AIDS is much more significant. Even though it is undeniable that certain private entities operating in the region have significant financial means and could provide a crucial support to the mobilization of financial resources, this point of view is only one part of the story and does not fully recognizes the great potential of private entities in the regional HIV/AIDS response.

Even though the primary impact of business involvement is generally an immediate influx of financial resources, it is crucial to explore more thoroughly the secondary impact of this involvement, which is an immense level of expertise on outreach.

3.1.1. A privileged location for outreach

First of all, as we have already seen, private entities are increasingly employing a larger percentage of the Arab population, and an individual will generally be easier to reach as an employee rather than as a citizen. In other words, the fact that a growing number of people are part of private companies makes it easier to get in contact with them and to provide relevant information to prevent the spread of HIV, stigma and discrimination. It also makes it easier to conduct realistic surveys on the level of infection and consequently to provide appropriate treatment and care to employees and their families. The ILO confirms this statement by defining the workplace as a "conducive setting for information dissemination and education about prevention and risk assessment, and counseling for additional support and care."[316] In addition, it is important to note that in certain Arab countries, the workplace might be the only reliable information source available. In this regard, we understand that the private workplace offers better accessibility to the people, thus representing a privileged location to reach, inform and/or treat the population.

3.1.2. Problem-solving Mindset & Entrepreneurial Spirit

In addition to a great accessibility to employees, private entities have the ability to extend this outreach to the rest of the community. According to Professor Diana Barrett from the Harvard Business School,[317] "the unique capabilities of businesses give to this sector new responsibilities: the same companies that have distribution network, the skill set and the

[315] *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction,* Carol Jenkins, David A.Robalino, The International Bank for Reconstruction and Development / The World Bank, 2003, p.77
[316] *HIV/AIDS and the World of Work, Regional Strategy and plan of Action for the Arab States,* International Labour Organization, Regional Office for the Arab States, June 2003, p. 19
[317] Interview of Prof. Diana Barrett by the Harbus Online team, *Corporate partnerships to combat HIV/AIDS*, May 2005

financial acumen to make certain companies' products available in every minuscule African town, have the ability to apply these capabilities to the problem of HIV/AIDS, with an efficiency, flexibility, and speed that governments can simply not match."

Further, the Global Business Coalition states that "efficiency of operations, overcoming obstacles, responsibility for achieving concrete outcomes, and accurately gauging perceptions and human behavior help business to thrive and are prerequisites for success in battling the pandemic locally, nationally, and internationally."[318]

In other words, the private sector in the Arab region has unique resources that could and should be leveraged in the response to HIV/AIDS.

3.2. Initiatives fostering the business response to HIV/AIDS

3.2.1. The ten UNAIDS cosponsoring organizations

Generally, UN agencies agree that they only recently became involved with AIDS in the Arab region, except the WHO that has been involved for more than 15 years. According to UNAIDS Regional Office for the Middle East and North Africa, the initiatives of the ten UNAIDS cosponsoring organizations (ILO, UNESCO, UNDP, WFP, WB, UNFPA, UNICEF, UNODC, WHO, UNHCR) whose aim is to involve the private sector operating in the region in the response to HIV/AIDS are very limited in the Arab region.

We have to clarify the fact that many UN cosponsoring agencies have important and efficient initiatives fostering the private sector's response to HIV/AIDS in other regions of the world, or are working on the response to HIV/AIDS with other stakeholders in the Arab region. However, even though many UNAIDS cosponsors receive financial support from private companies operating in the Arab region, these agencies are currently the only ones with such initiatives when it comes to HIV/AIDS and the private sector in the Arab region.

Currently, the few UN agencies that have initiatives targeting the private sector in the Arab region are the following:

International Labor Organization (ILO)

Due to its specific mandate targeting the world of work, the International Labor Organization is currently the most active agency fostering private sector's response to HIV/AIDS in the region. The ILO's initiatives enhancing the private businesses' participation to the response to the epidemic can be described as follows:

- Publication in June 2003 of a Regional Strategy and Plan of Action for the Arab States called "*HIV/AIDS and the World of Work*", which targets the world of work in general, i.e. both Public and Private entities.[319]
- Meetings and presentations at several enterprises in Lebanon, targeting workers and employers, in order to set a workplace policy that includes HIV/AIDS dimensions.

[318] *Opportunities for business in the fight against HIV/AIDS*, Global Business Coalition, January 2005, p.5

[319] This booklet is based on the ILO Code of Practice but takes into consideration the cultural characteristics of the region

- Two major tripartite workshops, one in Beirut and one in Syria, targeting health and labor inspectors by engaging them regarding their role in responding to HIV/AIDS through the workplace.
- Workshop in Turin, Italy for trade Union Representatives from 12 Arab States on HIV/AIDS as part of the Occupational Health and Safety system.
- Several radio and TV talk shows with the participation of all three constituents: employers' and workers' representatives, and government (Ministry of Labor).
- Survey of private institutions to assess their health system and whether it involves HIV/AIDS (so far, none of the companies surveyed have any applied policy on HIV/AIDS).
- In the process of producing a pamphlet targeting workers and employers in the private and public sector. It includes basic guidelines of their Code of Practice in addition to general awareness on the epidemic and the latest statistics. This is to be distributed in as many Arab States as possible.
- Plan to launch a project in seven Arab States for the Hotel Catering and Tourism (HCT) industry. The chosen countries are those most recognized for their tourism and entertainment industry in West Asia and in North Africa.

United Nations Children's Fund (UNICEF)

UNICEF's collaboration with private businesses is limited so far to its partnership with Coca-Cola. UNICEF collaborated with the Coca-Cola Africa Foundation in a regional multimedia campaign to raise the population's awareness about HIV/AIDS through TV spots, special events, SMS, etc. The UNICEF initiative was implemented in Egypt first, and could possibly be implemented in Tunisia and Sudan in the future.

United Nations Development Programme/HIV/AIDS Regional Programme in the Arab States (UNDP/HARPAS)

Due to their paramount outreach capacity, private medias are obviously a very important component of the response to HIV/AIDS in the Arab region. In this regard, UNDP/HARPAS Arts & Media initiative gathered over 130 Arts and Media professionals from 17 Arab countries during workshops held in March 2003, July 2003 and September 2004, as well as a recent partnership with Arascope Films on the creation of 26 television episodes about HIV/AIDS to be aired regionally.

Moreover, UNDP/HARPAS is currently working in collaboration with the private sector in order to create the basis for the establishment of an active regional mechanism that will support private companies operating in the Arab region in coordinating and fostering their response to HIV/AIDS. The first step of this initiative was a technical meeting in December 2005, which witnessed the creation of a steering committee composed of private companies operating in the region and in charge of further elaborating an appropriate strategy to respond to HIV/AIDS, in collaboration with other stakeholders of the Arab society.

United Nations Educational, Scientific and Cultural Organization (UNESCO)

UNESCO held a seminar on the role of media in raising awareness on HIV/AIDS held in September 2004 in Lebanon, where over 35 Media specialists and Journalists from 13 Arab countries participated in a three-day workshop on the "Role of the Media in Raising Awareness on HIV/AIDS Prevention."

World Food Programme (WFP)

WFP offices operating in the Arab region (Egypt, Syria, Jordan, Yemen, Occupied Palestinian Territories, and the UAE) do not have any specific collaboration with the private sector in the response to HIV/AIDS. However, the Regional Office is currently studying the possibility of providing HIV/AIDS prevention training sessions to its contractors operating in the Arab region, who are mainly warehouse workers and truck drivers (the latter being particularly vulnerable to HIV/AIDS).

World Health Organization (WHO)

WHO supports its Member States in the Eastern Mediterranean Region in strengthening all aspects of health sector responses to HIV/AIDS through advocacy, resource mobilization, policy and technical guidance, and technical capacity building. At regional level, the WHO collaborates with INGOs. Within countries, the WHO encourages and supports governments to collaborate with NGOs and the private sector to enhance access to prevention, treatment, care and support services for PLWHA. For example, in Pakistan, WHO will support a public-private partnership pilot project, where private doctors will provide affordable HIV/AIDS care including ART with medicaments and laboratory cost being covered by the government.

World Bank (WB)

The WB provides technical assistance to most of the governments in the Arab region for their health sector strategies including HIV/AIDS strategies such as in Lebanon and Morocco. However, the only major project that is creating a partnership with the private sector is in Djibouti, for a budget of US$ 12 million over 5 years (2003-2008). This project includes capacity building of different stakeholders, strengthening the health sector response, fostering a multisectoral response, and supporting the community response. The private sector is critically involved in the project, as many of the works, goods, and technical assistance contracts are carried out by national and international private sector firms.

Although the WB is involving the private sector in the provision of contractual and professional services, there are currently no initiatives aiming at directly fostering the private sector's involvement in the response to HIV/AIDS in the Arab region.

Private Sector Task Force - Egypt

The Expanded Theme Group (ETG) on HIV/AIDS put together a taskforce to support an initiative to increase private sector involvement in HIV/AIDS efforts in Egypt. This taskforce consists of MOHP/NAP, CARE Egypt, UNAIDS Egypt, ILO Egypt, and UNODC together with a group of businesses, the Friends of AAA, namely Shell, Cadbury, Trane, American Chamber of Commerce, Bristol Myers Squibb, and Coca-Cola. The objective of this initiative is to increase business sector engagement in the HIV/AIDS response through (1) Ensuring key businesses recognise HIV/AIDS as a business issue; (2) Supporting key businesses to develop and implement HIV/AIDS workplace policies based on the ILO HIV/AIDS Code of Practice; (3) Enforcing a core business group concerned with HIV/AIDS and business as a lead example of business engagement in the national HIV/AIDS response; (4) Assisting key business to direct financial and in-kind support to the national HIV/AIDS response.

The taskforce intends to work closely with the six companies in order to support them in developing and implementing workplace policies. A second phase would be to organize a national meeting for businesses in Egypt to present the business-to-business case study, together with other case studies from different countries. The meeting will be supported by the ETG and may be attended by the World Economic Forum and the Global Business Coalition on HIV/AIDS. In the process, the taskforce will work on developing a Partnership Menu for businesses wishing to support national HIV/AIDS response. It is vital that this initiative be linked with the regional work and followed up at country level.

3.2.2. International Organizations & International NGOs working with the Private Sector on a Regional Level

CARE International, the Global Fund to fight Aids Tuberculosis and Malaria, the Global Compact, the Association Tunisienne de Lutte contre le Sida et les Maladies Sexuellement Transmissibles, the Association de Lutte Contre le Sida au Maroc, and – in a more limited way – Family Health International, are the main organizations identified with initiatives aimed at fostering the private sector's response to HIV/AIDS in the Arab region.

CARE: AAA Project in Egypt

In the Middle East, CARE has 5 country offices: Egypt, Jordan, West Bank/Gaza, Yemen and Iraq (which is currently closed). For the moment, the only country office that implemented a program on HIV/AIDS in the region is Egypt, through the Awareness Against AIDS (AAA) project.

The AAA project aims at introducing a two-layered innovative approach to achieve the goal of maintaining low HIV/AIDS prevalence in Egypt. One of the levels of this approach consists of developing private sector engagement in HIV/AIDS prevention efforts for their employees and for rural communities. CARE provides private companies with orientation programs to increase staff members' knowledge about AIDS prevention, help them apply general messages to their own situation and behavior, and give them tools for making personal decisions about their exposure to risk and how they will manage it. Additionally AAA encourages corporate social responsibility through encouraging companies to support community based awareness campaigns in Aswan, Egypt. So far, companies that have participated with AAA for receiving orientations are Shell Egypt, Trane Egypt, The American Chamber of Commerce (AMCHAM), FedEx Egypt, Rotary Club of New Cairo (District 2450), General Motors Egypt and Conrad Cairo. Scheduled orientations with BG Egypt, Cadbury, and other companies have also been established.

As mentioned above, CARE Egypt recently established the Friends of AAA which is a group composed of private companies operating in Egypt who decided to respond positively to HIV/AIDS, namely Shell Egypt, Cadbury, Trane Egypt, AMCHAM, Bristol Myers Squibb Egypt, and Coca-Cola Egypt. This group is an advisory committee working with AAA to encourage more companies to engage in HIV/AIDS efforts, to participate in research studies to assess changes in knowledge, attitudes and behaviors of staff related to HIV/AIDS and to also engage in organizing a national summit for business and HIV/AIDS with various stakeholders.

CARE Egypt is encouraging other CARE offices in the Arab region in participating to this project. In an attempt to engage other CARE offices, AAA has invited CARE Country offices

to participate in the HIV/AIDS workplace training that is provided to WFP staff in 6 countries in the region, including Yemen, West Bank and Gaza, and Jordan.

FHI: IMPACT Project in Egypt and Jordan

The IMPACT (Implementing AIDS Prevention and Care) Project is the USAID flagship project for addressing the global HIV/AIDS pandemic in the Arab region. Managed by FHI, the project is designed specifically to help USAID missions and bureaus to support HIV/AIDS programs by increasing the capacity of local organizations – public and private (including community and faith-based organizations) – to implement effective HIV/AIDS strategies.

FHI operates in Egypt and Jordan. So far, FHI has not yet worked with private companies, mainly due to funding reasons. Under the umbrella of another donor, this support could be provided to private companies. In such a case, it would focus on the development of HIV/AIDS policies in the workplace exclusively, not on the implementation of such a policy.

Association Tunisienne de Lutte contre les MST et le Sida (ATL MST/SIDA in Tunisia) and Association de Lutte contre le SIDA (ALCS in Morocco): peer education with female workers

In Tunisia and in Morocco, these NGOs are currently providing prevention and information training to women working in factories. Through a programme of peer education, ATL MST/SIDA and ALCS are working in collaboration with trade union organizations to ensure vital information on HIV/AIDS is provided to female employees. In this regard, ATL MST/SIDA has received financial support from Coca-Cola Tunisia. In Morocco, the ALCS initiative benefited more than 13,000 employees working in 111 factories who received information training as well as condoms, in addition to access to VCCT.[320] It must be mentioned that the Confédération Générale des Entreprises Marocaines (CGEM) is a member of the Comité de Coordination Maroc (CCM), which is one of the main bodies in charge of the response to HIV/AIDS in the country.

The Global Fund to fight Aids, Tuberculosis and Malaria (GFATM)

The Global Fund, one of the world's principal funding mechanism for AIDS, Tuberculosis and Malaria, is actively seeking the full involvement of private players in the response to HIV/AIDS. Among a variety of options, GFATM promotes co-investment schemes through Country Coordinating Mechanisms (CCM), which submit country applications for grants to the Global Fund.[321] The GFATM granted the following amounts in the Arab region[322]:

[320] *Appui à la Mise en Oeuvre du Plan Stratégique National de Lutte contre le SIDA 2002 – 2004*, Royaume du Maroc, Ministère de la Santé - Direction de l'Epidémiologie et de Lutte contre les Maladies Service des IST/SIDA, 2ème Rapport Annuel, Avril 2004 – Mars 2005, p.15

[321] *Co-investment: a Central Mechanism for Establishing Public-Private Partnerships at Country Level*, GFATM, p.2

[322] *Grants to Members of the Organization of the Islamic Conference, Rounds 1-4 Fundings*, GFATM, August 2004

FIGURE 23: GRANTS OF THE GFATM TO MEMBERS OF THE ORGANIZATION OF THE ISLAMIC CONFERENCE (2004)

Country	*HIV/AIDS*	
	over 2 years (in US$)	*over 5 years (in US$)*
Algeria	6,185,000	8,869,360
Jordan	1,778,600	2,483,900
Morocco	4,738,806	9,238,754
Somalia	10,004,644	24,922,007
Sudan	16,659,310	49,216,366
Yemen	5,500,405	14,764,062

Source: *Grants to Members of the Organization of the Islamic Conference*, Rounds 1-4 Funding, *30 August 2004*

A sub-regional workshop of the GFATM was held in July 2005. Even though the conclusions of the workshop are not available, discussions with experts that attended the workshop revealed that the private sector's involvement in the response to HIV/AIDS will be noticeably encouraged.

Global Compact (GC)

The GC was launched in 2000 to encourage collaboration between the UN system and the private sector in addressing the challenges of globalization, and promoting GC's principles. The GC is a network-based initiative with the Global Compact Office, the Advisory Council and six UN agencies at its core.[323] It seeks to promote responsible corporate citizenship so that business can be part of the solution to the challenges of globalization. In this way, the private sector – in partnership with other social actors – can contribute to creating a more sustainable and inclusive global economy. The GC is a purely voluntary initiative with two objectives, which are: 1) Mainstream the ten principles in business activities around the world, 2) Catalyze actions in support of UN goals. In the Arab region, the GC's scope of action is still limited to Egypt, where a network of 56 companies has been successfully created in order to advance the GC's ten universal principles in the areas of human rights, labor, the environment, and anti-corruption. The need for a response to HIV/AIDS – even though never mentioned explicitly – is included in the area of Human Rights. Despite a very limited concern for HIV/AIDS from the companies involved in this initiative, the GC has a great potential for mainstreaming HIV/AIDS among companies' priorities – provided that the network extends to other Arab countries, and that the necessity for a response to HIV/AIDS is more clearly emphasized.

3.2.3. Corporate initiatives

As stated above, only 3 percent of private companies have a written policy against HIV/AIDS. However, some promising and inspiring regional initiatives deserve to be presented. Not surprisingly, most of these initiatives come from multinational companies, mainly because of the limited financial resources of smaller private entities. It is possible – though doubtful – that some national companies or SMEs operating in the Arab region implement HIV/AIDS policies. However, the lack of documentation from these entities prevents us from accurately reporting these initiatives.

[323] http://www.unglobalcompact.org

In other regions of the world, some very effective responses include the formation of business national or international coalitions or associations. So far, 44 coalitions are reported[324], like the Global Business Coalition against HIV/AIDS (GBC), the Business Exchange on AIDS and Infectious Diseases (BEAD), or the Asian Business Coalition (ABConAIDS), among others. These coalitions allow members of the business community to share best practices and to develop a coordinated response within the national strategy. Interestingly, this type of coalition – which does not yet exist in the Arab region– appears to be one of the most effective means to engage an increasing number of companies in the response to HIV/AIDS.

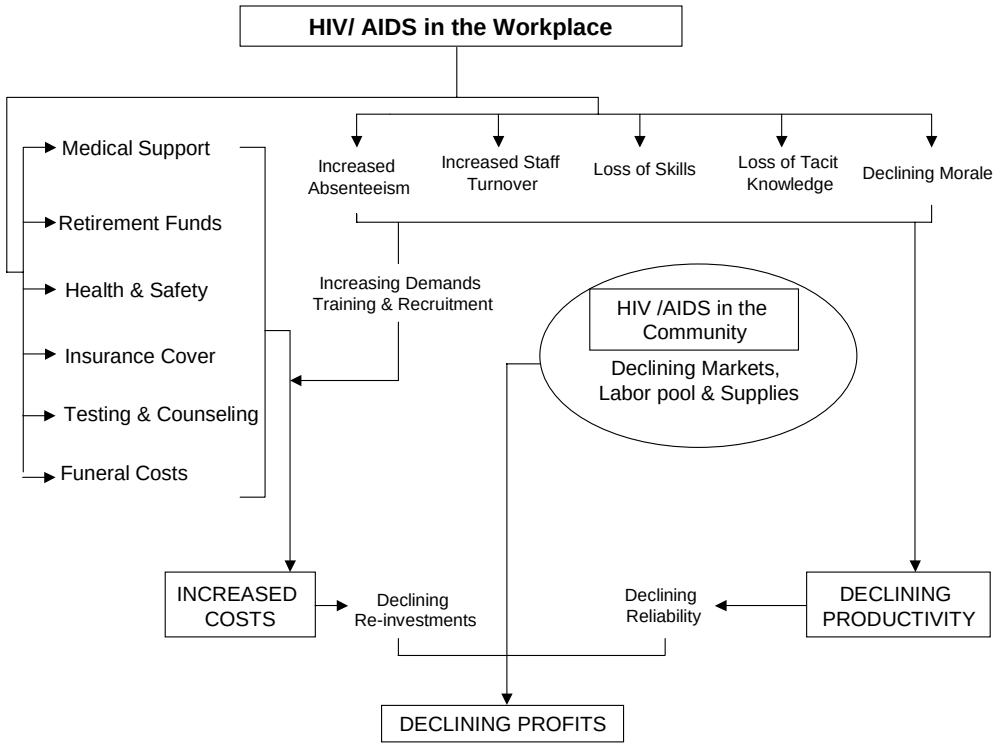
Once again, we have to stress the fact that there is no need to reinvent the wheel to be efficient against HIV/AIDS. Most of the companies involved are adopting basic but efficient policies which consist most of the time in providing relevant and vital information about HIV/AIDS to employees and their families, condoms, as well as supporting infected or affected employees or members of their family through health coverage and ARV treatment. These are some examples:

Shell: the risk management system in action

In 2003, Shell revised its 1993 global guideline for HIV/AIDS to the attention of its operation Units in the different regions of the world to help them elaborate adequate strategies in responding appropriately to the epidemic. In 2004, Shell implemented these guidelines in five pilot countries (Gabon, Ivory Coast, Kenya, Nigeria and South Africa). From the pilot experience in Africa, Shell has developed an approach to HIV/AIDS. The focus of the Shell approach is on their employees and their dependants. With regard to contractors Shell wants to ensure prevention efforts are made, awareness is raised and Voluntary Counselling and Testing is in place. With regard to the host community Shell aims to act as a catalyst for a comprehensive response to HIV/AIDS. Shell's efforts in the response to HIV/AIDS in the Arab region are mainly justified by its risk management system. In other words, the company is trying to adopt measures to respond to HIV/AIDS because it identified the virus as a threat to its employees and families, and therefore a threat to its activities. This system is very well detailed in the figure below:

[324] *Guidelines for Building Business Coalitions against HIV/AIDS*, Global Business Coalition, Appendix 1

FIGURE 24: "HIV/AIDS IN THE WORKPLACE" ACCORDING TO SHELL'S MANAGEMENT GUIDE



Source: A Management guide on HIV/AIDS, SHELL, March 2003

Recognizing HIV/AIDS to be a universal issue, Shell has started working on the implementation of the guidelines in other countries in Africa, Asia and the Middle East. The company is aware of the risk that HIV/AIDS represents in the Arab region and has begun activities to this end in three countries in the region: Qatar, Oman and Dubai. In addition, Shell Egypt also adopted a cultural-sensitive approach and has been working in collaboration with CARE International to implement the Awareness Against Aids training program for their staff and families. Regionally, the company is in the process of gathering information, doing situation and stakeholder analyses and developing a comprehensive programme. Shell is planning to roll-out this programme to other countries throughout the Middle East region in 2006.

Coca-Cola: embracing its leadership's responsibilities

Coca-Cola is one of the main workforce recruiters in Africa, including the North African region. In 2002, the company started to implement HIV/AIDS awareness trainings in North African countries, focusing on the bottling companies that represent most of Coca-Cola's workforce. Instructors hired by Coca-Cola from the Ministries of Health, provide trainings to the employees. The training has been based on a program designed by African managers that were witnessing a significant impact of the virus on their activities in Sub-Saharan countries.

Understanding the experience of their counterparts working in countries already affected by the epidemic, managers of certain Arab countries decided to anticipate the impact of the epidemic in an attempt to avoid dramatic effects of the virus on their communities and business activities in the coming years. Today, Coca-Cola Egypt, Tunisia and Morocco are implementing this training; and it is already planned that Coca-Cola Algeria, Libya, Somalia

and Mauritania will do the same by the end of 2005. With the exception of Egypt, none of these activities have been implemented in the Middle East so far.

Trane: Safety and Health as main priorities

As part of a multinational group, Trane is a company that manufactures and commercializes air conditioning systems in most of the countries of the Arab region. Their priorities include the health and safety awareness of their employees and communities. Aiming to minimize their business costs, Trane's managers in Egypt decided to implement the AAA program provided by CARE in 2005. according to Trane Egypt's Managing Director, raising awareness for its employees has been a very satisfactory investment because it will benefit its community, employees, and business activities.

Trane Egypt's Managing Director has planned to report the benefits of his investment in HIV/AIDS prevention policies to his regional office in order to study the possibility of duplicating such an initiative on a regional level.

3.3. Main Challenges & Needs

As once stated by the Global Business Coalition, "businesses, globally, are doing 5 percent of what they could do."[325] And when we have a closer look at the figures shown at the beginning of this section on the response to HIV/AIDS of private companies operating in the Arab region, we can undoubtedly assume that this figure is even lower in the MENA region. However, the companies do not always bear the responsibility for this lack of engagement. Due to its culture and traditions, involvement in the response to HIV/AIDS is a very sensitive issue in the MENA region, and it requires preliminary conditions and appropriate justifications.

3.3.1. Necessary green light from the Government

Our investigations demonstrate that many companies throughout the MENA region are willing to get involved in the response to HIV/AIDS, through financial support to organizations or through the implementation of constructive and profitable HIV/AIDS policies. However, their willingness is sometimes diffused due to the need for politically correct strategies that require the preliminary support of the governments before tackling such a sensitive issue like HIV/AIDS. Because governments in the region still have a relatively important influence on the economic activities despite the privatization process going on, all economic stakeholders operating in the region need to establish a cordial and fruitful relationship with governments, which sometimes implies the avoidance of delicate issues.

