COUNTRY PROGRESS REPORT

UNITED ARAB EMIRATES

Reporting period: January 2010-December 2011

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I. STATUS AT A GLANCE

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

The development of this Global AIDS Response Progress (GARP) Report 2012 was undertaken under the auspices of His Excellency Abdulrahman Mohammed Al-Owais, Minister of Culture, Youth and Community Development, Acting Minister of Health, and Dr. Mahmoud Fikri, Assistant Undersecretary for Public Health Policy. High-level officials of the Ministry of Health and the Abu Dhabi and Dubai Health Authorities have been involved from the beginning and provided support to the entire data collection, validation and review processes.

The process to develop the UAE GARP Report 2012 was led by the National AIDS Programme (NAP), under supervision of the Ministry of Health. The process involved consultations with key stakeholders involved in the national response to HIV/AIDS. UNAIDS MENA provided an international consultant to assist in the overall process of data collection and consolidation of the final report.

Data collection for the indicators and the NCPI took place through review of policy documents, programme reports, health statistics, health facility reports, research reports and studies, as well as site visits to key facilities and interviews with national stakeholders and key informants from government, civil society and UN agencies. Interviews and site visits included policy makers at MOH and other ministries, police authorities, several hospitals and health facilities involved in ART service delivery, PMTCT, drug-rehabilitation facilities and UN agencies.

After finalisation of the data-collection process, a roundtable meeting was held at the Ministry of Health in Dubai to present and discuss the preliminary findings of the data-collection process, whereby all key national stakeholders were invited and were given an opportunity to provide inputs, raise concerns and ask for further clarifications. This roundtable not only served to validate all data with key stakeholders, but also engendered a discussion with stakeholders from all sectors and constituencies with regard to priority issues to be addressed in the near future. These discussions will also serve as inputs for the revision and development of the National Strategic Plan, which is planned to take place in 2012.

After incorporation of all inputs that were received through the data-collection process described above, final data entry was done by the NAP and UNAIDS consultant. All data entered was cross-checked and discussed before final submission.

(b) Status of the epidemic

The HIV situation in UAE can be characterised as low-prevalence. Since the 1980s – when the first HIV case was reported in UAE – till the end of 2011, a cumulative total of 726 HIV still-alive cases has been reported among UAE nationals: 546 males (75.2%) and 180 females (24.8%). The majority of HIV cases was found in the emirates of Abu Dhabi and Dubai, reflecting the larger populations in those two emirates, as well as possibly higher levels of risk behaviours, as both cities may be more exposed to high-risk phenomena associated with HIV. In the period 2010-2011, a total of 93 new HIV cases were reported among UAE nationals: 36 in 2010 and 57 in 2011. However, it should be noted that these figures represent only the number of *officially reported* cases, most of which were found through screening of in the context of blood donations, pregnant women, premarital testing, and among TB patients. HIV-screening data do not accurately reflect the actual number of

new HIV cases. Those who suspect they may have been exposed to HIV – e.g. through sexual relationships or injecting drug use – may *avoid* the existing screening programmes. Thus, most-at-risk populations (MARPs) and other vulnerable groups may be particularly under-represented in these statistics. In the absence of surveillance among MARP groups it is very difficult to provide accurate figures for HIV rates in these high-risk groups, which are not accurately reflected in the available statistics.

In the absence of special sero-surveillance studies, there are no reliable estimates of HIV rates among *most-at-risk populations*, such as sex workers, MSM and IDUs. However, a number of factors could drive a future increase of the HIV epidemic in UAE, including massive labour migration, influx of tourists, changing sexual norms and practices among young people, as well as the presence of MARP groups. Recent studies among *young people* in UAE reveal relatively high HIV knowledge, but many misconceptions and negative attitudes towards PLHIV remain. The findings reveal a small proportion of youth, mainly males, admit to having had premarital sex. However, the actual percentage of sexually active young people may be higher, including high-HIV-risk behaviours.

While no studies have been conducted on sex work in UAE, key informants confirm that *sex work* is present in UAE. The demand for sex work may be driven by UAE's vibrant economy, open borders and tourism. Human trafficking by organised international crime rings also plays a role, with especially women from poor countries in Asia being trafficked for sex work. In the absence of any formal research on sex work in UAE, little is known about the exact scope and nature of the phenomenon. Sex work remains hidden, as it is illegal, and no HIV-prevention programmes are available for these women.

Similarly, despite the fact that homosexual acts are illegal in UAE, *men who have sex with men* exist, but little is known about the exact scope and nature of the phenomenon, as it is largely hidden from the public sphere. To date, there has been no research, nor HIV-prevention programmes for MSM in UAE. While no data is available on the HIV prevalence among MSM, official data from neighbouring countries show that as much as 15 percent of all HIV transmission is due to same-sex contacts between men. This shows the potential for a rapid spread of HIV within the MSM community in UAE as well.

While *injecting drug use* is present in UAE, the magnitude of the problem is unknown. There are mixed reports from drug-treatment facilities and health facilities treating HIV patients that injecting drug use is on the decline, and that there are few HIV cases among IDUs so far. However, accurate data is not available in the absence of proper bio-behavioural surveillance studies. Reports from neighbouring countries show that injecting drug use and sharing of injection equipment is a problem, and that HIV can spread particularly fast among this group. Therefore more research and HIV prevention programmes are needed for this group.

(c) Policy and programmatic response

The national response can be distinguished at two levels: 1) national *commitment and political support;* and 2) actual programme *implementation*.

1) High-level ***commitment and political support*** for the national HIV response continue to be crucial, as there are still a number of challenges in this area: overall, the profile of HIV/AIDS on the national agenda needs to be strengthened. Specific achievements and challenges in this field are reflected at: 1) the *institutional and organisational* level; 2) in *policy and programme development*; and 3) in terms of *allocation of human and financial resources*.

- While there is continued high-level political support for HIV/AIDS, at the *institutional level*, challenges remain with regard to the lack of an effectively functioning multisectoral coordination body that can guide and oversee the national response in different sectors. Furthermore, the lack of adequate allocation of human resources reflects the low level of priority that is still given to HIV: the MOH-based *National AIDS Programme* (NAP) remains under-staffed, while there is no dedicated HIV staff at the Dubai and Abu Dhabi health authorities.
- These challenges at the institutional level are reflected at the level of *policy and programme development*: the last national strategic plan (NSP) was not officially endorsed, which has hampered effective and targeted HIV responses in 2010-2011.
- The remaining challenges at the institutional and policy level, as described above, are further reflected at the level of *allocation of financial and human resources*: 96 percent of all HIV-related expenditure is on HIV screening – predominantly of expatriates in the context of residency permits. While 3 percent is spent on ARV treatment and care, there are virtually no allocations for HIV prevention: USD 200,000 in 2010, a mere 0.2 percent of the total.

