



**UNGASS COUNTRY PROGRESS
REPORT 2012**

**MINISTRY OF HEALTH
KINGDOM OF SAUDI ARABIA**

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Table of Contents

List of Tables	6
List of Figures	6
Acronyms	7
I. Status at a glance	8
Inclusiveness of the Stakeholders.....	8
Status of the Epidemic.....	8
Policy and Programmatic Response.....	9
UNGASS Indicator data in an overview table.....	10
II. Overview of the AIDS epidemic	16
I. Overview of the AIDS epidemic.....	17
I. National response to the AIDS epidemic	22
Prevention.....	22
Voluntary Counseling and Testing	25
Treatment	26
Prevention of Mother to Child Transmission	27
Care and Support	28
Impact Mitigation	29
Supportive political environment	29
Engagement with regional institutions.....	29
II. Best Practices	31
Facilitation of marriages between PLHIV	31
VCT for Vulnerable Population.....	32
Integration of HIV services with health services	32

III. Major challenges and remedial actions.....	32
IV. Support from the country’s development partners	34
V. Monitoring and evaluation environment	34
ANNEX 1 A: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the 2011 Declaration of Commitment on HIV/AIDS	37
ANNEX I B: List of Participants and Stakeholders involved in the consultative processes	39

List of Tables

Table 1 UNGASS Indicators Overview Table	10
Table 2 HIV Prevalence among Lower-Risk Proxy Populations.....	18
Table 3 HIV Prevalence among Higher Risk Proxy Groups.....	20

List of Figures

Figure 1 Reported HIV infections among Saudi Nationals (2000-2010).....	17
Figure 2 Reported HIV infections among Non-Saudi (2000-2010).....	18
Figure 3 Male to Female Ratio over Time	20
Figure 4 Reported HIV cases among Saudis and non-Saudis.....	21
Figure 5 Number and proportion of reported HIV cases receiving ARVs	27

Acronyms

ART	Antiretroviral Therapy
CSO	Civil Society Organization
FSW	Female Sex Workers
IDU	Injecting Drug User
IEC	Information, Education and Communication
KSA	Kingdom of Saudi Arabia
PWID	People who inject drugs
MSM	Men who have sex with men
NAP	National AIDS Program
PHC	Primary Health Center
PLHIV	People living with HIV
RANAA	Regional Arab Network against AIDS
RCH	Reproductive and Child Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
VCT	Voluntary Counseling and Testing
MARPS	Most At Risk Populations

I. Status at a glance

a. Inclusiveness of the stakeholders in the report writing process

The UNGASS 2012 report for the Kingdom of Saudi Arabia (KSA) was guided by the leadership of the National AIDS Program Manager for KSA, along with guidance and support of the senior Ministry of Health Officials, and intensive inputs from the NAP staff. All key stakeholders involved in the AIDS response in KSA, were consulted and gave inputs through a series of meetings and interviews over a four month period that dovetailed with the National Strategic Planning process including NGOs such as The Saudi Charity Association for AIDS Patients, Halfway House for IDUs in Riyadh, and PLHA and former IDU support groups.

b. Status of the epidemic

The ability to estimate of the number of people living with HIV in KSA remains a challenge. However, data on newly reported HIV infections suggest a low incidence among both Saudi nationals and non-Saudis, with approximately 1.5 newly detected HIV infections per 100,000 per year among Saudis and 1.2 per 100,000 per year among non-Saudis. Incidence can be expected to be significantly higher among vulnerable subsets of the population, and in general, reported infections will underestimate true infections.

The program relies mainly on reported HIV case data to track the epidemic. These data reflect a combination of people seeking medical treatment for HIV-related conditions or suspected HIV, and infections that are found through routine testing. There are several routine testing groups in KSA, some which provide proxy information for lower risk groups (e.g. pre-marital screening and blood donors), and higher risk groups (STI patients, prisoners, and IDUs in rehabilitation centers). The prevalence in these populations ranges between

0.03% in the lower risk proxy groups to between 0.15% and 0.8% in the higher risk proxy groups.

The annual number of detected cases among Saudi Nationals has risen over the past ten years (although there is slight dip after 2009). This increase may be due to the fact that more HIV testing is being done, or it could be the result of increasing numbers of infections, or a combination of the two. The male to female ratio of HIV among Saudi nationals (4:1) for the past ten years, indicating more infected males than females

c. Policy and programmatic response

The government has provided an active programmatic response and demonstrated high level commitment and support. Highlights of the programmatic response include 1) greatly increased involvement of civil society and NGOs, 2) strong efforts to integrate HIV services into health facilities, and 3) engagement of the NAP with multi-sectoral partners.

Intensified efforts to increase VCT and also to provide testing services in different health facilities (especially STI clinics, TB treatment centers, and at ART centers, for partners of PLHIV) is a big part of the response.

Multi-sectoral collaboration also features prominently, especially with support by the Ministry of Social Affairs to NGOs and civil society to provide assistance to PLHIV, but also through other Ministries (e.g. Ministry of Interior, Ministry of Education and Ministry of Sports and Youth Affairs) in helping to raise awareness and decrease stigma and discrimination.

Highlights of the policy response include engagement with regional initiatives e.g. Minister of Health's address at the GCC Ministerial Meeting in 2011 encouraging countries in the region to align strategic response supporting MDG goals and budget separately for prevention and care efforts; Arab League's call for 'Uniting Arab Countries to Fight Against AIDS and the launch of the regional 'Saudi Forum on HIV/AIDS' for the Arab countries have been

important milestones in the progress; advocacy efforts in to move the passage of bylaw protecting the rights of PLHIV to the stage where it is waiting for final approval from the “Shoura Council” (the highest body); and involvement of civil society on the National Steering and the National Scientific Committee, and in the development of the current National Strategic Plan, Operation Plan and M&E Framework.

d. UNGASS Indicator data in an overview table

Table 1 UNGASS Indicators Overview Table

Indicator	Comments
<p>Target 1.</p> <p>Reduce sexual transmission of HIV by 50 per cent by 2015</p>	
<p><i>General population</i></p>	
<p>1.1 Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission</p>	<p>No population based surveys have been carried out to supply the needed data for this indicator. However, there are plans to conduct KABP survey amongst young people aged 15-24 in the year 2012 as part of the general population survey.</p>
<p>1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15</p>	<p>Not relevant for low and concentrated epidemic</p>
<p>1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months</p>	<p>No population based surveys have been carried out to supply the needed data for this indicator. However, there are plans to conduct KABP survey amongst general population in the year 2012</p>

