UNGASS COUNTRY PROGRESS REPORT 2010

MINISTRY OF HEALTH
KINGDOM OF SAUDI ARABIA

Narrative Report

January 2008–December 2009

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I. Glossary of terms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
KSA	Kingdom of Saudi Arabia
MARPs	Most at risk populations
M&E	Monitoring and Evaluation
MENA	Middle East and North Africa
MOH	Ministry of Health, Kingdom of Saudi Arabia
MOHE	Ministry of Higher Education
MSM	Men Having Sex With Men
MTCT	Mother to Child Transmission
NAP	National AIDS Program – Ministry of Health, Kingdom of Saudi Arabia
NGOs	Non governmental Organizations
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RST	Regional Support Team
STI	Sexually Transmitted Infection
UNAIDS	The United Nations Joint Programme on HIV/AIDS.
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
WHO	World Health Organization

II. Status at a glance

(a) the inclusiveness of the stakeholders in the report writing process

This report was prepared with extensive input from the various HIV/AIDS stakeholders involved in the prevention, surveillance, education, treatment and advocacy efforts at the KSA. The MOH at KSA led the efforts with the support and patronage of the Assistant Deputy Minister of Health and Preventive Medicine, Dr. Ziad Memish. Support was also extended by the Director of Parasitic and Infectious Diseases at the MOH, Dr. Ra'afat Al-Hakeem. The NAP manager at the KSA, Dr. Khaled Al-Wah was also instrumental in charting the UNGASS 2010 reporting journey towards successful completion. In addition to the information provided by the MOH and other governmental organizations, the report includes extensive input from non-governmental stakeholders to enhance inclusiveness and improve the validity and accuracy of reported findings.

The input of NGOs was also pivotal in this report and has complemented the information reported by MOH and other governmental agencies. The contribution of Dr. Sana'a Filimban, the Chairman of the Board of Directors of the Saudi Charity Association for AIDS patients, is indeed commendable and has brought forward a unique and valuable perspective to the UNGASS 2010 report. The important contribution of Mayssam Tamim, Resident Coordinator UNDP, is also worthy of acknowledgment. Special regards are to be extended to PLHIV and AIDS patients that were brave enough to bring forward their perspective into the reporting process.

Last but not least, the KSA MOH would like to acknowledge the valuable contribution of the UNAIDS international consultant, Dr. Mohamad Alameddine, throughout the UNGASS 2010 report preparation.

(b) the status of the epidemic

The prevention and treatment of HIV/AIDs is a priority issue at the KSA. It has gained popularity over the last few years with significant public investments dedicated to responding to the AIDS epidemic. Important milestones have been achieved in AID prevention and treatment efforts over the last few years, yet additional challenges need to be addressed in the future. The mandatory testing for HIV and the national surveillance system are unearthing an increased incidence of HIV at KSA. Many governmental and non-governmental stakeholders agreed that the discovered and reported incident cases might under estimate the true incidence of HIV at the KSA.

The total number of HIV positive cases at KSA in 2008 was 13,926; 3,538 (25.4%) are KSA nationals and 10,388 (74.6%) were non-nationals. Note that 'heterosexual relationships' was the mean through which HIV was contracted in 88% (428) of the confirmed cases among Saudi nationals in 2008. An additional 9% (43) of cases were among IDUs. The remaining 3% (18 cases) were transmitted from mothers to their children.

It is important to pinpoint that 37% and 46% of incident cases among Saudi nationals and non-nationals, respectively, were discovered in Jeddah; the province has indeed the highest number of incident cases compared to the 19 other provinces of KSA in 2008.

(c) the policy and programmatic response

Significant efforts have been exerted in response to the AIDS epidemic at KSA including:

1- Increased political support from key national stakeholders and decision makers at the MOH and other sectors, evident in public announcement of HIV/AIDS as a national priority and public advocacy for the rights of PLHIV and AIDS patients.