In this regard, we understand that governments in the MENA region play a crucial role in unleashing most of the stakeholders' response to HIV/AIDS, and more specifically the response delivered by the region's largest private entities. Governments in the Arab region are increasingly aware of the challenge they are facing and the dramatic situation HIV/AIDS could generate. Some private companies leading the response to HIV/AIDS in North Africa are working in very close collaboration with the governments. However, Arab governments should facilitate these private initiatives by creating an enabling environment for an appropriate response to HIV/AIDS.

[325] Trevor Neilson, *Understanding the role of business in the Global AIDS crisis,* Global Business Coalition

3.3.2. Low quality of data available on HIV/AIDS

A necessary component for establishing an enabling environment towards a response to HIV/AIDS consists of providing reliable and realistic data on the HIV/AIDS epidemic in each country. This task should be part of the governments' responsibilities, and represents one of the main hurdles for an appropriate response to HIV/AIDS from private companies, regardless of their size and activities. As explained in section 2, the inadequate surveillance methods implemented by most of the Arab governments generates underestimated figures, which endanger the population by maintaining an illusionary "HIV/AIDS-almost-free" environment. Without realistic data and consequent forecasts, decision-makers logically do not feel concerned with such an issue. Even when some feel concerned, many consider their involvement against HIV/AIDS as an act of charity, and restrict their action to passive and limited financial support to NGOs or other institutions.

3.3.3. Critical lack of resources

As presented in section 1, the majority of the Arab workforce is employed in SMEs. Unlike regional or multinational companies, these SMEs generally have very limited funds – if any at all – to be allocated to HIV/AIDS policies. Most of their budgets are allocated to daily priorities, such as production, management, communications, etc. This is due to the fact that smaller entities generally have short-term visions, and before eventual business growth, they tend to have more difficulties adopting a long-term vision. This long-term and cost-saving strategy is one of the factors that encouraged some multinationals to adopt HIV/AIDS policies in the Arab region.

Paradoxically, SMEs in the Arab region will be the first entities to see their activities affected by the epidemic due to their high HIV/AIDS vulnerability.

3.3.4. Critical lack of knowledge

The pendant of the previous hurdle to the response to HIV/AIDS is mere but often-generalized lack of knowledge for companies in terms of HIV/AIDS policies. In other words, companies that are aware of the consequences of the epidemic on their businesses and willing to take further steps often face difficulties in adopting a relevant and appropriate response due to a lack of concrete proposals from governments, NGOs, or UN agencies. For the moment, most of the companies willing to anticipate the consequences of HIV/AIDS on their activities obtain the information and the technical support from NGOs or UN agencies, such as the ILO and its Code of Conduct.

3.3.5. HIV/AIDS is taboo

The fact that HIV/AIDS is a strong taboo in the Arab region can make it particularly difficult for private companies to tackle the HIV/AIDS threat. Today, many employers, employees, people from the governments, decision-makers, and an important part of the Arab population in general view HIV/AIDS as a disease related to improper behaviors. As a consequence of this systematic stigma and discrimination, many private companies consciously decide not to engage themselves in the response to HIV/AIDS, fearing for their products or their image to be associated with the epidemic. Ironically, it is the very attempt of the companies to protect their activities by denying any impact of HIV/AIDS or any HIV/AIDS policy that may speed up the deterioration of their businesses, as presented in section 2. The only effective way to address these concerns is, for all the stakeholders of the Arab society, to raise public

awareness. The appropriate and vital message on HIV/AIDS has to be provided as widely as possible to the population by governments, religious leaders, Media, NGOs, private companies, and any other stakeholders who are concerned about the future of the Arab region.

HIV/AIDS is clearly a taboo for companies when we compare private entities' positions on HIV/AIDS treatment versus cancer treatment. The most common cancers for men are generally lung cancer or prostate cancer, while women are mainly affected by breast, uterus and ovarian cancer. It is interesting to notice that cancer treatment is generally twice to three times more expensive than HIV/AIDS treatment[326] - sometimes reaching US$ 5,000 to US$ 6,000 per patient per year. These types of cancers generate a 10-15 percent of absenteeism for the employee[327], due to the disease and the side effects. Still, most of the companies do provide and cover the costs of the treatment for their employees, generally without the slightest doubt on the necessity and its justifications. Similarly, the treatment of Hepatitis C – a disease with similar means of transmission compared as HIV – generates significant costs that can reach US$ 1000 per patient per month in countries like Egypt.[328] Still, companies generally provide their employees with adequate treatment and cover expenses.

Furthermore, one must ask: why would a company, after discovering an employee's HIV+ status, decide to lay him off? In light of the information mentioned above, the most likely answer appears to be neither an economic justification nor a moralistic one, but a mere lack of appropriate information; since an infected employee receiving adequate treatment can be perfectly productive for more than 10-15 years, with no risk of transmitting the virus to his/her colleagues through the daily work encounter. A better understanding of the epidemic already generated a positive response from unexpected partners in the multisectoral response to HIV/AIDS, such as the Arab religious leaders from the Muslim and Christian communities, as mentioned previously. This change of attitude from religious leaders of the Arab world allows us think that the private sector, if provided with the appropriate information, will take a step and will join the various stakeholders – governments, religious leaders, NGOs, Arts & Media professionals, and civil society – already engaged in the response to HIV/AIDS.

[326] Interview Dr. Tarek El Sheikh by UNDP/HARPAS, HIV Business & Training Manager – ME Bristol Myers Squibb Company, July 2005
[327] *Ibid.*
[328] *Ibid.*

4. SHARING BEST PRACTICES FROM OTHER REGIONAL RESPONSES

As Antonio Vigilante, UNDP Resident Representative in Egypt, once stated: "there are no copyrights when it comes to good social engagement". In other words, the response of Arab companies to HIV/AIDS does not require constantly reinventing the wheel. Basic but efficient policies, described in the following section, have already made a real difference and have allowed certain countries to reverse the trend of the epidemic. Private companies operating in the region that have not yet taken any measures against HIV/AIDS should be inspired by those who have already responded to HIV/AIDS in their community and their business's interest.

As mentioned at the beginning of this report, a company's response can target different groups or populations. A company can decide to implement an internal policy focused on its employees and their families by providing information and raising awareness as well as providing care, support, and treatment to its infected and affected employee. Another possibility for the company is to adopt an external policy, which consists mainly in focusing on communities. Of course, these two types of policies are perfectly compatible, and many companies implementing internal policies generally combine them into community outreach policies. This latter approach involves direct cash or in-kind contributions to the HIV/AIDS prevention activities of governments and NGOs, as well as sponsoring different events (concerts, sport event, etc.). According to FHI, multinational corporations, large local businesses, and private foundations and institutions currently play a limited role in funding HIV/AIDS prevention and care in developing countries.[329] But a number of institutions are leading the way in contributing some of their profits to reduce the burden of HIV/AIDS prevention and care on the communities where their businesses are based.

Another possible external initiative for private companies is to get involved in social marketing campaigns, whose aim is the elimination of stigma and discrimination or the promotion of appropriate behaviors, and raising funds for the response to HIV/AIDS. The concept is similar to traditional marketing, but the campaign focuses on selling "behavior change." We have to say that this type of involvement requires a minimum level of awareness among the population in order to generate a "win-win" situation, in which both the consumers and the company benefit from the initiative. In the Arab region, many companies decided to keep their involvement against HIV/AIDS low profile because of the high stigma and discrimination towards people living with HIV/AIDS and anything associated with the disease in general. Thus, a normalization of HIV/AIDS and a better understanding of the situation of people infected or affected by the virus appear to be compulsory preliminary steps before the implementation of such initiatives in the Arab region are successful. In other regions of the world, social marketing policies of organizations like Futures Group in Pakistan, Brazil, Botswana, China or Bangladesh are noteworthy.[330]

However, in the following section we would like to focus on successful internal policies implemented by private companies in other regions of the world. The Global Health Initiative – a public-private partnership of business, non-governmental organizations, civil society, academic institutions, and governments – provides detailed and comprehensive private sector

[329] Peter Lamptey, *Opinion: Expanding the Partnership -- The Private Sector's Role in HIV/AIDS Prevention*, Family Health International, 2005
[330] http://www.futuresgroup.com/Services.cfm?area=1

intervention case examples, as presented below (the full version of these case examples are available in the annexes).

4.1. Implementing a regional workplace prevention and voluntary testing programme: General Motors in Thailand

A case example of General Motors' Global Health Initiative[331] on intervention with the private sector in Thailand offers an interesting description of a successful and comprehensive internal policy. This kind of policy contributed to Thailand's success in reducing risk behaviors, thus resulting in declining levels of new HIV infections on a national level.[332]

General Motors Corporation (GM) is the world's largest vehicle manufacturer. The company has manufacturing operations in 32 countries. GM Asia Pacific (GMAP) includes GM's activities in Japan, Korea, China, ASEAN and India, Australia, and New Zealand. In 2003 GMAP employed 14,000 people. In Thailand, GM employs 2,500 people.

The vision of GMAP's HIV/AIDS programme is to ensure a policy of non-discrimination and support for those employees living with HIV/AIDS as well as to invest in prevention to reduce the incidence of HIV/AIDS in employees, their families and the communities in which GM operates and sells its products. GMAP gained top management support for a regional HIV/AIDS programme after being inspired by guidance from headquarters and informed by local experts.

GMAP's two-year budget for the pilot projects in Thailand and India was US$ 50,000, which corresponds to approximately US$ 8 per employee per year.

GM's programme focused on developing and communicating a clear workplace policy, peer education, access to voluntary counseling and testing, and community outreach activities

- GMAP developed HIV/AIDS programme guidelines for each plant, which included a sample workplace policy. GM Thailand developed its policy in mid-2002.
- GMAP's prevention and awareness programme uses peer education to train employees, managers, and families in awareness as well as prevention messages.
- GMAP employees are encouraged to access voluntary counseling and testing services either through company facilities or through external resources.
- While developing the workplace education content, the steering committees developed contacts with local NGOs and used these contacts to identify and select community outreach activities.

After a formal review process, GMAP believes that this pilot project has been successful and is in the process of rolling it out to additional facilities. Based on the success of the pilot project in Thailand and India, it is being expanded to include Indonesia and China.

[331] *GM HIV/AIDS Thailand Case Study*, World Economic Forum Global Health Initiative, June 2004
[332] *AIDS epidemic update*, UNAIDS, December 2004, p.43

4.2. Partnering with an NGO to implement a workplace HIV/AIDS prevention programme: GTG in Indonesia

An additional case example of the Global Health Initiative's intervention with the private sector is the Gajah Tunggal Group in Indonesia[333] which offers yet another interesting example of implemented internal policy against HIV/AIDS. This case reflects the growing concern of the Indonesian business community on the impact of HIV/AIDS on their activities. The Gajah Tunggal Group (GTG) is a large Indonesian conglomerate and a leading tire manufacturer in South East Asia. GTG is a diversified group including interests in integrated shrimp farming, tire manufacturing, petrochemical, and consumer network services in the Asia Pacific region. In 2003 the group managed more than 60 companies and directly employed 55,000 people.

PT Gajah Tunggal Tbk. (GT Tire) is South East Asia's largest tire manufacturer. GT Tire uses five factories in Indonesia to produces radial, bias, and motorcycle tires. GT Tire has a distribution network of more than 50 dealers throughout Indonesia and other international outlets in over 75 countries. In 2003, GT Tire employed approximately 14,000 workers, including 7,500 at its factory site in Tangerang, outside of Jakarta.

In 2002, GTG Executive Director visited South Africa, and saw first hand the impact of a large-scale HIV/AIDS epidemic on businesses and society. Upon returning home to Indonesia she became aware that without a significant investment in prevention from all sectors of society, Indonesia risked a similar future. In response to this threat she established a workplace prevention programme not only to reduce the risk to her businesses, but also to set an example for other businesses and other sectors of society.

GTG believes that its employees and their families are directly at risk for contracting sexually transmitted infections, including HIV/AIDS through unsafe sexual practices. Approximately 95 percent of the workers at GT Tires facility in Tangerang are men. Most of these men are between 20 and 40 years old and have received a vocational high school education. Many of these workers are not originally from the Tangerang area, having moved there for work. There is also a well-established commercial sex industry near the factory.

GT Tire has not established an HIV/AIDS-specific budget. The company's main expense is the opportunity cost of lost work time spent on workplace training activities.

GTG workplace prevention programme focuses on mandatory employee training:

- GTG does not have a written HIV/AIDS-specific policy, but senior managers have expressed and communicated a commitment to maintain prevention activities in the workplace and community, as well as to ensure HIV+ employee rights.
- Top management drives GT Tire's workplace prevention programme. The programme focuses on management training and mandatory staff training through peer educators. GT Tire estimates that its training has already reached 60 percent of its factory staff.

In the future GTG aims to understand its employee needs and extend workplace prevention efforts to cover additional at-risk employees in Indonesia.

[333] *GTG HIV/AIDS Indonesia Case Study*, World Economic Forum Global Health Initiative, July 2004

4.3. **Providing comprehensive treatment to employees:** IBM in South Africa

As far as treatment to employees is concerned, the Global Health Initiative provides us with the useful description of IBM's HIV/AIDS policy in South Africa.[334] IBM South Africa focuses on providing information technology solutions and services to Central and Southern Africa. In 2002, the subsidiary had approximately 1,350 employees and 350 external contractors.

The aim of IBM South Africa's programme is to provide an HIV/AIDS awareness and support programme and to inculcate responsibility among employees, for the well being of all IBM South Africa employees. IBM South Africa is aware of the current and future impact of HIV/AIDS on its employees, their families, and the communities in which it operates. In addition to these social motivations, the company expects that with a successful treatment programme it could avert 42 percent of US$ 10.6 million in HIV/AIDS related expenses over the ten-year life of the programme.

IBM South Africa's 2003 HIV/AIDS workplace budget was US$ 53,000, which corresponds to approximately US$ 40 per employee per year.

IBM South Africa's programme focuses on prevention through access to self-serve HIV/AIDS education through interactive software and treatment including Highly Active Anti-Retroviral Therapy (HAART).

- Management approved IBM South Africa's HIV/AIDS policy in October 2001. The policy was revised in early 2003. It was developed by the Human Resources department in consultation with other companies with existing workplace policies. The Human Resources department worked to ensure that the policy was compliant with all relevant legislation.
- In addition to annual events, condom distribution, and sexually transmitted infection (STI) treatment, IBM South Africa's awareness campaigns focus on providing self-service interactive software to raise employee knowledge and awareness.
- Voluntary Counseling and Testing (VCT) has been available through IBM South Africa's Medical Centre since the early 1980's.
- HIV+ employees gain access to IBM South Africa's treatment programme, including access to Highly Active Anti-Retroviral Treatment (HAART).

Since the launch of the programme, IBM has noticed that HIV/AIDS related absenteeism for HIV+ employees has dropped from approximately 25 days to 3 per year. In the future, IBM hopes to extend the treatment programme to cover dependants.

4.4. **Partnering with workers and the community to reduce the impact of HIV/AIDS in the workplace:** Chevron Texaco in Nigeria

The Global Health Initiative's private sector intervention case example of the Oil & Gas company Chevron Texaco in Nigeria reflects the willingness of a company to protect its employees, families and business, despite low prevalence rates among its employees.[335] Chevron Nigeria Limited (CNL) employs roughly 1,800 employees and 3,000 contractors (90 percent Nigerian nationals). It has to be mentioned that field-based oil workers are considered

[334] *IBM South Africa Case Study*, World Economic Forum Global Health Initiative, April 2003
[335] *Chevron Texaco Nigeria Case Study*, World Economic Forum Global Health Initiative, 2002

to be at-risk because of their distance from their spouses, their comparatively high disposable incomes, single sex housing facilities while on location, and the presence of sexual networking at these locations.

Because of high prevalence rates in the community where its employees are working, the employees' poor HIV knowledge, and some high risk-taking behaviors, CNL decided to take effective measures to respond to HIV/AIDS. Although CNL did not conduct a formal economic impact assessment, it was determined that investing in the community, families and workers is a necessary and economical method to prevent significant costs associated with a larger scale HIV epidemic.

CNL's HIV/AIDS programmes focus mainly on prevention of the escalation of the epidemic by targeting employees, their families, the community and Commercial Sex Workers, as well as supporting and caring for HIV+ employees.

- Chevron's Workplace AIDS Prevention Programme (CWAPP) focuses on peer education, workplace events, condom distribution, manager and supervisor training, and awareness tools.
- Community prevention programmes focus on workshops for children of employees, joining HIV/AIDS awareness events and working with CSWs.
- CNL offers Voluntary Confidential Counseling and Testing (VCCT) services to its employees; however, only 1 percent of its workforce took advantage of VCCT in 2001.
- CNL provides support for HIV+ employees through a joint support agreement with government clinics and home based care. Anti-retrovirals are used to prevent mother to child transmission (MTC) and for post-exposure prophylaxsis (PEP).
- Capacity building efforts focus on providing funding for the Nigerian Government to provide HIV/AIDS education in schools, and with the media to increase journalists' HIV/AIDS knowledge.

The programme has reached the majority of workers with its education and awareness activities, improved employee health seeking behavior, increased stakeholder involvement and successfully prevented mother to child transmissions. CNL will expand its programmes to ensure that it is able to meet the goals stated in its vision of minimizing increases in prevalence and treating HIV+ workers.

5. THE WAY FORWARD

5.1. Recommendations

The following recommendations are based on the academic research and the comments from stakeholders contacted for the private sector's involvement in the response to HIV/AIDS in the Arab region:

- **"Business to Business" for a more efficient message**: the way to approach private companies is crucial. Businessmen will be more receptive if the advises and recommendations on HIV/AIDS policies are provided by other businessmen, preferably from similar country/region and/or economic sector (Business to Business). This approach should ideally develop into an interest in establishing a regional business coalition for Arab countries, with a core group of companies advocating for a better response to HIV/AIDS.

- **The Coalition needs its "regional champion":** if the involvement of foreign multinational companies is obviously important, it is crucial that the Arab Business Coalition also finds its "regional champion". The symbol is very important and the impact in terms of image makes a great difference.

- **Translate the epidemic into key figures:** the language to address businessmen is very important. Reminding them that the epidemic in the region is costing thousands of human lives, we also have to adopt a business language to explain the epidemic and its consequences. The human impact of HIV/AIDS must also be translated into key figures, so that its economic impact on businesses activities is clearly understood (loss of employees, loss of customers, loss of trade partners, etc.). We must bear in mind the main objective of a for-profit entity is to logically maximize profits. Some interviewees pointed out their involvement for their communities. However, many made it clear that economic interest would foster businessmen' engagement in the response. Therefore, the involvement in the response to HIV/AIDS in this region has to be understood as a rational cost-effective and profitable long-term investment that will benefit the communities AND the company's activities. We are not talking about "charity" (as perceived by some businessmen), but about a policy of corporate self-interest.

- **Early involvement of the top managers:** the high rank decision makers must be involved from the beginning. They are the ones who will be discussing the possible adoption of an HIV/AIDS policy with their board members. A preliminary meeting with a person from the company can be interesting for adopting the most appropriate approach towards the manager of the company later on.

- **HIV/ AIDS awareness within the company:** just as the lack of data on the extent of the epidemic in each country delays the national response, the lack of data on employees infected or affected by HIV/AIDS in the company also inhibits an appropriate and effective cost-saving response. Therefore, more companies should propose confidential HIV tests to their employees. However, we must clearly underline the fact that testing employees and disclosing their seropositivity without providing the adequate information to their colleagues and establishing an HIV/AIDS sensitive

workplace may in fact create hostile encounters for PLWHA and thus generate undesired effects.

- **Development of the UNAIDS/World Economic Forum "Menu of Partnership options" in the Arab region**: as far as external initiatives (focusing on communities) are concerned, the "Menu of partnership options" currently developed in Egypt by the Expanded Theme Group on HIV/AIDS Task Force composed of CARE, UNAIDS, ILO, UNODC and UNDP should be rapidly duplicated in other Arab countries. Businessmen want to know where their money is going and what could be the impact of their financial support. The "Menu of partnership options" offers a comprehensive overview of the different vulnerable groups who should be privileged targets in the response to HIV/AIDS.

- **Approaching SMEs as sub-contractors:** certain organizations like the Global Business Coalition are studying the possibility of approaching SMEs as sub-contractors of larger – and already involved in the response to HIV/AIDS – national/multinational companies. Similarly, The WEF Global Health Initiative is launching an innovative HIV/AIDS program in Sub Saharan Africa to reach SMEs through the supply chains of large companies. The program will track at least five multinational companies, each embarking on their own Supply Chain project. The program will produce a modular based library of guidelines and tools to support large companies extending HIV/AIDS workplace programs along their supply chain. The WFP is also studying the possibility of providing HIV/AIDS training to its contractors. Approaching SMEs directly appears more than challenging and significantly reduces the chances of involving them in the response to the epidemic.

- **Grabbing SMEs' interest:** several experts explained to us the great difficulties they were experiencing to attract SMEs operating in the region to free workshops aiming at improving their management skills (which could benefit the SMEs' activities almost immediately). Therefore, we understand that grabbing the SMEs' interest on issues such as HIV/AIDS (in order to prevent costs in 5 to 10 years) is very challenging. A possibility could consist in organizing workshops on several issues that would represent an immediate benefit for SMEs (ICT, Management, etc), and include HIV/AIDS as one of the topics. This kind of workshop/training must offer a short-term benefit at some point. Another possibility would be to combine HIV/AIDS with other STDs such as Hepatitis B and C (whose transmission modes are quite similar to those for HIV/AIDS) in order to have a potential greater impact in terms of policy benefits. Certain agencies such as the WHO also start considering that hepatitis have to be integrated in the discourse on HIV/AIDS.

- **Financial support for SMEs:** even considering that certain SMEs might show an interest in implementing HIV/AIDS polices, a great majority of them do not have the financial means to do so. Therefore if we want to engage them in a response, we must find a way to finance these policies. One possibility could consist of establishing a partnership with micro-credit institutions, like what has been done in Zambia with UNAIDS and the Population and Community Development. To identify suitable micro lending modalities for Zambia, UN Volunteers together with UNDP, the Grameen System of Bangladesh and two Zambian micro-finance NGOs have started a pilot project called "Micro-finance for poverty reduction". The project was launched in October 2004. It centers on providing small loans to poor women who can engage in income generating activities. By 2007, a total of 2,400 poor people, especially women

will have received micro-loans through the project.[336] Within the project's framework, HIV/AIDS has been considered a major challenge, which stakeholders are trying to tackle in such a way that no potential client is excluded because of their status. At the same time, the project attempts to strike a balance between the risk and sustainability of the project. In this regard, a solidarity insurance scheme is being examined as a measure to meet the challenge, which is yet to be tested. Another possibility would be to study, together with the International Finance Corporation (IFC), the possibility of duplicating their program "IFC Against AIDS", which provides advisory services on HIV/AIDS to SMEs in South Africa. IFC Against AIDS works with client companies to develop specifically tailored tools and advice to address workforce and community-related concerns stemming from the disease. [337]

- **The media coverage**: the media coverage of the companies' involvement in the response to HIV/AIDS and participation in this kind of workshop is a sensitive issue. Some companies may show an interest in disclosing their engagement and their concern about the well being of their employees, but several have already made it clear that they want to maintain a low-profile on this matter.

- **Piloting the initiatives before a large-scale implementation:** according to IFC experts, we should pilot the initiatives that will come out of the regional workshop in a few companies before implementing them on a regional scale.

- **Networking as a key for involving companies:** networking in the business community is a key element for engaging companies in the response to HIV/AIDS. Influential businessmen usually know each other, and the involvement of key figures could significantly help in convincing others. We should use a "Golden Book" (showing pictures of businessmen during our meeting) to show to other businessmen: The "Your friend got involved! What about you?" method could help for fund-raising as well.

- **HIV/AIDS addressed during the company's annual meeting:** in order to reduce the costs of information and prevention trainings and involve key managers from the region, several interviewees proposed to hold this kind of training during their annual meeting. This kind of recommendation applies almost exclusively for large companies.

- **A training for locals by locals:** because of the sensitivity of the issue of HIV/AIDS and in order to be fully understood and accepted by the employees, it seems that the awareness raising training should be provided to local employees by local/national trainers. In other words, it might be more efficient if Moroccans would be trained by Moroccans, Kuwaitis trained by Kuwaitis, Syrians trained by Syrians, etc.

- **A religious support:** similarly, a support from Muslim and/or Christian religious leaders already involved in the response to HIV/AIDS (through UNDP/HARPAS Religious Leaders Initiative) should be seriously considered. Such a support could possibly foster the acceptance and understanding of HIV/AIDS information and policies by the company's management and employees.