2) A major stumbling block for ***programme implementation*** in 2010-2011 has been the absence of an officially endorsed NSP: without the guidance of a common HIV/AIDS policy, the national response has remained scattered and ad-hoc.

Nevertheless, there are important achievements to be mentioned. All nationals in need have the right to free HIV treatment and care. There are good models of comprehensive treatment, care and support for HIV patients, with multidisciplinary hospital teams of clinicians, psychologists and counsellors providing high-quality services, which respond to the needs of PLHIV. Furthermore, Emirati PLHIV enjoy legal protection in terms of their rights to health, employment, education and non-discrimination. ANC screening provides HIV-infected women and men the possibility to protect their unborn child against HIV infection. Involvement of non-health sectors is evidenced by the joint efforts of the Human Rights department of the Dubai Police and UNICEF in the field of support for victims of human trafficking; this may be a powerful model for the implementation of similar programmes for HIV prevention among most-at-risk populations. Furthermore, IEC materials are provided at HIV-testing centres for expatriates in their local languages. The Red Crescent conducts HIV peer education among youth.

Key challenges remain with regard to strengthening HIV prevention, especially among MARPs and vulnerable groups, including *young* people. A major problem is the lack of accurate data on at-risk groups and behaviours, which hampers an evidence-informed response, targeted to the most-at-risk and most vulnerable populations. Existing HIV-prevention efforts need to move beyond ad-hoc, project-based activities, which are typically discontinued after 1-2 years. Successful experiences need to be carefully evaluated, so that they can be used for continued programme implementation. E.g. existing screening programmes could be used to strengthen HIV awareness and prevention. This could also help develop VCT services, which are currently still unavailable. Furthermore, existing drug-treatment services could be used to strengthen HIV prevention among IDUs. The most challenging area is to develop effective HIV prevention among sex workers and MSM, given their illegal status and strong social rejection and stigma of HIV-risk behaviours among these groups.

(d) Indicator data in an overview table

NO.	INDICATOR	REPORTED DATA AND COMMENTS
		SEXUAL TRANSMISSION
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	In 2010-2011, a study was conducted on knowledge, attitudes and practices on HIV/AIDS among students of three universities in the United Arab Emirates. The sample included 3,359 students (approximately 75% females- 25% males, 63% Emirati nationals and 34% other nationalities). Preliminary results showed that approximately 50% of the respondents had overall "good" knowledge of HIV and AIDS; although scores on specific key questions were relatively poor. Emirati respondents had less knowledge than other nationalities. Female Emirati respondents were least knowledgeable about HIV and AIDS. Key results regarding "Accurate knowledge" on prevention of HIV: 1. Sex with only one uninfected partner: 37% 2. Consistent condom use: 36% 3. Healthy-looking person can have HIV: 73% 4. Mosquito bites cannot transmit HIV: 79% 5. Sharing food cannot transmit HIV: 84%
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	No study has been conducted on sex before the age of 15. However, in a HIV/AIDS KAP study among university students at 3 Universities in UAE (2/3 Emiratis, 1/3 foreign students) conducted in 2010-2011, approximately 10% of respondents reported having had sexual experiences without marriage. Of those (10%) who had had sex without being married, only 50% reported having used a condom last time they had sex outside marriage. Almost 40% of them (these 10%) reported having had sex with multiple partners and 7% (so effectively less than 1%) reported having had sex with sex workers. While this does not show what proportion had sex before the age of 15, it does show that a small proportion of young people in UAE admit they become sexually active before marriage, and engage in high-risk sex with multiple partners.
1.3	Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	No study has ever been conducted regarding multiple sex partners among the general population 15-49 years. However, it is assumed that percentages are very low. While changing sexual norms and practices among the younger population may lead to increasing proportion of persons engaging in multiple sexual partnerships, a recent study (2011) among university students (72% females, 25% males; 3% unspecified) reveals that sexual contacts outside marriage are very low: 91% reported never having had sex outside marriage. Only 8% reported at least one sexual experience outside marriage: this was slightly higher among male respondents (11%); and among non-UAE nationals (19%). Out of these 8%, only 39% (i.e. 3% of all respondents) reported having had sex with multiple partners, although one-fifth of these respondents did not answer this question.
1.4	Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse	No data is available on this indicator, as it is a sensitive research topic. As mentioned for the previous indicator, a recent study among university students showed very low % of persons having had sex outside marriage (8% overall; 11% of males), and only 3% of all respondents had had multiple sexual partnerships. However, among those who had had sex without marriage, condom use was low: 57% did not use a condom at last sex, which indicates that HIV knowledge does not necessarily lead to high HIV protection behaviours.
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	In the absence of any data from surveys or other studies, it is not possible to provide an accurate picture on the “Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results”. However, results from such a survey would likely reveal very low percentages of people who had been tested “and knew their results”, since there are no voluntary counselling and testing (VCT) services available in UAE. Most HIV

		testing takes place in the context of massive screening, e.g. in the context of pre-marital and pre-employment testing, or blood transfusions and major invasive operations; and only those who test positive are informed of their status and counselled accordingly.
1.6	Percentage of young people aged 15–24 who are living with HIV	The indicator is irrelevant to the epidemiologic context of the UAE.
1.7	Percentage of sex workers reached with HIV prevention programmes (condom distribution; HIV testing)	While sex work does exist in UAE, it is illegal and criminalised by law, and it takes place hidden. Overall, there is very little information available on sex work in UAE, as no study has ever been conducted among sex workers. Data from Dubai police show that sex work is to some part linked to human trafficking. The illegal character, social rejection, and the possible relation to organised crime and human trafficking make it extremely challenging to reach these women with HIV-prevention programmes.
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	As mentioned before (1.7), sex work is present in UAE. However, there are no special surveys or data on condom use by sex workers.
1.9	Percentage of sex workers who received an HIV test in the past 12 months and know their results	As mentioned under previous indicators (1.7 & 1.8), sex work in UAE is extremely hidden and no HIV-prevention programmes are available for these women. In addition, no (voluntary) counselling and testing services are available for the general population in UAE. Hence, there is no data on this indicator.
1.10	Percentage of sex workers who are living with HIV	As mentioned before (1.7-1.9), sex work in UAE is hidden and little is known about the exact scope and nature of the phenomenon. To date, there has been no research, nor HIV-prevention programmes for sex workers in UAE. In this context, it is extremely difficult to conduct a sero-survey to assess HIV-prevalence rates among sex workers.
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	No surveys or other studies have ever been conducted among MSM in UAE, and no preventive programmes exist. However, experiences in the wider region show that MSM tend to be relatively well-informed about HIV/AIDS through the internet and social media.
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No data is available from studies among MSM in UAE, hence it is not possible to provide accurate data on condom use by MSM.
1.13	Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results	No data is available for this indicator. Although MSM are present in UAE, they are extremely hidden and no HIV-prevention programmes are available for these men. In addition, no VCT services are available in UAE yet.
1.14	Percentage of men who have sex with men who are living with HIV	Given the hidden nature of MSM in UAE, there has been no research, nor HIV-prevention programmes for MSM. In this context, it is extremely difficult to conduct a sero-surveillance study to assess HIV-prevalence rates among MSM, as this requires trust and confidentiality.
		INJECTING DRUG USERS
2.1	Number of Syringes distributed per person who injects drugs per year by Needle and Syringe Programmes	Despite the fact that no surveys or other studies have ever been conducted among IDUs, it is safe to say that the "Number of Syringes distributed per person who injects drugs per year by Needle and Syringe Programmes" is zero, because no such programmes exist in UAE. Needle-and-syringe-exchange programmes (NSEP) are not available in UAE. The only services for (injecting) drug users are provided through the National Rehabilitation Centre (NRC) in Abu Dhabi, and include detoxification and rehabilitation services. Opioid substitution therapy (OST), however, is not available.