2- The opening of 20 VCT clinics dispersed across the KSA
3- The opening of 4 new ARV treatment centers in KSA in Al-Jouf, Al-Maddenah Al-Monawwara, Al-Ahsaa and Aseer. These clinics are added to the four existing clinics in KSA (Jeddah, Riyadh, Dammam and Gazan).
4- The inauguration of two NGOs dedicated to the support of PLHIV and AIDS patients; the first in Jeddah (the Saudi Charity Association for AIDS patients) and the second in Riyadh (the philanthropic organization for the care of AIDS patients in Riyadh).
5- The drafting of a bylaw to protect the human and civil rights of AIDS patients at KSA

(d) UNGASS indicator data in an overview table

Serial	Indicator	Remarks
Reported Indicators		
1	Indicator 1: Domestic and International AIDS Spending	Approximately 75 million riyals (20 million USD) in public funding; 50% of which is dedicated to buying ARV drugs.
2	Indicator 2: National Composite Policy Index	Completed
3	Indicator 3: Percentage of donated blood units screened for HIV in a quality assured manner	100% of the donated blood units at KSA are screened in a quality assured manner. The central blood bank at the MOH, KSA uses the standard operating procedures of the American Association of Blood Banks. The same association provides external quality assurance reviews to the Saudi blood bank. In year 2009, 138 cases out of 433,441 were HIV positive (0.03%).
Indicators with no information to report on/ Irrelevant to KSA		
4	Indicator 4: Percentage of Adults and Children with advanced HIV Infection receiving ART	Denominator estimates are not available. In 2009, 1125 adults and children with advanced HIV infection received ARV therapy in accordance with the nationally approved treatment protocols. Note that this represents a 23% increase in the number of individuals receiving ARV therapy compared to 2008 figures (865).
5	Indicator 5: Percentage of HIV-positive pregnant women who receive ARV to reduce the risk of MTCT.	Denominator estimates are not available. Note that the total number of HIV-infected pregnant women who received ARV to reduce MTCT in 2008 was 44, divided by ARV regimen as follows:

		1- 8 women on Single-dose Navirapene only 2- 15 women on prophylactic regimens using combination of two ARVs 3- 21 women on prophylactic regimens using a combination of three ARVs
6	Indicator 6: Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	The NAP office did not keep record of required data on this indicator. The TB program reports a total of 17 incident HIV cases among the 4125 confirmed TB cases in KSA in 2009 (0.4%).
7	Indicator 7: Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	Indicator is relevant but there are no population based surveys to populate it. The establishment of VCT clinics and mandating premarital testing have increased the number of people testing for HIV. Monitoring data from the VCT clinic in Jeddah indicate that 182 out of 255 individuals (71.4%) came back for their test results in 2009.
8	Indicator 8: Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results	There are no behavioral surveys providing the required data for this indicator. It should be noted though that prostitution and homosexuality are very rare at KSA in light of the religious, social and cultural fabric of the country. Sentinel surveillance of STI is starting to gather behavioral data from primary health care clinics in every region of the KSA. There are some questions incorporated into the confidential case reporting form investigating sexual habits and risky behaviors. This reporting system is expected to grow into hospitals over the next few years. There are also future plans to mandate HIV testing for individuals diagnosed with STIs.
9	Indicator 9: Percentage of most-at-risk populations reached with HIV prevention programs	There are no behavioral or special surveys to provide the necessary data for this indicator. Note that the introduction of VCT clinics and future plans to increase their number might help provide a venue for individuals with risky behavior to test their HIV status. Note that FSWs and MSMs are not acknowledged as a sub-category of MARPs at KSA. Also note that condom distribution is illegal at KSA and could be viewed as a strategy to encourage extra-marital relationships, though condoms are widely available for purchase in all pharmacies. In addition, it is illegal to run needle exchange programs at the KSA. Drug addicts are referred to rehabilitation facilities for appropriate treatment.
10	Indicator 10: Percentage of orphans and vulnerable children	The indicator is irrelevant to KSA's epidemic context as the country has a low prevalence of HIV.

	aged 0-17 whose households received free basic external support in caring for the child	
11	Indicator 11: Percentage of schools that provided life-skills based HIV education within the last academic year	There are no school surveys providing relevant information regarding this indicator. Note that there is evidence that education about AIDS is integrated into the curricula of all secondary schools at KSA but the number of educational hours is less than 30 and the education is focused on raising awareness and is not life-skill based.
12	Indicator 12: Current school attendance among orphans and non-orphans aged 10–14	Indicator is irrelevant to the epidemic context at the KSA
13	Indicator 13: Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	No population based surveys have been carried out to supply the needed data for this indicator. Evidence of serious misconceptions about AIDS risk factors and modes of transmission surfaced in the MENA HIV/AIDS epidemiology Synthesis Report.
14	Indicator 14: Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	There has been no behavioral or general population surveys carried out at KSA to help populate this indicator. Note that it is very difficult to identify FSWs and MSMs as a sub-category of MARPS since prostitution and homosexuality are illegal and are highly stigmatized at KSA. Note that Assessing the knowledge about HIV prevention among IDUs is an identified priority.
15	Indicator 15: Percentage of young women and men who have had sexual intercourse before the age of 15	Sex is illegal outside the wedlock at KSA. Religious, cultural, social and legal restrictions prevent sexual activity for individuals younger the 15 years. Surveying school attendants might be necessary to substantiate the above mentioned assumptions.
16	Indicator 16: Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	Indicator is irrelevant to KSA's epidemiologic context. In addition, it is illegal in Saudi Arabia to have sex with multiple partners unless within the boundaries of marriage. Individuals found guilty of adultery will be prosecuted and penalized. This indicator is not culturally appropriate.
17	Indicator 17: Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last sexual intercourse	Indicator is irrelevant to KSA's epidemiologic context. In addition, it is illegal to have sex with multiple partners at KSA unless within the boundaries of marriage. Individuals committing adultery are prosecuted and penalized. Promoting the use of condoms among the youth or the general population is deemed culturally unacceptable and inappropriate,