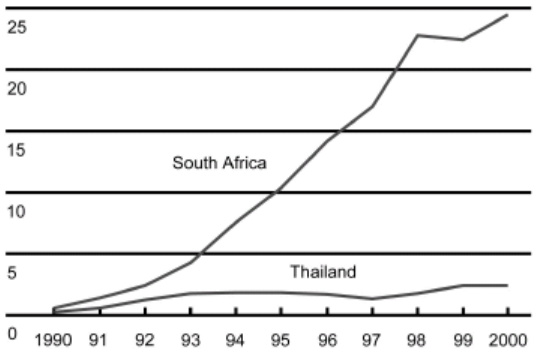
[336] http://www.undp.org.zm/?file=show_news.html&id=2993
[337] http://www.ifc.org/ifcagainstaids

CONCLUSION

We met and discussed with several stakeholders in the Arab region during the course of this research, and many expressed their honest concern that private companies might not act before the epidemic is "in front of their door". We believe that decision makers of private companies operating in the region will have the wisdom and the perspicacity not to wait until the moment that they begin to experience significant losses generated by the epidemic. In the case that they wait, it would mean it is too late and we would have lost the chance to help prevent the spread of HIV/AIDS in Arab countries. By then, the region would have already begun to lose a devastating amount of human lives and financial capital.

Private companies and foreign investors operating in the region should realize that MENA is one of the last regions of the world that has a monumental chance to maintain its low rates of HIV/AIDS prevalence, and hence low production costs. Many other regions in the world are experiencing a rapid spread of the epidemic, which has generated or will generate an increase in the costs of business for the coming years. In terms of human life, businessmen operating in the region must accept their prestigious role as corporate citizens and contribute to the health and wealth of future generations. Economically, local and foreign businessmen must act together to maintain low levels of HIV/AIDS infections in the very interest of their economic sustainability in the region.

FIGURE 25: HIV/AIDS IN SOUTH AFRICA AND THAILAND: IMPACT OF EDUCATION AND TREATMENT PROGRAMS



Source: Laura M. Kelley and Nicholas Eberstadt, *Behind the Veil of a Public Health Crisis: HIV/AIDS in the Muslim World*, National Bureau of Asian Research, June 2005

The Arab region is at a crossroads in regards to the destiny of the HIV/AIDS epidemic, like Thailand and South Africa at the beginning of the 90s, as shown by the evolution of the HIV/AIDS prevalence rates in the figure above. The position adopted by the private sector will play a crucial role in the spread of HIV/AIDS. Maintaining low prevalence rates means, in less technical words, that business leaders in the region have a chance to offer a better life to future generations. Businessmen can decide to deny the problem, and to wake up in 10 years when – according to projections – many Arab countries will be facing a widespread epidemic affecting many of their employees and population. Or businessmen can begin to realize the urgency and necessity to apply specific measures addressing and tackling the problem of HIV/AIDS in the Arab region, in the interest of both their population and business activities. By working in close collaboration with other stakeholders (government, civil society, etc.), private companies can make a real difference in the response to HIV/AIDS by promoting and implementing the policies described in this report and working towards a collective change.

BIBLIOGRAPHY

2. *3x5 Progress Report*, UNAIDS/WHO, December 2004

3. *A Global Review of the Business Response to HIV/AIDS 2004-2005*, World Economic Forum, January 2005

4. *Abdullah and Goh urge closer Asia-Middle East business ties,* The Daily Star, AFP, April 2005

5. Adrian Blomfield, *Orphans of Somali lose their home in war on terrorism*, Telegraph.co.uk, February 2004

6. *AIDS epidemic update*, UNAIDS, December 2005

7. Alberto Abadie, *Poverty, Political Freedom, and the Roots of Terrorism*, Harvard University and NBER, October 2004

8. *Annual Review of Developments in Globalization and Regional Integration in the Countries of the ESCWA Region*, ESCWA, 2002

9. Antoinette Pienaar, *AIDS weighs on attendance*, News 24 Special Report, February 2004

10. A*ppui à la mise en œuvre du plan stratégique national de lutte contre le SIDA 2002 – 2004*, Royaume du Maroc, Ministère de la Santé - Direction de l'Epidémiologie et de Lutte contre les Maladies Service des IST/SIDA, 2ème Rapport Annuel, Avril 2004 – Mars 2005

11. *Arab Human Development Report*, UNDP/Arab Fund for Economic and Social Development, 2002

12. *Arab Human Development Report*, United Nations Development Programme/Arab Fund for Economic and Social Development /Arab Gulf Programme for United Nation Development Organizations, 2004

13. Bonnie L. Shepard, Jocelyn L. DeJong, *Review of Young People's Sexual and Reproductive Health and Rights In the Arab States and Iran*, September 2004

14. Bright E. Okogu, *The Middle East and North Africa in a Changing Oil Market*, International Monetary Fund, 2003

15. *Building Partnerships with the Private Sector*, UNAIDS, March 2005

16. *Business & HIV/AIDS: A Healthier Partnership? - A Global Review of the Business Response to HIV/AIDS 2005-2006*, World Economic Forum/ Global Health Initiative, January 2006

17. Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, The International Bank for Reconstruction and Development / The World Bank, 2003

18. *Co-investment: a central mechanism for establishing Public-Private Partnerships at country level*, GFATM

19. *Declaration of the Arab-African Forum Against Sexual Exploitation of Children*, Rabat, Morocco, October 2001

20. Dipak Dasgupta, Mustapha Kamel Nabli, T.G. Srinivasan, Aristomene Varoudakis, *Current World Trade Agenda: Issues and Implications for the MENA Region*, May 2004

21. *Economic Developments and Prospects, Oil Booms and Revenue Management*, World Bank, 2005

22. *Economic Trends in the MENA region*, Economic Research Forum, 2000

23. *Egypt Country Profile, The Road Ahead for Egypt*, Economic Research Forum & Institut de la Méditerranée, December 2004

24. *Financing the expanded response to AIDS*, UNAIDS, July 2004

25. Frank Feeley, Paul Bukuluki, Alizanne Collier, Matthew Fox, *The Impact of HIV/AIDS on Productivity and Labor Costs in Two Ugandan Corporations*, October 2004

26. Friedrich Schneider, *Size and Measurement of the Informal Economy in 110 Countries around the World*, July 2002

27. George Ionita, Jamsheeda Parveen, *Iraq Social Sector Watching Briefs, HIV Prevention*, August 2003

28. George Ionita, *UNDP Youth Policies and MDG*, May 2005

29. *GM HIV/AIDS Thailand Case Study*, World Economic Forum Global Health Initiative, June 2004

30. *Grants to Member of the Organization of the Islamic Conference, Rounds 1-4 Fundings,* GFATM, August 2004

31. *GTG HIV/AIDS Indonesia Case Study*, World Economic Forum Global Health Initiative, July 2004

32. *Guidelines for Building Business Coalitions against HIV/AIDS*, Global Business Coalition, 2004

33. Helmo Preuss, *South Africa economic growth as good as it gets*, Mail & Guardian, April 2005

34. *HIV/AIDS and the World of Work, Regional Strategy and plan of Action for the Arab States,* International Labour Organization, Regional Office for the Arab States, June 2003

35. *HIV/AIDS as a Security Issue*, International Crisis Group, June 2001

36. *IBM South Africa Case Study*, World Economic Forum Global Health Initiative, April 2003

37. *Impact of the World Oil Market on the Economies of GCC States: Quantitative Assessment and Forecast*, ESCWA, 2001

38. *Indonesia Country Profile*, National Authorities, WHO Country Office for Indonesia and WHO Regional Office for South-East Asia, June 2005

39. Interview of Mr. Diaa Nour-el-Din by UNDP/HARPAS team, Lecturer, Economics Department, American University in Cairo, former Senior Economist, Economic Research Forum, July 2005

40. Interview of Dr. Tarek El Sheikh by UNDP/HARPAS team, HIV Business & Training Manager – ME Bristol Myers Squibb Company, July 2005

41. Interview of Professor Diana Barrett by the Harbus Online team, *Corporate partnerships to combat HIV/AIDS*, May 2005

42. *Intra-Arab exports and Direct Investment*, Arab Monetary Fund, Ali A. Bolbol and Ayten M.Fatheldin, June 2005

43. *InvestorWords*, 2000

44. Jennifer Kates, *Financing the Response to HIV/AIDS in Low and Middle Income Countries: Funding for HIV/AIDS from the G7 and the European Commission*, Kaiser Family Foundation, July 2005

45. Jennifer Loewenstein, *Watching the Gazan Fiasco, the shame of it all*, www.counterpunch.com, August 2005

46. John S. James, *World Issues Today: Interview with Peter Piot, Executive Director of UNAIDS*, June 2000

47. Jumana Al Tamimi, *Arab Common Market: a dream that must come true*, Jordan Times, July 2001

48. Khalid Sekkat & Marie-Ange Véganzonès-Varoudakis, *Trade and foreign exchange liberalization, investment climate, and foreign direct investments in the Middle East and North Africa (MENA) countries*, September 2004

49. Kitty K. Chan and Edward R. Gemayel, *Risk Instability and the Pattern of Foreign Direct Investment in the Middle East and North Africa Region*, IMF, August 2004

50. Laura M. Kelley and Nicholas Eberstadt, *Behind the Veil of a Public Health Crisis: HIV/AIDS in the Muslim World*, National Bureau of Asian Research, June 2005

51. Lucy Clayton, *Adherence to HIV Treatment in China*, Doctors Without Borders, e-newsletter issue 24, June 2004

52. *Macro-economics Trends in the ME and Africa*, Economic Research Forum, 2002

53. *Making Violence Against Women Count - Facts and Figures,* Amnesty International, 2004

54. Mariette Le Roux, *First South African Trade Deficit in 22 years*, Mail & Guardian, September 2004

55. Nabil Ziar, *la Place des PMEs dans une Economie en Transition*, Université d'Oran, 2002

56. Neesa Moodley, Business Report, *Absenteeism costs R12bn a year, with up to R2.2bn due to AIDS*, February 2005

57. *MENA, World Bank Regional Brief,* September 2004

58. Nadereh Chamlou, *Speech at the Arab Women International Forum*, June 2004

59. Nawaal Deane, *HIV/AIDS Raises the Risk Premium On Foreign Investment in SA,* Mail & Guardian (Johannesburg) - February 1, 2002

60. *North Africa Enterprise Development, Supporting the SME sector in Algeria, Egypt and Morocco,* Highlights 2003-2004, International Finance Corporation

61. *Opportunities for business in the fight against HIV/AIDS,* Global Business Coalition, January 2005

62. Peter Lamptey, *Opinion: Expanding the Partnership - The Private Sector's Role in HIV/AIDS Prevention*, Family Health International, 2005

63. *Private sector development, World Development Indicators,* International Monetary Fund/World Bank, 2005

64. *Progress on Global Access to HIV Antiretroviral Therapy, An Update on 3x5*, UNAIDS/WHO, June 2005

65. *Report on the Global AIDS epidemic,* UNAIDS, 2004

66. *Report on global trends in the HIV/AIDS epidemic,* UNAIDS, 2004

67. Robert Greener, *AIDS and Macroeconomic Impact*, Botswana Institute for Development Policy Analysis, 2001

68. Roget's New Millennium Thesaurus, First Edition, *2005*

69. *Sector Brief*, World Bank Group, September 2004

70. *Small Business Activities, Annual Review*, International Finance Corporation, 2004

71. Sydney Rosen, Jonathan Simon, William MacLeod, Matthew Fox, Donald M. Thea, Jeffrey R. Vincent *AIDS is Your Business*, Harvard Business Review, February 2003

72. The American Heritage Dictionary of the English Language, Fourth Edition, 2000

73. *The impact of Travel & Tourism on Jobs and Economy,* World Travel & Tourism Council, 2004

74. *The State of World Population*, UNFPA, 2004

75. *Trade, Investment, and Development in the Middle East and North Africa, Engaging the World*, World Bank, August 2003

76. *Trade, Market Access and Food Safety in the Near East Region*, Food and Agriculture Organization of the United Nations – Islamic Development Bank, October 2003

77. Trevor Neilson, *Understanding the role of business in the Global AIDS crisis*, Global Business Coalition

78. *Unleashing Entrepreneurship – making business for the Poor*, Commission on the Private Sector and Development, March 2004

79. *World Development Indicators database*, World Bank Group, April 2005

80. *World Development Indicators,* The World Bank, 2004

81. *Youth Unemployment and Macroeconomic Policies*, American University of Cairo, 2002

WEBSITES:

1. http://counterpunch.com
2. http://devdata.worldbank.org
3. http://encarta.msn.com/
4. http://europa.eu.int/
5. http://hdr.undp.org/statistics/data/
6. http://pages.zdnet.com/
7. http://portal.unesco.org
8. http://users.erols.com/mwhite28/warstat4.htm
9. http://web.amnesty.org/
10. http://www.al-bab.com/
11. http://www.amf.org.ae
12. http://www.bilaterals.org
13. http://www.businessfightsaids.org
14. http://www.cia.gov
15. http://www.dcci.gov.ae
16. http://www.epc.gov.jo/programs.html
17. http://www.export.gov
18. http://www.futuresgroup.com/Services.cfm?area=1
19. http://www.harpas.org
20. http://www.hivaids.co.za
21. http://www.ifc.org
22. http://www.ifc.org/ifcagainstaids
23. http://www.igad.org
24. http://www.ilo.org
25. http://www.ilo.org/public/english/bureau/leg/agreements/

26. http://www.intl-crisis-group.org

27. http://www.InvestorGuide.com

28. http://www.ippph.org/

29. http://www.irinnews.org

30. http://www.maghrebarabe.org

31. http://www.mapsofworld.com/world-news/brasilia-summit.html

32. http://www.positivemuslims.org.za/

33. http://www.sesrtcic.org/statistics/byindicators.php

34. http://www.sme.gov.eg

35. http://www.thebody.com

36. http://www.un.org/Depts/rcnyo/no61999/ESCWAactivities.htm

37. http://www.undp.org/rbas/regional/aids

38. http://www.unfpa.org

39. http://www.unglobalcompact.org

40. http://www.unhcr.ch

41. http://www.unicef.org

42. http://www.unodc.org

43. http://www.wfp.org

44. http://www.who.int

45. http://www.worldbank.org

46. http://www.wto.org

ANNEXES

In Bold : people interviewed by the UNDP/HARPAS Team

The other person/organizations have been contacted by phone and/or e-mails

Location	Name	Organization	Position	E-mail Address
Egypt	**Ahmed Farouk**	**Orascom Construction Industries**	HR Manager International Operations	ahmed.farouk@orascomci.com
Egypt	**Rawya El Dabi**	**IDRC - Regional Office**	Regional Outreach Officer	REldabi@idrc.org.eg
Egypt	**Ridha Guissouma**	**ALO**	Human Resources Director	n.a.
Egypt	**Alaa El-Din El-Fouly**	**Unilever Mashreq**	Head of Occupational Health	alaa.el-fouly@unilever.com
Egypt	**Alaa Hasaballah**	**Unilever Mashreq**	PR Manager	alaa.hasaballah@unilever.com
Egypt	**Amr El Hamalawy**	**Orascom Construction Industries**	HR Director	amr.elhamalawy@orascomci.com
Egypt	**Amr El koosy**	**Coca Cola Company- Egypt**	Community Affairs Manager	aelkosy@mena.ko.com
Egypt	**Caroline Fayek Fahmy**	**Barclays**	Service & Recognition Manager	caroline.fayek@barcalyscorporate.com
Egypt	**Charles Gerhardt**	**European Commission**	Programme Manager Health and Population	charles.gerhadt@cec.eu.int
Egypt	**Tarek El-Sheikh**	**Bristol-Myers Squibb Company**	HIV Business&Training Manager	tarek.el-sheikh@bms.com
Egypt	**Diaa Nour-el-Din**	**American University**	Lecturer, Economics Department	diaanour@aucegypt.edu
Egypt	**Hassan Rifaat Shokeir**	**Shell Egypt**	Medical Advisor	H.shokeir@scegypt.simis.com
Egypt	**Wessam El Beh**	**UNICEF**	UNICEF HIV/AIDS Officer	welbeih@unicef.org
Egypt	**Hatem Shafie**	**Sekem Group**	Deputy Managing Director	hatem.shafie@sekem.com
Egypt	**Ghada Abdel Hamid Makady**	**Coca Cola Company - Egypt**	Region Communication Manager North Africa Region	gabdelhamid@mena.ko.com
Egypt	**Kamal Siblini**	**IFC - PEP MENA**	Monitoring and Evaluation Officer	ksiblini@ifc.org
Egypt	**Magda Sami**	**Cairo Sheraton**	Director of Public Relations Dpt.	magda.sami@sheraton.com
Egypt	**Hanan Ibrahim**	**CARE Egypt**	Corporate Social Relation Specialist	hkamel@egypt.care.org
Egypt	**Hossam faried Ibrahim**	**Vacsera**	Pharmacist	n.a.
Egypt	**Ibrahim M. Attout**	**Alexandria Real Estate Invest. Co.**	General Manager Office Administration Staff	iattout@tmg.com.eg
Egypt	**Ilham Ibrahim Abdelhai**	**WFP - Regional Office**	HIV/AIDS Regional Coordinator in the workplace	ilham-abdelhai@wfp.org
Egypt	**Iris Semini**	**UNAIDS - Regional Office**	Intercountry Programme Development Advisor	seminii@unaids.org
Egypt	**Maha Aon**	**UNAIDS**	HIV/AIDS Focal Point Egypt	aonm@unaids.org
Egypt	**Mary Porter Peschka**	**IFC - PEP MENA**	Operations Officer	mpeschka@ifc.org
Egypt	**Mohamed El Hawary**	**Intl. Association of Lions Clubs**	Governor	elhawary@hotmail.com
Egypt	**Mona Amer**	**Cairo University**	Economist	mona_amer@yahoo.fr
Egypt	**Moustafa Ashour**	**BG Egypt**	Medical Advisor	moustafa.ashour@bg-group.com
Egypt	**Nabil I. Attia**	**Trane Air-conditioning**	Managing Director	nabil_attia@trane.com
Egypt	**Nadia_Mahmud**	**IFC - PEP MENA**	Operations Officer	nmahmud@ifc.org
Egypt	**Noha Hossam El Din**	**EAN Egypt**	Communication Manager	N.Hossam@eanegypt.com
Egypt	**Ola El Bitar**	**Coca Cola Company- Egypt**	Community Affairs Coordinator	oelbitar@mena.ko.com
Egypt	**Ola El Khawaga**	**Center for developing countries**	Deputy Director	olakhawaga@yahoo.com
Egypt	**Nanna Ahlmark**	**UNDP**	HIV/AIDS Focal Point Egypt	nanna.ahlmark@undp.org
Egypt	**Sameh Samaan**	**Tetra Pak Egypt**	Environment & Food for Dvpt. Executive	Sameh.Samaan@tetrapak.com
Egypt	**Sherine El Maghraby**	**Talal Abu -Ghazaleh Organization**	Director-Business Development Center	smaghraby@tagi.com
Egypt	**Nasser Toliymat**	**Talal Abu -Ghazaleh Organization**	Financial Manager	tagco.cairo@tagi.com

Egypt	**Ahmed Ismail**	**Sekem Academy**	Medical Director	ahmed.ismail@sekem.com
Egypt	**Sigward Vonlaue**	**Sekem Academy**	Project Manager - Scientific Advisor	Sigward.Vonlaue@sekem.com
Egypt	**Amal Magzoub**	**WFP - Regional Office**	HIV/AIDS Regional Focal Point	Amal.Magzoub@wfp.org
Egypt	Samar Al-Labbad	Talal Abu -Ghazaleh Organization	Group Executive Director	sla@tagi.com
Egypt	Abdel Hafez El Sawy	ERF	Research & Media Coordinator	abdelhafez@erf.org.eg
Egypt	Ahmed Salem	Cooperation Society for Small Businesses	Chairman	ahmedsalem123@yahoo.com
Egypt	Yehia Sadak	Cooperation Society for Small Businesses	General Secretary	ysadak@yahoo.com
Egypt	Deena Nasser	Office of the Ministry of Finance	Administrative Assistant	dnasser@sme.gov.eg
Egypt	Oussama Tawil	UNAIDS - Regional Office	Team Leader	tawilo@unaids.org
Egypt	Fouad Thabet	FEDA	Chairman	adelam@menanet.net
Egypt	Alaa Abdel Hamid	FEDA	n.a.	n.a.
Egypt	Gabriele Riedner	WHO, Eastern Mediterranean Regional Office	Regional Advisor on HIV/AIDS	riednerg@emro.who.int
Egypt	Greg Goodwin	IDRC / Ministry of Finance	Senior SME Specialist	ggoodwin@sme.gov.eg
Egypt	Hala Shalaby	Orascom Construction Industries	HR Manager	hala.shalaby@orascomci.com
Egypt	Hany Ziady	WHO, Eastern Mediterranean Regional Office	Medical Officer	ziadyh@emro.who.int
Egypt	Rawia Hassan	FHI Egypt	Secretary	Rajesh.Anandan@TheGlobalFund.org
Egypt	Sahar Hegazi	UNICEF - Regional Office	Programme Communication officer	shegazi@unicef.org
Egypt	Sameh El-Saharty	WB - Regional Office	Senior Health Policy Specialist	selsaharty@worldbank.org
Egypt	Hossam Alem	UNICEF - Regional Office	n.a.	n.a.
Egypt	Jean-Yves Moisseron	IRD	Directeur du Centre IRD-Egypte	irdegypt@idsc.gov.eg
Egypt	Nadra Zaki	UNICEF - Regional Office	Child Protection Officer	nzaki@unicef.org
Egypt	Samir Radwan	ERF	Managing Director	sradwan@erf.org.eg
Egypt	Sany Kozman	RANAA	RANAA Secretariat	caritasalex@link.net
Egypt	Cherif Soliman	FHI Egypt	Country Director	rhassan@fhi-egypt.org
Egypt	Michele Nahmias	ILO - Regional Office for N.A.	OHS Officer	nahmias@ilo.org
Egypt	Sherri Bishara	Orascom Construction Industries	HR Manager for Financial Issues	n.a
Egypt	Simone Salem	UNAIDS - Regional Office	Adminstrative Assistant	salems@unaids.org
Egypt	Souad Hussein	UNAIDS - Regional Office	Information and Documentation officer	husseins@unaids.org
Egypt	Magdi Sanadi	UNICEF - Regional Office	Health Officer	n.a.
Egypt	Ashraf Azer	n.a.	Doctor & Graduated from the Senghor University - Alexandria	azer@unhcr.org
Egypt	Yasmine Refaat Fahim	ERF	Researcher/Librarian	yfahim@erf.org.eg
Egypt	Yasmine Shafei	UNODC - Regional Office	Regional Officer for MENA	yasmine.shafei@unodc.org
Egypt	Youssef Aziz	CARITAS	Director of CARITAS Alexandria	caritasalex@link.net
Egypt	Zoheir Hallaj	WHO, Eastern Mediterranean Regional Office	Director, Division of Communicable	hallajz@emro.who.int
Algeria	Adel ZEDDAM	AIDS Algérie / ANAA	Président de AIDS Algérie/Coordinateur du réseau ANAA	aids_algerie@yahoo.fr
Algeria	Nadia Bellal	UNDP	HIV/AIDS Focal Point Algeria	nadia.bellal@undp.org