2.2	Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse	In the absence of any data from surveys among IDUs in UAE, it is not possible to provide an accurate picture on condom use by IDUs. Although there is no direct evidence about condom use among (male) IDUs, results from studies in the Middle East reveal that IDUs are more likely to engage in unprotected sex with multiple partners than the general population.
2.3	Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected	In the absence of reliable data from surveys among injecting drug users (IDUs), or from drug-treatment facilities or police, it is not possible to provide an accurate picture on sharing of injection equipment among IDUs in UAE. However, anecdotal evidence from drug-treatment experts and health staff treating HIV-infected IDUs, seems to indicate that needle-sharing is declining. More research is needed to get a clear picture of this important HIV-risk behaviour.
2.4	Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results	In the absence of any behavioural surveillance studies or surveys among IDUs on the issue of HIV status, there is no data on this indicator. Injecting drug users are tested for HIV when they are arrested and imprisoned, as well as when they are admitted to rehabilitation centres, but it is unknown what percentage of the total IDU population in UAE they represent. In order to increase IDUs' awareness of their HIV status, more attention needs to be given to counselling and the systematic sharing of test results (from screening), including negative results, with IDUs. Furthermore, the absence of voluntary counselling and testing (VCT) services in UAE does not allow IDUs to get tested outside the screening programmes in prisons and rehab centre.
2.5	Percentage of people who inject drugs who are living with HIV	To date, no HIV sero-surveillance studies have been conducted among IDUs in UAE. In contrast to sex workers and MSM – who remain largely hidden from the public eye – IDUs are more frequently seen in HIV screening programmes, e.g. on admission to prisons or the drug-treatment facilities. While these data from screening programmes among IDUs reveal high levels of Hepatitis C, to date they have shown few HIV cases. However, these screening data do not provide a reliable picture of the true HIV prevalence rates among the overall IDU population, as it is not known how large this group is, or where they can be found. Furthermore, many IDUs may go for drug treatment outside the country, and are thus not screened through UAE facilities. This makes it very difficult to get a true picture of the scale and nature of the IDU population in UAE. As mentioned above, clinicians treating HIV patients report a declining trend in IDU patients, which may indicate HIV is also on the decline among IDUs. However, accurate data will require scientific rather than anecdotal evidence, as there is no room for complacency given the high HIV-risk of unsafe injections.
		PMTCT
3.1	Percentage of HIV-positive pregnant women who received anti-retrovirals to reduce the risk of mother-to-child transmission	As there is no accurate estimate (e.g. Spectrum modelling) of the total number of HIV-infected pregnant women in UAE, accurate data cannot be provided. However, since all pregnant women in UAE are tested for HIV, it is likely that a very large percentage of eligible pregnant women have access to PMTCT. In 2010, 50,895 women were screened at ANC facilities: 6 were found positive; 2 of whom left for treatment abroad; 4 received ARVs to prevent mother-to-child transmission.
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	All ANC women are screened for HIV. Those who test positive are entered in PMTCT protocols, which includes EID. Results from 2010 show that out of 3 live births, all infants got EID; subsequently, 2 tested positive.
3.3	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	UAE did not conduct a Spectrum modelling exercise, therefore estimates using latest Spectrum data is not available. However, since pregnant women in UAE are routinely screened for HIV, and confirmatory tests and EID is conducted systematically, actual data for 2010 can be used: out of 3 live births 2 children were HIV-positive in that year.

		ANTIRETROVIRAL TREATMENT
4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy	Currently, 202 UAE patients are enrolled in ART; in addition, 27 non-local patients are on ART. However, no denominator data is available in the absence of estimations regarding the actual number of adults and children with advanced HIV infection; hence, no accurate percentages can be given beyond the absolute number of people known to be on ART.
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Data not available, however, discussion with key informants have revealed that high percentage of HIV patients are still on treatment 12 months after initiation of ART
		TB-HIV CO-INFECTION
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	In the absence of the estimated number of incident TB cases in PLHIV, no accurate data is available on the "percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV". However, in 2010, there were 16 adults on ART and ATT (source MOH, Dubai Health Authority, and Zayed Military Hospital)
		AIDS SPENDING
6.1	Domestic and international AIDS spending by categories and financing sources	Total spending in 2010: approx. USD 25.5 million HIV testing: approx. USD 24.6 million HIV drugs: approx. USD 860,000 Health education: USD 54,500
		CRITICAL ENABLERS & SYNERGIES
7.1	National Commitments & Policy Instruments (NCPI)	Overall ratings (1-10) 1. Civil Society involvement: 2 2. Strategic Planning: 5 3. Political Support & Leadership: 8 4. Human Rights: 5 5. Prevention: 5 6. Treatment, care & support: 7 7. M&E: 3
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	No data available
7.3	Current school attendance among orphans and non-orphans aged 10–14	This indicator is irrelevant to UAE's epidemic context, as the country has a low prevalence of HIV.
7.4	Proportion of the poorest households who received external economic support in the past 3 months	Indicator not relevant for context of UAE as high-income country with very few HIV cases, and good social services.