		though condoms are available for purchase in any pharmacy.
18	Indicator 18: Percentage of female and male sex workers reporting the use of a condom with their most recent client	Indicator is irrelevant and inappropriate at KSA. Prostitution is a crime that leads to prosecution and punishment. Although the presence of prostitution can not be ruled out in KSA, it is very rare and is hidden in the society. It is extremely difficult to map out the existing cases of FSWs.
19	Indicator 19: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Indicator is irrelevant and inappropriate at KSA. Homosexuality is deemed as a criminal social evil that is highly stigmatized. MSMs are prosecuted and penalized. The society highly discourages homosexuality. The few cases of MSMs are usually hidden and are extremely difficult to map out.
20	Indicator 20: Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	There are no surveys to help populate this indicator. Note that although condoms are available for purchase in all pharmacies, promotion of condoms among IDUs has not been approved at KSA yet.
21	Indicator 21: Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	No behavioral surveys have been carried out to gather relevant information for this indicator. Note that needle exchange programs are illegal at the KSA.
22	Indicator 22: Percentage of young people aged 15-24 who are HIV-infected	The indicator is irrelevant to the epidemiologic context of the KSA.
23	Indicator 23: Percentage of most at risk populations who are HIV-infected	Prostitution and homosexuality are illegal at KSA. FSWs and MSMs are not acknowledged as a sub-category of MARPs. HIV prevalence among FSWs and MSMs was never assessed. There are no recent sentinel surveillance data on IDUs to populate this indicator. Note that a 2007 survey on a representative sample of 1500 IDUs revealed a prevalence rate of 0.27%.
24	Indicator 24: Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of ART	Program monitoring does not regularly collect the relevant information for this indicator from ARV treatment sites. There is difficulty in following up AIDS patients receiving ARV treatment longitudinally throughout the course of their treatment. The presence of an electronic reporting system could help facilitate monitoring patients on ARV treatment.
25	Indicator 25: Percentage of infants who are born to HIV-infected mothers who are infected	Program monitoring does not regularly collect the relevant information for this indicator from PMTCT treatment sites. In addition, denominator estimates have not been generated yet for this indicator.

III. Overview of the AIDS epidemic

Overview of Literature

Literature reports that the first case of AIDS at the KSA was diagnosed in 1984 at King Faisal Specialist Hospital and research center in Riyadh (Alrajhi, 2004). Evidence and early reports pointed to the fact that the outbreak of early cases was due to transfusion of infected imported blood. Blood importation was subsequently banned. Indeed, it is reported that multi-transfused patients have contributed to the majority of cases of HIV infections in KSA during the first 10 years of its outbreak at the kingdom. Hence, hemophiliacs, thalassemics and blood transfusion recipients were the first victims of HIV at the KSA. It was reported that the rate of infection due to infected blood has dropped to zero since 2001 (Madani et al., 2004). Nowadays, the main risk factor lies in extramarital heterosexual relations of married men, who transmit it to the spouses, and who might subsequently transmit it to the children (perinatal infection). Other risk factors include injecting drugs and homosexual relations.

Over the last two decades there have been some shy attempts to measure the prevalence of HIV at the KSA, yet the exact prevalence of the epidemic in the KSA has been always hard to underscore. This is because HIV/AIDS is a syndrome that is linked to sexual promiscuity and public information on the issue in a conservative country is not readily available.

Nonetheless, scattered reports are available and some figures and estimates on HIV/AIDS in the KSA were presented over last few years. In a 2003 report by the UNAIDS, it was estimated that 0.3% of the population in the KSA is HIV positive. According to this, a population of 15,590,000 nationals and 5,260,000 expatriates is estimated to have 45,000 individual that are HIV positive (Alrajhi, 2004). The same author highlighted the fact that surveillance still faces many challenges at KSA, including under-reporting and difficulty reaching high risk groups, added to the fact that there is some difficulty reaching high risk groups (ex. drug users).