1.4 Percentage of adults 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 intercourse	No population based surveys have been carried out to supply the needed data for this indicator. However, there are plans to conduct KABP survey amongst general population in the year 2012.
1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	No population based surveys have been carried out to supply the needed data for this indicator. However, there are plans to conduct KABP survey amongst general population in the year 2012. However, premarital testing is mandatory, so 100% of people getting married know their status.
1.6 Percentage of young people aged 15-24 who are living with HIV	As the epidemic is not generalized in KSA, routine ANC screening is not carried out in all hospitals. However, in some are as routine screening of pregnant women for HIV is carried out with other testing.
Sex workers	
1.7 Percentage of sex workers reached with HIV prevention programs	The term sex worker is not relevant in the socio-cultural and religious context of Kingdom of Saudi Arabia. For women and men who are vulnerable and at higher risk of acquiring HIV, the need for prevention services is recognized and provided accordingly. Qualitative behavioral studies are currently in the planning stages which will provide a better understanding of this population and facilitate the ability to provide adequate services.
1.8 Percentage of sex workers reporting the use of a condom with their most recent client	The term sex worker is not relevant in the socio-cultural and religious context of Kingdom of Saudi Arabia. For women and men who are vulnerable and at higher risk of acquiring HIV, the need for prevention services is recognized. Condoms are distributed among people living with HIV, in ART treatment centers, PHC and STI clinics.
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	The term sex worker is not relevant in the socio-cultural and religious context of Kingdom of Saudi Arabia. For women and men who are vulnerable and at higher risk of acquiring HIV, the need for prevention services is recognized. Provision of services to higher risk men and women will increase utilization of VCT services and enable people to know their current status and referral to specialized centers are done for further managements.
1.10 Percentage of sex workers who are living with HIV	The term sex worker is not relevant in the socio-cultural and religious context of Kingdom of Saudi

	Arabia. As the proportion of higher risk men and women utilizing VCT services increases, proxy information on prevalence of HIV in higher risk populations will become available.
Men who have sex with men	
1.11 Percentage of men who have sex with men reached with HIV prevention programs	The term men who have sex with men are not relevant in the socio-cultural and religious context of Kingdom of Saudi Arabia. For women and men who are vulnerable and at higher risk of acquiring HIV, the need for prevention services is recognized. Qualitative behavioral studies currently in the planning stages will provide a better understanding of this population and facilitate the ability to provide adequate services.
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	The term men who have sex with men is not relevant in the socio-cultural and religious context of Kingdom of Saudi Arabia. For men who are vulnerable and at higher risk of acquiring HIV, the need for prevention services is recognized. Condoms are distributed among people living with HIV, in ART treatment centers, PHC, STI clinics and VCT centers.
1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	The term men who have sex with men is not relevant in the socio-cultural and religious context of Kingdom of Saudi Arabia. For men who are vulnerable and at higher risk of acquiring HIV, the need for prevention services is recognized. Provision of services to higher risk men will increase utilization of VCT services and enable people to know their status.
1.14 Percentage of men who have sex with men who are living with HIV	The term men who have sex with men is not relevant in the socio-cultural and religious context of Kingdom of Saudi Arabia. As the proportion of higher risk men utilizing VCT services increases, proxy information on prevalence of HIV in these populations will become available.
Target 2.	
Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015	
2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programs	Needle and syringe programs are not part of the package of services offered for intravenous drug users.
2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	Currently data not available. Qualitative behavioral studies currently in the planning stages will provide a better understanding of this population and facilitate

	the ability to provide adequate services.
2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	Currently data not available. Qualitative behavioral studies (including injecting practices) currently in the planning stages will provide a better understanding of this population and facilitate the ability to provide adequate services.
2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	All Intravenous Drug Users are tested for HIV and know their results
2.5 Percentage of people who inject drugs who are living with HIV	Data from the largest drug detoxification centre shows 9 cases were found to be HIV positive out of 111 number of opioid dependency (Intravenous Drug Users). A total of 1641 admissions of drug users have been handled during last year (Dec 2010 - Nov 2011).
<p>Target 3</p> <p>Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths</p>	
3.1 Percentage of HIV-positive pregnant women who receive ARVs to reduce the risk of mother-to-child transmission	A total of 75 pregnant women were detected to be HIV positive by 2010, All those who were HIV positive received Maternal Triple ARV (Option B) therapy. (Note: denominator based on known HIV positive pregnant women, not estimated). Plans to implement PMTCT program in 2012
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	A total of 75 pregnant women were treated and followed by end of 2010 and a total of 82 babies were born. Some were twin pregnancies. All infants born to HIV positive mothers have been tested and only 2 were found to be positive (Note: denominator based on known HIV positive pregnant women, not estimated)
3.3 Mother-to-child transmission of HIV (modeled)	No modeling has been carried out.
<p>Target 4</p> <p>Have 15 million people living with HIV on antiretroviral treatment by 2015</p>	
4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy.	Denominator data not available. In 2010, total of 1850 HIV positive were on ART - break up data: Males 1300, Females excluding pregnant women 378, and Pregnant women 75, Neonates 2 and Pediatric cases 95.

<p>4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy</p>	<p>Data available from ART treating centers in 2010: Total number of people on ART=1850; Number of males on ART=1300 Number of Females on ART (including pregnant women) =453; Number of pregnant women on ART=75; Pediatric cases (including neonates) on ART=97; Neonates on ART=2. Note that sex disaggregated data of pediatric and neonatal cases are not known. The number of females including pregnant women on ART (453)+ number of males on ART (1300) + pediatric & neonatal cases (97) totals to 1850.</p>
<p>Target 5</p> <p>Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015</p>	
<p>5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV</p>	<p>In 2010 the number of TB cases tested for HIV was 3487. The number of HIV positive cases detected was 79. Once diagnosed, all TB patients were referred to ART treatment centers for further management of both TB and HIV/AIDS.</p>
<p>Target 6</p> <p>Reach a significant level of annual global expenditure (US\$22-24 billion) in low- and middle-income countries</p>	
<p>6.1 Domestic and international AIDS spending by categories and financing sources</p>	<p>Information in the attached National funding matrix</p>
<p>Target 7</p> <p>Critical Enablers and Synergies with Development Sectors</p>	
<p>7.1 National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programs, stigma and discrimination and monitoring and evaluation)</p>	<p>Online submission done</p>
<p>7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months</p>	<p>Data on Gender based violence currently not available</p>

<p>7.3 Current school attendance among orphans and non-orphans aged 10–14</p>	<p>Not relevant. Applicable for concentrated epidemic.</p>
<p>7.4 Proportion of the poorest households who received external economic support in the last 3 months</p>	<p>PLHA and the family members receive economic support from the Ministry of Social Affairs (SAR 2000/- per person /per month). In addition unemployed PLHA receive SAR 2000/- per month like other unemployed individuals from the Government. The civil society through the community / home based care and support for PLHA and their family members provide nutritional support, income generating activities, household / electrical goods (especially for the newly married PLHAs) and other material support as required.</p>