II. OVERVIEW OF THE AIDS EPIDEMIC

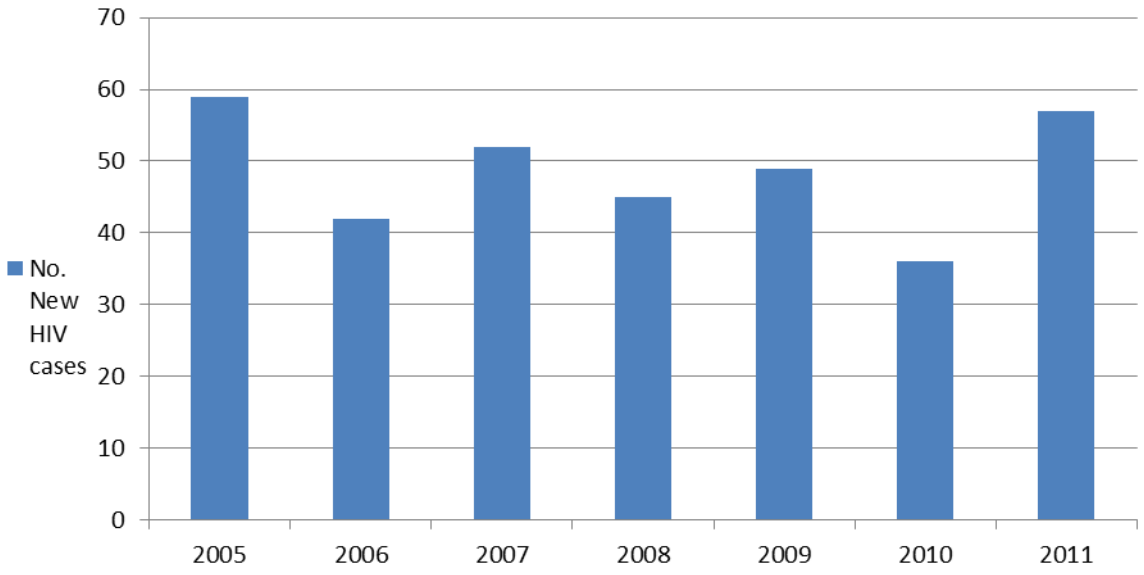
The United Arab Emirates (UAE) is e federation of the seven emirates of Abu Dhabi, Dubai, Sharjah, Ajman, Umm Al-Quwain, Ras al-Khaimah and Fujairah. The HIV situation in UAE can be characterised as low-prevalence. Since the 1980s – when the first HIV case was reported in UAE – till the end of 2011, a cumulative total of 726 HIV cases has been reported among UAE nationals: 546 males (75.2%) and 180 females (24.8%). The majority of HIV cases were found in the emirates of Abu Dhabi and Dubai, reflecting the larger populations in those two emirates, as well as possibly higher levels of risk behaviours, as both cities may be more exposed to high-risk phenomena associated with HIV. In the period 2010-2011, a total of 93 new HIV cases were reported among UAE nationals: 36 in 2010 and 57 in 2011. Table (1) shows the number of new HIV cases among men and women for 2010 and 2011 per emirate.

Table 1. New reported HIV cases among UAE nationals, by Emirate, 2010-2011

	2010				2011			
	Male	Female	Total	% of Total	Male	Female	Total	% of Total
Abu Dhabi	10	3	13	36.1	19	4	23	40.4
Dubai	7	1	8	22.2	10	1	11	19.3
Sharjah	6	5	11	30.6	11	4	15	26.3
Ajman	0	0	0	0	3	1	4	7.0
Umm Al-Quwain	0	0	0	0	0	0	0	0
Ras Al-Khajmah	3	0	3	8.3	2	1	3	5.3
Fujairah	1	0	1	2.8	1	0	1	1.8
TOTAL	**27**	**9**	**36**	100	**46**	**11**	**57**	100
% of Total (male-female)	75.0	25.0			80.7	19.3		

The annual number of new cases in the 2005-2011 period does not show any clear trend, but remained relatively stable, ranging between 36 (2010) and 59 (2005), as shown in Figure (1).

Figure 1. New HIV cases among UAE nationals, 2005-2011



However, it should be noted that these figures represent only the number of *officially reported* cases, most of which were found through screening of in the context of blood donations, pregnant women, premarital testing, and among TB patients. HIV-screening data do not accurately reflect the actual number of new HIV cases.

Those who suspect they may have been exposed to HIV – e.g. through sexual relationships or injecting drug use – may *avoid* the existing screening programmes. Thus, most-at-risk populations (MARPs) and other vulnerable groups may be particularly under-represented in these statistics. Also, experiences with premarital testing in neighbouring GCC countries have shown that over time, fewer HIV cases are found, because those who fear a positive HIV test will first go for a confidential and voluntary test elsewhere, and if found positive cancel the marriage, before being screened in the premarital programme. These and similar practices show that official HIV statistics from screening programmes should be interpreted carefully.

In the absence of surveillance among MARP groups it is very difficult to provide accurate figures for HIV cases in these high-risk groups, which are not accurately reflected in the available statistics.

Table 2: Numbers of persons screened for HIV and numbers of HIV positive found, 2010

Sentinel population	Number tested	% of total tests	Number positive	% of total cases
Blood donors (No. of blood units screened)	22,465	1.0%	1	0.15%
TB patients	132	0.006%	4	0.6%
Pregnant women	50,895	2.4%	6	0.9%
Other (pre-marital)	18,558	0.9%	3	0.45%
Other (residency applicants)	2,067,451	95.7%	651	97.9%
TOTAL	**2,159,501**	**100%**	**665**	**100%**

Table (2) presents an overview of the numbers of persons screened for HIV in 2010. It shows that the vast majority (96% of all HIV tests in 2010) is conducted among non-UAE nationals, mainly in the context of residency applications.

HIV risks and vulnerabilities among most-at-risk and other vulnerable populations

In the absence of special sero-surveillance studies, there are no reliable estimates of HIV rates among most-at-risk populations, such as sex workers, MSM and IDUs. Furthermore, no research has been conducted on the size, networks dynamics and risk behaviours of these groups, which makes it difficult to assess the HIV risks among these MARP groups, or among vulnerable groups.

However, a number of factors could drive a future increase of the HIV epidemic in UAE, including massive labour migration, influx of tourists, changing sexual norms and practices among young people, as well as the presence of MARP groups. Moreover, UAE's bustling economy and increasing tourism also attracts foreign sex workers, who are not screened, as many will stay for a consecutive number of short periods. Furthermore, globalisation has an impact on changing sexual norms and practices, especially among young people.

Behavioural risks among young people

A number of KAP studies on HIV/AIDS have been conducted among young people in UAE in 2005 and 2006. Most of these studies were conducted among male and female students at universities and secondary schools (16-19 years). The results reveal relatively high HIV awareness, but also many misconceptions about HIV transmission and prevention methods, as well as high levels of stigma and negative attitudes towards PLHIV.

While these studies merely address knowledge and attitudes, a new UNICEF-supported study conducted in 2010-2011 among students at three universities sheds more light on HIV-risk behaviours among young people. The study was conducted among 3,359 university students (75% females, 25% males; 63% Emirati nationals, 34% other nationalities). Key findings show that less than half (42%) of the respondents had good knowledge of HIV/AIDS (i.e. 5-7 correct answers out of 7 key questions). Emirati students, especially females, had less knowledge than other nationalities.

While overall knowledge about *modes of transmission* was relatively high, a considerable proportion held misconceptions, e.g. on HIV transmission through using a public toilet (38%); mosquito bites (21%); sharing a meal with a PLHIV (16%); or even by touching a PLHIV (9%). Similarly, while overall knowledge of *HIV-prevention methods* was relatively high, there were important misconceptions, such as not knowing that a healthy-looking person can have HIV (21%); while 14 percent did not know how to prevent HIV at all. A very low percentage of 15 percent considered young people in the UAE to be at significant risk of contracting HIV.