A study published in 2004 presented the results of 18 years of HIV surveillance activities conducted between 1984 and 2001. The results confirmed a total of 6,046 cases of HIV infection, among which 21.3% only were Saudis and 78.7% were non-Saudis. Of all infected patients, 71.6% were males; 41.1% were aged 30 to 39; and 33.5% were aged 20 to 29. The same study reports that 57.1% of patients indicated that they did not know the reason why they were infected and 30.4% said the reason was a heterosexual contact (Madani et al., 2004).

The numbers and reported trends presented by Madani et al. (2004) were updated and confirmed by Al-Mazrou et al. in 2005. The authors described the pattern and characteristics of HIV/AIDS cases at the KSA between 1984 and 2003. They argue that as of 2003, 1,743 Saudi nationals and 6,064 non Saudi were infected with HIV. Among the nationals, 872 were AIDS cases. Males accounted for 77% of all cases, and adults aged 15 to 49 accounted for 78% of all infected cases. According to Al-Mazrou et al. (2005), 46% of HIV/AIDS cases were infected through sexual activity. Most cases (67%) were registered in Jeddah, Riyadh and Dammam. Alrajhi, Halim & Al-Abdely (2006) further added that females may be younger, compared to males, at diagnosis. Yet, it is important to pinpoint that these estimates were unofficial and could not be verified.

Table 1. Progression of the epidemic in the KSA between 2004 and 2007

Goal Indicators	**2004**	**2005**	**2006**	**2007**
No. of HIV cases (cumulative)	8,919	10,120	11,510	12,652
Percent increase from year t+1 and year t		13.5%	13.7%	9.9%

Source: UNDP/MoEP, 2008 – Percentage increases were calculated by the authors of this report

A 2008 UNDP report (in collaboration with the Ministry of Economy and Planning) on a Human Development Project indicated that by the end of 2007, the cumulative number of reported cases reached 12,652 (3,033 citizens and 9,619 expatriates). Detailed numbers of the progression of the epidemic between 2004 and 2007 are presented in Table 1. In 2007, 1,142 HIV positive cases were reported (767

expatriates and 375 citizens). Within the latter category, 5% were below 15 years old, 78% were 15 to 49 years old , and 17% were more than 49 years old (UNDP/MoEP, 2008). Please check Table 1.

In June 2006, official sources announced that 10,000 people in Saudi Arabia were HIV positive or had AIDS. Many doctors challenged the official numbers (Fattah, 2006). Note that official reports are often accompanied by a disclaimer indicating that reported numbers are largely tentative and might be downsized because of the social stigma surrounding this issue in the KSA (Al Haddad & Billing, 2009).

A comprehensive report characterizing the HIV / AIDS epidemiology in the MENA region estimated that at the KSA, the prevalence rate of HIV is as follows: 0.15% among IDUs (Njoh and Zimmo, 1997); 1.1% among TB patients (Al-Rajhi et al, 2002); 0.0% to 0.02% among blood donors (El-Hazmi, 2004; Alamawi et al., 2003) and 1.3% among multi-transfused thalassaemic and sickle cell patients (El-Hazmi and Ramia, 1989). This category was classified in the report as a population at risk of parental HIV acquisition. With respect to the mode of transmission for HIV in the KSA literature reports the following: 37.9% to 46% through heterosexual relations; 2.5% to 5% through homosexual relations; 1.3% to 2% through injecting drug transmission; 25% to 26% through blood or blood products transmission and 6.5% to 12% through mother to child transmission (Al-Mazrou, Abouzeid and Al-Jeffri, 2005; Alrajhi, Halim and Al-Abdely, 2004).

A 2008 Human Development report set a target to halt and begin to reduce the rate of incidence of HIV/AIDS by 2015. It was reported that it was “expected” that the target will be achieved and that the current status of supporting environment was “good” (UNDP/MoEP, 2008). The report argues that despite the large number of expatriates in the country, efforts made to combat HIV/AIDS have succeeded in controlling it and halting its spread. Noteworthy is the significant decline in the morbidity rates (by 80%) among patients receiving continuous treatment at specialized AIDS treatment centers (UNDP/MoEP, 2008).