II. Overview of The AIDS Epidemic

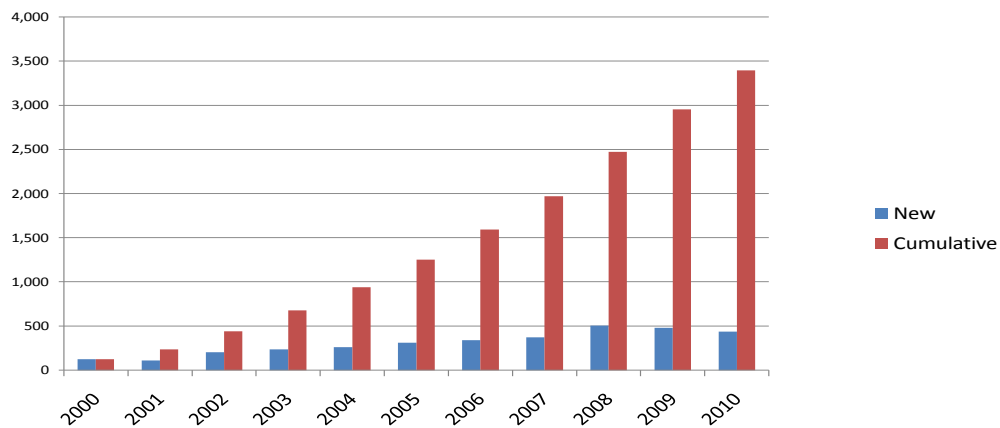
I. Overview of the AIDS epidemic

Estimated number of people living with HIV:

A view of newly reported HIV infections suggest a low incidence among both Saudi nationals and non-Saudis, with approximately 1.5 newly detected HIV infections per 100,000 per year among Saudis (see Figure 1) and 1.2 per 100,000 per year among non-Saudis (see Figure 2).

Incidence can be expected to be higher among vulnerable subsets of the population, and in general, reported infections will underestimate the true current number of infections.

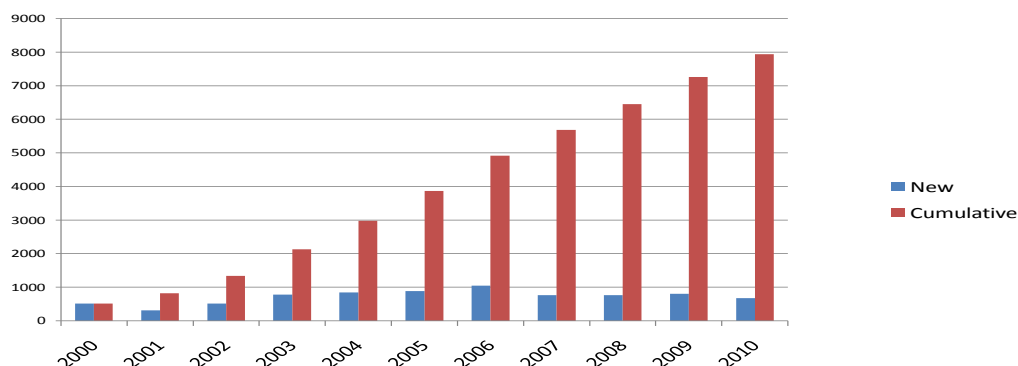
Figure 1: Reported HIV infections among Saudi Nationals (2000-2010)¹



Reported new infections = .0015% per year or 1.5 per 100,000 people per year

¹ Data from Annual Reports, National AIDS Program, KSA

Figure 2: Reported HIV infections among Non-Saudi (2000-2010)²



Reported new infections = .012% per year or 1.2 per 100,00 people per year

The closest proxy data for estimating the prevalence of HIV in the lower-risk (i.e. general population) of KSA comes from blood donor data and mandatory testing data for couples undergoing premarital testing. These two groups are among 11 routinely tested populations in the Kingdom (see Table 2)

Table 2: HIV Prevalence among Lower-Risk Proxy Populations

Group	# Tested	# Positive	Prevalence
Blood Donors			
2008	1800	2	0.1%
2009	400632	189	0.05%
2010	436650	130	0.03%
Pre-Marital			
2008	259018	62	0.02%
2009	296284	60	0.02%
2010	316837	63	0.02%
2011	201288	70	0.03%

² Data from Annual Reports, National AIDS Program, KSA

The data in Table 2 represent the prevalence of HIV among those people who undergo premarital testing or who donate blood. They do not represent the true prevalence in the population at-large. Nonetheless, at a population level, they point to prevalence close to 0.03% (three per 10,000) among the general population, which can be expected to be higher after adding infections from higher risk groups.

Other groups tested routinely for HIV include STI patients, prisoners, and IDU patients at rehabilitation centers. These populations give us some “window” into levels of infection among populations at higher risk, although the extent to which these routine testing groups represent the larger risk groups cannot be quantified. As seen in Table 3 different data sources in these populations suggest different levels of HIV prevalence. The prevalence of 0.3% among a large sample of prisoners is quite high and it would be informative for the program to have more information about how those infections occurred.

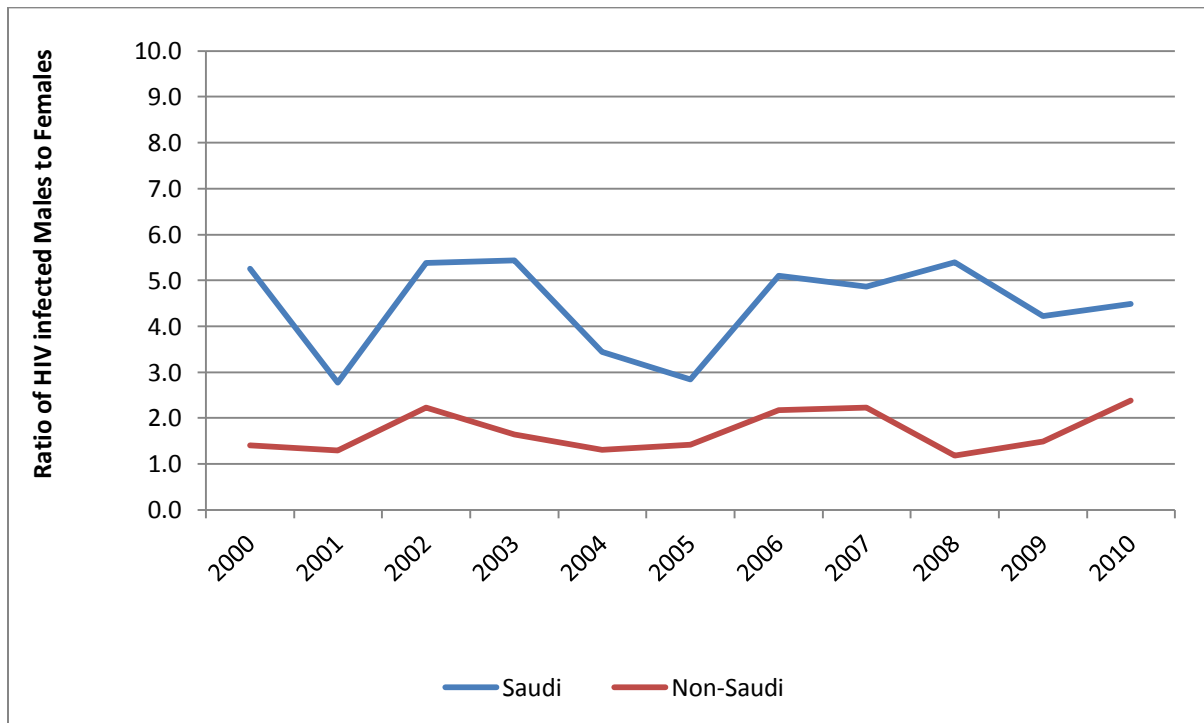
Table 3: HIV Prevalence among Higher Risk Proxy Groups