Results further show that more than half (51%) of the respondents had negative attitudes to persons using condoms, as it was associated with extramarital sex or having diseases. More than one-third (36%) expressed high stigma towards PLHIV; this included statements that HIV-infected students should be isolated (37%); reported to the authorities (27%) or sent away (18%). Forty percent of respondents said PLHIV were to be blamed themselves.

Asked about risk practices, a large majority reported they had never had sex without marriage (91%). However, 8 percent reported at least one sexual contact without marriage, with a significant difference between Emirati (3%) and foreign students (19%). The difference was also high between males (11%) and females (1%). Of those who reported sex without marriage, 39 percent reported having had sex with multiple partners, while a small proportion reported sex with sex workers (7%). It should be noted that the true extent of sex outside marriage might be higher, as this is self-reported data, and young people may be reluctant to admit this socially-rejected behaviour. Nevertheless, although this is a small percentage, it shows that sex is practised by unmarried students.

HIV risks among female sex workers

While no studies have been conducted on sex work in UAE, interviews with key informants from Dubai Police and other national institutions and UN in the context of this GARP report confirm that sex work is present in UAE. The demand for sex work may be driven by UAE's vibrant economy, open borders and tourism. Reportedly, the large majority of sex workers are foreign women, especially catering to the needs of foreign men, including expatriates living in UAE, as local men (reportedly) prefer to travel abroad for sex. Most sex work is arranged anonymously, using cell phones, with sex workers making home visits or working from rented apartments.

While many female sex workers operate on a voluntary basis – on their own or in small groups of women – human trafficking by organised international crime rings also plays a role, with especially women from poor countries in Asia being trafficked for sex work. In this

context, a special Human Trafficking Department has been created under the General Department of Human Rights of the Dubai Police, which reports approximately 50 cases of sex-work-related human trafficking per year.

In the absence of any formal research on sex work in UAE, little is known about the exact scope and nature of the phenomenon. Sex work remains hidden, as it is illegal, and no HIV-prevention programmes are available for these women. More research is needed to identify the nature and scale of sex work, and to identify the HIV-prevention needs of these women and their clients. While sex work is a very sensitive issue in UAE, neglecting these realities will result in preventable HIV infections among the population in the near future.

HIV risks among men who have sex with men (MSM)

While homosexual acts are illegal and punishable by law in UAE, MSM and homosexuality exist. However, the MSM community is largely hidden from the public sphere, and little is known about the exact scope and nature of the phenomenon. To date, there has been no research, nor HIV-prevention programmes for MSM in UAE. In this context, it is extremely difficult to conduct a sero-surveillance study to assess HIV-prevalence rates among MSM, as this requires trust and confidentiality. Hence, no data is available on the HIV prevalence among MSM.

While there is no conclusive evidence of HIV rates among MSM in UAE, official data on reported HIV cases from neighbouring countries show that as much as 15 percent of all HIV transmission is due to same-sex contacts between men. This shows the potential for a rapid spread of HIV within the MSM community. In this context, it is a priority to conduct studies among MSM to better understand the HIV risks in this community, and guide future policies and programmes for HIV prevention among MSM. This includes mapping, size-estimation studies and socio-anthropological research.

HIV risks among injecting drug users (IDUs)

While drug use – including injecting drug use – is present in UAE, the magnitude of the problem is unknown. A UNODC-supported study among drug users was conducted recently, but results are not yet available. Information on drug use is mainly available from police reports and drug treatment facilities, such as the National Rehabilitation Centre (NRC) in Abu Dhabi, which is currently the only dedicated centre for drug users in UAE. However, these institutions only see a small proportion of (injecting) drug users, and cannot provide a comprehensive overview of the drug problem in the country: in the 7-year period of 2002-2009, only 300-400 patients were seen at the NRC, while this number grew to 800 in the 3-year period of 2009-2012.

To date, no HIV sero-surveillance or behavioural studies have been conducted among IDUs in UAE. However, in contrast to sex workers and MSM – who remain largely hidden from the public eye – IDUs are more frequently tested for HIV, e.g. when arrested by the police, or on admission to prisons or drug-treatment facilities. It remains difficult, however, to get accurate data on reported HIV cases among IDUs, since aggregated data from different sources (prisons, NRC, hospitals, police) and different ministries is not easily available. Isolated information from different sites seem to indicate that there are few HIV cases among IDUs. As mentioned already, however, the IDUs admitted to these institutions represent a small and selective proportion of the total IDU community, and therefore no conclusions can be drawn regarding HIV in the wider IDU community.

Apart from accurate data on HIV numbers and rates, more information is also needed about *behavioural* risks among IDUs, as well as the total size of the IDU population and in what settings injecting drug use takes place. Key informants report that injecting drug use represents a relatively small proportion of the overall drug use in UAE. The NRC reports that most drug users are poly-drug users – mainly using prescribed drugs – while there are few IDU clients. This may be partly explained by the fact that many IDUs prefer to be treated at drug-treatment facilities abroad.

Reports from neighbouring countries show that injecting drug use and sharing of injection equipment is a problem, although exact numbers are not available either. Anecdotal reports from ARV treatment facilities in Dubai and Al Ain (Abu Dhabi emirate) seem to indicate there are few IDUs among their HIV patients. In some cases this is attributed to the 'fact' that needle sharing is on the decline, as is also evidenced by decreasing Hepatitis C infections among IDUs seen at these facilities.

In summary, the current lack of reliable information on the scale of injecting drug use, behavioural risks among IDUs, and HIV rates among this group makes it impossible to assess the extent to which IDUs are a key HIV-risk group in UAE. Experiences in other countries, however, have shown that sharing of injection equipment is a particularly efficient way of transmitting HIV, and that HIV can spread very quickly in the IDU community, unless adequate HIV-prevention programmes are put in place. Therefore, more research regarding the specific HIV risks among IDUs is urgently needed to inform an adequate response.

III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

The previous section showed that UAE remains a low-prevalence country, with a relatively stable number of new cases each year. It also revealed, however, that there are many potential drivers in UAE that could lead to a more rapid increase of the number of HIV cases in the near future, unless effective measures are taken. The first condition for an adequate national response to HIV is political support and leadership.

1. National Commitment

In the previous UNGASS / GARP report two years ago, UAE reported [quote] *"a good 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. UAE governmental officials speak publicly and favourably about HIV efforts in major domestic forums."* Two years on, the high-level commitment and political support that was reported in 2010 continues to be crucial, as there are still a number of challenges in this area: overall, the profile of HIV/AIDS on the national agenda needs to be strengthened.

Achievements as well as challenges with regard to political support and leadership in the field of HIV in UAE are reflected at: 1) the *institutional and organisational* level; 2) in *policy and programme development*; and 3) in terms of *allocation of human and financial resources*.