There is a dearth of studies examining the knowledge and attitudes of individuals at KSA towards HIV. Al-Mazrou et al. (2005) reported that in the KSA paramedical students, primary healthcare users, men in management training institute and bus drivers had a low comprehensive knowledge of HIV/AIDS. Generally, paramedical students in the KSA were reported as being highly misinformed on the issue (e.g. 49% of healthcare workers identified kissing as a mode of transmission), and were also identified as the population holding negative attitudes towards people living with HIV /AIDS (Al-Mazrou, Abouzeid and Al-Jeffri, 2005).

Overview of the AIDS epidemic at KSA nowadays[1]

HIV incidence and prevalence data for January 2009 to December 2009 was still being compiled at the time of the write up of this report. The latest available information was for the period of January 2008 to December 2008.

As noted under section II (b), the total number of HIV positive cases at KSA in 2008 was 13,926. In terms of nationality, 25.4% (3,538) of these cases were KSA nationals and 74.6% (10,388) were non-nationals. It is important to note that it is the national policy at KSA to report statistics only for KSA nationals as most non-nationals will be referred for care and treatment at their country of origin.

There was a total of 1274 indent HIV cases at KSA in 2008, 505 (39.6%) of which were among KSA national and 769 (60.4%) of which were among KSA non-Nationals. This resembles a 12% increase in the number of incident cases at KSA compared to year 2007 (1142). Note that the incidence increase was most noticeable among KSA nationals with a 35% increase in the number of incident cases in 2008 compared to 2007 numbers; 505 versus 375, respectively. This increase could be attributed to the newly enforced policy mandating premarital testing for HIV, which

[1] Note that the source of all the reported numbers in this section is the NAP office at the Department of Preventive Medicine at the MOH, KSA

discovered 46 new HIV positive cases, as well as, the mandatory testing of all prisoners. Please check the Table 2 for additional details on HIV positive incident cases at KSA in 2008.

Table 2. Distribution of Incident HIV cases in KSA by nationality and gender (2008)

Nationality/ gender	Saudi		Non-Saudi		Total	Percent
	Number	Percent	Number	Percent (%)		
Male	426	84%	417	54%	843	66%
Female	79	16%	352	46%	431	34%
Total	505	100%	769	100%	1274	100%

Heterosexual relationships was the most common mean through which HIV was contracted among Saudi nationals in 2008, followed by intravenous drug injection and mothers to child transmission. Please see table 3 below.

Table 3. Distribution of Incident HIV cases in KSA among KSA nationals by means of contraction, age group and region (2008)

Means of HIV contraction among KSA nationals (2008)	Number (%)
Heterosexual relationships	445 (88%)
Intravenous injection of drugs	43 (9%)
MTCT	17 (3%)
Total	555 (100%)
Age distribution of incident HIV positive cases among KSA nationals (2008)	Number (%)
<15 years	17 (3%)
15-49 years	471 (85%)
>50 years	67(12%)
Total	555 (100%)
Percent distribution of incident HIV positive cases among KSA nationals by region (2008)	Percentage
Jeddah	37%
Riyadh	25%
Eastern Region	8%
Remaining KSA provinces	30%
Total	100%

Table 3 also exhibits the distribution of incidents HIV cases in KSA by age group in 2008. Note that the vast majority of incident cases in 2008 belonged to the age group 15-49, followed by individuals more than 50 years old and only 17 cases that were less the 15 years old.

It is important to pinpoint that 37% and 46% of incident cases among Saudi nationals and non-nationals, respectively, were discovered in Jeddah; indeed the province has the highest number of incident cases compared to the 19 other provinces of KSA in 2008. Note that the three regions of Jeddah, Riyadh and Eastern region accounted for 70% of incident HIV cases in KSA in 2008.

In 2007, a sero-prevalence survey of five identified risk groups was carried out over a 12 weeks period at six main cities in KSA (Riyadh, Jeddah, Makah, Dammam, Tabouk and Gazan). The five risk group in this survey included:

(1) IDU attendants of drug rehabilitation centers (identified as high risk for HIV);
(2) Individuals with STDs attending of STDs clinics (identified as high risk for HIV);
(3) Pregnant females attending antenatal clinics (low risk for HIV);
(4) Attendants of tuberculosis treating centers (low risk for HIV); and
(5) Blood donors in blood banks over the timeframe of the study (low risk for HIV).