Group	Sentinel Surveillance in 2007	Routine testing in 2010	Drug users at AL Amal Hospital, Riyadh in (2010-2011)
STI Patients	0.7% (n=1500)	0.15% (n=13672)	NA
Prisoners	NA	0.3% (n=13251)	NA
IDUs	0.8%(n= 750)	0.4% (n=2925)	0.6% (n=3441)

HIV by gender:

A factor that provides some insight into HIV transmission dynamics in a country is the ratio of HIV infected males vs. females. In KSA, that ratio constant over the past ten years (around 4:1) among Saudi nationals, implying that there are more males than females infected. Over time it is expected that the male to female ratio will decrease, as more infected males infect their female sexual partners, unless transmission is predominantly among male PWID and/or same sex behavior among them. However, more information on the number of males vs. females tested over time is necessary to better interpret these figures.

Figure 3: Male to Female Ratio over Time



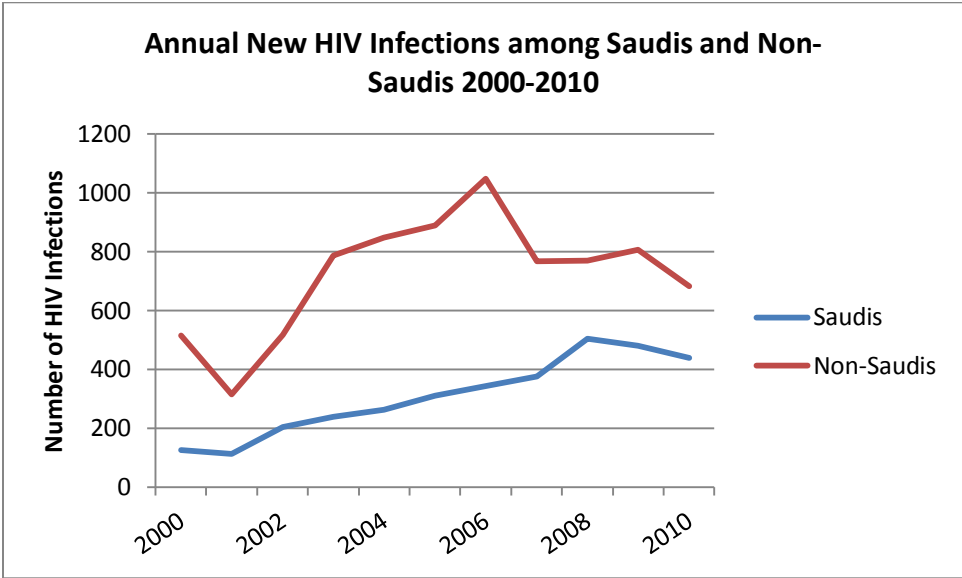
The ratio of infected males to females among non-Saudis is lower than that of Saudis, and has also remained constant over time. This could be because heterosexual

transmission is more common among non-Saudis, or because the number of males and females tested is more equal.

Infections among Saudis vs. non-Saudis:

The number of reported HIV cases in KSA during the ten year period between 2000 and 2010 indicates more cases among non-Saudis than among Saudis. However, the pattern over the past ten years is changing, with a declining number of new cases among non-Saudis over time, and an increasing number of cases among Saudis (although there is a downward dip among both Saudis and non-Saudis after 2009).

Figure 4: Reported HIV cases among Saudis and non-Saudis



It is important to interpret the data from Figure 5 in light of the data source, and the number of Saudis and non-Saudis who are tested each year. Non-Saudis are tested systematically when they migrate to KSA legally for work. Those who are positive are generally deported back to their country of origin except for individuals legible for treatments e.g. born in KSA or being spouse of nationals plus other cases. Some of the cases are detected when the person renews their residence status. Others are

detected through routine testing of suspected cases, blood donors, STI patients, TB patients, prisoners, IDUs, etc. (which applies to both Saudis and non-Saudis).

There are many possible explanations for the narrowing of the gap between the number of Saudi and non-Saudi infections. The number of Saudis being tested has increased as greater testing opportunities have been created viz. provider initiated voluntary testing in health facilities and greater uptake of pre-marital testing facilities in KSA. Therefore, the increased infections among Saudis could be merely the result of more testing among Saudis (relative to non-Saudis).

Nonetheless, the data suggest that the incidence of HIV among Saudis is not stable, but rather is rising over time. Patterns over the next few years will be critical to watch and it will be important to keep track of numbers and profiles of people being tested over time.

I. National response to the AIDS epidemic

During this reporting period the National AIDS Program has been significantly scaled up. It now has a strong, well-managed central unit with more staff and better capacity. This, combined with increased political support, have resulted in more visibility for the program, more involvement of civil society, and ultimately more open discussion of HIV.

Prevention

Due to the unique socio-cultural and religious context in KSA and non-acceptance of individuals with HIV-related risk behaviors, prevention program remains a challenge. However, there are still active prevention responses with many highlights and progress over the past two years including 1) greatly increased involvement of civil society and NGOs, 2) strong efforts to integrate HIV services into health facilities, and 3) engagement of the NAP with multi-sectoral partners.

Activities implemented through NGO and CSO collaborations:

The National AIDS Program has provided good support and partnership to civil society for campaigns to increase awareness and reduce stigma. Prevention programs, run by the NGOs started in Jeddah and Riyadh are expanding through satellite units and branches in other cities.

They provide many services including:

- Operation of a VCT services through static and mobile clinics.
- Income-generation activities.
- Education on HIV transmission and sex-related topics.
- Services for PLHIV (see section on care and support).