1) While there is continued high-level political support for HIV/AIDS, at the ***institutional level***, challenges remain with regard to the effective coordination of the HIV response. UAE does not have a specific multisectoral HIV coordination body, although there is a multisectoral *team,* which consists of the leadership of the MOH and other key Ministries, as well as other governmental and non-governmental partners, such as the Police, UNICEF, Red Crescent and others. In addition, the MOH-based *National AIDS Programme* (NAP) works in close collaboration with HIV focal points in the Health Authorities of Dubai and Abu Dhabi.

Despite these efforts, coordination at the *operational* level remains challenging in the absence of an adequate secretariat to provide effective support to this multisectoral collaboration. To date, the NAP remains under-staffed at the MOH while there is no dedicated staff at the level of the Dubai and Abu Dhabi health authorities. This lack of adequate allocation of human resources reflects the low level of priority that is still given to HIV.

2) These challenges at the institutional level are reflected at the level of ***policy and programme development***: to date, the status of the multisectoral National Strategic Plan (NSP) that was drafted in 2006-07 has still not been endorsed as an official policy document. The absence of an approved NSP and operational plan has been hampering the implementation of a comprehensive HIV programme. As will be discussed in the following sections, in the 2010-2011 period, the national response has remained limited to a few components – most notably HIV screening and ARV treatment – while there have been very few efforts to systematically implement HIV-prevention programmes. The previous NSP had expired in December 2010: since then, no new NSP has been developed. A positive development, however, is the recent decision by the MOH-NAP and UNAIDS to review and update the NSP in 2012.

3) The remaining challenges at the institutional and policy level, as described above, are further reflected at the level of ***allocation of financial and human resources***. Table (3)

gives an overview of the national resources spent on HIV/AIDS in 2010. More than any description of HIV-related interventions in the *"Programme implementation"* section below, this Table reveals the programmatic priorities in the reporting period 2010-2011. Although not all government spending – such as staffing and health systems support for HIV care and treatment – may be accurately reflected in this table, it shows the unilateral attention for massive screening (96.4% of all funds spent) – predominantly of expatriates in the context of residency permits – and for ARV treatment and care, albeit at a much lower level (3.4%), and the virtual absence of resources allocated to HIV-prevention efforts, which represents *a mere 0.2 percent* of all expenses.

Table 3. Total AIDS spending in 2010, UAE (NAP, 2012)

Programme / service	Total funds spent (UAE Dirhams)	% of total spending
HIV testing (screening programmes)	90,152,644	96.4
HIV medications (ARVs and other drugs)	3,161,997	3.4
HIV health education and other activities	200,000	0.2
Total AIDS spending	**93,514,641** (USD 25,480,829)	100

The table also reflects another challenge, namely the difficulty to gather information on financial expenses on HIV in non-health sectors: most of the activities that may have been conducted by non-health sectors do not have clearly earmarked allocations for "HIV/AIDS", which makes it particularly difficult to adequately track the national response in terms of spending.

2. Programme Implementation

As mentioned in the previous section, a major stumbling block for programme implementation in the 2010-2011 period has been the absence of an officially endorsed national strategic plan and operational plan, which ended in 2010, and was subsequently not revised. Without the overall guidance of a commonly agreed HIV/AIDS policy, the national response has remained scattered and ad-hoc, with most HIV-related interventions taking place in the context of other existing public health policies and strategies, without having a clear, specific vision on comprehensive HIV prevention, care, treatment and support.

HIV prevention

The limited resources available for HIV prevention in 2010-2011 have mainly been spent on a range of general awareness-raising activities, which were ad-hoc or part of more comprehensive programmes. In this sense it is difficult to provide a comprehensive picture of these activities, as there is no clear overview. The main challenge is to move beyond ad-hoc, project-based activities, which are typically discontinued after 1-2 years. Successful experiences need to be carefully evaluated, so that they can be used for continued programme implementation.

Examples include World AIDS Day activities, and small-scale, ad-hoc educational activities, which were often supported by non-governmental partners. In the previous period, UNICEF

supported the Dubai Police in the *"Unite for Children, Unite Against AIDS"* campaign, which was also supported by the private sector but this was not followed up in 2010-2011. Since 2011, UNICEF has been working with the General Women's Union on issues regarding violence against women. Since recently, UNICEF is trying to become more (pro) active in the HIV field: it is currently developing an HIV strategy and 2-year workplan. Part of their objective is to help gradually strengthen civil society capacity and interest in working in HIV prevention.

Ongoing programmes include the provision of IEC materials on HIV/AIDS at HIV testing centres for expatriates in their local languages, including Chinese, English, Russian, Tagalog, Urdu and other languages.

The Red Crescent has volunteers throughout the country, which have been involved in various general HIV-education activities, including peer education, workshops and lectures, as well as HIV-related activities in the context of the UNFPA-supported "Y-Peer" initiative, which is a regional programme for sensitisation of young people in the field of sexual and reproductive health issues, including HIV. Future plans include a collaborative effort with the Abu Dhabi National Oil Company (ADNOC) for workplace HIV education.

HIV education in schools and universities – HIV has been part of the curriculum for secondary school children since many years, but education is limited to factual knowledge, without attention for life skills or specific HIV-prevention methods. A specific problem that was expressed with regard to HIV programmes in educational settings, is that many universities are reluctant to be associated with HIV-prevention efforts, while they can play a very important role in HIV education for young people, who increasingly engage in high-risk behaviours.

HIV screening and testing – Massive screening is a major component of the national response to HIV: more than 95% of national resources for HIV is spent on screening of large numbers of people each year, predominantly expatriate workers and other foreigners (>95% of all HIV tests).

Despite of this screening, the preventive impact of screening on the population is limited: Mass screening would provide a good opportunity to raise awareness among a large group of the UAE community, but this has not been considered to date. Furthermore, the screening programmes tend to have a systematic bias towards certain at-risk groups: those who suspect they may have been exposed to HIV may tend to select themselves out of certain screening categories, e.g. by seeking an HIV test elsewhere, including abroad. Hence reported HIV cases from the screening programmes do not reflect the picture of HIV in the country, especially among MARP groups.

Voluntary counselling and testing (VCT) services could provide added value to the existing screening programmes. In this regard, a positive development in the 2010-2011 period has been the revision of existing policies and legislation with regard to HIV screening and testing, in order to allow anonymous, voluntary counselling and testing. VCT will allow people to get a voluntary HIV test without being reported. However, actual implementation of VCT services and training of staff are still pending. A challenge in this regard is the fact that many staff involved in screening or other HIV-related health-care services have little confidence in the added value of VCT: they often consider that existing screening programmes are highly-effective in identifying most HIV cases, not realising the selection bias associated with those programmes.