Table 4. Distribution of participants in the 2007 sentinel surveillance study by city and risk group

City/ risk group	Patients with STDs	IDUs	Pregnant women	Blood donors	TB patients	Total
Riyadh	250	250	400	300	300	1500
Jeddah	250	250	400	300	300	1500
Makah	250	250	400	300	300	1500
Dammam	250	250	400	300	300	1500
Tabouk	250	250	400	300	300	1500
Gazan	250	250	400	300	300	1500
Total	1500	1500	2400	1800	1800	9000

Sample sizes, adopted according to the WHO recommended minimal appropriate sample size for each sentinel site, comprised of a total of 9000 participants divided as

illustrated in Table 4. All the participants in this study were new attendants to the sentinel sites aged 15-60 years**.** Note that unlinked anonymous testing of blood samples for HIV via rapid simple assay with ELISA was used in this survey.

The study revealed that sero-prevalence rates of HIV among STD clinics attendants and drug rehabilitation centers attendants (high-risk groups) were 0.67% and 0.27% respectively. It was 0.0%, 011% and 0.11% among attendants of antenatal clinics, TB treating centers and blood banks (low-risk groups), respectively. See Table 5. Worth investigating is the relatively high HIV prevalence among STD patients in Riyadh.

Table 5. Number and proportion of HIV positive cases by City and Risk group

City	Patients with STDs		IDUs		Pregnant women		Blood donors		TB patients	
	No	%	No	%	No	%	No	%	No	%
Riyadh	7	2.8	1	0.4	1	0.3	0	0	0	0.0
Jeddah	3	1.2	4	1.6	0	0.0	0	0	2	0.67
Makah	0	0.0	0	0.0	0	0.0	0	0	0	0.0
Dammam	0	0.0	1	0.4	1	0.3	0	0	0	0.0
Tabouk	0	0.0	0	0.0	0	0.0	0	0	0	0.0
Gazan	0	0.0	0	0.0	0	0.0	0	0	0	0.0
Total	10	0.67	6	0.27	2	0.11	0	0	2	0.11

IV. National response to the AIDS epidemic

Considerable progress has been achieved in KSA's national response to the AIDS epidemic over the last few years. The sections below highlight the most important developments in 2008 and 2009.

(a)Political leadership & supportive policy environment

There is an excellent degree of political support from leaders and policy makers to the national efforts to curb the spread of HIV and provide care and support services to AIDS patients. On a regular basis, governmental officials speak publicly and favorably about HIV in major domestic forums. For example, the Minister of Culture and

Information, H.E. Abdul Aziz Al-Khoja, sponsored and attended the World AIDS day conference in January 2010 and spoke publicly in support of the rights of AIDS patients. In the conference, the Minister reiterated his full commitment to boost the awareness efforts about AIDS, to fight the social stigma and to protect the rights of PLHIV and AIDS patients. Another example, relates to the Assistant Deputy Minister of Health and Preventive Medicine, Dr. Ziad Memish, declaring publicly that fighting the spread of HIV and providing excellence in clinical service is a national priority at an AIDS/TB workshop organized in Riyadh in February 2010.

Perhaps one of the most encouraging examples highlighting the supportive policy environment is the licensure and support of AIDS NGOs in Jeddah and Riyadh. Such an endorsement is an evident testament to the resolve of political decision makers to promote the wellbeing and rights of PLHIV and AIDS patients at the KSA.

The political support is also evident in the approval and funding of AIDS programs including the planning and implementation of the syndromic approach for STIs, establishing of VCT clinics and the endorsement of a 5-years strategic plan for NAP (2010-2015).

Last but not least, it is noteworthy that a bylaw protecting the human and civil rights of people living with HIV and AIDS patients is going through formal approval processes and is expected to be approved over the next few months. Such a bylaw, will guarantee the rights of PLHIV and AIDS patients for education, employment and proper treatment.

(b) Prevention programs

The KSA has significantly expanded its HIV screening efforts with the addition of mandatory premarital screening in 2007 as well as screening for prisoners and detainees.

Worth highlighting is the growth in testing and counseling efforts at KSA with the establishment of 20 VCT clinics dispersed around KSA. For example, one fixed and one mobile VCT clinics were established in Jeddah in 2008. The two clinics screened a total of 2,363 individuals in 2008-2009 (92% males and 8% females) and confirmed a total of 38 HIV positive cases along the same period of time. All individuals visiting the VCT clinics received pre-counseling from a nurse and all HIV positive patients were referred for treatment. Note that the mobile VCT clinic was set in exhibition centers, malls, beach areas and other locations heavily attended by teenagers and youth.

(c) Care, treatment and/or support programs

KSA offers a universal free, comprehensive and unlimited access to AIDS treatment to all Saudi patients. Note that most non-Saudis diagnosed with AIDS are deported to their country of origin, yet an estimated 15% of them are also treated free of charge in KSA. Those are individuals that are born in KSA or have considerable ties to the KSA (e.g. a non-Saudi married to a Saudi woman). The logic for deporting non-Saudis diagnosed with AIDS relates to the fear that they might develop resistance should treatment be initiated in KSA and discontinued upon return to home country.