The NAP also supports hotlines for HIV counseling services, a twenty-four hour call center system that provides HIV information and counseling services for the general population, and edutainment programs with messages on HIV/AIDS e.g. at malls, as well as on new media like YouTube and Face book.

There are halfway houses located in Jeddah, Dammam and Riyadh to which IDUs are referred after being released from rehabilitation centers. Teams of ex-IDUs do outreach to find IDUs in need of care, treatment and support, visit to prisons, facilitate access of services for IDUs and other vulnerable members of their network.

Involvement of other sectors and stakeholders in addressing stigma and discrimination has increased; e.g. different ministerial sectors , other NGOs ,Saudi Islamic Bank and different pharmaceutical companies working on supporting HIV/AIDS awareness building measures, better involvement of media and many others.

Integration of HIV services into health facilities:

There has been a strong push to integrate HIV services into different health facilities.

This has included:

- Condom promotion among discordant couples, STI clinics and in PHC.
, VCT and IEC material distribution at STI, , TB and ART clinics...etc,

- Introduction of systematic HIV testing at all STI clinics at the PHCs.
- Scaled up STI care using syndromic management at STI clinics in >2000 PHCs and in some hospitals where etiologic diagnostic facilities are not available.
- Strengthening STI case management and treatment through intensive training and capacity building initiatives on STI syndromic and etiological treatment and case management for physicians at PHC and hospitals STI clinics.
- Positive prevention programs for PLHIV.
- HIV testing for people with TB and TB testing for people with HIV.

Engagement with multi-sectoral partners:

The National AIDS Program has engaged proactively with multi-sectoral partners including media, faith-based organizations, the Ministry of Interior, Ministry of Social Affairs and the Ministry of Sports and Youth Affairs. This involves partners using their own funding and planning separate activities, but with technical and material support from the NAP.

Examples of these types of engagements include:

- Collaboration with the Ministry of the Interior to run detoxification and rehabilitation programs for IDUs (e.g. at Al Amal hospital in Riyadh). These programs offer social and psychological support, medications to reduce cravings. (Note: although legal obstacles to oral substitution therapy for IDUs were removed several years ago, logistical challenges to dispensing OST still remain)
- Provision of IEC materials for school education programs, health providers, at traveler exit-points (e.g. airport and border-crossings), and at mosques, prisons, traffic signal points, supermarkets and malls, etc.

- Technical support and vocational opportunities for an open discussions on HIV/AIDS with parent-teacher, and teacher-youth meetings
- Technical support for “Media and HIV” workshops on HIV awareness, rights and elimination of stigma.
- Technical and material support for mobile VCT services at soccer match in Jeddah (Ministry of Youth and Sports Affairs)
- Promotion of the concept of ‘Volunteerism’ through involvement of e.g. PLHA, ex-IDUs, medical students and nurses ...etc., for outreach work and peer support groups to create awareness on HIV/AIDS. For example, current campaign for volunteering by medical students in many different cities “Get to Zero New Infections, Zero Discrimination, and Zero AIDS related deaths” was a great success and thus greater effort is being made in encouraging volunteer work in the overall program.
- Support to civil society including:
 - Different campaigns to increase awareness.
 - Leadership development.
 - Establishment of peer support programs for PLHIV, semi drop-in centers, and care and support programs (CSOs cannot offer treatment). For example, PLHA have formed many small support groups and network e.g. with “Al-hosen”, which is an active PLHIV network in Saudi Arabia having separate networks for men and women).
 - Economic support and training facilities to PLHIV and their families.
 - Unemployment financial benefits.

Voluntary Counseling and Testing:

In addition to integration of VCT in the different types of health facilities mentioned above, there is also a lot of effort going toward widespread scale-up of separate VCT

services. In the 2010 UNGASS report, it was reported that 20 new VCT clinics had been opened. Although there is a VCT center now in every region, the volume of testing has been slow to accelerate, in part because many of the centers are located inside hospitals. As part of the VCT scale-up effort, there are now 6 new mobile VCT units, four of them added in the last year (two in Jeddah, 1 in Riyadh, 1 in Medina, 1 in Damamm and 1 in Jazan). These mobile units are targeting people at high risk by operating in areas where both vulnerable and Most at Risk Populations (MARPS), both Saudi and non-Saudi, are more likely to be found.

The completely anonymous nature of the service provides increased access for illegal foreigners, who would otherwise face deportation if discovered to be HIV positive.

As part of the scaled-up VCT effort and offered services, there is ongoing training of health care workers, (nurses and social workers) in counseling and testing. Inclusion of rapid testing (saliva, blood, serum) is a new initiative and the NAP is in the process of further stocking supplies in the field.

The services are being advertised through mass media, websites and the internet. There is a special website for VCT that provides general information about HIV, services available and modes of transmission, along with the names, locations, hours of operation and contact information for the VCTs. Services at the VCT include individual pre-test and post testing counseling. VCT clients are given an anonymous code and the HIV screening system is explained. Those having reactive tests are told that their initial result was positive, but that the result is inconclusive without confirmation. They are then referred to one of the testing and treatment centers for further diagnosis and eventual treatment if necessary.

Treatment:

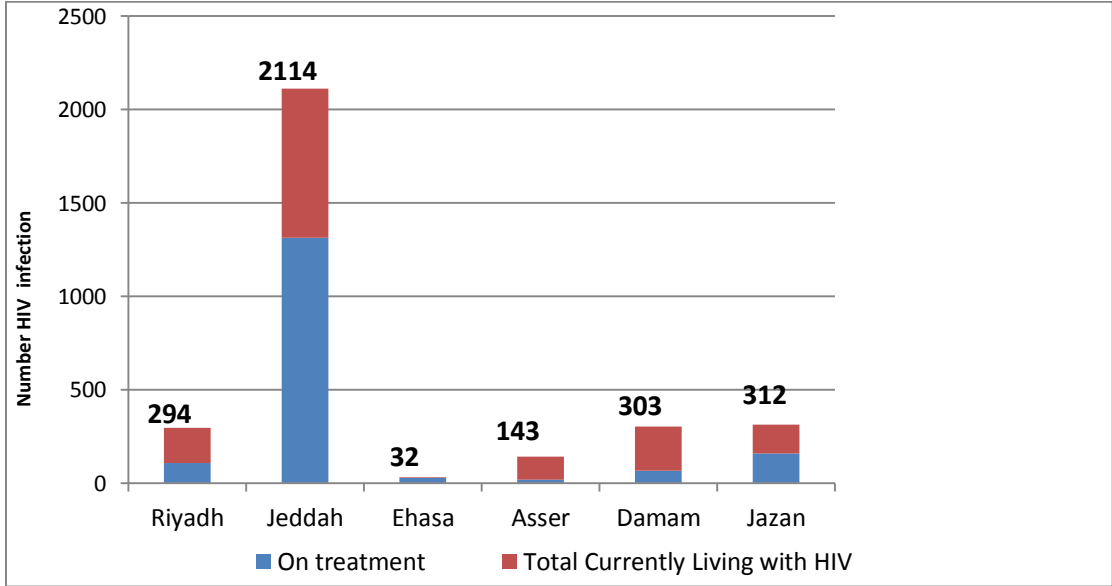
Provision of ART and medication for Saudi nationals is provided free of charge at currently 8 treatment centers throughout the country .Escale up of services from centers are in considerations according to need . The pattern of diagnosis and treatment is shown in Figure 5. By far most patients are treated at the center in Jeddah,

and the proportion of detected cases on ART is also high in Jeddah, perhaps because many advanced cases are referred there.