PMTCT – Antenatal care attendees in UAE are systematically screened for HIV to allow PMTCT. ANC services are provided at 193 health-care facilities. Twenty-six of these also provide CD4 testing on site, or have a system for collecting and transporting blood samples

for CD4 testing for HIV-infected pregnant women. In 2010, 50,895 pregnant women were tested for HIV. Six women tested positive: out of these four received antiretroviral drugs to reduce the risk of mother-to-child transmission. One was diagnosed and followed early during pregnancy and received ARV; three presented at labour and subsequently received the HIV management once diagnosed; while the remaining two women left the country after diagnosis to be managed in their home countries. Out of the four women who were enrolled in PMTCT, three had live births, while one had a still-birth. All three children born were tested within two months of birth: two were HIV-positive.

Targeted interventions for MARPs and other vulnerable groups – As mentioned, the draft 2008-2010 NSP, which was never formally endorsed, did not contain specific interventions for MARPs, although they were mentioned in general terms. In the 2010-2011 period, the continued lack of a clear legal framework, a clear vision on HIV prevention, coupled with stigma, discrimination and criminalisation of MARP groups continued to hamper targeted HIV-prevention programmes for MARPs.

Still, there has been little progress towards addressing HIV risks among these groups. Therefore, one of the first priorities will be to conduct more research into the HIV risks of these groups –including mapping and size estimations – in order to provide the evidence base needed for policy and programmatic decisions on HIV prevention for MARPs.

Another challenge for implementing HIV prevention among MARPs is the overall weak development of the civil society sector in UAE. Most civil society organisations focus on overall charity activities, but outside the Red Crescent, few have a specific interest in being involved in HIV/AIDS, much less for working with MARPs.

Injecting drug users are the (relatively) easiest-to-reach MARP group. Existing drug-treatment services are provided by the National Rehabilitation Centre (NRC) in Abu Dhabi, the Psychiatric Department in Sharjah, and a drug-treatment facility run by the Dubai police. All patients who enter the programmes – either voluntarily or referred by the police – are tested for HIV, HBV and HCV. At the NRC, only two HIV cases were reported (period not specified). The main services offered by the NRC include detoxification and rehabilitation programmes, as well as opioid substitution therapy (currently for 8 patients) using *Suboxone* – a combination of *buprenorphine* and *naloxone*.

However, current capacity is low and the services offered by the NRC are still not well-known among drug users and their families. Hence, coverage is still low, with approximately 800 patients per year at the NRC in the 2010-2011 period. Treatment results to date are still sub-optimal, with high rates of relapse and re-admission. Plans exist to open a new facility in 2015 with a capacity of 200 beds. In addition, there are still unsubstantiated plans to open a facility for female drug users.

One of the challenges is the fact that little research has been done: hence the NRC and other institutions do not have a clear overview of the magnitude of the drug problem and clients' treatment needs and expectations. Poly-substance use is reported to be on the rise, affecting 70-80% of all clients. Injecting drug users (mostly heroin) are a minority group at the NRC, but this is not representative of the total drug-user community in the country.

Outside these drug-treatment programmes, no specific HIV-prevention programmes for IDUs exist. There are no outreach or peer education programmes, and needle-exchange programmes are non-existent. As mentioned above, lack of reliable data on the scale and scope of the drug-use problem in UAE hampers effective programmes and services, also for HIV prevention.

Female sex workers – While sex work does exist in UAE, it is illegal and criminalized by law, and extremely hidden. Overall, there is very little accurate information available on sex work in UAE, as no proper qualitative research, mapping or size estimations, or any other type of study or survey has ever been conducted among sex workers. The illegal character, extreme social rejection, and the possible relation to organised crime and human trafficking make it extremely challenging to reach these women with HIV-prevention programmes.

Men who have sex with men – For similar reasons as for sex workers, there have been no HIV-prevention activities for MSM in the 2010-2011 period. Overall, MSM and homosexuality are rejected by society norms, criminalised by law, and surrounded by severe stigma and discrimination. Nevertheless, most MSM will avoid openly expressing their sexual identity and behaviours; thus, it is very difficult to reach them with HIV-prevention, or any other type of programme.

In addition, self-stigma may further hamper identifying and working with MSM: very few of the newly-found HIV cases in 2010-2011 reported MSM contacts, which seems to indicate that HIV-infected MSM will avoid at all cost being identified as MSM (in addition to being HIV-infected).

Therefore, future HIV-prevention programmes for MSM need to build on confidentiality and peer outreach work. More research is needed to better understand the social networks of MSM in UAE, and the link with MSM communities in other countries in the region through internet groups and international networks.

HIV treatment, care and support

UAE continues to offer universal access to free and comprehensive HIV treatment, care and support for all UAE nationals. This includes antiretroviral therapy (ART); paediatric AIDS treatment; STI management; palliative care and treatment of common HIV-related infections; HIV testing and counselling for TB patients; TB screening for HIV-infected people; TB preventive therapy for HIV-infected people; and cotrimoxazole prophylaxis in HIV-infected people.

Table 4. Number of adults and children currently receiving ART, December 2010

	Abu Dhabi Health Authority		Dubai Health Authority		Ministry of Health	
	males	females	Males	Females	males	females
< 15 yrs	1	1	0	1	0	0
>= 15 and above	73	31	62		20	13
Total	74	32	63		20	13
Total for each authorities/MOH	**106**		**63**		**33**	
Grand total	**202**					

- Abu Dhabi Health Authority manages an additional 24 non-local patients
- MOH manages an additional 3 non-local
- Grand total = 202 + 24 + 3 = **229**

In 2010, 11 public (governmental) health facilities throughout the UAE were offering ART. By the end of 2010, a total of 229 HIV patients were enrolled in ART: 202 UAE nationals and 27

foreigners *(see Table 4)*. ART patients are administrated through the Abu Dhabi and Dubai Health Authorities, while the Ministry of Health manages the patients in the remaining five emirates. Most patients are registered under the Abu Dhabi Health Authority (130, 56.8%), while Dubai manages 63 (27.5%) and the MOH 36 (15.7%). It should be noted, however, that many Emirati PLHIV choose to seek treatment overseas out of fear of HIV-related stigma, social rejection and discrimination.

Challenges with treatment, care and support

While HIV treatment and care is of overall high quality, a number of challenges were reported by ART facilities in Dubai and Al Ain (Abu Dhabi emirate) that were visited. While patient follow-up is done in accordance with WHO standards, problems with follow-up or adherence exist among some patients. This is due to the fact that there is no national database that allows following up HIV patients throughout the country. Health information systems in UAE are often still scattered across the different systems of Abu Dhabi, Dubai and the MOH.

Approximately 10 percent of ART patients have problems with drug resistance due to poor compliance. In general women show better adherence than men.