The scaling-up of treatment and support programs at KSA is most evident in the opening of four new ARV treatment centers in KSA in 2009 (Al-Madeenah Al-Monawwara, Al-Jouf, Al-Ahsa and Aseer). Note that KSA currently has eight ARV treatment centers dispersed around the various regions of the country.

Scaling-up support programs is also evident in the inauguration of two NGOs for the support of AIDS patients. One NGO located in Jeddah (The Saudi Charity Association for AIDS patients) and the second in Riyadh (the philanthropic organization to care for AIDS patients in Riyadh).

V. Best practices

A number of best practices warrant highlighting in KSA's response to the AIDS epidemic over the last two years, including:

(1) The inauguration of two NGO providing vital support to PLHIV and AIDS patients. These NGOs are presenting much needed support services to PLHIV and AIDS patients including social, economic, emotional, psychological and other types of support. For example, the NGO in Jeddah is running support groups for AIDS patients, organizing social gatherings, providing economic support, running a matrimonial and job-match programs. Following the Saudi example, such NGO should not only be authorized to operate but also should be endorsed and supported in other countries in the Gulf region.

(2) The establishment of 20 VCT clinics dispersed around the Saudi territory. In addition to the provision of much needed confidential testing services to both KSA nationals and expatriates, these clinics provide IEC services to all clinic visitors, through the pretest counseling. They also provide counseling and referral services to individuals testing positive for HIV. Other countries in the region, that do not have VCT clinics, can learn from the experience of KSA in that regard.

(3) The support exerted by politicians and decision makers to the rights of AIDS patients and PLHIV is exemplary. Indeed, embarking on a formal process for the passage of a bylaw protecting the rights of AIDS patients and PLHIV is an important step forward that constitute and example to follow to other countries in the region that do not have such laws.

VI. Major challenges and remedial actions

Despite the multiple successes that KSA's response to the AIDS epidemic has witnessed over the last two years, a few challenges remain on the agenda of decision and policy makers and might require, under the patronage of the MOH, a concerted effort

between the various governmental and non-governmental stakeholder in the country, including:

(1) There is an urgent need for behavioral, BBS and/or population based studies to help identify the main groups and behaviors associated with new infections, ensure a shared understanding of the "drivers" of the epidemic, and clearly link prevention interventions to this information. The MOH identifies the need for such surveys as a programmatic priority incorporated in the next cycle of strategic planning for the NAP. The technical support from international partners would be highly appreciated in that regard.
(2) There is a need to investigate, in collaboration with other sectors (health, education, social affairs, etc.); the socio-vulnerabilities that might influence further HIV transmission, and barriers to accessing and using HIV prevention services. Inter-sectoral collaboration is planned to respond to this need.
(3) Although there is a single national AIDS Program in KSA, the services and functions of this program are fragmented under multiple MOH departments with varying degrees of coordination. This often hinders planning and implementation efforts and slows down the execution of predetermined strategic objectives. For example, the NAP program (under the preventive medicine department at the MOH) has little say with respect to the types/quality of HIV test kits that should be used since this falls under the jurisdiction of the laboratory department. The NAP program has also limited say with respect to ARV drugs that should be rendered since this falls under the jurisdiction of medical supplies. Streamlining the processes related to the NAP is a necessity identified by the MOH. Proper action on that front will require time.
(4) More effort could be exerted with respect to investigating the modes of transmission of HIV and identification of MARPs. Note that under Islamic penal code, prostitution and homosexuality are considered criminal acts that could lead to punishment and imprisonment. While, utmost respect are paid to the religious and cultural beliefs at KSA, optimal response to the epidemic requires acknowledging the presence and identification of high-risk groups such as MSMs

and FSWs. The MOH is fully aware for the need to identify the various MARPs and is working on that front. Yet, the acknowledgement of FSWs and MSMs will require a lot of time as they are related to deep rooted societal, cultural and religious values.

(5) Optimal response to the AIDS epidemic requires the build up of a strategic alliance between the MOH, NGOs, educational/research facilities and international organizations. The MOH in Riyadh acknowledges the need to strengthen the level of cooperation and coordination with non-governmental stakeholders and representatives of the civil society.

(6) Evidence from other jurisdictions proves that NGOs and civil society organizations have often carried a successful track record with respect to dealing effectively and efficiently with high risk groups that may exist to some degree in Saudi Arabia, including MSMs, FSWs and migrant populations. The MOH acknowledges the need to enhance the representation of NGOs, PLHIV, academicians/researches and international organizations in the committees and formal structure that are shaping the strategy and planning activities for HIV at KSA.