The policy in KSA is to put people on ART when their CD4 cell counts drop below 500 cells/ μ l or ever higher for in practice early treatment and for prevention (whereas most countries wait until the counts fall below 350cells/ μ l) The Kingdom of Saudi Arabia follows the North American DHSS guidelines. Based on the information about reported cases, the treatment coverage is excellent.

Almost all detected cases that are eligible for treatment are receiving ART in one of the AIDS Treatment Centers as shown in the figure below.

Figure 5 Number and proportion of reported HIV cases receiving ARVs



Prevention of Mother to Child Transmission:

In facilities where PMTCT is done, mothers and babies receive proper care, treatment and long term follow-up. But not all ANC units have PMTCT programs. Initiation of more systematic PMTCT is a national priority for implementation.

Care and Support:

NGO are playing a strong role in the provision of psycho social care and support to PLHA. It is largely happening through the Saudi Charity Association for AIDS Patients (SACA), an NGO in Jeddah covering few cities funded by the Saudi government through the Ministry of Social Affairs. Civil society also accesses funding from corporate sector viz. oil companies, some private sectors, institutes and pharmaceutical companies are supporting for program implementation... and others.

Among the services provided are:

- Psychosocial support for PLHIV and their family members
- PLHIV support groups
- Food support, households, mini loans, trainings, self-income opportunities.
- Facilitation of marriage of PLHA and equipping the home of the newly married with household goods and items.

These NGOs encourage volunteerism”, and there are hundreds of PLHIV clients providing services to PLHIV and their families and children, not only through NGOs, but also through faith-based organizations such as “Egatha Foundation”.

Civil society has established strong linkages with Regional and Sub-regional networks e.g. (RANAA). These regional networks provide capacity building and technical support to the local networks (e.g. Leadership Development training Programs for PLHIV).

Impact Mitigation:

In addition to the care and support services mentioned above, many other support services are in place for PLHIV to mitigate the impact of illness on the family. These include:

- Economic support and unemployment benefits to PLHIV and their families – around SAR 1000- 2000 per person per month.
- Loans and micro-finance programs to assist PLHIV in pursuing self-employment opportunities and/or to start-up small businesses
- Coupon distribution for food, clothing and Children nutritional support.
- Distribution of blankets and seasonal requirements.
- Priority admission for educational opportunities e.g., schooling and university education for students from families with PLHIV.
- Vocational training and skills enhancement for better employment opportunities.

Support for these efforts is provided through the Ministry of Social Affairs.

Supportive political environment:

The supportive political environment in KSA in the last years is evidenced through the high level commitments for regional initiatives, including:

Engagement with regional institutions

- Minister of Health, KSA at the GCC Ministerial Meeting (April 2011) urged each country in the region to budget separately for HIV prevention and care activities and to have a unified Regional HIV/AIDS strategy for GCC countries on issues concerning the region.
- The ministry of health under the umbrella of Arab League called for a regional meeting of Government, non-Government and UN agencies in October 2011 with representation from 22 countries for "Uniting Arab Countries to unify efforts Fight Against AIDS" and recommended to have a common strategic

plan for the Arab region and align the regional strategy with the global strategy on HIV/AIDS

- Further, there was a Launch of recommendations during the regional ' Saudi Forum on HIV/AIDS' uniting the Arab countries in November 2011 which was approved by all Arab health ministries and initiatives are to be taken forward and headed by Saudi Arabia.

Perhaps of most note is the drafting of a bylaw to protect the rights of PLHIV in KSA, in relation to human and civil rights, (i.e. employment and work, right to education, and right to marriage), which has been working its way through the legal system. Two years ago at the time of last UNGASS report, the bylaw had already been drafted, but advocacy efforts in the last two years have moved the process to the point where it is now awaiting final approval from the highest body, the "Shoura Council". Although the bylaw has not yet been passed, if any complaints are received by the Ministry, either directly or through the local courts, they are investigated promptly and corrective actions are taken.

KSA is also a signatory to local Islamic non-discriminatory laws insuring basic rights to health, education, food, employment and marriage for all, including PLHIV.

- Some rights accorded to PLHIV include:
 - PLHIV youth receive unemployment benefits like any other.
 - Rights to education, marriage, work opportunities, and all other benefits same as others not infected with HIV.
 - Rights to access and receive proper care, treatments and health support.
 - Prison inmates can receive treatment and care at ART centers.
 - IDUs in detention are not sent to prisons but to hospitals for treatment and rehabilitation services (unless there is concomitant criminal offense).
- Agencies such as the Human Rights Commission, Women's Rights Commission, National NGO on Human Rights in Saudi Arabia, and civil society representatives in

the Law Reform Commission work for the protection and promotion of human rights including that of HIV positive individuals.

- Increased involvement of civil society
 - Involvement of civil society on the National Steering Committee and the National Scientific Committee, which is the highest body taking technical and policy decisions.
 - Involvement of civil society in multi-sectoral strategy development for current National Strategic Plan, Operation Plan and M&E Framework.
 - Engagement with regional initiatives viz. GCC Ministerial Meeting, Arab League meetings for "Uniting Arab Countries to fight against AIDS" and at the Saudi Forum on HIV/AIDS' for the Arab countries in 2011 and bringing in inputs from the grass root to the regional strategy and the forum.

II. Best Practices:

Facilitation of marriages between PLHIV

Eight years ago the NAP launched a project to facilitate marriage between HIV positive individuals. The project was implemented through the Saudi Charity Association for AIDS Patients; the project has resulted in marriage of nearly 100 individuals that gave way for healthy deliveries of many babies. The quality of life for these couples has been improved through economic support for home furnishing, support for finding employment, trainings, and a sense of “well-being” that comes from being part of a family. The project has also provided health education, treatment & counseling services, drop in center facilities, and peer group support, and helped to minimize stigma and discrimination.

VCT for vulnerable populations:

VCT services are available in all regions within the Kingdom to all those in need of it. The testing and counseling center is always attached to a health facility (Central Hospital) where facilities of advanced testing are available. Also being part of a hospital will decrease stigma attached to the disease and will enhance access to MARPS and other vulnerable groups to the counseling and testing services. Recognizing the need to access VCT services, the NAP has made voluntary HIV counseling and testing available on a completely anonymous basis.