Algeria	Rédha Ameur	ILO	Focal Point HIV/AIDS	AMEUR@alger.ilo.sita.net
Algeria	Samia Lounnas	UNAIDS	HIV/AIDS Focal Point Algeria	samia.lounnas@undp.org
Bahrain	Ela Chirileanu	UNDP	HIV/AIDS Focal Point Bahrain	cla.chirileanu@undp.org
Belgium	Walter Seidel	European Commission	Senior Public Sector Health Specialist	walter.seidel@cec.eu.int
Djibouti	Hassan Ali	UNDP	HIV/AIDS Focal Point Djibouti	hassan.ali@undp,org
France	Anthony Camilotti	FTSE Group	Regional Director (France, Belgium and Switzerland)	Anthony.Camilotti@ftse.com
France	Christophe Longuet	Merck Sharp & Dohme	Medical Manager Africa HIV/AIDS	christophe_longuet@merck.com
France	Thérèse Lethu	GBC	Director of the European Office	tlethu@businessfightsaids.org
France	Eric Maville	GBC	Consultant	n.a.
France	Julien Grouillet	Lafarge	HIV/AIDS Coordinator	julien.grouillet@lafarge.com
France	Juliette Bastin	Transversal - SIDACTION	Rédactrice en Chef	j.bastin@sidaction.org
France	Anthony Parkes	World Chambers Federation	Director	anthony.parkes@iccwbo.org
France	Hélène Kolmodin	World Chambers Federation	n.a.	helene.kolmodin@iccwbo.org
Germany	Reinhold Kopp	Volkswagen AG	Group Senior Vice President	reinhold.kopp@volkswagen.de
Indonesia	Adi Sasongko	Yayasan Kusuma Buana	Director of Health Services	ykb-jkt@idola.net.id
Indonesia	Alan Boulton	ILO	Director	boulton@ilojkt.or.id
Indonesia	Galuh Sotya Wulan	ILO	HIV/AIDS National Programme Coordinator	galuh@ilojkt.or.id
Indonesia	Hadi S. Topobroto	NBA on HIV/AIDS	Chairman	nba_aids@uninet.net.id
Indonesia	Jane Wilson	UNAIDS - Indonesia	Country Coordinator	jwilson.unaids@undp.org
Jordan	Basma Khraisat	FHI Jordan	Country Director	basmakh@go.com.jo
Jordan	Firas Gharaibeh	UNDP	HIV/AIDS Focal Point Jordan	firas.gharaibeh@undp.org
Jordan	George Ionita	UNICEF - Regional Office	Regional Advisor on HIV/AIDS	Gionita@unicef.org
Kenya	Patterson Njogu	UNHCR	Regional Coordinator Kenya	kennarsc@unhcr.ch
Kenya	Veronicah Omunga	NAP+	Administrative Secretary	nap@africaonline.co.ke
Kuwait	Rajaa Behaisi	UNDP	HIV/AIDS Focal Point Kuwait	Raja.behaisi@undp.org
Lebanon	Ghada Khoury	UNDP/SURF for Arab States	Research Assistant Macroeconomics	ghada.khoury@undp.org
Lebanon	Khalid Abu Ismail	UNDP/SURF for Arab States	Macroeconomics Advisor	khalid.abu-ismail@undp.org
Lebanon	Lina Habre	UNDP/SURF for Arab States	Research Officer	lina.habre@undp.org
Lebanon	Manal Azzi	ILO - Regional Office for Arab States	HIV/AIDS consultant	HIV_AIDS@ilo.org
Lebanon	Rita Menassa	UNESCO - Regional Office	Programme Assistant	r.menassa@unesco.org
Lebanon	Sawsan Baage	ESCWA - Regional Office	Library Section Chief	library-escwa@un.org
Lebanon	Seiko Sugita	UNDP	HIV/AIDS Focal Point Lebanon	seiko.sugita@undp.org
Lebanon	Sonya Knox	UNDP/SURF for Arab States	Research Assistant	sonya knox@undp.org
Lebanon	Sulieman A. Sulieman	UNESCO - Regional Office	Programme Specialist	s.sulieman@unesco.org
Lebanon	Walid Mehalaine	UNDP/SURF for Arab States	Trade Advisor	walid.mehalaine@undp.org
Libya	Asma Muttawa	UNDP	HIV/AIDS Focal Point Libya	Asma.muttawa@undp.org
Mauritania	Holger Osterrieder	UNDP	HIV/AIDS Focal Point Mauritania	Holger.osterrieder@undp.org
Morocco	Kamal Alami	UNAIDS	HIV/AIDS Focal Point Morocco	alamik@unaids.org
Morocco	Myriem Zniber	UNDP	HIV/AIDS Focal Point Morocco	myrieme.zniber@undp.org
Netherlands	Hans Peter Wiebing	Shell International B.V.	HIV/AIDS Coordinator	HansPeter.Wiebing@shell.com
Palestine	Rohini Kohli	UNDP	HIV/AIDS Focal Point Palestine	Rohini.kohli@undp.org

Saudi Arabia	Mayssam Tamim	UNDP	HIV/AIDS Focal Point Saudi Arabia	myssam.tamim@undp.org
Senegal	Bernard Taverne	IRD	Researcher	bernard.taverne@ird.sn
Senegal	Charles Becker	CNRS	Researcher	beckerleschar@SENTOO.SN
Senegal	Jerome Gerard	IDRC Regional Office	n.a.	jgerard@idrc.org.sn
Senegal	Moussa Samb	IDRC	Senior Program Specialist	msamb@idrc.org.sn
Somalia	Leo Kenny	UNAIDS	HIV/AIDS Focal Point Somalia	leo.kenny@undp,org
Somalia	Ruth Pfeiderer	UNDP	HIV/AIDS Focal Point Somalia	ruth.pfleiderer@undp.org
South Africa	Carol O'Brien	GBC	Director of the African office	COBrien@angloamerican.co.za
South Africa	E. Kenneth Andoh	ILO	Chair, UN Theme Group on HIV/AIDS	andohk@ilo.org
South Africa	Head Office	Illovo Sugar Limited	n.a.	website@illovo.co.za
South Africa	Mbulawa Mugabe	UNAIDS	Country Coordinator	mmugabe@un.org.za
South Africa	Shuiab Manjra	British Petroleum	Lead Physician in Southern Africa	Shuaib.Manjra@za.bp.com
South Africa	Solomon Molekwa	British Petroleum	wellness coordinator and lead on HIV/AIDS in Southern Africa	solomon.molekwa@za.bp.com
South Africa	Susan Cleary	School of Public Health and Family Medicine, University of Cape Town	Health Economic Unit	scleary@heu.uct.ac.za
Sudan	Musa Bungudu	UNAIDS	HIV/AIDS Focal Point Sudan	bungudu@un.org
Sudan	Rihab Osman	UNDP	HIV/AIDS Focal Point Sudan	Rihab.osman@undp.org
Switzerland	Beatrice Bernescut	GFATM	Communication manager	Info@TheGlobalFund.org
Switzerland	David Kim	WEF / Global Health Initiative	Africa Manager	david.kim@weforum.org
Switzerland	Francesca Boldrini	WEF / Global Health Initiative	Associate Director	francesca.boldrini@weforum.org
Switzerland	Kate Taylor	WEF / Global Health Initiative	Director	kate.taylor@weforum.org
Switzerland	Michel Lavollay	GFATM	Senior Advisor - Private Sector	Michel.Lavollay@TheGlobalFund.org
Switzerland	Roy Widdus	Global Health Futures	International Center Cointrin	roy.widdus@globalhealthfutures.net
Syria	Roula Koudsi	UNDP	HIV/AIDS Focal Point Syria	roula.koudsi@undp.org
Tunisia	Aida Robbana	UNDP	HIV/AIDS Focal Point Tunis	Aida.robbana@undp.org
Tunisia	Akthem Fourati	UNAIDS	HIV/AIDS Focal Point Tunisia	fourati@unaids.org
Tunisia	Tom Hurley	UNDP	Senior Advisor - GFATM Partnership	tom.hurley@undp.org
Tunisia	Anouar Moalla	NANASO	Executive Coordinator	amoalla@planet.tn
Tunisia	Zied Mhirsi	UNFPA	Resource person Tunisia	ziedmhirsi@yahoo.fr
UAE	Amjad Bhatti	Standard Chartered Bank	Regional Head of Security- UAE	bhatti.amjad-h@ae.standardchartered.com
UAE	Hamda El Otaiba	UNDP	HIV/AIDS Focal Point UAE	hamda.alotaiba@undp.org
UAE	Niall McLoughlin	Standard Chartered Bank	Corporate Office Manager - UAE	niall.macloughlin@ae.standardchartered.com
UAE	Freddy Becker	Shell International Limited	Policy and Employee Relations Manager	freddy.becker@shell.com
UAE	Mary Malca	Shell International Limited	Regional Health Advisor	mary.malca@shell.com
UK	Alison Martin	British Petroleum	Regional Medical Director - MENA	alison.martin@uk.bp.com
UK	Christopher Roythorne	British Petroleum	HSE Policy and Performance Department	chris.roythorne@uk.bp.com
UK	Emma Schmitt	Standard Chartered Bank	Group Corporate Affairs - UK	Emma.Schmitt@uk.standardchartered.com
UK	Jean-Marc Jacobs	BEAD	Administrator	beadwork@dircon.co.uk
UK	Jennifer Boyle	Dpt for Intl. Development - British Government	n.a.	Enquiry@dfid.gov.uk
UK	Jonathan Ross	British Gas Group	Chief Medical Adviser	jonathan.ross@bg-group.com

UK	To whom it may concern	OXFAM	Middle Eastern Department	enquiries@oxfam.org.uk, information@oxfaminternational.org
USA	Bill Rau	UNRISD	External Coordinator	brau42@yahoo.com
USA	Chevron Texaco Response Team	Chevron Texaco	n.a.	Comment@chevrontexaco.com
USA	Joseph Collins	UNRISD	External Coordinator	jcollins@cruzio.com
USA	Margaret	Ford Motor Company	Customer Relationship Center	crcfmc@ford.com
USA	Peter Mann	WHY	International Director	peter@worldhungeryear.org
USA	Sabine Durier	IFC	Program Leader "IFC Against AIDS"	sdurier@ifc.org
USA	Elizabeth Ashbourne	WB	AIDS Campaign Team for Africa - Private Sector Partnerships	Eashbourne@worldbank.org
USA	Sharlene D.	Home Depot	n.a.	customercare@homedepot.com
USA	Steven Forsythe	Futures Group	Director of Planning and Finance HIV/AIDS	sforsythe@futuresgroup.com
USA	Kelly Mc Koy	Center for International Health and Development	Program Manager	mccoyk@bu.edu <mccoyk@bu.edu>
USA	Susan Mitchell	Exxon Mobil Corporation	n.a.	customer.relations.e-mail@exxonmobil.com
Yemen	Fauzia Gharama	Ministry of Health - Yemen	Manager of the National AIDS Programme	fouziaabdallah@yahoo.com
Yemen	Khaled Abdo Al Magead	UNDP	HIV/AIDS Focal Point Yemen	khaled.magead@undp.org
n.a.	David Harris	FTSE Group	Senior Executive	David.Harris@ftse.com
n.a.	Fabio Russo	UNIDO	Industrial Development Officer - SME Branch	F.Russo@unido.org
n.a.	Helen Sullivan	Shell International Limited	External Relations and Policy Adviser	h.sullivan@shell.com
n.a.	Paul Haddad	Alexander Forbes Group	n.a.	gsc@thewayout.net
n.a.	Hind Khatib Othman	GFATM	Fund Portfolio Manager (S.E. Asia & M.E)	Hind.Othman@TheGlobalFund.org
n.a.	Jo Chandler	Shell Foundation	n.a.	Jo.Chandler@shell.com
n.a.	Laura Bennett	EIRIS Ltd.	Senior Research Analyst (Corporate Governance)	Laura.Bennett@eiris.org
n.a.	Mairead Hancock	EIRIS Ltd.	Client Services Adviser	mairead.hancock@eiris.org
n.a.	Marianna Huvé-Allard	FTSE Group	Director	Marianne.Huve-Allard@ftse.com
n.a.	Norbert Otten	Daimler-Chrysler	Director Policy Issues	Norbert.Otten@daimlerchrysler.com
n.a.	Rajesh Anandan	GFATM	n.a.	rhassan@fhi-egypt.org
n.a.	Stefaan Van der Borght	Heineken	Medical Advisor	Stefaan.vanderBorght@heineken.com
n.a.	Tina Draser	GFATM	Fund Portfolio Manager (Africa)	Tina.Draser@TheGlobalFund.org
n.a.	To whom it may concern	Prince of Wales Business Leaders Forum	n.a.	info@iblf.org
n.a.	To whom it may concern	UNAIDS	n.a.	hivstrategicinfo@who.int
n.a.	To whom it may concern	UNAIDS	n.a.	estimates@unaids.org
n.a.	Vijay Ramamoorthy	IBM	n.a.	askIBM@vnet.ibm.com
n.a.	Wael Ben Romdhane	GFATM	n.a.	Wael.BenRomdhane@TheGlobalFund.org

Interview with Ms. Sherine El Maghraby

Talal Abu-Ghazaleh Organization
Director - Business Development Center

(12/06/2005)

1. Talal Abu-Ghazaleh Organization is the largest Arab group of professional service firms in the fields of accounting, management consulting, training, intellectual property, legal services, information technology, capacity building, credit information and legal translation. Could you give us an update on the geographical presence of TAG Organization in the Arab region?

2. At the end of May 2005, Mr. Abu Ghazalah called on the international community to employ new strategies in order to achieve the Millennium Development Goals. Reversing the spread of HIV/AIDS is the 6th MDG. What is the position of TAGO regarding Corporate Social Responsibility in general, and HIV/AIDS in particular?

3. Could you give us an update on the measures currently being implemented/or future plans in the response to HIV/AIDS by your company in the Arab region?

4. Could you describe the focus of these measures? (Internal policies focusing on employees, external policies focusing on communities)

5. Are the policies and measures for responding to HIV/AIDS determined on a regional or national level?

6. What internal & external factors slow your company's response to HIV/AIDS?

7. According to your experience, what are the main hurdles faced by a private company attempting to get involved in the HIV/AIDS response in the Arab region?

8. How could your company's response to HIV/AIDS be more efficient and/or effective?

9. To what extent are you cooperating with the government in your response to HIV/AIDS?

10. Why is it important for your company to get involved in the response to HIV/AIDS?

11. Do you know any organisation/company/person dealing with the private sector's involvement in the HIV/AIDS response? Can you provide us with their contact details (name, organisation/company, email address)?

Cost Simulation of Egyptian branch, company A

The purpose of this simulation is to demonstrate that the implementation of prevention and treatment measures makes sense in terms of corporate social responsibility, and also in terms of cost-saving investments. In other words, this simulation proves that companies which respond to HIV/AIDS will save lives and money.

This simulation has been based on World Bank projections regarding HIV/AIDS trends in the Arab region and several assumptions, as detailed below. Three scenarios likely to occur have been considered:

Scenario A: the company's management decides not to take any kind of measures to respond to HIV/AIDS in its workplace.

Scenario B: the company's management decides not to take any measures to respond to HIV/AIDS in its workplace and to terminate the contract of its employees living with HIV.

Scenario C: the company's management decides to take effective measures (prevention, treatment, and care) to respond to HIV/AIDS in its workplace.

The measures mentioned in the third scenario are prevention measures (provision of annual awareness raising training, including information material), as well as treatment and care measures (provision of anti-retroviral treatment, referred as ARV treatment).

Moreover, in order to have a better understanding of the implications generated by the working experience on the on the calculations of this “AIDS tax” in the company, three categories of employees have been considered, namely Auditing Manager (minimum 10 years of working experience), Major Auditor (minimum 6 years of working experience), and Auditor (from 2 years of experience).

Common assumptions to the 3 scenarios:

1. The total number of employees (100) remains constant over the period 2005-2015
2. If no specific measures are implemented in the company's workplace, the employees of the studied company will experience the same infection rates as the rest of the population in the country
3. The different categories of employees face the same probability of being infected with HIV
4. The HIV/AIDS epidemic is increasing in a linear way (+0,42 percent/year)

Evolution of the HIV/AIDS epidemic in Egypt[338]	
HIV Prevalence in 2005	<0,1%
HIV Prevalence in 2006	0,5%
HIV Prevalence in 2007	0,9%
HIV Prevalence in 2008	1,3%
HIV Prevalence in 2009	1,7%
HIV Prevalence in 2010	2,1%
HIV Prevalence in 2011	2,6%
HIV Prevalence in 2012	3,0%
HIV Prevalence in 2013	3,4%
HIV Prevalence in 2014	3,8%
HIV Prevalence in 2015	4,2%

Moreover, company A provided us with the following information:

	Auditing Manager	***Major Auditor***	***Auditor***
Financial compensation for termination of employment	2 months salary + paid leaves (0 to 2 months)	2 months salary + paid leaves (0 to 2 months)	2 months salary + paid leaves (0 to 2 months)
Recruitment process	$345	$345	$345
Training process (employee/day)	$202,50 (1 month required)	$94,50 (1 month required)	$27,00 (4 months required)
Absenteeism (employee/day)	$135	$63	$18

Recruitment process: the costs are equivalent to the advertisement of the new position in a newspaper.

Training process: since the newly recruited employee is not considered fully productive by the company, the costs are equivalent to the cost of absenteeism (the profit that should be generated if the employee was productive), to which the company adds half of the trainer's day pay because of the time spent to train the newly recruited employee.

Absenteeism: the costs are equivalent to the profits that should be generated by the employee if he/she was fully productive, but are being lost due to the employee's lack of productivity and/or absence from the workplace.

We must also differentiate what we will be defined as "direct costs", which relate to a certain amount of money the company will have to pay, from "loss of profits", which relate to the fact that the company will not pay extra money nor will it receive the profit it was supposed to generate. For example, the recruitment process is considered a direct cost because the company will have to pay a certain amount of money to advertise for the new position. However, even if the training process will not generate extra costs (the employee receives his/her salary), the trainee and the trainer will not be not considered fully productive. Therefore, they will not be able to generate the expected profit related to their position, resulting in a loss of profit for the company.

[338] Based on World Bank projections, see Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, The International Bank for Reconstruction and Development / The World Bank, 2003, p. 109

1. **Scenario A: the company's management decides not to take any measures to respond to HIV/AIDS**

Three additional assumptions have been made for the scenario A:

a. The viral load will increase the susceptibility of employees infected with HIV to AIDS related illnesses five years after infection
b. According to a survey of the American Insurance Company, people living with advanced AIDS related illnesses are absent, on average, 32 days per year from the workplace (three times more than those on ART)[339]
c. The total indirect costs amount to 200 percent of the total direct costs[340]

- **COST OF ABSENTEEISM**

Auditing Manager:

According to the company, the one-day absence of an auditing manager will generate a loss of $135 per day, totaling $4 320 per year (32 days)

	Cost of absenteeism for Auditing Manager	**HIV Prevalence (number of employees infected)**	***Total Cost of absenteeism***
2005	$4 320,00	0,1	$432,00
2006	$4 320,00	0,5	$2 160,00
2007	$4 320,00	0,9	$3 888,00
2008	$4 320,00	1,3	$5 616,00
2009	$4 320,00	1,7	$7 344,00
2010	$4 320,00	2,1	$9 072,00
2011	$4 320,00	2,6	$11 232,00
2012	$4 320,00	3	$12 960,00
2013	$4 320,00	3,4	$14 688,00
2014	$4 320,00	3,8	$16 416,00
2015	$4 320,00	4,2	$18 144,00

Average cost of absenteeism for Auditing Manager over 2005-2015 (sum total cost of absenteeism between 2005 and 2015): $101 952

Average cost of absenteeism for Auditing Manager per year: $101 952/11 = $8 496

Major Auditor:

According to the company, the one-day absence of a major auditor will generate a loss of $63 per day, i.e. $2 016 per year (32 days)

[339] Antoinette Pienaar, *AIDS Weighs on Attendance*, News 24 Special Report, February 2004
[340] Sydney Rosen et al, *AIDS is Your Business*, Harvard Business Review, February 2003

	Cost of absenteeism for Major Auditor	HIV Prevalence (number of employees infected)	*Total Cost of absenteeism*
2005	$2 016,00	0,1	$201,60
2006	$2 016,00	0,5	$1 008,00
2007	$2 016,00	0,9	$1 814,40
2008	$2 016,00	1,3	$2 620,80
2009	$2 016,00	1,7	$3 427,20
2010	$2 016,00	2,1	$4 233,60
2011	$2 016,00	2,6	$5 241,60
2012	$2 016,00	3	$6 048,00
2013	$2 016,00	3,4	$6 854,40
2014	$2 016,00	3,8	$7 660,80
2015	$2 016,00	4,2	$8 467,20

Average cost of absenteeism for Major Auditor over 2005-2015 (sum total cost of absenteeism between 2005 and 2015)*:* $47 577,60

Average cost of absenteeism for Major Auditor per year: $47 577,60/11 = $3 964,80

Auditor:

According to the company, the one-day absence of an auditor will generate a loss of $18 per day, i.e. $576 per year (32 days)

	Cost of absenteeism for Auditor	HIV Prevalence (number of employees infected)	*Total Cost of absenteeism*
2005	$576,00	0,1	$57,60
2006	$576,00	0,5	$288,00
2007	$576,00	0,9	$518,40
2008	$576,00	1,3	$748,80
2009	$576,00	1,7	$979,20
2010	$576,00	2,1	$1 209,60
2011	$576,00	2,6	$1 497,60
2012	$576,00	3	$1 728,00
2013	$576,00	3,4	$1 958,40
2014	$576,00	3,8	$2 188,80
2015	$576,00	4,2	$2 419,20

Average cost of absenteeism for Auditor over 2005-2015 (sum total cost of absenteeism between 2005 and 2015): $13 593,60

Average cost of absenteeism for Auditor per year: $13 593,60/11 = $1 132,80

- **COST OF SICK LEAVE**

Sick leave policy for Auditing Managers & Major Auditors:

Company's insurance can provide per employee/month (30 days): $203,30
75 percent of this amount is provided by the company: $152,48

If the employee is absent 32 days, the cost of the insurance provided by the company will reach : $162,64

	Cost of sick leave for Auditing Manager & Major Auditor	HIV Prevalence (number of employees infected)	*Total Cost of Sick Leave*
2005	$162,64	0,1	$16,26
2006	$162,64	0,5	$81,32
2007	$162,64	0,9	$146,38
2008	$162,64	1,3	$211,43
2009	$162,64	1,7	$276,49
2010	$162,64	2,1	$341,54
2011	$162,64	2,6	$422,86
2012	$162,64	3	$487,92
2013	$162,64	3,4	$552,98
2014	$162,64	3,8	$618,03
2015	$162,64	4,2	$683,09

Average cost of sick leave for Auditing Manager & Major Auditor over 2005-2015:
$3 838,30

Average cost of sick leave for Auditing Manager & Major Auditor per year:
$3 838,30/11 = $319,86

Sick leave policy for Auditors:

Company's insurance can provide per employee/month (30 days): $138,40
75 percent of this amount is provided by the company: $103,80

If the employee is absent 32 days, the cost of the insurance provided by the company will reach $110,72

	Cost of sick leave for Auditor	HIV Prevalence (number of employees infected)	*Total Cost of sick leave*
2005	$110,72	0,1	$11,07
2006	$110,72	0,5	$55,36
2007	$110,72	0,9	$99,65
2008	$110,72	1,3	$143,94
2009	$110,72	1,7	$188,22
2010	$110,72	2,1	$232,51
2011	$110,72	2,6	$287,87
2012	$110,72	3	$332,16
2013	$110,72	3,4	$376,45
2014	$110,72	3,8	$420,74
2015	$110,72	4,2	$465,02

Average cost of sick leave for Auditors over 2005-2015: $2 612,99

Average cost of sick leave for Auditors per year: $2 612,99/11 = $217,75

- **SUMMARY SCENARIO A**

	If all employees with HIV/AIDS are:		
	Auditing Manager	***Major Auditor***	***Auditor***
Direct costs:			
Sick leave	$3 838,30	$3 838,30	$2 612,99
Loss of profit:			
Absenteeism	$101 952,00	$47 577,60	$13 593,60
TOTAL COSTS over 2005-2015 period	$105 790,30	$51 415,90	$16 206,59
TOTAL COSTS per year	**$9 617,30**	**$4 674,17**	**$1 473,33**
Potential Indirect Costs over 2005-2015 (200% of direct costs):	$7 676,61	$7 676,61	$5 225,98

Scenario A: if the company does NOT take measures to respond to HIV/AIDS between 2005-2015, its management will have to bear annual costs equivalent to approximately US$5 265,82 [$9617,30-$1 473,33]. It must be added that the indirect costs generated by HIV/AIDS and presented in the previous sub-section (2.3.1) have not been added in this assessment. However, these costs can amount to approximately 200 percent of the direct costs, which would represent in this case additional costs equivalent to US$6 859,73 [$7 676,61-$5225,98] over 2005-2015.[341]

2. **Scenario B: the company's management decides to terminate the contract of its employees**

Five additional assumptions have been made for the scenario B:

a. The total indirect costs amount to 200 percent of the total direct costs[342]
b. The annual salary of an employee will increase on average by 10 percent every year
c. The termination of employment is compensated by an amount equivalent to 2 months of salary + account for paid leaves/vacancies if any (0 to 2 months)
d. According to the company's training policy, a newly recruited employee will be trained by another employee occupying a similar position
e. The new employee's working experience in other companies will be taken into consideration by the financial department in order to calculate his/her salary upon recruitment (ex: an auditing manager with more than 10 years of working experience outside the company as an auditing manager could be recruited in 2005 with a $5187,48 monthly salary. Similarly, an employee with 10 years experience as a major auditor outside the company could be recruited in 2015 with $2 200 monthly salary if he/she starts as an Auditing Manager in the studied company. For this reason, the calculation of the average salary allows us to include the factor "working experience" in this simulation).

It must be added that terminating employees' contract because of their HIV status, despite a screening of the newly recruited employees, might NOT change the number of employees infected since no prevention measures are being implemented in the company.