(7) There is a need to enhance the staffing level of the NAP office at the MOH in Riyadh, as well as strengthen the technical qualifications of the employees. The technical expertise of NAP staff is being gradually scaled up through local and international course, workshops and training programs. The number of full time staff will be increasing on as needed basis.

(8) IEC programs need to be expanded and strengthened in order to improve the awareness of the population about AIDS and help reduce the stigma against PLHIV and AIDS patients. Special attention needs to be dedicated to school children and teenagers who do not appear to be receiving optimal education about HIV. The MOH acknowledges this need and will be working towards a concerted effort with other stakeholders to boost up IEC programs, especially those targeting the youth.

(9) There is an obvious need to strengthen the HIV M&E capacity at KSA. This could be an area were capacity building effort could be pooled. The help of

international organizations and education institutions will be sought to help build the M&E capacity at KSA.

VII. Support from the country's development partners

Based on the discussions in the above mentioned sections, a number of recommendations and improvement opportunities arise that are best carried out in collaboration with international development partners, including:

1- The proper Monitoring and Evaluation of AIDS in KSA requires the MOH to build a strategic alliance with three main stakeholders: International organizations (especially UNAIDS), NGOs with interest in AIDS and academic institutions. UNAIDS leadership plays a dominant role in bringing those strategic partners together to build trust and negotiate the terms of this strategic alliance.

2- The KSA does not have reliable behavioral or population based studies. MOH stakeholders, including the Deputy Minister of Health and Preventive Medicine and the NAP manager are convinced of the value of such studies and are looking for external technical support to help initiate them. UNAIDS could play a leading role in providing technical support to the MOH and training programs to the staff in order to initiate these studies. Note that the cooperation of the stakeholder outlined above is essential for the success of behavioral and population based surveys.

3- There is a consensus among stakeholders that more efforts should be dedicated to raising the awareness about AIDS at KSA. There is a serious lack of knowledge coupled to deep routed misconceptions in the society leading to the continued spread of the disease and a strong stigma against AIDS patients and PLHIV. The MOH and other stakeholder are willing to dedicate efforts towards raising public awareness and decreasing stigma but would need the help of international partners in organizing and diversifying these efforts. UNAIDS could possibly provide advice and technical support to KSA to support awareness raising efforts.

4- UNAIDS could indeed extend much needed support to strengthen the M&E environment and capacity at the MOH, including but not limited to:
    a. Identification of a minimum dataset of indicators that both public and private institutions should be reporting on.
    b. Providing advise on the creation of proper committees and formal structures that could lead HIV/AIDS M&E activities at KSA
    c. Enhancing the M&E technical expertise by training staff members at the MOH in Riyadh and other provinces
    d. Providing advice on the creating of proper monitoring tools and the means to ensure endorsement and standardization across various provinces
    e. Extending support on the creation of an electronic reporting system that could boost M&E efforts

VIII. Monitoring and evaluation environment

KSA has taken some good steps towards strengthening the HIV/AIDS M&E environment and infrastructure, such as the creation of a single national M&E plan. Yet, there remains ample opportunity for improvement on multiple fronts, including:

1- The approval of a designated budget for the implementation of M&E plans and activities
2- Carrying out a national M&E system assessment to identify M&E priorities at KSA
3- The establishment of a national M&E committee or working group with a clear mandate and terms of reference to coordinate M&E activities at KSA
4- The existing national HIV database could be strengthened by the inclusion of information on the content, target population, geographical coverage of HIV services, as well as implementing organizations.
5- Knowledge translation and transparency could be improved through the publishing of an annual M&E report on HIV, including HIV surveillance data.

6- The is a need to enhance the M&E technical expertise of NAP staff at the national and sub-national levels
7- There is a need to design, disseminate and computerize standardized monitoring forms at both national and sub-national levels
8- Need to strengthen relationships between the MOH and external stakeholders in order to ensure that all M&E data/reports are submitted to and compiled by the single national M&E unit at the MOH.

Despite the limited number of indicators reported on in the UNGASS report 2010, working on the report was a valuable exercise and an eye opener to decision/ policy makers and other stakeholder. An action plan to build on the successes identified on this report and address identified shortcomings will be formulated in order to strengthen KSA's future response to the HIV/AIDS epidemic. A synergistic role between the various governmental and non-governmental stakeholders will be a distinguishing characteristic of this response.

IX. References

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