Integration of HIV services with health services

One approach to increase access of population at risk to health facilities is the integration of HIV services into mainstream health services. Many prevention services, including VCT, distribution of condoms and IEC materials, etiological and syndromic management of STIs are now being delivered through hospitals, PHC, RCH and TB clinics.

III. Major challenges and remedial actions

Stigma and discrimination are most often cited as the major obstacle to the HIV response in KSA. It is difficult for the national AIDS program to access and directly provide prevention services to at risk populations, but they are being addressed indirectly through different programs such as peer education, support groups, drop-in centers, and mobile and fixed VCT services. Efforts to understand sexual networks are also being attempted through civil society initiatives and NGOs that are branching out in the major cities.

Reaching all illegal migrants and MARPS in KSA and engage them in needed prevention interventions targeting this two groups is a challenge for NAP and other NGOs/CBOs working with these communities, The usual stigma that causes people with risky behavior to remain hidden is a challenge . Naturally this deters access to

preventive or counseling and testing services, although there are anonymous VCT services available. As efforts to reach out to at risk populations is more expanded, special attention on how to include different illegal migrants and other at risk populations will be imperative.

Returning Saudi citizens, who might have travelled to higher prevalence countries and engaged in some risky behaviors, appear to play a role in the epidemic. Promoting VCT among these groups after they return may be an important role in prevention strategy.

The absence of surveillance data to characterize the epidemic makes it difficult to prioritize the response. There are many groups that undergo routine HIV testing, which is helpful for early detection and treatment. Some of the populations that are tested routinely serve as proxy sentinel groups. For example, blood donors and couples undergoing premarital testing provide some basis for assessing HIV prevalence in the general population. However, in low prevalence countries like Saudi Arabia, a disproportionately high number of infections may be present among sections of vulnerable men and women at higher risk of acquiring HIV/AIDS. These people are harder to map and capture through routine testing. STI patients, prisoners, IDUs in rehabilitation centers, and TB patients provide some access to high risk populations. But the extent to which these routine testing groups represent the higher risk groups cannot be quantified. The lack of information about the number and profile of people tested over time adds to this problem.

Most infections are identified as being sexually transmitted. But in terms of targeting prevention efforts, it would be more useful to know whether those infections were acquired outside KSA, or if inside the country, or through sexual liaisons or same sex behaviors. More planning efforts are needed to identify the magnitude of transmission through same sexual behavior than is currently acknowledged, which may be playing a role in country epidemic. Going forward, a greater effort will be made to identify the actual mode of transmission of people in the routine testing populations.

Other issues of concern include the following:

- The involvement of PLHIV, men and women at higher risk of acquiring of HIV/AIDS in the response is still limited.
- Sexual health and safe sexuality education is limited to HIV/AIDS awareness only in schools.
- Collaboration between different sectors and NGOs is still poor and in general, more NGO involvement is needed.
- Strong and continuous inter-sectoral collaborations between different governmental and non-governmental departments needs to be strengthened.

IV. Support from the country's development partners:

Not Relevant

V. Monitoring and evaluation environment:

Since the time of UNGASS reporting in 2010, there has been a significant increase in the number of staff devoted to M&E issues, some dedicated full time while others certain amount of time. Staff at the central level NAP now includes an HIV Surveillance Officer, a Program Officer, an STI and Treatment Center Coordinator, Training and Evaluation Officer, and a Data Systems Manager. There is also a Technical Officer at the Directorate of Primary Health Care for monitoring and reporting of STI to the NAP data unit. There are data analysis specialists, and a variety of technical consultants and field investigators recruited for surveys and research. And at the regional level, there is a National AIDS Coordinator based in each governorate that takes care of regional program monitoring and reporting. There are IT programmers and data entry operators both at central and regional units.

M&E capacity building has been prioritized by the program and there have been numerous trainings of field investigators and laboratory technicians on data collection for research and medical personnel on HIV/STI surveillance systems, data collection and reporting.

There is now a central data base managed by the central unit of NAP that collates health sector data electronically. Regional coordinators, ART treatment centers, VCT centers, and the national STI program report health-related statistics (e.g. HIV case notification, routine reporting from STI clinics at PHC, and treatment data) from the periphery. The completeness of reporting is improving though timeliness remains an issue. There are plans to make this unit part of the National Surveillance System.

The central level team proactively engages in obtaining blood donor data, TB program data, premarital and pre-employment data testing, and data from the other routine testing populations. In 2009-2010 they managed to rely 100% on electronic data to generate annual and quarterly reports, with 100% of regions reporting.

Special data collection efforts to obtain information about HIV prevalence and characterizing the pattern of risk behavior in specific populations, is still a weak point for the program, though the need for more comprehensive information is recognized.

There is no formal sentinel surveillance system, although routine reporting provides some proxy information. Facility-based surveillance was conducted in 2007 and plans are to carry out again in 2012 amongst STI clinic attendees, drug users and IDUs, pregnant women, blood donors, and TB patients.

National estimates and projections of the number of people living with HIV/AIDS have not been attempted using the UNAIDS tools. There are plans to do so in the future. In the meantime, efforts are underway to try to estimate the number of PLHIV, and especially those in needs for ART, using data on clinical stage and CD4 counts at the time of HIV diagnosis.

There have been limited biological or behavioral researches studies conducted among high-risk populations, and provide little information about the transmission dynamics of HIV. However, qualitative behavioral studies for men and women at higher risk are

currently in the planning stages. Given the sensitivities and stigma around these risk behaviors in KSA, planning such research will be challenging, but critically important.

It is important to improve the utilization of routine data, especially since they provide some access to risk populations. For this reason, there are plans to introduce data collection on condom use and sexual partners as part of VCT for STI patients. It will be even more useful if the data can be used to determine the mode of transmission.

The program is doing a good job of monitoring coverage in the health sector (e.g. ARV treatment and STI case management). However, monitoring prevention coverage among high risk populations is more problematic because of the absence of well-defined program targets based on need, and the difficulties of reaching high-risk populations. This is an area that needs improvement.

Efforts will be made to get information on age and sex disaggregated data of the groups that undergo routine HIV testing (blood donors, pre-marital testing) as they can serve as proxy groups for understanding the epidemic (HIV prevalence in general population). Identification of a set of minimum indicators for routine reporting was suggested by the Scientific Committee members at the sharing meeting of UNGASS draft report and this is to be worked out.

Lastly, greater effort in improving coordination with key partners for optimal utilization of M&E data is required and is being made.