[341] Antoinette Pienaar, *AIDS weighs on attendance*, News 24 Special Report, February 2004
[342] Ibid

- **AVERAGE SALARY**

	Monthly Salary for Auditing Manager (+10% every year)	***Monthly Salary for Major Auditor (+10% every year)***	***Monthly Salary for Auditor (+10% every year)***
2005 (no experience in this specific position)	$2 000,00	$785,00	$280,00
2006 (1 year experience)	$2 200,00	$863,50	$308,00
2007 (2 years experience)	$2 420,00	$949,85	$338,80
2008 (3 years experience)	$2 662,00	$1 044,84	$372,68
2009 (4 years experience)	$2 928,20	$1 149,32	$409,95
2010 (5 years experience)	$3 221,02	$1 264,25	$450,94
2011 (6 years experience)	$3 543,12	$1 390,68	$496,04
2012 (7 years experience)	$3 897,43	$1 529,74	$545,64
2013 (8 years experience)	$4 287,18	$1 682,72	$600,20
2014 (9 years experience)	$4 715,90	$1 850,99	$660,23
2015 (10 years experience)	$5 187,48	$2 036,09	$726,25

If the employee's working experience is included in the calculations, the average monthly salary is:

(Sum of monthly salary between 2005 to 2015)/11 years =>

$3 369,30 for an Auditing Manager
$1 322,45 for a Major Auditor
$471,70 for an Auditor

- **AVERAGE COST OF TERMINATION OF EMPLOYMENT**

Auditing Manager:

	Average salary	***Total number of employees infected out of 100 employees***	***Average cost per employee per year***
2005	$3 369,30	0,1	$673,86
2006		0,5	$3 369,30
2007		0,9	$6 064,75
2008		1,3	$8 760,19
2009		1,7	$11 455,63
2010		2,1	$14 151,07
2011		2,6	$17 520,38
2012		3	$20 215,82
2013		3,4	$22 911,26
2014		3,8	$25 606,70
2015		4,2	$28 302,15

Average cost for termination of employment without paid leave (2 months salary):
$14 457,37

Average paid leaves to be added (0 to 60 days salary = 30 days): $3 369,30

Average cost of termination of employment for Auditing Managers with HIV: (2 months salary + average paid leave): $17 826,68

Major Auditor:

	Average salary	*Total number of employees infected out of 100 employees*	*Average cost per employee per year*
2005	$1 322,45	0,1	$264,49
2006		0,5	$1 322,45
2007		0,9	$2 380,41
2008		1,3	$3 438,37
2009		1,7	$4 496,33
2010		2,1	$5 554,30
2011		2,6	$6 876,75
2012		3	$7 934,71
2013		3,4	$8 992,67
2014		3,8	$10 050,63
2015		4,2	$11 108,59

Average cost for termination of employment without paid leave (2 months salary):
$5 674,52

Average paid leaves to be added (0 to 60 days salary = 30 days): $1 322,45

Average cost of termination of employment for Major Auditors with HIV: (2 months salary + average paid leave): $6 996,97

Auditor:

	Average salary	*Total number of employees infected out of 100 employees*	*Average cost per employee per year*
2005	$471,70	0,1	$94,34
2006		0,5	$471,70
2007		0,9	$849,06
2008		1,3	$1 226,43
2009		1,7	$1 603,79
2010		2,1	$1 981,15
2011		2,6	$2 452,85
2012		3	$2 830,21
2013		3,4	$3 207,58
2014		3,8	$3 584,94
2015		4,2	$3 962,30

Average cost for termination of employment without paid leave (2 months salary):
$2 024,03

Average paid leave to be added (0 to 60 days salary = 30 days): $471,70

Average cost of termination of employment for Auditors with HIV: (2 months salary + average paid leave): $2 495,73

- **AVERAGE COST OF RECRUITMENT**

As mentioned above, the costs for the recruitment process of a new employee are equivalent to a publication in one newspaper: $345

	Total number of employees infected out of 100 employees	*Cost of recruitment*	*Cost of recruitment per employee/year*
2005	0,1	$345,00	$34,50
2006	0,5	$345,00	$172,50
2007	0,9	$345,00	$310,50
2008	1,3	$345,00	$448,50
2009	1,7	$345,00	$586,50
2010	2,1	$345,00	$724,50
2011	2,6	$345,00	$897,00
2012	3	$345,00	$1 035,00
2013	3,4	$345,00	$1 173,00
2014	3,8	$345,00	$1 311,00
2015	4,2	$345,00	$1 449,00

Average cost of recruitment for 2005-2015: $740,18

- **AVERAGE COST OF TRAINING**

The costs generated by the training process are equivalent to the cost of absenteeism + 50 percent of the trainer's day pay (the company considers the trainer won't be fully productive while training the newly recruited employee).

Auditing Manager:

	Total number of employees infected out of 100 employees	*Cost of training ($202,50 x 30 days)*	*Cost of training per employee/year*
2005	0,1	$6 075,00	$607,50
2006	0,5	$6 075,00	$3 037,50
2007	0,9	$6 075,00	$5 467,50
2008	1,3	$6 075,00	$7 897,50
2009	1,7	$6 075,00	$10 327,50
2010	2,1	$6 075,00	$12 757,50
2011	2,6	$6 075,00	$15 795,00
2012	3	$6 075,00	$18 225,00
2013	3,4	$6 075,00	$20 655,00
2014	3,8	$6 075,00	$23 085,00
2015	4,2	$6 075,00	$25 515,00

Average cost for training new Auditing Managers over 2005-2015: $13 033,64

Major Auditor:

	Total number of employees infected out of 100 employees	*cost of training ($94,50 x 30 days)*	*Cost of training per employee/year*
2005	0,1	$2 835,00	$283,50
2006	0,5	$2 835,00	$1 417,50
2007	0,9	$2 835,00	$2 551,50
2008	1,3	$2 835,00	$3 685,50
2009	1,7	$2 835,00	$4 819,50
2010	2,1	$2 835,00	$5 953,50
2011	2,6	$2 835,00	$7 371,00
2012	3	$2 835,00	$8 505,00
2013	3,4	$2 835,00	$9 639,00
2014	3,8	$2 835,00	$10 773,00
2015	4,2	$2 835,00	$11 907,00

Average cost for training new Major Auditors over 2005-2015: $6 082,36

Auditors:

	Total number of employees infected out of 100 employees	*cost of training ($27 x 120 days)*	*Cost of training per employee/year*
2005	0,1	$3 240,00	$324,00
2006	0,5	$3 240,00	$1 620,00
2007	0,9	$3 240,00	$2 916,00
2008	1,3	$3 240,00	$4 212,00
2009	1,7	$3 240,00	$5 508,00
2010	2,1	$3 240,00	$6 804,00
2011	2,6	$3 240,00	$8 424,00
2012	3	$3 240,00	$9 720,00
2013	3,4	$3 240,00	$11 016,00
2014	3,8	$3 240,00	$12 312,00
2015	4,2	$3 240,00	$13 608,00

Average cost for training new Auditors over 2005-2015: $6 951,27

- **SUMMARY SCENARIO B**

	If all employees with HIV/AIDS are:		
	Auditing Manager	***Major Auditor***	***Auditor***
Direct costs:			
Financial compensation for termination of employment	$17 826,68	$6 996,97	$2 495,73
Recruitment process	$740,18	$740,18	$740,18
Loss of profits:			
Training process	$13 033,64	$6 082,36	$6 951,27
TOTAL COSTS over 2005-2015 period	$31 600,49	$13 819,52	$10 187,19
TOTAL COSTS per year	**$2 872,77**	**$1 256,32**	**$926,11**
Potential Indirect Costs over 2005-2015 (200% of direct costs)	$37 133,72	$15 474,30	$6 471,83

Scenario B: if the company decides to systematically terminate the contract of PLWHA between 2005-2015, its management will have to bear costs equivalent to US$1 685 [$2 872,77-$926,11] per year. Once again, the indirect costs generated by poor HIV/AIDS policies and presented in the previous sub-section (2.3.1) have not been added in this assessment. In light of the information presented above, they could represent additional costs equivalent to 200 percent of the direct costs, i.e. approximately US$19 693,28 [$37 133,72-$6 471,83] over 2005-2015.

3. Scenario C: The company's management decides to adopt and implement measures to respond to HIV/AIDS

Four additional assumptions have bee made for the scenario C:

a. PLWHA would require treatment 5 years after being infected (8 years on average), and they would stay on treatment for the rest of their working lives[343]
b. US$10/employee/year Prevention measures can decrease the infection rate by 50 percent[344]
c. The cost of ARV treatment in Egypt is equivalent to US$2/employee/day i.e. US$730/employee/year.[345]
d. PLWHA receiving ART are consistent in following their medical treatment, i.e. they take their medicines regularly and on time

[343] Sydney Rosen, Jonathan Simon, William Mac Leod, Matthew Fox, Donald M. Thea, Jeffrey R. Vincent *AIDS is Your Business*, Harvard Business Review, February 2003
[344] *Ibid.*
[345] *source:* Ministry of Health of Egypt. It must be mentioned that since the publication of this research, The Egyptian National AIDS Program provides triple therapy for free to Egyptians needing it based on a CD4 test conducted at the Egyptian Central Laboratory.

Evolution of the HIV/AIDS situation in Egypt (projections):		*Total number of employees infected*	
		If prevention measures are NOT being implemented	***If prevention measures are being implemented***
HIV Prevalence in 2005	0,1%	0,1	0,05
HIV Prevalence in 2006	0,5%	0,5	0,25
HIV Prevalence in 2007	0,9%	0,9	0,45
HIV Prevalence in 2008	1,3%	1,3	0,65
HIV Prevalence in 2009	1,7%	1,7	0,85
HIV Prevalence in 2010	2,1%	2,1	1,05
HIV Prevalence in 2011	2,6%	2,6	1,3
HIV Prevalence in 2012	3,0%	3	1,5
HIV Prevalence in 2013	3,4%	3,4	1,7
HIV Prevalence in 2014	3,8%	3,8	1,9
HIV Prevalence in 2015	4,2%	4,2	2,1

- **COST OF PREVENTION MEASURES**

As mentioned above, studies show that prevention measures costing US$ 10 per employee per year would allow the company to reduce its HIV prevalence by 50 percent.

- **COST OF ARV TREATMENT**

Total number of employees infected out of 100 employees WITH PREVENTION MEASURES		***Cost of ART/employee /year***	***Cost of ART for the company (starting 5 years after infection)***	
2005	0,05	$730,00		
2006	0,25	$730,00		
2007	0,45	$730,00		
2008	0,65	$730,00		
2009	0,85	$730,00		
2010	1,05	$730,00	$36,50	*<- for employees infected in 2005*
2011	1,3	$730,00	$182,50	*<- for employees infected in 2006*
2012	1,5	$730,00	$328,50	*<- for employees infected in 2007*
2013	1,7	$730,00	$474,50	*<- for employees infected in 2008*
2014	1,9	$730,00	$620,50	*<- for employees infected in 2009*
2015	2,1	$730,00	$766,50	*<- for employees infected in 2010*

Average cost of ART over 2005-2015: $2 409

Average cost of ART per year: $200,75

- **SUMMARY SCENARIO C**

	If all employees living with HIV/AIDS are:		
	Auditing Manager	***Major Auditor***	***Auditor***
Prevention measures for all employees ($10/employee between 2005 and 2015)	$11 000,00		
ARV Treatment for employees living with HIV/AIDS	$2 409,00		
Absenteeism	$0,00		
Recruitment	$0,00		
Training	$0,00		
TOTAL COSTS over 2005-2015	$13 409,00		
TOTAL COSTS per year	**$1 219,00**		

Scenario C: if the company decides to implement HIV/AIDS measures between 2005-2015, its management will have to bear costs equivalent to approximately US$1 219 per year. One must notice that prevention, care and treatment policies represent measurable and therefore foreseeable costs. This allows companies to avoid unexpected and more important costs such the loss or decrease in productivity of promising and talented employees and/or experienced managers who, apart from generally benefiting of several years of diverse training and knowing the assets and weaknesses of the employees, generally represent the backbone of a company's successful strategy.

4. COST COMPARISON OF THE THREE SCENARIOS AND CONCLUSION

	If all employees living with HIV/AIDS are:			***Average annual costs for company***
	Auditing Manager	***Major Auditor***	***Auditor***	
Scenario A: no policy implemented to respond to HIV/AIDS	*$9 617,30*	*$4 674,17*	*$1 473,33*	***$5 254,93***
Scenario B: terminate PLWHA's contract	*$2 872,77*	*$1 256,32*	*$926,11*	***$1 685,07***
Scenario C: implementation of measures to respond HIV/AIDS	*$1 219,00*	*$1 219,00*	*$1 219,00*	***$1 219,00***

Scenario A: if the company does NOT take any measures to respond to HIV/AIDS between 2005-2015, its management will have to bear costs equivalent to approximately US$5,254,93 [$9 617,30-$1 473,33] per year

Scenario B: if the company decides to systematically terminate the contract of PLWHA between 2005-2015, its management will have to bear costs equivalent to US$1 685,07 [$2 872,77-$926,11] per year

Scenario C: if the company decides to implement HIV/AIDS measures between 2005-2015, its management will have to bear costs equivalent to approximately US$1 219 per year

Note:

- In scenario C, it was demonstrated that ART allows PLWHA to prevent AIDS related illnesses. However, we assumed in this scenario that PLWHA take their medicines regularly and on time. If they do not, the virus in their body will build up resistance to the ARV drugs and the treatment might fail. In other words, in order to avoid developing resistance to the ARV treatment, they need to achieve an "adherence" of 95%. That translates into missing less than three doses of ARVs per month.[346]

- As far as the cost of training is concerned, this figure was limited to the minimal cost, i.e. the training provided to the employee upon his/her recruitment. One must bear in mind that most of the companies also provide regular trainings to their employees. Even though these costs are not included in this simulation, they can represent direct financial losses if the employees who benefited from these trainings do not use this acquired knowledge to generate profit, due to absenteeism or termination of their contract.

[346] Lucy Clayton, *Adherence to HIV Treatment in China*, Doctors Without Borders, e-newsletter issue 24, June 2004

Cost simulation of Lebanese branch, company B

This following simulation has been based on World Bank projections regarding HIV/AIDS trends in the Arab region and several assumptions, as detailed below. Two scenarios likely to occur have been considered:

Scenario A: the company decides not to implement any measures to respond to HIV/AIDS and to terminate the contract of its employees living with HIV/AIDS.

Scenario B: the company's management decides to take effective measures (prevention, treatment and care) to respond to HIV/AIDS in its workplace

The scenario that consists in calculating the costs generated by the lack of response of the company has not been considered. The company's policy in case of absenteeism is the following. If an employee is absent for several days, the company will consider a sick leave if there is a medical report/or we will deduct it from his/her yearly holiday days if there is no report. If the absence is highly recurrent, up to one continuous month, and depending on the case itself and the experience of the employee, the company may take measures and terminate the employee's contract.

The Lebanese law states that for the 1st two months of justified absence, the company will still pay for the employee's salary; after the 2nd month, the company will pay half of the salary; and at the end of the 3rd month, the employee's contract is considered terminated. For this simulation and with the agreement of the company's management, it has been considered that the company will not wait for this situation to occur, reason for which only two scenarios have been considered.

Common assumptions for the two scenarios:

1. According to the management, the total number of employees in the Lebanese branch (62) will grow by 5 percent yearly between 2005-2015.
2. If no specific measures are implemented in the company's workplace, the employees of the studied company will experience the same infection rates as the rest of the population of the country.
3. The different categories of employees face the same probability of being infected with HIV.
4. The HIV/AIDS epidemic is increasing in a linear way (+0,46 percent/year)

Evolution of the HIV/AIDS situation in Lebanon (based on WB's "The Costs of Inaction" projections)[347]:	
HIV Prevalence in 2005	0,10%
HIV Prevalence in 2006	0,56%
HIV Prevalence in 2007	1,02%
HIV Prevalence in 2008	1,48%
HIV Prevalence in 2009	1,94%
HIV Prevalence in 2010	2,40%
HIV Prevalence in 2011	2,86%
HIV Prevalence in 2012	3,32%
HIV Prevalence in 2013	3,78%
HIV Prevalence in 2014	4,24%
HIV Prevalence in 2015	4,60%

+4600% between 2005 and 2015

[347] Based on World Bank's projections, see Carol Jenkins, David A.Robalino, *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, The International Bank for Reconstruction and Development / The World Bank, 2003, p. 109

The company provided us with the following information:

	Department Head	***Junior Executive***	***Front line employee***
Financial compensation for termination of employment	1 to 3 months salary + paid leaves	1 to 3 months salary + paid leaves	1 to 3 months salary + paid leaves
Recruitment process	full salary of trainee	full salary of trainee	full salary of trainee
Training process (employee/day)	full salary of trainee + 50% of salary of trainer (60 days required)	full salary of trainee + 50% of salary of trainer (30 days required)	full salary of trainee + full salary of technical trainer (45 days required)

Recruitment process: according to the company's management, the recruitment cost is usually one full month salary given to the agent upon successful acceptance of the candidate. In newspaper ads, the ad usually costs US$200- US$ 300 per day, which usually comes up to the same as recruitment agent cost if the ad is placed for 3 days. The company's policy is exclusive with agents or direct posting.

Training process: since the newly recruited employee is not considered fully productive by the company, the costs are equivalent to loss of profit (the profit that should be generated if the employee was fully productive), to which the company adds half or the total of the trainer's salary because of the time spent to train the newly recruited employee. It must be mentioned that the newly recruited department heads and junior executives are being trained by an employee with a similar position, while the newly recruited front line employees are being trained by a specific technical trainer (the not-in-training time is used for development of new training material, improving delivery systems, research and development, etc).

1. **Scenario A: the company decides to terminate the contract of employees living with HIV/AIDS**

Four additional assumptions have been made for the scenario A:

a. The total indirect costs amount to 200 percent of the total direct costs (Rosen et al)
b. The annual salary of an employee will increase on average by approximately 5 percent every year, based on his/her performance
c. The termination of employment is compensated by an amount equivalent to 1 to 3 months of salary + account for paid leaves/vacancies if any (0 to 15 days)
d. According to the company's training policy, a newly recruited front line employee will be trained by a trainer specifically dedicated to technical training. As mentioned above, newly recruited department heads and junior executives will be trained by another employee occupying a similar position

It must be added that terminating employees' contract because of their HIV status, despite a screening of the newly recruited employees, might NOT change the number of employees infected since no prevention measures are being implemented in the company.

	Total number of employees (+5% per year)	***Total number of employees infected***
2005	62	0,06
2006	65	0,36
2007	68	0,70
2008	72	1,06
2009	75	1,46
2010	79	1,90
2011	83	2,38
2012	87	2,90
2013	92	3,46
2014	96	4,08
2015	101	4,65

- **AVERAGE SALARY**

	Monthly Salary for Department Head (potential raise based on performance twice a year)	***Monthly Salary for Junior Executive (potential raise based on performance twice a year)***	***Monthly Salary for front line employee (potential raise based on performance twice a year)***
2005 (no experience in this specific position)	$850,00	$500,00	$300,00
2006 (1 year experience)	$875,00	$550,00	$325,00
2007 (2 years experience)	$900,00	$600,00	$350,00
2008 (3 years experience)	$950,00	$650,00	$375,00
2009 (4 years experience)	$1 000,00	$700,00	$400,00
2010 (5 years experience)	$1 050,00	$750,00	$425,00
2011 (6 years experience)	$1 100,00	$800,00	$450,00
2012 (7 years experience)	$1 150,00	$850,00	$475,00
2013 (8 years experience)	$1 200,00	$900,00	$500,00
2014 (9 years experience)	$1 250,00	$950,00	$550,00
2015 (10 years experience)	$1 300,00	$1 000,00	$600,00

If the employee's working experience is included in the calculations, the average monthly salary is:

Average monthly salary	$1 056,82	$750,00	$431,82

- **AVERAGE COST OF TERMINATION OF CONTRACT**

Department Head:

	Average salary	*Total number of employees infected*	*Average cost per employee per year*
2005	$1 056,82	0,06	$126,82
2006		0,36	$760,91
2007		0,70	$1 479,55
2008		1,06	$2 240,45
2009		1,46	$3 085,91
2010		1,90	$4 015,91
2011		2,38	$5 030,45
2012		2,90	$6 129,55
2013		3,46	$7 313,18
2014		4,08	$8 623,64
2015		4,65	$9 828,41

Average cost for termination of employment without paid leaves (1 to 3 months = 2 months salary):	$4 421,34
Average paid leave to be added (0 to 15 days salary = 7 days):	$246,59
Average cost of termination of employment for Department Heads: (1 and 3 months salary + 0 to 15 days paid leave)	$4 667,93

Junior Executive:

	Average salary	*Total number of employees infected*	*Average cost per employee per year*
2005	$750,00	0,06	$90,00
2006		0,36	$540,00
2007		0,70	$1 050,00
2008		1,06	$1 590,00
2009		1,46	$2 190,00
2010		1,90	$2 850,00
2011		2,38	$3 570,00
2012		2,90	$4 350,00
2013		3,46	$5 190,00
2014		4,08	$6 120,00
2015		4,65	$6 975,00

Average cost for termination of employment without paid leave (1 to 3 months = 2 months salary):	$3 137,73
Average paid leave to be added (0 to 15 days salary = 7 days):	$175,00
Average cost of termination of employment for Junior Executives: (1 and 3 months salary + 0 to 15 days paid leave)	$3 312,73

front line employee:

	Average salary	*Total number of employees infected*	*Average cost per employee per year*
2005	$431,82	0,06	$51,82
2006		0,36	$310,91
2007		0,70	$604,55
2008		1,06	$915,45
2009		1,46	$1 260,91
2010		1,90	$1 640,91
2011		2,38	$2 055,45
2012		2,90	$2 504,55
2013		3,46	$2 988,18
2014		4,08	$3 523,64
2015		4,65	$4 015,91

Average cost for termination of employment without paid leave (1 to 3 months = 2 months salary):	$1 806,57
Average paid leave to be added (0 to 15 days salary = 7 days):	$100,76
Average cost of termination of employment for front line employee: (1 and 3 months salary + 0 to 15 days paid leave)	$1 907,33

- **AVERAGE COST OF RECRUITMENT**

As indicated previously, the costs for the recruitment process are equivalent to one full month salary given to the agent upon successful acceptance of the candidate.

	Total number of employees infected	*Cost of recruitment (one month salary)*	*Cost of recruitment per employee/year*
2005	0,06	$1 056,82	$63,41
2006	0,36		$380,45
2007	0,70		$739,77
2008	1,06		$1 120,23
2009	1,46		$1 542,95
2010	1,90		$2 007,95
2011	2,38		$2 515,23
2012	2,90		$3 064,77
2013	3,46		$3 656,59
2014	4,08		$4 311,82
2015	4,65		$4 914,20

Average cost of recruiting a Department Head for 2005-2015:	$2 210,67

	Total number of employees infected	*Cost of recruitment (one month salary)*	*Cost of recruitment per employee/year*
2005	0,06	$750,00	$45,00
2006	0,36		$270,00
2007	0,70		$525,00
2008	1,06		$795,00
2009	1,46		$1 095,00
2010	1,90		$1 425,00
2011	2,38		$1 785,00
2012	2,90		$2 175,00
2013	3,46		$2 595,00
2014	4,08		$3 060,00
2015	4,65		$3 487,50

Average cost of recruiting a Junior Executive for 2005-2015: $1 568,86

	Total number of employees infected	*Cost of recruitment (one month salary)*	*Cost of recruitment per employee/year*
2005	0,06	$431,82	$25,91
2006	0,36		$155,45
2007	0,70		$302,27
2008	1,06		$457,73
2009	1,46		$630,45
2010	1,90		$820,45
2011	2,38		$1 027,73
2012	2,90		$1 252,27
2013	3,46		$1 494,09
2014	4,08		$1 761,82
2015	4,65		$2 007,95

Average cost of recruiting a Front Line employee for 2005-2015: $903,29

- **AVERAGE COST OF TRAINING**

As for department heads and junior executives, the costs generated by the training process are equivalent to the full salary of the trainee + 50 percent of the trainer's salary (the company considers the trainer won't be fully productive while training the newly recruited employee). As for the front line employees, the costs generated by the training process are equivalent to the full salary of the trainee + full salary of the trainer (as mentioned previously, the front line employees are provided with a technical training by a specific trainer).

Department Head:

A department head will need a 60-day training upon recruitment.

Cost of training:	**full salary of trainee:**	$1 056,82
	50 percent salary of trainer:	$528,41
		$1 585,23
	multiplied by 2 months	x 2
	Total	$3 170,46

	Total number of employees infected	*Cost of training (1056,82 + 528,41) x 2 months*	*Cost of training per employee/year*
2005	0,06	$3 170,46	$190,23
2006	0,36	$3 170,46	$1 141,37
2007	0,70	$3 170,46	$2 219,32
2008	1,06	$3 170,46	$3 360,69
2009	1,46	$3 170,46	$4 628,87
2010	1,90	$3 170,46	$6 023,87
2011	2,38	$3 170,46	$7 545,69
2012	2,90	$3 170,46	$9 194,33
2013	3,46	$3 170,46	$10 969,79
2014	4,08	$3 170,46	$12 935,48
2015	4,65	$3 170,46	$14 742,64

Average cost for training new Department Heads over 2005-2015: $6 632,03

Junior Executives:

A Junior Executive will need a 30-day training upon recruitment.

Cost of training:	**full salary of trainee:**	$750,00
	50 percent salary of trainer:	$375,00
	Total (30 days training)	$1 125,00

	Total number of employees infected	*Cost of training ($750 + $375) x 1 month*	*Cost of training per employee/year*
2005	0,06	$1 125,00	$67,50
2006	0,36	$1 125,00	$405,00
2007	0,70	$1 125,00	$787,50
2008	1,06	$1 125,00	$1 192,50
2009	1,46	$1 125,00	$1 642,50
2010	1,90	$1 125,00	$2 137,50
2011	2,38	$1 125,00	$2 677,50
2012	2,90	$1 125,00	$3 262,50
2013	3,46	$1 125,00	$3 892,50
2014	4,08	$1 125,00	$4 590,00
2015	4,65	$1 125,00	$5 231,25

Average cost for training new Junior Executives over 2005-2015: $2 353,30

Front line employee:

A front line employee will need a 45-day training upon recruitment.