ANNEX 1A: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the 2011 Declaration of Commitment on HIV/AIDS

The UNGASS 2012 report for the Kingdom of Saudi Arabia (KSA) has been prepared with the inputs of all the key stakeholders involved in the AIDS response in KSA. The National AIDS Program Manager ably steered the whole process and provided leadership support in bringing the whole process towards a successful completion. The report preparing process received a major guidance from Dr Ziad Ahmed Memish, Deputy Minister of Public Health, Dr Ra'afat Al-Hakeem Director of Infectious Diseases MOH and Scientific Committee members,

There has been an intense effort put in by the National AIDS Program in the last few months in engaging the stakeholders not only for the implementation of the overall program, but also for seeking inputs for the two key processes KSA is currently engaged in i.e. developing the National Strategic Plan for KSA (2012-2017) and UNGASS 2012 reporting. Utilizing existing opportunities and creating some new initiatives was the strategy undertaken for reporting on the progress made since the last UNGASS 2010 report. A focal point person was identified from within the central NAP team to coordinate all the efforts for this process. Technical assistance was provided by a consultant from UNAIDS in developing the report.

Efforts were made to collect data and information for the recommended indicators of UNGASS, National AIDS Spending Matrix, National Composite Policy Index (Part A and B). This brought us to interact with stakeholders of other Governmental departments i.e. National TB Program, Ministry of Interior, General Director of Education, Drug Treatment Department, National Testing and Laboratories, Department of Community and Family Medicine, Primary Health Centre Directorate General, Physicians of Military Hospitals, National Guard Hospitals, Security Force, University teaching hospitals and ART centers.

Inputs from NGOs have been very valuable towards developing this report. To name some of them – are the Board members and staff of The Saudi Charity Association for AIDS Patients, Halfway House for IDUs in Riyadh, PLHA and ex—IDU support groups and their networks, volunteers and outreach workers of Halfway House and others. The field visit to the NGO working sites, ART and VCT centers and interaction with the community members and their networks have been immensely beneficial.

Annex IB: List of Participants and Stakeholders involved in the consultative processes

A. List of the participants present during UNGASS 2012 report sharing meeting at Ministry of Health, 10th March 2012

1. Dr. Ziad Ahmed Memish, Deputy Minister For Public Health , Ministry Of Health
2. Dr. Ra'afat Al-Hakeem, Director Of Infectious Diseases, MOH
3. Dr. Fahd Al Rabiah, Consultant, Infectious Disease, King Faisal Hospital, Riyadh
4. Mr. Adel Al Oteb, School Education Program .
5. Dr. Mustafa Tayen, WHO
6. Dr .Jamal Abouissa, WHO
7. Dr. Maha Al Efringi, UNICEF
8. Dr. Abdalla Al Hokeel, Consultant Infectious Disease, King Faisal Hospital, Riyadh
9. Dr. Esam Al Shora Chief Of Drug Treatment Department (Al Amal Psychiatric Hospital), Riyadh
10. Dr. Md Yahya Sayeedi, General Directory For Non-Infectious Disease Department
11. Dr Sanaa Mostafa Abbass Filemban National AIDS Program Manager
12. Dr. Mohammed Mohammed Al-Hazmi Consultant Infectious Diseases, King Fahd Hospital. Jazan.
13. Dr. Salem Elwi Baharoon Consultant Infectious Diseases King Abdulaziz Medical City.
14. Dr. Awad Bin Raheel Al-Anzi. Professor King Khaled University Hospital, Riyadh.
15. Dr. Ali Bin Mansour Albarrak. Consultant Infectious Diseases, Military Hospital.

16. Dr. Mohammed Bn Hamdan Alzahrani. Consultant Infectious Diseases, Security Force Hospital.
17. Dr. Abdulla Bin Mefreh Ali Asseri, General Directorate Of Infection Control Department.
18. Dr. Tarek Bin Abdulla Alazraqi Consultant Infectious Diseases, Asser Central Hospital.
19. Dr. Batool Mohammed Ali Suliman, Consultant Infectious Diseases, King Saud Hospital, Jeddah.

B. List of individuals (not included in the above) consulted during the process of preparation of UNGASS 2012 Report:

1. Dr. Naela Abu Al Jadaiel, Director of National TB Program
2. Dr. Houda, Public Health Department, MOH
3. Dr. Manal, Public Health Department, MOH
4. Dr. Ahmed Kholaidy, MOH
5. Dr. Mohammed Sulaiman, Medical Director, GSK
6. Dr. Hassan Al Hennawi, MSD
7. Dr. MdSaeedi, Consultant, Community & Family Medicine, MOH
8. Dr. Abdulelah Al Shareef, Drug Addiction Prevention & Control
9. Dr. En Ahmed Bin Saleh Al Fares, Drug Addiction Prevention & Control
10. Dr. Faten Abdullah Bin Saif, Laboratories and Blood Bank Directorate
11. Mr Kanen Mohammed, Lab Specialist, Riyadh
12. Mr Abdul Elah Shariq, Drug Prevention for Addiction, Ministry of Interior.
13. Dr. Magdy Hamed Hussein, Infectious Disease Specialist, NAP STI Unit
14. Dr. Yasser Awadhallah Yasein, Training Coordinator & STI, NAP
15. Dr. Sayedgotb M Elrashied, HIV/AIDS Surveillance & Research Focal Point, NAP
16. Dr. Abdullah. I. Fidail, PH Consultant, HIV Health Education Counselling, NAP
17. Dr. Asha Rao, Technical Advisor HIV/AIDS, NAP
18. Mr Moussa, Director, Saudi AIDS Charity Association
19. Mr. Salim, Saudi AIDS Charity Association
20. Board members of Saudi AIDS Charity Association

C Participant list of the consultative meeting with IDU, ex-IDU, volunteers, PLHA and physicians (March 2012):

1. Mr. Abdul Garni, Psychologist - Halfway house, Riyadh
2. Dr. Esam Al-Shora, Chief of Drug Treatment Department (Al Amal Psychiatric Hospital), Riyadh
3. Ms. Batool Al Enzi- Nurse, King Saud Hospital, Riyadh
4. Mr. Bander Al Ouzemi, Nurse, King Saud Hospital, Riyadh
5. Ms. Fouzia Al Khlawi, Writer, volunteering for AIDS Programme
6. Mr. Khaled Al Zahaki, Outreach Worker of Halfway house
7. Mr. Sayeed Al Garni, Outreach Worker of Halfway house
8. Volunteers from community members, PLHA networks
 - a. Mr. Sultan Al Ariri
 - b. Mr. Tourki Fahd Al Mehdani
 - c. Mr. Hassan Al Garni
 - d. Mr. Abdulla Shamas
 - e. Mr. Tourki Al Hazani
 - f. Mr. Abdulla Ghani Abbas Rozi (volunteer Al Amal Hospital)
 - g. Ms. Mariam Kassem
 - h. Ms. Fatima Al Dosari