Cost of training:	**Full salary of trainee:**	$431,82
	Full salary of trainer (Msc. Agriculture Engineer):	$850,00
		$1 281,82
	Multiplied by 1,5 months	x 1,5
	Total	$1 922,73

	Total number of employees infected	*cost of training ($431,82 + $431,82 x 1,5 month)*	*Cost of training per employee/year*
2005	0,06	$1 922,73	$115,36
2006	0,36	$1 922,73	$692,18
2007	0,70	$1 922,73	$1 345,91
2008	1,06	$1 922,73	$2 038,09
2009	1,46	$1 922,73	$2 807,18
2010	1,90	$1 922,73	$3 653,18
2011	2,38	$1 922,73	$4 576,09
2012	2,90	$1 922,73	$5 575,91
2013	3,46	$1 922,73	$6 652,64
2014	4,08	$1 922,73	$7 844,73
2015	4,65	$1 922,73	$8 940,68

Average cost for training new front line employees over 2005-2015: $4 022,00

- **SUMMARY SCENARIO A**

		If all employees with HIV/AIDS are:	
	Department Head	*Junior Executive*	*Front line employee*
Direct costs:			
Financial compensation for termination of employment	$4 667,93	$3 312,73	$1 907,33
Recruitment process	$2 210,67	$1 568,86	$903,29
Loss of profits*:			
Training process	$6 632,03	$2 353,30	$4 022,00
TOTAL COSTS over 2005-2015 period	$13 510,63	$7 234,89	$6 832,61
TOTAL COSTS per year	**$1 228,24**	**$657,72**	**$621,15**
Potential Indirect Costs over 2005-2015 (200% of direct costs)	$13 757,21	$9 763,18	$5 621,23
TOTAL INDIRECT COSTS per year	**$1 250,66**	**$887,56**	**$511,02**

2. Scenario B: the company decides to implement HIV/AIDS measures

- **COST OF PREVENTION MEASURES**

As mentioned above, studies show that prevention measures costing US$10 per employee per year would allow the company to reduce its HIV prevalence by 50 percent. In Lebanon, companies can provide 60 to 90 minutes trainings to their employees with a National Consultant for US$50-75 per session (approx. US$600/day).[348]

	Total number of employees (+5% per year)	***Cost of Prevention measures per year (US$10 / employee)***
2005	62	$620
2006	65	$651
2007	68	$684
2008	72	$718
2009	75	$754
2010	79	$791
2011	83	$831
2012	87	$872
2013	92	$916
2014	96	$962
2015	101	$1 010

Total cost over 2005-2015:	$8 808
Average cost per year between 2005-2015:	$801

- **COST OF ARV TREATMENT**

The Lebanese Ministry of Health covers the cost of ARV treatment. In other words, the company will not bear any drug purchasing cost by providing ARVs to its employees.[349]

- **SUMMARY SCENARIO B**

	If all employees with HIV/AIDS are:		
	Department Head	***Junior Executive***	***front line employee***
Prevention measures for all employees ($10/employee between 2005 and 2015)	$8 808,21		
ARV Treatment for employees living with HIV/AIDS	$0,00		
Absenteeism	$0,00		
Recruitment	$0,00		
Training	$0,00		
TOTAL COSTS over 2005-2015	$8 808,21		
TOTAL COSTS per year	**$800,75**		

[348] Source: UNDP Lebanon - HIV/AIDS Focal Point
[349] Source: UNDP Lebanon - HIV/AIDS Focal Point

- **COST COMPARISON OF THE 2 SCENARIOS & CONCLUSION:**

	If all employees with HIV/AIDS are:			*Average annual costs for company*
	Department Head	*Junior Executive*	*Front line employee*	
Scenario A: terminate PLWHA's contract				
Annual Direct costs	*$1 228,24*	*$657,72*	*$621,15*	***$835,70***
Annual Indirect costs	*$1 250,66*	*$887,56*	*$511,02*	***$883,08***
TOTAL Costs Scenario A if Indirect Costs included	*$2 478,89*	*$1 545,28*	*$1 132,17*	***$1 718,78***
Scenario B: implementation of measures to respond HIV/AIDS	*$800,75*	*$800,75*	*$800,75*	***$800,75***

Summary of the Results of the WB/IBRD's Simulations

First Scenario: *Status Quo*

Descriptive Statistics for Output Variables: Status Quo

Country	Statistic	pvGDP [2000–25] loss (percentage of today's GDP)	Average GDP growth rate, 2000–25 (percent)	Population change in 2025, (percent)	HIV prevalence, 2015 (percent)	Health expenditures, 2015 (percentage of GDP)
Algeria	Mean	41.2	–0.40	–4.1	4.5	1.5
	Standard deviation	53.0	0.63	4.9	6.4	2.2
	Minimum	2.8	–4.36	–35.0	0.1	0.0
	Maximum	363.9	–0.01	–0.3	45.4	15.4
Djibouti	Mean	150.8	–1.34	–16.7	15.9	5.6
	Standard deviation	114.8	1.43	13.1	16.4	5.8
	Minimum	31.6	–7.02	–69.3	0.6	0.2
	Maximum	609.4	–0.15	–3.6	79.2	28.4
Egypt, Arab	Mean	51.3	–0.42	–3.8	4.2	1.4
Rep. of	Standard deviation	69.3	0.69	4.6	6.1	2.1
	Minimum	2.6	–4.67	–33.8	0.1	0.0
	Maximum	474.3	–0.01	–0.3	44.1	15.1
Iran, Islamic	Mean	38.7	–0.42	–3.8	4.2	1.4
Rep. of	Standard deviation	52.1	0.70	4.7	6.0	2.1
	Minimum	2.0	–4.73	–34.1	0.1	0.0
	Maximum	358.1	–0.01	–0.3	43.8	15.0
Jordan	Mean	33.6	–0.35	–3.2	3.7	1.3
	Standard deviation	46.8	0.59	3.9	5.3	1.8
	Minimum	1.2	–4.08	–27.6	0.1	0.0
	Maximum	324.5	–0.01	–0.2	38.2	13.2
Lebanon	Mean	30.0	–0.45	–4.4	4.6	1.5
	Standard deviation	38.5	0.72	5.4	6.7	2.2
	Minimum	2.1	–4.87	–39.3	0.1	0.0
	Maximum	265.8	–0.02	–0.4	48.3	15.9
Morocco	Mean	39.5	–0.42	–4.0	4.3	1.4
	Standard deviation	52.0	0.68	4.8	6.1	2.1
	Minimum	2.2	–4.62	–34.3	0.1	0.0
	Maximum	354.5	–0.01	–0.3	43.8	15.0
Tunisia	Mean	54.0	–0.44	–4.2	4.4	1.4
	Standard deviation	70.7	0.71	5.0	6.3	2.1
	Minimum	3.4	–4.78	–36.3	0.1	0.0
	Maximum	479.7	–0.01	–0.3	45.3	14.9
Yemen,	Mean	36.5	–0.34	–2.9	3.6	1.3
Rep. of	Standard deviation	51.3	0.58	3.6	5.3	1.9
	Minimum	1.3	–4.04	–25.7	0.1	0.1
	Maximum	358.5	–0.01	–0.2	38.1	14.1

Note: pvGDP, present value of gross domestic product.

Source**:** *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, Carol Jenkins, David A.Robalino, The International Bank for Reconstruction and Development / The World Bank, 2003, p.109

Summary of the Results of the WB/IBRD's Simulations

Second Scenario: *Under Policy interventions*

Output Variables under Policy Interventions

Country	Statistic	pvGDP [2000–25] loss (percentage of today's GDP)	Average GDP growth rate, 2000–25 (percent)	Population change, 2025 (percent)	HIV prevalence, 2015 (percent)	Health expenditures, 2015 (percentage of GDP)
Algeria	Mean	19.5	–0.1	–1.4	1.3	0.4
	Standard deviation	21.1	0.2	1.7	2.0	0.7
	Minimum	2.8	–1.8	–12.4	0.0	0.0
	Maximum	171.3	0.0	0.0	15.3	5.1
Djibouti	Mean	93.5	–0.6	–8.4	6.0	2.1
	Standard deviation	59.7	0.6	6.1	7.3	2.6
	Minimum	31.5	–4.5	–39.8	0.2	0.1
	Maximum	422.9	–0.1	–2.9	45.2	16.0
Egypt, Arab Rep. of	Mean	23.2	–0.1	–1.3	1.2	0.4
	Standard deviation	27.2	0.2	1.6	1.9	0.6
	Minimum	2.5	–2.0	–11.7	0.0	0.0
	Maximum	222.0	0.0	0.1	14.4	4.9
Iran, Islamic Rep. of	Mean	17.7	–0.1	–1.3	1.1	0.4
	Standard deviation	20.5	0.2	1.6	1.8	0.6
	Minimum	2.1	–2.0	–11.8	0.0	0.0
	Maximum	167.3	0.0	0.1	14.3	4.8
Jordan	Mean	17.1	–0.1	–1.0	1.0	0.3
	Standard deviation	18.2	0.2	1.3	1.6	0.5
	Minimum	2.4	–1.7	–9.3	0.0	0.0
	Maximum	147.1	0.0	0.0	12.1	4.1
Lebanon	Mean	12.4	–0.1	–1.5	1.2	0.4
	Standard deviation	15.1	0.2	1.8	2.1	0.7
	Minimum	1.3	–2.1	–13.9	0.0	0.0
	Maximum	123.8	0.0	0.1	16.3	5.3
Morocco	Mean	18.5	–0.1	–1.3	1.2	0.4
	Standard deviation	20.6	0.2	1.6	1.8	0.6
	Minimum	2.3	–1.9	–11.8	0.0	0.0
	Maximum	165.4	0.0	0.1	14.2	4.8
Tunisia	Mean	21.0	–0.1	–1.4	1.2	0.4
	Standard deviation	26.9	0.2	1.7	1.9	0.6
	Minimum	1.9	–2.0	–12.6	0.0	0.0
	Maximum	217.8	0.0	0.1	14.8	4.8
Yemen, Rep. of	Mean	37.7	–0.1	–1.0	1.1	0.4
	Standard deviation	25.9	0.2	1.2	1.6	0.6
	Minimum	6.6	–1.8	–8.9	0.0	0.0
	Maximum	208.1	0.0	0.0	12.3	4.5

Note: GDP, gross domestic product; pvGDP, present value of gross domestic product.

Source: *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, Carol Jenkins, David A.Robalino, The International Bank for Reconstruction and Development / The World Bank, 2003, p.127

Summary of the Results of the WB/IBRD's Simulations

Third Scenario: *If Policy Intervention is postponed for 5 years*

Output Variables if Policy Intervention Is Postponed for Five Years

Country	Statistic	pvGDP [2000–25] loss (percentage of today's GDP)	Average GDP growth rate, 2000–25 (percent)	Population change, 2025 (percent)	HIV prevalence, 2015 (percent)	Health expenditures, 2015 (percentage of GDP)
Algeria	Mean	28.6	–0.2	–2.4	2.1	0.7
	Standard deviation	30.3	0.3	2.6	3.1	1.1
	Minimum	4.0	–2.5	–19.3	0.0	0.0
	Maximum	236.4	0.0	–0.1	23.3	7.9
Djibouti	Mean	120.6	–0.8	–11.7	8.8	3.1
	Standard deviation	81.8	0.8	8.7	10.2	3.6
	Minimum	33.0	–5.4	–52.4	0.3	0.1
	Maximum	524.7	–0.1	–3.3	57.9	20.6
Egypt, Arab Rep.	Mean	34.5	–0.2	–2.2	2.0	0.7
	Standard deviation	38.7	0.3	2.5	3.0	1.0
	Minimum	4.2	–2.7	–18.4	0.1	0.0
	Maximum	305.6	0.0	–0.1	22.3	7.6
Iran, Islamic Rep. of	Mean	26.3	–0.2	–2.2	2.0	0.7
	Standard deviation	29.3	0.3	2.5	2.9	1.0
	Minimum	3.2	–2.7	–18.5	0.0	0.0
	Maximum	231.0	0.0	–0.1	22.1	7.5
Jordan	Mean	24.3	–0.2	–1.8	1.7	0.6
	Standard deviation	26.0	0.3	2.1	2.5	0.9
	Minimum	2.8	–2.2	–14.6	0.0	0.0
	Maximum	202.3	0.0	0.0	18.6	6.4
Lebanon	Mean	19.5	–0.2	–2.6	2.2	0.7
	Standard deviation	21.9	0.3	2.9	3.3	1.1
	Minimum	2.5	–2.9	–21.8	0.1	0.0
	Maximum	173.3	0.0	–0.1	25.1	8.2
Morocco	Mean	27.5	–0.2	–2.3	2.0	0.7
	Standard deviation	29.5	0.3	2.6	3.0	1.0
	Minimum	3.6	–2.6	–18.6	0.0	0.0
	Maximum	229.1	0.0	0.0	22.1	7.5
Tunisia	Mean	33.2	–0.2	–2.4	2.1	0.7
	Standard deviation	38.9	0.3	2.7	3.1	1.0
	Minimum	4.0	–2.7	–19.7	0.0	0.0
	Maximum	303.7	0.0	–0.1	23.0	7.5
Yemen, Rep. of	Mean	44.9	–0.2	–1.7	1.7	0.6
	Standard deviation	34.6	0.3	1.9	2.5	0.9
	Minimum	6.9	–2.3	–13.8	0.0	0.0
	Maximum	267.2	0.0	–0.1	18.7	6.9

Note: GDP, Gross domestic product.; pvGDP, present value of gross domestic product.

Source**:** *HIV/AIDS in the Middle East and North Africa, The Costs of Inaction*, Carol Jenkins, David A.Robalino, The International Bank for Reconstruction and Development / The World Bank, 2003, p.128

"GLOBAL BUSINESS COALITION's FRAMEWORK OF ANALYSIS FOR COST OF HIV/AIDS ON BUSINESS AND BENEFITS OF ACTION"

	Costs of inaction	Benefits of action	Possible interventions
International	Potential disruption in global FDI flows International resources diverted from other international crises Threats to cross-border security Increased demands and challenges in global governance	Enhanced global response with business skills and expertise Minimize infrastructure gaps through pubic-private partnerships Decreased threats to free trade zones without vulnerability from mobile populations Business respected as a global leader in the international response to AIDS	Partnerships with international institutions, donor governments and foundations to advance common goals Implementation of global awareness campaigns Collective bargaining for global action in relation to HIV policies and HIV related commodities for testing and treatment Advocacy and leadership by CEO's and business leaders to address urgency of crisis, stigma and discrimination and need for greater action
National/ Regional	**Impact on market and economy** Higher prices for non-labor inputs including plant security Rising wages for scare skills Loss of investor confidence Exchange rate risk Reduced demand for company's product Threats to FDI and trade **Impact on governance** Threats to political stability, security, and law and order Increasing burden of disease on national budgets Greater inefficiency of government operations	**Impact on market and economy** Overall public health benefits decrease in mortality and morbidity and incidence of HIV Security in future workforce Increased consumer confidence and spending Increased attractive to foreign investors New opportunities for trade and market development **Impact on governance** Improved stability and economic security Decreased burden of HIV/AIDS Possible tax incentives for greater involvement in AIDS Business considered a partner in public health policy setting and program implementation. Opportunity for business involvement on resource mobilization through National AIDS Control Organizations and Country Coordinating Mechanisms (Global Fund)	**Direct company action** Extending workplace programs to local communities Implementation of national awareness campaigns Support training of medical professionals Speak out to break stigma and keep AIDS on the agenda **Partnership with governments and civil society** Lobby governments for increased response and resource mobilization Participate on National AIDS Control Organizations Increase involvement of Business Associations and Coalitions in tackling AIDS at a national level Managing intervention efforts (assisting governments and public health communities)
Firm	**Productivity loss** Loss of morale and workplace cohesion Training and re-hiring of workers Leave to care for dependents with AIDS **Increased Worker Costs** Loss of life, bereavement, and funeral costs Increased demands on health benefits and sick leave, premature start of pensions. **Inefficiency in management** Less productive workforce Reduction in skill level Cost of legal protections/worker rights Reputational risks/public relations Reliability of supply chain/distribution channels	**Productivity gain** Capacity deepening (increased life expectancy and reduced morbidity allows employees to develop skills and capacity for promotion) Improved morale and workplace cohesion **Healthier workforce and community** Decreased demands on health care services over time Decreased absenteeism due to illness and caring for dependents **Managerial leadership** De-stigmatizes disease for employees Cost savings from reduced hospitalizations Positive public relations impact for taking leadership Legal compliance Improved sustainability of company operations Sustained operations create opportunities for growth	**Implementation of a comprehensive workplace response to HIV** Nondiscrimination Awareness and Prevention (including distribution of condoms) Testing (in – house/out) Care, support and treatment for employees **Supporting families and local communities** Extend workplace interventions to support families, schools and local service organizations Involve people living with AIDS, Unions, government and community/faith based organizations to increase relevance and reach of interventions

Source**:** *Opportunities for business in the fight against HIV/AIDS*, Global Business Coalition, January 2004

GLOBAL HEALTH INITIATIVE PRIVATE SECTOR INTERVENTION CASE EXAMPLE

Implementing a regional workplace prevention and voluntary testing programme for a major automotive company using existing project management expertise

Case categories

Company: General Motors (GM) Industry: Automotive Location: Thailand Programme: **HIV/AIDS**

Key questions

- How can other multinationals adapt this programme initiation and implementation model for success in their companies?
- Can other smaller companies in Thailand piggy-back on these existing tools and processes to reduce the investment required to implement a prevention programme?
- Although the programme is successful in measuring activities, how can the project team ensure that it achieves the desired outcomes?

Overview

Company

General Motors is a global automotive company with substantial operations and markets in the Asia-Pacific Region.

- General Motors Corporation (GM) is the world's largest vehicle manufacturer. The company has manufacturing operations in 32 countries and its vehicles are sold in 192 countries. In 2003, GM sold more than 8.5 million cars and trucks, representing approximately 15 percent of the global vehicle market. In 2003 GM employed 326,000 people and generated US$ 186 billion in revenues.
- GM Asia Pacific (GMAP) includes GM's activities: Japan, Korea, China, Association of South East Asian Nations (ASEAN) and India, and Australia and New Zealand. In 2003 GMAP employed 14,000 people and generated US$ 5.3 billion in revenues.
- This case is illustrated with examples from a representative programme in Thailand which employs 2,500 people. GMAP locations which have, or soon will have, programmes include: Halo, India, which employs 600 people; Jakarta, Indonesia, which employs 500 people; and China which employs 9,000 people.

Business Case

The vision of GMAP's HIV/AIDS programme is to ensure a policy of non-discrimination and support for those employees living with HIV/AIDS as well as to invest in prevention to reduce the incidence of HIV/AIDS in employees, their families and the communities in which GM operates and sells its products.

- GMAP gained top management support for a regional HIV/AIDS programme after being inspired by guidance from headquarters and informed by local experts.
- Although the company recognized the potential business threat to its employees and markets, it was motivated primarily by a belief in the principles behind corporate social responsibility and the company's moral imperative to respond proactively towards HIV/AIDS.
- GMAP's two-year budget for the pilot projects in Thailand and India was US$ 50,000, which corresponds to approximately US$ 8 per employee per year.

Programme Description

GM's programme focused on developing and communicating a clear workplace policy, peer education, access to voluntary counselling and testing, and community outreach activities.

- GMAP developed HIV/AIDS programme guidelines for each plant, which included a sample workplace policy. GM Thailand developed its policy in mid-2002.
- GMAP's prevention and awareness programme uses peer education to train employees, managers, and families in awareness as well as prevention messages.
- GMAP employees are encouraged to access voluntary counselling and testing services either through company facilities or through external resources.
- While developing the workplace education content, the steering committees developed contacts with local NGOs and used these contacts to identify and select community outreach activities.

Programme Evaluation

After a formal review process, GMAP believes that this pilot project has been successful and is in the process of rolling it out to additional facilities.

- GM has developed the four main lessons to share with other companies: (1) use your company's existing project management expertise (2) select motivated high-energy champions (3) look at the long-term perspective (4) don't go it alone.
- The project is managed by an HIV/AIDS project coordinator and guided by a steering committee. Selecting these country-resources is the first step in the project rollout.
- GMAP evaluated this project both on a country and a regional level using standard internal tools. In addition to this, the project also received a number of external certifications and awards.
- Based on the success of the pilot project in Thailand and India, it is being expanded to include Indonesia and China.

Business Case

Vision

The vision of GMAP's HIV/AIDS programme is to ensure a policy of non-discrimination and support for those employees living with HIV/AIDS as well as to invest in prevention to reduce the incidence of HIV/AIDS in employees, their families and the communities in which GM operates and sells its products.

Case for Action

GMAP gained top management support for a regional HIV/AIDS programme after being inspired by guidance from headquarters and informed by local experts. Although the company recognized the potential business threat to its employees and markets, it was motivated primarily by corporate social responsibility and the company's moral imperative to respond proactively towards HIV/AIDS.

- In early 2001, GM's International Medical Director, Maria Bradshaw, visited the GMAP region. One of the purposes of her trip was to introduce regional and plant leadership to the growing global and Asia-Pacific-specific HIV/AIDS threat to GM's business. Dr Bradshaw left each plant a copy of the United States Government's Centre for Disease Control's (CDC) HIV/AIDS programme recommendations.
- In response to the discussion with Dr Bradshaw, GM Thailand attended a programme sponsored by the International Labour Organization (ILO) and the Thailand Business Coalition on HIV/AIDS (TBCA). This meeting provided the GMAP Regional Health and Safety Manager with the inspiration to develop a regional proposal. In order to further develop this proposal key staff joined a regional conference on HIV/AIDS in Bangkok, Thailand, co-sponsored by UNAIDS, the ILO, the CDC, and TBCA. The information gathered as well as the networks developed from business, labour, NGO, and academic contacts provided sufficient information to further develop this proposal.
- One of the main themes emphasized in these interactions was the need for top management support. With this in mind, in February 2002, a presentation was made to GM's Asia Pacific Strategy Board (APSB), including the company's regional president as well as all of the vice-presidents and managing directors within the region. Although the presentation included some discussion on business impact and programme costs it mainly focused on: (1) the nature of HIV/AIDS (2) how HIV/AIDS could affect the Asia-Pacific region based on lessons from South Africa (3) key programme elements (4) motivations for GMAP to implement the programme. The motivations focused on the benefits to GM's employees as well as the communities in which GM facilities operate or GM customers live. GM believes that if these communities are impaired due to the economic or social impacts of HIV/AIDS that the company cannot be successful.
- The board decided based on the presentation that supporting the HIV/AIDS initiative was "the right thing to do" from both a corporate social responsibility standpoint but also from a moral perspective. The board approved and regionally funded a pilot project for GM's Thailand facility in Rayong and its India facility in Halo. Built on a foundation of top management support, the team then made similar presentations at each of the chosen pilot facilities. Aided by the regional budget, the plants agreed to implement the GMAP HIV/AIDS programme.

Financing

GMAP's two-year budget for the pilot projects in Thailand and India was US$ 50,000, which corresponds to approximately US$ 8 per employee per year.

- GMAP's initial regional HIV/AIDS workplace and community HIV/AIDS outreach budget was US$ 50,000. This two year budget was approved in February 2002 to fund the pilot projects. The same budget has subsequently been extended to include GMAP's factory in Jakarta, Indonesia.
- Since 2003 GM Thailand has also contributed to a community HIV/AIDS budget. Their 2004 budget is US$ 1,350 and is allocated to support local activities, including an HIV/AIDS information hotline.

Programme Description

Policy

GMAP developed HIV/AIDS programme guidelines for each plant, which included a sample workplace policy. GM Thailand developed its policy in mid-2002. All of the policies adhere to the following common elements.

- **Non-discrimination:** (1) employees will not be dismissed on the grounds of their HIV status; (2) employment, transfer and promotional opportunities are not based on HIV status, (3) the company will not conduct pre or post employment HIV testing; (4) there is no tolerance for HIV/AIDS-related discrimination or harassment by management or co-workers.
- **Confidentially and disclosure:** (1) employees are not required to disclose status; (2) employees are encouraged to disclose their status so the company can arrange for counselling services for the employee and his/her family; (3) if status is disclosed, it cannot be disclosed to others without prior consent of the respective employee.
- **Benefits:** employees with life threatening illnesses, including HIV/AIDS, are entitled to the same privileges and benefits afforded to all GM employees.
- **Termination:** (1) reasonable accommodations is made to adjust to the limitations of qualified individuals provided that s/he is able to meet the job requirements and does not cause a negative health effect on themselves or their co-workers; (2) if the employee is unable to work s/he may be eligible for a disability pension or lump-sum payment just as for any other medical impairment.
- **Suppliers and distributors:** GMAP does not currently have an HIV/AIDS-specific supplier or distributor policy.

Prevention and Awareness

GM's prevention and awareness programme uses peer education to train employees, managers, and families in awareness and prevention messages.

- **Peer education.** Each location selects peer educators who can conduct the training with their respective peer group. This corresponds to at least one management peer educator and at least one 'team member' peer educator per 'main shop.' In Thailand this corresponded to a total of 6 peer educators, or a ratio of 417 employees per peer educator. The peer educators were trained in a 24 hour session by TBCA using train their specially developed train the trainer materials.
- **Workplace training format.** Training sessions rely on peer educator training materials supplied by TBCA are conducted by peer educators in groups of 25 to 30 people, lasting two hours. The main topics of the training include: (1) GM HIV/AIDS policy; (2) definitions of HIV/AIDS; (3) routes of exposure; (4) how to treat a subordinate or co-worker who has HIV/AIDS; (5) outside resources available in the community for further education, testing and counselling; (6) assurances of strict confidentially of health information; (7) information on voluntary testing and its importance.
- **Induction training.** Since all employees in Thailand have been reached through peer education by the end of 2003, the content has been integrated into the new employee orientation programme for all new employees and managers.
- **Family.** GM Family Education includes the following four main topics: (1) what is HIV/AIDS (2) how to prevent it (3) community HIV/AIDS testing and counselling services (4) what and why GM is doing something about HIV/AIDS. Since programme launch, GM Thailand has held two family training and awareness campaigns during its annual Family Day. The company estimates that it reached 2,000 family members through the awareness messages and Family Day activities.
- **Condoms.** Each plant or facility can determine if it would like to include condom promotion as part of its prevention programme. GM Thailand distributed approximately 1,000 condom key-chains with the Chevrolet logo during its 2003 Family Day activities.

Programme Description (…continued)

Voluntary Counselling & Testing

Employees are encouraged to access voluntary counselling and testing services either through company facilities or through external resources.

- Employees may access on-site VCT resources for free. Since it was first made available in 2002, 375, or 15% of GM Thailand employees have accessed this service. To date there have been no confirmed HIV-positive cases. This test is offered during the employee annual physical program. If an employee requests the testing he is provided with pre-test counselling by the trained medical staff.
- Two GM Thailand medical staff received 40 hours of training from TBCA and the local hospital on HIV/AIDS pre and post test counselling.
- GM Thailand uses the Western blot test. If an employee is HIV-positive, the test is re- confirmed with a second Western blot test and s/he receives post test counselling. If the second test is also positive, GM Thailand provides access to further post-test counselling and additional emotional support.
- HIV-positive employees are advised to follow up with the company's doctor at the local hospital. If the patient has any opportunistic infections, s/he will be recommended to access treatment from his/her doctor and covered through the standard medical schemes.

Community Outreach

While developing the workplace education content, the steering committees developed contacts with local NGOs and used these contacts to identify and select community outreach activities. These projects were funded primarily through regional public relations budgets.

- GM Thailand provided funding $500 USD to support the operation and promotion of a HIV/AIDS Hot Line which can be called by anyone from anywhere in the country. The Hot Line provides counselling and local referrals for testing and additional counselling and treatment. Since its launch in June of 2000, the Hot Line has logged on average over 100 calls per day.
- GM Thailand provided funding and employee clothing and toys to a local Buddhist Temple that provide an orphanage service for children with parents affected or infected by HIV/AIDS. The amount given in funding, clothes and toys helped to support approximately 2,000 children.
- GM, GMAP, GM Thailand, and the Elizabeth Glaser Paediatric AIDS Foundation are co-sponsoring the showing of the film "A Closer Walk" by Robert Bilheimer" at the International AIDS Conference in Bangkok, Thailand in July 2004. The movie was filmed over two and a half years visiting dozens of locations on four continents. It interviewed or profiled more than 75 children, women and men across the broad spectrum of the global AIDS experience.

Programme Evaluation

Key Success Factors

Since initiating and implementing its regional HIV/AIDS programme, GM has developed the following key lessons to share with other companies:

- **Use your company's existing project management expertise.** Treat the HIV/AIDS programme in a similar way as your company handles other important projects. Gain top management approval early in the process. Allocate funding and assign responsibilities. Use existing project management processes to ensure proper implementation.
- **Select motivated high-energy champions.** Don't just assign people to the project, select highly motivated people for the steering committee and the coordinator functions.
- **Look at the long term perspective.** Starting a programme for purely short-term cost- benefit driven reasons may not be successful. It is difficult to measure and quantify these short-term benefits, especially for prevention programmes in low-prevalence regions such as Asia. It is important to consider a second dimension including the corporate social responsibility or moral motivations. These long-term drivers can help ensure the longer-term management commitment required for success.
- **Don't go it alone.** There are many country-level, regional and global resources available to help you develop and implement your workplace and community programme. Many of these government, NGO, and business groups provide access to networks, best practices, and technical or implementation expertise. These resources can substantially reduce the investment required for a successful implementation.

Self-evaluation process

The project is managed by an HIV/AIDS project coordinator and guided by a steering committee. Selecting these country-resources is the first step in the project rollout.

- **Steering committee composition.** The steering committees are chaired by a senior manager and include representatives from the following three functions: medical, human resources, training. They also include a manufacturing supervisor and at least one employee representative.
- **Steering committee responsibility.** Each steering committee has the following responsibilities: (1) develop and review the HIV/AIDS policy (2) select peer educators (3) select and develop education materials for management, employees and family education programmes (4) select and develop ongoing education materials (5) monitor educational programmes implementation (6) select community outreach activities (7) monitor HIV/AIDS programme implementation and provide for ongoing continuos improvement.
- **Coordinator selection criteria:** The country or plant HIV/AIDS programme coordinator is selected based on the following criteria: (1) medical background or an understanding of the HIV/AIDS issues: (2) drive and willingness to work on the programme (3) good organizational skills (4) good communications skills (5) English and local language skills
  (6) Availability to devote 20% of his/her time to the programme, with an understanding that this allocation will higher at the start of the project.
- **Coordinator duties:** The coordinator has the following main duties: (1) be available as a resource to the steering committee (2) arrange all steering committee meetings (3) research and develop available educational material (4) work with training department to arrange for management and employee education (5) liaise with local HIV/AIDS organizations (6) liaise with local community on community outreach.

GMAP used standard internal tools to monitor and evaluate this project.

- Each facility participating in the pilot project was managed using GM's common process, the Business Plan Deployment Process. This process requires that each element and sub-element be planned with timelines. The plant-level steering committee tracks progress against the plan every month.
- The pilot project results and key milestones are aggregated to a regional level and evaluated on an annual basis by the APSB.

The project has received a number of external certifications and awards.

- In June 2003, GM Thailand received an award from the Thai Minister of Social Welfare in recognition of their contributions to the communities.
- In December 2003, Thailand's Royal Princess presented GM Thailand with an award from the Thailand Red Cross for this HIV/AIDS programme.

Future Goals

Based on the success of the pilot project, the APSB has authorized the project expansion for Indonesia and China.

- GM Indonesia is currently establishing its steering committee.
- Pending local government approval, GM China will begin project implementation at its six facilities in mid-2004.

Case-specific HIV/AIDS Resources

Documents

GM Asia Pacific Sample HIV/AIDS Policy (2002)

GM Asia Pacific HIV/AIDS Pilot Programme Elements & Guidelines (2002)

GM Asia Pacific Project Proposal to Regional Strategy Board (February 2002)

GM Asia Pacific Programme Update to Regional Strategy Board (October 2002)

GM Asia Pacific Sample Annual Business Plan Deployment Worksheet (2002)

Contacts

General Motors Corporation (GM)	Mr Kenneth Thompson Asia Pacific Regional Safety Manager Tel.: +66 38 667 024 E-mail: kenneth.thompson@gm.com Mrs. Suttiluk Srisawang HIV/AIDS Programme Coordinator, Thailand Tel.: + 66 38 667 025 E-mail: suttiluk.srisawang@gm.com
Thailand Business Coalition on AIDS (TBCA)	Dr Anthony Pramualratana Executive Director, TBCA Tel.: +66 2 643 9891-3 E-mail: tbca@ksc.net.th
Asian Business Coalition on HIV/AIDS (ABC)	Mr Simon Graham Asia Regional Programme Manager Tel.: +66 2 643 9891-3 E-mail: simon@abconaids.org
International Labour Organization	Mr Gunnar Walzholz Technical Specialist on HIV/AIDS in the World of Work Regional Office for Asia and Pacific Tel.: +66 2 288 1765 E-mail: walzholz@ilo.org

This case study uses the following exchange rate: 44.5 Thai Baht to 1 United States Dollar.

The World Economic Forum Global Health Initiative Private Sector Case example was written by Peter DeYoung and developed in collaboration with the featured company, however, GHI member companies and partners, the World Economic Forum and the contributing company do not necessarily subscribe to every view expressed herein. The case is based on a self-reporting model. Although the GHI makes reasonable efforts to ensure the accuracy of the statements, this report should not be viewed as an external audit of the programme described.

This case study is a part of the GHI's Case Study and Supporting Document Library, which is available at www.weforum.org/globalhealth/cases. Please contact the Global Health Initiative at the World Economic Forum for any questions, feedback or submissions related to this case study.

World Economic Forum
91-93 route de la Capite
CH-1223 Cologny/Geneva – Switzerland
Tel.: +41 (0) 22 869 1212
Fax: +41 (0) 22 786 2744
E-mail: globalhealth@weforum.org
www.weforum.org/gobalhealth

GLOBAL HEALTH INITIATIVE PRIVATE SECTOR INTERVENTION CASE EXAMPLE

Partnering with an NGO, Yayasan Kusuma Buana, to implement a workplace HIV/AIDS prevention programme in Indonesia

Case categories

Company: Gajah Tunggal Group Industry: Conglomerate Location: Indonesia Programme: **HIV/AIDS**

Key questions

- How can GTG sustain interest in behaviour change efforts after it has trained all of its workers?
- Is it necessary for GTG to develop and socialize a written HIV policy to promote an environment conducive to prevention efforts?
- If it necessary for GTG to conduct a baseline before initiating training efforts to determine if its behaviour change efforts are effective?

Overview

Company

The Gajah Tunggal Group (GTG) is a large Indonesian conglomerate and a leading tyre manufacturer in South East Asia.

- GTG is a diversified group including interests in integrated shrimp farming, tire manufacturing, and petrochemical and consumer network services in the Asia Pacific region. In 2003 the group managed more than 60 companies and directly employed 55,000 people.
- PT Gajah Tunggal Tbk. (GT Tire) is South East Asia's largest tyre manufacturer. GT Tire uses five factories in Indonesia to produces radial, bias, and motorcycle tires. GT Tire has a distribution network of more than 50 dealers throughout Indonesia and other international outlets in over 75 countries. In 2003, GT Tire employed approximately 14,000 workers, including 7,500 at its factory site in Tangerang, outside of Jakarta.

Business Case

In 2002, GTG Executive Director, Cherie Nursalim, visited South Africa, and saw first-hand the impact of a large-scale HIV/AIDS epidemic on businesses and society. After returning home to Indonesia she became aware that without a significant investment in prevention from all sectors of society, Indonesia risked a similar future. In response to this threat she established a workplace prevention programme not only to reduce the risk to her businesses, but also to set an example for other businesses and other sectors of society.

- The Indonesian Department of Health estimated that there are currently 90,000 to 130,000 Indonesians who are HIV+, and that this number will continue to increase unless radical steps are taken.
- Indonesian government estimates show that Indonesia has a large commercial sex industry. Approximately nine million men purchase sex from roughly 300,000 commercial sex workers multiple times each year in Indonesia. Consistent condom usage among these male clients is consistently less than 10%, and the prevalence of sexually transmitted infections in these sex workers is 60%.
- GTG believes that its employees and their families are directly at risk for contracting sexually transmitted infections, including HIV/AIDS through unsafe sexual practices. Approximately 95% of the workers at GT Tires facility in Tangerang are men. Most of these men are between 20 and 40 years old and have received a vocational high school education. Many of these workers are not originally from the Tangerang area, having moved there for work. Additionally there is a well-established commercial sex industry near the factory.
- GT Tire has not established an HIV/AIDS-specific budget. The company's main expense is the opportunity cost of lost work time spent on workplace training activities.

Programme Description

GTG workplace prevention programme focuses on mandatory employee training.

- GTG does not have a written HIV/AIDS-specific policy, but senior managers have expressed and communicated a commitment to maintain prevention activities in the workplace and community, as well as to ensure HIV+ employee rights.
- Top management drives GT Tire's workplace prevention programme. The programme focuses on management training and mandatory staff training through peer educators. GT Tire estimates that its training has already reached 60% of its factory staff.

Programme Evaluation

GT Tire monitors the reach of its prevention efforts and the core team meets on a monthly basis to resolve operational issues.

- GT Tires management asks the core team to provide regular updates on the number of employees reached through the prevention efforts.
- Since March 2004, the GT Tire HIV prevention programme core team has held monthly meetings with its implementing NGO partner, Yayasan Kusuma Buana (YKB). These meetings are a venue to discuss tough questions raised during workplace training sessions, share new information to include in future training, and plan future activities.
- In May 2004, GTG received an AIDS Award presented by the National AIDS Commission, UNAIDS, ILO and FHI in collaboration with a number of leading NGOs, including YKB for its successful efforts to implement workplace prevention activities.

In the future GTG aims to understand its employee needs and extend workplace prevention efforts to cover additional at-risk employees in Indonesia.

- Conduct behavioural surveys and focus group discussions to gain a deeper understanding of the company's current situation, employee needs, and the effectiveness of prevention measures.
- Extend its workplace prevention efforts to include other GTG companies.
- Encourage other companies in Indonesia to adopt workplace prevention initiatives.

Programme Description

Policy

GTG does not have a written HIV/AIDS-specific policy, but senior managers have expressed and communicated a commitment to maintain prevention activities in the workplace and community, as well as to ensure HIV+ employee rights.

- **Non-discrimination:** (1) hiring decisions are not based on HIV status; (2) hiring decisions do not include an HIV assessment; and (3) employees will not be dismissed based on their HIV status.
- **Confidentiality and disclosure:** GTG management will preserve the confidentiality of individuals affected by HIV/AIDS.
- **Benefits:** (1) employees with HIV/AIDS are entitled to the same privileges and benefits afforded to all GTG employees; (2) In May 2004, GTG management pledged to provide reasonable support, including access to life-saving anti-retroviral drugs, to HIV-positive employees; and (3) the company is not yet aware of any employees who require these treatment benefits.
- **Ill-health retirement:** if HIV+ employees are no longer able to work, GTG will provide disability benefits according to Indonesian labour law.
- **Contractors:** GTG does not have an HIV-specific policy for its contractors or suppliers.

Prevention and awareness

Top management drives GT Tire's workplace prevention programme. The programme focuses on management training and mandatory staff training through peer educators. After more than half of the workers were educated, GT Tire management invited other GTG managers to implemented similar programmes.

- **GTG management briefing.** In May 2003, GTG invited Yayasan Kusuma Buana (YKB) and Family Health International (FHI) to conduct an executive briefing for Cherie Nursalim, head of corporate communications, head of the tire factor, head of human resources, and the head of the company's internal university. The briefing lasted two hours and included a discussion of the (1) current HIV situation in Indonesia; (2) basics of HIV and how it is transmitted, (3) business impact of HIV; and (4) components of a workplace prevention programme. During this meeting GTG management committed to conduct a pilot prevention project for its university and tire factory.
- **University training.** GTG invests in promising employees by enrolling them in an internal company technical university. The company first implemented its prevention efforts on this group to pilot YKB's training tools as well as to protect its investment in human capital. From May to July 2003, YKB conducted three separate training sessions for the GTG Polytechnic's 22 person teaching staff, 15 person admin staff, and 30 students. The staff's training sessions were one-day long and the student training lasted three days. The student components also included communications training.
- **GT Tire management briefing**. In November 2003, YKB conducted a half-day management briefing for 15 members of GT Tire' top management team, which was opened by the head of the factory. The session followed the same format as the GTG management briefing, but also included a work-planning session where the participants developed an implementation plan and assigned responsibilities to a core team to implement a workplace prevention programme at the tire factory's five locations.

Programme Description (…continued)

Prevention and awareness

(..continued)

- **GT Tires Train-the-Trainers**. GT Tires' management invited 28 people to serve as peer educators to deliver HIV-prevention education to the 7,500 employees at the company's five plants (268 employees per core team member). These people were selected because they were senior, well respected by their peers and subordinates, and effective communicators. The group included representatives from production, health and safety, labour, and human resources. In December 2003, the 28 peer educators participated in a two-day train-the-trainers workshop. This workshop provided them with the skills and knowledge required to train their colleagues. The workshop also included a pre and post-test assessment to validate that there was sufficient knowledge capture.
- **GT Tires worker training**. From February to June the core team held 163 worker-training sessions, covering an estimated 60% of GT Tires 7,500 factory workers. The company estimates that it will have trained all of its workers through mandatory training sessions by the end of 2004. The two-hour training sessions are capped at 30 participants to ensure that they are interactive. Two to three core team members teach each session which includes the following topics: (1) basics of HIV/AIDS; (2) how HIV/AIDS is transmitted; (3) how to prevent HIV transmission; and (4) condom demonstration. During the initial sessions YKB sends a training specialist to observe the training sessions and provide the training team with feedback to improve their technique. After the trainers were confident in their capabilities and knowledge, YKB reduced its frequency of sending observers. One common question asked during these sessions was, "Will I get fired if I get HIV?" Peer educators asserted that the employees would not be fired if they were HIV-positive.
- **Celebrate success.** In May 2004 GT Tires conducted a factory gathering including 25 top management members from eight other GT Group companies to celebrate the success of the GTG winning the AIDS Award. The management meeting included the standard executive briefing as well as (1) an extended question and answer section; (2) a knowledge quiz where peer educators were asked questions by the core team on key HIV facts in front of the manager; (3) a planning session where managers discussed how best to implement similar efforts in their workplaces. The management decided that their efforts would be most successful if they each implemented individual programmes to match their employee needs. In addition to the management briefing, 3,000 HIV/AIDS awareness leaflets were distributed to the first shift as the workers passed through the factory gates.

Case-specific HIV/AIDS Resources

Supporting Documents

YKB Train the Trainer 2-Day Course Outline (2004)

Contacts

Gajah Tunggal	Ms Cherie Nursalim Executive Director Ms Catharina Widjaja Director Tel. +62 21 381 1102 Email: gajahjak@rad.net.id Mr Buddy Tanasaleh Chief Operating Officer Tel.: +62 21 351 2461 E-mail: buddy.tanasaleh@gt-tires.com
Yayasan Kusuma Buana (YKB)	Dr Adi Sasongko Director for Health Care Tel.: +62 21 829 6337 E-mail: ykb-jkt@idola.net.id
Family Health International, Indonesia - Aksi Stop AIDS	Mr Richard S Howard Private Sector Specialist Tel.: +62 21 422 3463 E-mail: rhoward@fhi.or.id
Joint United Nations Programme on HIV/AIDS (UNAIDS), Indonesia	Ms Dyah Anggraini Project Officer Partnerships and Private Sector Tel.: +62 21 314 1885 E-mail: dyah.unaids@undp.org

International Labour Organization, Indonesia

Mr Tauvik Muhamad
National Programme Coordinator on
HIV/AIDS Tel.: +62 21 391 3112 x116
E-mail: tauvik@ilo.org

This case study uses the following exchange rate: 8,600 Indonesia Rupiahs to 1 United States Dollar.

The World Economic Forum Global Health Initiative Private Sector Case example was written by Peter DeYoung and developed in collaboration with the featured company, however, GHI member companies and partners, the World Economic Forum and the contributing company do not necessarily subscribe to every view expressed herein. The case is based on a self-reporting model. Although the GHI makes reasonable efforts to ensure the accuracy of the statements, this report should not be viewed as an external audit of the programme described.

This case study is a part of the GHI's Case Study and Supporting Document Library, which is available at www.weforum.org/globalhealth/cases. Please contact Peter DeYoung at the World Economic Forum for any questions, feedback or submissions related to this case study.

World Economic Forum
91-93 route de la Capite
CH-1223 Cologny/Geneva – Switzerland
Tel.: +41 (0) 22 869 1212
Fax: +41 (0) 22 786 2744
E-mail:
globalhealth@weforum.org
www.weforum.org/gobalhealth

WORLD ECONOMIC FORUM

COMMITTED TO IMPROVING THE STATE OF THE WORLD

GLOBAL HEALTH INITIATIVE
Private Sector Intervention Case Example

Providing comprehensive treatment to employees, thereby reducing HIV/AIDS-related expenses by 40% if the programme is successful

Case categories

Company: **IBM** Industry: **Information Technology** Location: **South Africa** Programme: **HIV/AIDS**

Key questions

- Can a company provide HIV/AIDS benefits to HIV+ employees outside the medical aid scheme?
- How does having an employee co-pay for treatment services affect treatment seeking behaviour?
- Can companies in countries with a much lower HIV prevalence use this approach to treat their employees?

Overview

Company

International Business Machines (IBM) is a leading hardware, software and services company with global operations.

- IBM is the world's top supplier in computer hardware, the largest provider of technology services, the second largest provider in software, and a leader in semi-conductor manufacturing. In 2002, IBM had approximately 320,000 employees, which generated US$ 81 billion in revenues and US$ 3.6 billion in net income.
- IBM South Africa focuses on providing information technology solutions and services to Central and Southern Africa. In 2002, the subsidiary had approximately 1,350 employees and 350 external contractors.

Business Case

The aim of IBM South Africa's programme is to provide an HIV/AIDS awareness and support programme and to inculcate responsibility among employees, for the well being of all IBM South Africa employees.

- IBM South Africa is aware of the current and future impact of HIV/AIDS on its employees, their families and the communities in which it operates. In addition to these social motivations, the company expects that with a successful treatment programme it could avert 42% of US$ 10.6 million in HIV/AIDS related expenses over the ten-year life of the programme.
- IBM South Africa's 2003 HIV/AIDS workplace budget is US$ 53,000, which corresponds to approximately US$ 40 per employee per year.

Project Description

IBM South Africa's programme focuses on prevention through access to self-serve HIV/AIDS education through interactive software and treatment including Highly Active Anti-Retroviral Therapy (HAART).

- Management approved IBM South Africa's HIV/AIDS policy on 1 October 2001. The policy was revised in early 2003. The policy was developed by the human resources department in consultation with other companies with existing workplace policies. Human Resources worked to ensure that the policy was compliant with all relevant legislation.
- In addition to annual events, condom distribution, and sexually transmitted infection (STI) treatment, IBM South Africa's awareness campaigns focus on providing self-service interactive software to raise employee knowledge and awareness.
- Voluntary Counselling and Testing (VCT) has been available through IBM South Africa's Medical Centre since the early 1980's.
- HIV+ employees gain access to IBM South Africa's treatment programme, including access to Highly Active Anti-Retroviral Treatment (HAART).

Project Evaluation

The company's external service provider for the care, support and treatment programme, Innovir Institute, provides IBM South Africa with bi-annual reports. IBM's HR director and Medical Centre evaluate the results of these reports against the programme's targets. Access to confidential information in these reports relating to HIV infected employees is reserved for the occupational health nurse.

Since the launch of the programme, IBM has noticed that HIV/AIDS- related absenteeism for HIV+ employees has dropped from approximately 25 days to 3 per year.

In the future, IBM hopes to extend the treatment programme to cover dependants.

Business Case

Vision

The aim of the programme is to provide an HIV/AIDS awareness and support programme and to inculcate responsibility among employees, for the well being of all IBM South Africa employees.

Case for Action

IBM South Africa is aware of the current and future impact of HIV/AIDS on its employees, their families and the communities in which it operates. In addition to these social motivations, the company expects that with a successful treatment programme it could avert 42% of US$ 10.6 million in HIV/AIDS related expenses over the ten-year life of the programme.

- In 2001, UNAIDS estimated the HIV/AIDS prevalence in South Africa to be 20.1%. In 1998 IBM contracted Dr Clive Evian of Alexander Forbes' HIV/AIDS research team to estimate IBM's future prevalence based on IBM South Africa's demographics. The initial assessment estimated that in eight years IBM South Africa would have a prevalence of approximately 7%. Since that report, IBM South Africa's demographics have changed, which suggests **that the company's prevalence will peak at approximately 5% in 2006, which corresponds to approximately 80 employees.** In the last seven years, IBM South Africa has experienced four HIV/AIDS-related deaths from its estimated 60 HIV+ employees and five deaths from HIV+ contractors.
- IBM South Africa viewed the **implementation of a treatment programme as in-line with IBM's Corporate Health and Safety Policy**. "IBM has a long-standing tradition of excellence in employee well-being and product safety. The importance we place on these efforts is a result of our commitment to our employees, customers and the communities in which we operate. Like quality, employee well-being and product safety is a fundamental component, a value in our company's strategic vision and critical to our continued success." – *Louis V Gerstner, Jr*
- IBM South Africa estimated that without a treatment programme **the company would incur US$ 10.6 million in HIV/AIDS-related losses over the next ten years**. The company estimated that if employee enrolment in a comprehensive treatment programme increased from 25% of eligible employees in 2001 to 50% in 2010 (with an average of 42%) that the **treatment would require incremental expenditures of US$ 970,000 over the ten years**. IBM estimated that if the treatment programme is successful in reducing missed work and HIV/AIDS related deaths, that the company would **reduce the expected HIV/AIDS-related losses by US$ 4.4 million over the ten-year life of the programme**.
- IBM South Africa estimated that the **economic impact of an employee dying** from AIDS would be: (1) lost investment of US$ 4,700 in skills development; (2) average-case pension and death benefits of US$ 100,000; (3) 25% lower productivity while in the symptomatic stages of the disease. Also, the company assumes an ongoing US$ 1,000 per annum medical aid contribution for the surviving spouse and dependants.

Financing

IBM South Africa's 2003 HIV/AIDS workplace budget is US$ 53,000, which corresponds to approximately US$ 40 per employee per year.

- IBM South Africa's 2002 treatment budget was US$ 43,000, which is expected to rise to US$ 53,000 in 2003, corresponding to approximately US$ 40 per employee per year. The programme is currently running significantly under budget, which has allowed IBM to **invest the savings in prevention and awareness education campaigns**. IBM South Africa believes that it is under-budget because it over-estimated the anticipated prevalence rate as well as the cost of providing treatment.
- IBM South Africa's treatment programme requires that each enrolled employee contribute 20% towards the ongoing cost of the programme, payable directly to the medical service provider. IBM's subsidy to the programme is limited to US$ 2,000 per enrolled employee per year. However, the employee can continue at his or her own expenses should the IBM subsidy be exhausted. Since the launch there has only been one case in 2001 when the annual benefit limit has been exceeded. This is unlikely to re-occur as drug prices have since been reduced.
- IBM South Africa finances this programme out of its annual Welfare Budget. This allowed IBM South Africa to run the programme independently of the employee medical aid programme. As the programme was not in conflict with the Medical Schemes Act the government authority has confirmed the acceptability of this arrangement.

Project Description

Policy

Management approved IBM South Africa's HIV/AIDS policy on 1 October 2001.

The policy was revised in early 2003. The policy was developed by the human resources department in consultation with other companies with existing workplace policies. Human resources worked to ensure that the policy was compliant with all relevant legislation.

- **Non-discrimination:** (1) employees will not be dismissed based on their HIV status; (2) IBM South Africa will not undertake pre-employment testing for HIV.
- **Confidentiality and disclosure:** (1) employees are not obliged to disclose HIV status; (2) status can only be disclosed to a third party with the prior written consent of the infected employee; (3) IBM South Africa's Medical Centre will not divulge the employee's status to other areas of IBM; (4) the employee accesses treatment through an external provider with similar confidentiality and non-disclosure policies.
- **Benefits:** (1) no discrimination in the allocation of employee benefits based the employee's HIV status; (2) **approximately 90% of employees are currently enrolled in IBM South Africa's health insurance** scheme – 100% of IBM South Africa's employees are covered by a medical aid scheme (those which are not on the IBM scheme must be dependants on their spouse's scheme); (3) due to the structure of the programme, **employees do not need to be enrolled in a health insurance scheme to access the programme's benefits**; (4) employees can register for IBM South Africa's HIV/AIDS management programme and qualify for the **annual limit of US$ 2,000 per employee per year**; (4) this benefit includes any chronic medication and blood tests required for the treatment of this condition; (5) dependants may participate in the treatment programme, but must fund 100% of the programme costs; (6) IBM South Africa's medical, death and retirement benefits do not discriminate based on HIV status.
- **Ill-health retirement/disability:** (1) after a six month period, an employee may apply for ill-health retirement benefits; (2) on application the insurer will verify that the applicant meets disability benefit criteria; (3) the disability benefit is part of the IBM retirement plan; (4) the benefit is equal to 75% of the employee's pensionable salary and is annually adjusted for the rate of increase in the consumer price index.
- **Contractors:** Contractors are not eligible for treatment programme benefits, but may gain access to the counselling and awareness campaigns.

Prevention and Awareness

In addition to annual events, condom distribution and STI treatment, IBM South Africa's awareness campaigns focus on providing self-service interactive software to raise employee knowledge and awareness.

- Each year on **World AIDS Day** the country office CEO and other important figures address all of the employees. The discussion includes the current national status on the epidemic as well as IBM's current position.
- On 3 December 2002, IBM launched a voluntary **self-service HIV/AIDS awareness and education campaign using software to target staff, suppliers and contractors**. The interactive software was developed by a South African adult education and training organization, **Self-Empowerment International.** The software is available both on the company's **intranet** as well as kiosks, which are **accessible to suppliers and contractors**. The electronic information kiosks use voice guidance in a number of South Africa's official languages and animated graphics on a touch-screen to **enable even those staff members with no computer skills to access information** about HIV/AIDS.
- Since 2001, IBM South Africa has installed more than 35 **condom dispensers** throughout all of its offices in the country. The dispensers distribute free government male condoms. The company estimates that it distributes **1.5 condoms per employee and contractor per month**.
- Employees with medical insurance have access to treatment for **sexually transmitted infections (STIs)** through their regular external medical providers. Although not common, the employee may also access STI treatment through the company medical centre. Given the large number of employees who access the service through external providers, IBM South Africa does not currently track STI treatment rates.

Project Description (continued…)

Prevention and Awareness (continued…)

IBM does not have a formal community outreach programme, but IBM South Africa supports business unit and employee outreach.

- Along these lines, IBM South Africa has made cash donations of US$ 4,000 to hospices in Cape Town and around Johannesburg as well as donations of computer equipment.
- It also encourages individual business units to support specific community projects. For example, the Business Operations Business Unit launched their own initiative in support of the Starfish Organisation to "turn the tide on AIDS". This initiative will serve to contribute to the nutrition, education, shelter and clothing of many AIDS orphans in South Africa. The Business Unit Team responded with an initial donation of US$ 600. Future support will be made in the form of voluntary monthly contributions from interested employees and the collection of small change at the end of each month.
- The Senior Leadership Team/Management has opened a special fund where they donate a certain percentage of their salaries to assist even more hospices. The funds collected from this management team are used to buy food parcels or other necessities for these hospices.

Voluntary Counselling and Testing

Voluntary Counselling and Testing (VCT) has been available through IBM South Africa's Medical Centre since the early 1980's.

- All employees and contractors may access the service for free during normal business hours.
- Since the programme's launch the **service has tested approximately 480 employees, which corresponds to 36% of all employees**. Furthermore, although treatment is not subsidised, approximately 120, or 34% of contractors have taken advantage of the VCT service.
- Pre-test counselling is held to discuss the purposes behind the test. Post-test counselling is only provided in the event of a positive result. In that case, it addresses the following topics: (1) the implications and need for a second test if the result is positive; (2) details of the treatment programme including a health and lifestyle prognosis.
- There are two nurses in the Medical Centre, trained through a number of on-going workshops, who are available to perform VCT services.

Care, Support and Treatment

HIV+ employees gain access to IBM South Africa's treatment programme, including access to Highly Active Anti-Retroviral Treatment (HAART).

- An independent service provider, Innovir Institute, manages the HIV/AIDS treatment programme. Innovir provides follow-up, monitoring, and treatment. The treatment includes medically appropriate access to **Highly Active Anti-Retroviral Treatment (HAART)**. When medically appropriate, the programme provides treatment for opportunistic infections including tuberculosis.
- The programme has been available to employees as a pilot programme since 1999. The programme was officially launched by the country CEO during a staff meeting on 2 November 2001.
- As of March 2003, the company estimates that approximately 14 employees have enrolled in treatment.

Case-specific HIV/AIDS Resources

Documents

IBM South Africa HIV/AIDS Policy (October 2001)
IBM South Africa Internal Proposal for Funding HIV/AIDS Program (March 2001)
Example Innovir Institute Status Report (January 2003)

Contacts

IBM South Africa	Mrs Dudu Nyamane Director Human Resources Tel.: +27 11 302 9284 E-mail: dudun@za.ibm.com Mr Kurt Wissler (Principal Officer, IBM Medical Aid Society Tel.: +27 11 302-9516 E-mail: kurtw@za.ibm.com Sister Gwynneth Staples Occupational Health Nurse Tel.: +27 11 302-9016 E-mail: gwynnethstaples@za.ibm.com
Self-Empowerment International	Ms Denese Schneider Managing Director Tel. : +27 11 440-0076 E-mail: denese@sei.co.za
Alexander Forbes HIV/AIDS Research	Mr Bernie Clark Tel.: +27 11 269-1118 E-mail: clarkb@aforbes.co.za
Innovir Institute	Mr Eric Benz Managing Director Tel. : +27 11 616-7585 E-mail: epb@innovirinstitute.com

This case study uses the following exchange rate: 10 South African rands to 1 United States dollar.

The World Economic Forum Global Health Initiative Private Sector Case example is developed in collaboration with the featured company. However, GHI member companies and partners, the World Economic Forum and the contributing company do not necessarily subscribe to every view expressed herein. The case is based on a self-reporting model. Although the GHI makes reasonable efforts to ensure the accuracy of the statements, this report should not be viewed as an external audit of the programme described.

World Economic Forum
91-93 route de la Capite
CH-1223 Cologny/Geneva
Switzerland
Tel.: +41 (0)22 869 1212
Fax: +41 (0)22 786 2744
E-mail: globalhealth@weforum.org
www.weforum.org/gobalhealth

WORLD ECONOMIC FORUM

COMMITTED TOIM PROVING THE STATEOF THE WORLD

GLOBAL HEALTH INITIATIVE Private Sector Intervention Case Example

ChevronTexaco partnering with workers and the community to reduce the impact of HIV/AIDS in the workplace in Nigeria

Case categories

Company: ChevronTexaco Industry: Extraction Location: Nigeria Programme: **HIV/AIDS**

Key questions

- How can ChevronTexaco expand its programmes to ensure that it meets its goal of minimizing workplace prevalence and the business impact of HIV/AIDS?
- To what degree is a workforce prevalence and impact assessment required to launch an HIV/AIDS programme?
- How can ChevronTexaco influence the minimum level of care for contract employees?

Overview

Company

ChevronTexaco is a large, international, integrated oil company.

- ChevronTexaco, the second largest US-based integrated oil and gas company, engages in oil and gas exploration, production, refining, supply, transportation and marketing around the world, with operations in nearly 180 countries and territories. In 2001 ChevronTexaco's sales were $104 billion and income was $3.3 billion.
- ChevronTexaco has upstream (extraction) operations in African countries including Angola, Cameroon, Chad, Democratic Republic of Congo, Republic of Congo, Equatorial Guinea, Namibia, and Nigeria. In 2001, the company directly employed more than 55,000 people worldwide.
- Chevron Nigeria Limited (CNL) is 60% owned by the Nigerian Government and 40% owned by ChevronTexaco. CNL's upstream operations produce 517,000 barrels per day from 39 field operations and 6 shallow-water fields. CNL employs roughly 1,800 employees and 3,000 contractors (90% Nigerian nationals).

Business Case

Through proposed interventions, CNL aims to reduce the risk of HIV to its employees, families and business. Although HIV prevalence among workers is less than 2.5%, they are at risk because of a higher prevalence in the community, their poor HIV knowledge, and high risk-taking behaviours.

- In 2001, UNAIDS estimated Nigeria's HIV prevalence to be 5.8%. In 1999, HIV sero-prevalence surveys conducted by the Federal Ministry of Health demonstrated that the prevalence in the communities where CNL workers live were 1-2% higher than the national average. Although CNL did not conduct a worker prevalence assessment, they estimate that their workforce HIV prevalence is <2.5%.
- A knowledge, attitude, and practice (KAP) assessment of workers, and a Participatory Rural Rapid Assessment (PRRA) of community members and commercial sex workers (CSW) indicated that there is a high level of sexual networking amongst these groups.
- Field-based oil workers are considered to be high risk because of their distance from their spouses, their comparatively high disposable incomes, as well as the single sex housing while on location, and the presence of sexual networking at these locations.
- Although CNL did not conduct a formal economic impact assessment, it was determined that investing in the community, families and workers is a necessary and economical method to prevent significant costs associated with a larger scale HIV epidemic.

Programme Description

CNL's HIV/AIDS programmes focus mainly on prevention of the escalation of the epidemic by targeting employees, their families, the community and CSWs, as well as supporting and caring for HIV+ employees.

- Chevron's Workplace AIDS Prevention Programme (CWAPP) focuses on peer education, workplace events, condom distribution, manager and supervisor training, and awareness tools.
- Community prevention programmes focus on workshops for children of employees, joining HIV/AIDS awareness events and working with CSWs.
- CNL offers Voluntary Confidential Counselling and Testing (VCCT) services to its employees; however, only 1% of its workforce took advantage of VCCT in 2001.
- CNL provides support for HIV+ employees through a joint support agreement with government clinics and home based care. Antiretrovirals are used to prevent mother to child transmission (MTC) and for post-exposure prophylaxsis (PEP).
- Capacity building efforts focus on providing funding for the Nigerian Government to provide HIV/AIDS education in schools, and with the media to increase journalists' HIV/AIDS knowledge.

Programme Evaluation

The programme has reached the majority of workers with its education and awareness activities, improved employee health seeking behaviour, increased stakeholder involvement and successfully prevented mother to child transmissions.

CNL will expand its programmes to ensure that it is able to meet the goals stated in its vision of minimizing increases in prevalence and treating HIV+ workers.

Business case

Vision

To prevent HIV/AIDS from significantly impacting CNL Nigeria's profitability, workers and families.

- Given that 97.5% of the employees are HIV-negative, the primary objective is to keep prevalence at or below 2%. This requires prevention programmes targeting workers, their families, community members and CSW.
- For the 2.5% of employees who are HIV-positive, the goal is to work with all major stakeholders to jointly fund and manage the provision of total care and support for employees who have HIV/AIDS.

Case for Action

Through proposed interventions, CNL aims to reduce the risk of HIV to its employees, families and business. Although the HIV prevalence amongst workers is less than 2.5%, they are at risk because of a higher prevalence in the community, their poor HIV knowledge, and high risk taking behaviours.

- In 2001, UNAIDS estimated Nigeria's HIV prevalence to be 5.8%. In 1999, HIV sero-prevalence surveys conducted by the Federal Ministry of Health and NACA demonstrated that the prevalence in the communities where CNL workers live were 1-2% higher than the national average.
- Although CNL did not conduct a worker prevalence assessment, they estimate that their workforce HIV prevalence is <2.5%.
- In 1997, CNL sent a KAP survey to approximately 500 employees and contractors, with a ~75% return rate. The survey indicated that there was a low level of HIV/AIDS knowledge, poor risk perceptions and a high level of sexual networking.
- In 1997, the CNL medical group conducted a rapid assessment survey to assess the community and CSW knowledge, attitudes and behaviours patterns. The test covered the surrounding regions, which correspond to approximately 60% of the labour sending areas for CNL. The survey used pictures to determine the participant's knowledge, attitudes and behaviours, which allowed illiterate people to take part. The rapid assessment also indicated that there was a low level of HIV/AIDS knowledge, poor risk perceptions, and a high level of sexual networking.
- Although CNL did not conduct a formal economic impact assessment it was determined that investing in the community, families, and in workers was a necessary and economical method to prevent significant costs associated with a larger scale HIV epidemic.

Financing

Funding for CNL's HIV/AIDS prevention, care, support and treatment programmes is currently funded by CNL medical budgets. Selected community outreach programmes are funded by the public affairs budget.

Programme description

Policy

Although CNL does not have an explicit HIV/AIDS policy, the programme has adhered to international guidelines since 1999.

- A draft policy is being developed and reviewed, which will address issues like: non-discrimination, confidentiality and non-disclosure, termination, benefits and other key issues.
- The process will involve the union, management and other stakeholders. Currently, union leaders, supervisors and managers are being trained to develop knowledge and the capacity to contribute to this process.

Prevention and Awareness

CWAPP focuses on knowledge transfer, attitude change and behavioural modification.

- **Awareness** is increased through the CWAPP's use of posters, flyers, newsletters, e-mails and campaigns.
- **HIV/AIDS management training programme** for managers, supervisors and union leaders has been offered since 2001. This **full day programme will be required for all new managers and supervisors**. **Persons living with HIV (PLWH)** in the community act as resource persons for this training programme, which addresses positive living, staying negative and the management of the positive employees.
- CNL has had a **peer education** programme since 1997. CNL's medical divisions train peer educators through edu-tainment sessions. Most times, the peer educators share knowledge at lunch, on oil platforms and at bars near the workplace.
- **Male condoms** are available during HIV/AIDS campaigns and events, at all medical consulting rooms and at the tank farm (one of CNL's land-based facilities in Nigeria).

CNL's community prevention since 1999

- Since 1999, CNL has participated in the **International AIDS Candlelight Memorial**, which honours the memory of those lost to AIDS, shows support for those living with HIV/AIDS, raises community awareness, celebrates life and mobilizes community involvement. Also, since 1998, CNL has participated in **World Aids Day** through community advocacy activities. In 2001, at both events, CNL distributed more than 5,000 **free condoms**.
- The CNL **Adolescent Reproductive Health Programme** (CHARP) focuses on workers' children ages 12-19. The programme is an edu-tainment model that addresses issues of adolescent reproductive health, career guidance, violence and role modelling. About 150-200 children and parents have participated in the annual HIV/AIDS workshops. Some of the adolescents who pass through the workshop become members of the Chevron's Lifeline Adolescent Reproductive Education Klub (CLARK). They serve as resource persons for other youth-to-youth programmes and as dramatists and poets in programmes for parents.
- CNL has built and financed the operation of a community health clinic near the tank farm. The clinic provides free comprehensive medical services to the community for in-patient and out-patient services. These services include syndromic management of sexually transmitted infections (STIs) for community members and CSWs

Programme descriptions (...continued)

Voluntary Confidential Counselling and Testing

CNL offers Voluntary Confidential Counselling and Testing (VCCT) to employees on demand since 1999, but only strongly encourages it in the pre-natal clinic for pregnant women.

- In order to receive an HIV test, employees first meet with a CNL doctor and are requested to think about the impact of their choice. The confidentiality of the process is explained to the patient. After a one week waiting period, the employee returns to speak with a counsellor, sign an informed consent waiver and then have their blood tested.
- The employee's status is assessed through a rapid blood test. If it is negative, the employee is immediately notified by the telephone. If positive, a second blood test is conducted and the employee is notified of his or her status the next day. HIV positive employees are offered counselling and referred to the company wellness programme.
- Uptake of pre-natal HIV testing is very high, with approximately 120 women taking the test in 2001 (approximately 99% of pregnant women). However, in 2001, less than 1% of the workforce took advantage of the test.

Care, Support, and Treatment

CNL works with community partners to ensure that HIV+ employees are provided with care and support to manage the disease.

- CNL provides treatment to HIV+ employees and their families through a **joint care management programme** with government health clinics in Lagos. The programme provides: (1) diagnostic support to perform blood tests and assays; (2) drugs for opportunistic infections not available through the government; (3) nutrition counselling.
- CNL also provides **home based medical care** on demand to HIV/AIDS employees, but less than 5% of CNL's estimated HIV/AIDS patients requested the free service in 2001.
- CNL offers **mother to child (MTC)** transmission prevention through comprehensive treatment including the use of anti-retrovirals. The programme is available to employees and their spouses and the point of entry into this programme is VCCT. In 2001, all of the HIV+ women who took advantage of the VCCT programme were successfully offered anti-retroviral treatment. CNL's medical division has a post-exposure policy, which includes **Post-Exposure Prophylaxis (PEP)**.

Capacity Building

CNL supports local HIV/AIDS education for students and journalists.

- In 2001, CNL provided sole funding support for **the African Women's Media Centre's Cyber Training for the Reporting on HIV/AIDS**. The one week training seminar reached 130 journalists from 12 countries
- In 1996, CNL contributed to the funding to the Federal Ministry of Health and to the Ministry of Education in Nigeria, under the supervision of the World Health Organization (WHO) to create an **HIV/AIDS and STI education programme for public school classrooms**. The project trained public health workers, and established a curriculum for teaching HIV/AIDS awareness.

Programme evaluation

Key Success Factors

Since 1994, when CNL first launched its HIV/AIDS programmes, immediately after observing their first HIV+ employee, they have compiled the following learnings.

- Work with **all stakeholders to ensure programme success**: **(1) Work with the labour unions** initially to develop a knowledge base and a trust-based relationship because they will be essential for mobilizing the workers. **(2) Work with management and supervisors** to provide knowledge required to treat HIV+ employees with respect and to destigmatize the disease. **(3) Work with employees and their families** to reach adolescents. **(4) Work with CSW** to deal with high risk pockets of potential exposure.
- The nearly 100% uptake of the VCCT programme for pregnant women is due to the fact that there is anti-retroviral treatment available to protect the baby if the mother is HIV+.
- CHARP is very successful because of the larger number of youths directly involved in the planning and the execution of the programme, coupled with the use of edu-tainment tools.

Self-evaluation Process

CNL's programmes are regularly reviewed through both internal and external venues.

- Two years after the launch of CWAPP, the project team re-evaluated the content and delivery of the education outreach and decided to add VCCT and MTC transmission prevention to the programme.
- Programme effectiveness is regularly reviewed by CNL's medical director. The CNL programme is also reviewed by the regional medical director, CNL management and the corporate medical director, the CNL government and public affairs department and the other stakeholders.
- CNL's medical division presents its workplace and community programmes at both national and international conferences and improves programme elements based on knowledge sharing at these events.

Since 1997, the programme has met many process and outcome goals.

- Since 1997, CWAPP has reached 80% of CNL workers and 40% of the surrounding communities with education, resulting in higher HIV/AIDS awareness.
- There has been a 50% reduction in STIs and patients are self-presenting much earlier in the infection since 1997. Phone-ins and requests for counselling have increased 40% since 1997. Condom demand has increased 40% since 1997.
- CWAPP's multi-stakeholder approach has resulted in increased management attention. Communities are now facing the challenges of HIV/AIDS and the labour union is becoming more supportive.
- MTC prevention services have resulted in no recorded cases of maternal mother to child transmission for workers and their spouses since its launch in 1999.

Future Goals

CNL will expand its current programmes to ensure that it is able to meet the goals stated in its vision of minimizing increases in prevalence and treating HIV+ workers.

- To develop a strong multi-stakeholder partnership with labour unions, employees, the government and contractors to provide funding and resources required to offer care, including antiretrovirals, for HIV+ employees and their families.
- To influence contracting companies to provide similar care and treatment for their workers as CNL provides its employees through increased educational outreach on the business impact of HIV/AIDS.
- To increase partnerships with other stakeholders including government agencies and NGOs in order to amplify already successful programmes.
- To increase worker uptake of VCCT, and increase the care and support capacity for HIV+ employees.
- To participate in business to business peer advocacy focusing on workplace and community HIV/AIDS prevention, care and support programmes.

Case-specific HIV/AIDS resources

Contacts

ChevronTexaco	Dr Steve Simpson Regional Medical Director Luanda, Angola +1 925 842 1111 (phone) stsi@chevrontexaco.com Dr Omatsola Kpiasi CNL Medical Director and Director CWAPP +234 1 2 600 600 x 7047 +234 1 775 6949 (mobile) eokp@chevrontexaco.com Dr Philip Sharples Clinical Standard Advisor +234 1 2 600 600 x 7045 philip.sharples@chevrontexaco.com Dr bode-law Faleyimu Coordinator- CWAPP +234 1 2 600 600 x 2224 bofa@chevrontexaco.com
Nigeria Institute of Medical Research	Dr E. Oni Idigbe Director- Nigeria Institute of Medical Research, Yaba, Lagos 6, Edmond Crescent (Off Muritala Muhammed Way) +234 1 77 44 723 nim@supernet300.com
Nigeria Youth AIDS Programme	+234 1 54 55 368 nyap@home.panafrica.com

World Economic Forum
91-93 route de la Capite
CH-1223 Cologny/Geneva – Switzerland
Telephone (41 22) 869 1212
Fax (41 22) 786 2744
E-mail: globalhealth@weforum.org
www.weforum.org/gobalhealth

Dr. Gabriele Riedner - HIV/AIDS Regional Advisor, World Health Organization Eastern Mediterranean Regional Office

"This is an interesting, informative and excellently written document."

Mr. Diaa Nour El Din - Lecturer, Economics Department, American University in Cairo and former Senior Economist, Economic Research Forum

"This document tackles an important issue for the Arab region, especially in regard to the likely economic implications of an HIV/AIDS epidemic. It should stimulate a prudent private sector response."

Dr. Christophe Longuet - Medical Manager Africa HIV/AIDS, Merck Sharp & Dohme Interpharma

"Congratulations for this very exhaustive work. I subscribe to this analysis."

Mrs. Ilham AbdelHai - HIV/AIDS Regional Coordinator in the workplace, UNWFP Regional Bureau for Middle East, Central Asia and Eastern Europe

"The report is comprehensive and it touched on all the relevant aspects as well as highlighting specific activities the UNDP is intending to organize in this regard."

Dr. Sulieman Sulieman – Programme Specialist, Technical and Vocational Education, UNESCO Regional Office for Education in the Arab States

"All professionals working in this field will benefit from this study."

Mr. Jean Michel Delmotte, UNICEF Representative, HIV/AIDS UN Theme Group, Tunisia

"The document is indeed an important contribution to our initiatives aiming at supporting the MENA countries."

Dr. Ashraf Azer, Medical Doctor & Graduate from the Senghor University - Alexandria

"The region will indeed benefit from such a leading research work. This enlightening research work will hopefully engage the Private Sector in its broader definition to a much needed and enhanced scaled up response to HIV/AIDS in the region at a time its 300% infection pace is becoming one of the most alarming and for which indeed a uni-sectoral response won't suffice."

HIV/AIDS Regional Programme in the Arab States
United Nations Development Programme

1191 Corniche El Nil, World Trade Centre
Boulac, Cairo, Egypt
P.O. Box: 982, Post Code: 11599
Tel.: +202 5791 733
Fax: +202 5784 847

www.harpas.org