Challenges also exist with regard to the provision of comprehensive care and support: not all ART facilities have enough trained staff to offer comprehensive treatment, care and support to HIV patients, due to problems with high staff turnover, especially expatriate health workers. In this regard, Tawam hospital in Al Ain is renowned for its comprehensive and high quality of services, which builds on a strong team of multisectoral experts, including clinicians and specialised nurses, clinical pharmacists, counsellors, clinical psychologists. However, even when comprehensive HIV treatment teams exist, many patients eventually present social problems that are not directly, but indirectly linked to HIV, and need special care.

ART facilities also mention a shift towards younger patients, as a consequence of more liberal sexual morale, including multiple sexual relationships and MSM contacts

Social, psychological and legal position of PLHIV

An important achievement in 2010-2011 with regard to the *legal rights* of PLHIV has been the *official endorsement* of a bylaw for the protection of the legal (health, employment, education) rights of PLHIV, as well as for the protection of the community against HIV. This was an important step, since the NSP 2008-2010 itself was never *formally* endorsed by officials.

Social support is not part of the standard treatment-and-support package for PLHIV. However, social support can be provided if needed, based on the individual needs of the client. Furthermore, the pension system allows PLHIV to enrol in full medical retirement if needed.

IV. BEST PRACTICES

Best practices with regard to UAE's national response to HIV include a number of particularly successful services, interventions or initiatives:

- The legal status of PLHIV has been officially protected in terms of their right to health, employment, education and non-discrimination. This involves free access to comprehensive treatment, care and support services for all UAE nationals; including economic support and the right to full medical retirement; social support services based on individual needs; and legal protection with regard to employment. An excellent treatment-and-care model exists in Tawam hospital, Al Ain, which involves continuity of HIV treatment and care through a multidisciplinary team of clinical, psychological and social support service providers.

- The creation of a General department of Human Rights by the Dubai Police in 2006 has strengthened protection of women who are victims of human trafficking. While this was done in the context of a short-term collaborative programme, the Dubai police has integrated these departments into its organisational structure. The experience with regard to the protection of the human rights of vulnerable populations is a powerful model for the development and implementation of similar programmes for HIV prevention among most-at-risk populations.

- Screening in the context of antenatal care provides HIV-infected women and men the possibility to have children and protect their unborn child against HIV infection, and allows them to lead normal lives.

- Involvement of government ministries and institutions, civil society organisations, UN agencies and private sector in partnerships – albeit on a limited scale to date – presents promising models for the development and implementation of targeted HIV-prevention programmes and services for most-at-risk populations.

V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

The previous chapters revealed that there are still many challenges facing the national response to HIV in UAE. Most of these challenges were already reported in the previous UNGASS report in 2010, and while some were addressed in the 2010-2011 period, many remain.

HIV-prevention efforts have been suboptimal, especially among MARP groups, for whom no special programmes have been available in the past, including in 2010-2011. While the absence of targeted MARP programmes does not seem to have resulted in high numbers of HIV cases among these groups so far, complacency with regard to HIV prevention for MARPs may lead to a sharp increase in future years. In this context, changing sexual norms and values among Emirati youth, and the influence of large numbers of expats on traditional Emirati society should not be underestimated.

Specific challenges, specific remedies

A more systematic, evidence-informed response to HIV in the next two years, 2012-2013, requires addressing the main challenges in a number of areas:

1. Strengthening and operationalizing political support – despite the available high-level political support, the status of HIV as a public health priority still needs further strengthening. In particular, this needs to translate into political and financial support for HIV-prevention programmes for most-at-risk populations and young people, which have so far been hindered by legal, social and cultural obstacles.

Remedial action: A combination of strong evidence *(see next)* and effective advocacy is needed to further convince high-level decision-makers of the need to strengthen HIV prevention, and to provide proactive support, especially for HIV prevention among MARPs. In addition, leadership from the highest levels is needed to garner support at lower administrative levels. International experience and technical assistance may help highlight the priority issues.

2. Lack of evidence regarding the potential drivers of a future HIV epidemic, the existence and scale of high-risk behaviours, and effective interventions makes it difficult to convince political leaders and policy makers to provide political and financial support, and to establish effective HIV-prevention, care and treatment programmes. The absence of adequate surveillance systems, research and M&E systems hampers an *evidence*-informed approach, which includes effective national policies and strategic frameworks, as well as adequate budgets.

Remedial action: 1) Research on social and behavioural dynamics of MARP groups, youth and other vulnerable groups, that increase HIV risks. 2) Strengthening of existing surveillance systems, especially bio-behavioural surveillance studies among MARPs; as well as improved national M&E systems, that support effective information flows from data collection down to the use of data for evidence-informed decision-making; 3) Effective operational research and M&E systems that allow assessing and identifying effective HIV interventions, that are based on the specific service needs of PLHIV and at-risk groups.

3. Inadequate institutional support systems an budgets – The absence of a functional *National AIDS Council* (NAC), comprising high-level leadership from different sectors, hampers the establishment of a strong, multisectoral response to HIV. In addition, the current MOH-based *National AIDS Programme* (NAP) remains understaffed and under-resourced. A well-resourced NAP with adequate institutional and operational budgets and infrastructure is instrumental to oversee and support the implementation of the national response and to support the NAC.

Remedial action: 1) Establishment of a functional NAC, with effective membership from key sectors – including but not limited to health, police and interior, education, social affairs, labour – as well as clear mandates and TORs, and adequate administrative support; 2) Strengthening of NAP through: a) Increased technical and administrative staff, with clearly described mandates and TORs that allow NAP to act accordingly; and adequate budgets.

4. The current absence of an officially endorsed National Strategic Plan and costed Operational Plan has left the national response without a clear focus on priority interventions. Without an NSP and specifically described priority strategies (OP) and allocated budgets the national response will remain scattered, ad-hoc and ineffective – especially in the HIV-prevention field.

Remedial action: Development (2012) of an NSP and costed Operational Plan, with active involvement and participation of all key stakeholders – governmental, civil society including PLHIV, private sector and UN agencies.

5. Lack of effective interventions – especially in the field of HIV prevention for MARPs and vulnerable groups; PLHIV and stigma and discrimination – fail to address priority issues and meet the service needs of MARPs and vulnerable populations. To date, the national response has been biased towards HIV screening and ART; A new vision is needed that prioritises HIV prevention from a human rights perspective: interventions need to be based on sound evidence, proven cost-effectiveness, and meet the needs of key populations with regard to information, skills, treatment, care and (social, legal) support.

Remedial action: Develop and implement HIV programmes and services – in accordance with the revised NSP and OP – especially in the field of targeted HIV prevention for key populations. Decisions regarding priority interventions need to be based on proven (cost) effectiveness, social and cultural acceptability; and expressed needs of beneficiaries. Examples include VCT services; programmes to reduce stigma and discrimination; peer education and outreach for MARPs and young people; workplace programmes; PLHIV support groups; harm reduction programmes for IDUs; advocacy for and involvement of social, political and religious leaders in HIV prevention; and regional collaboration.

6. Lack of experience and capacity in HIV prevention and weak civil society – To date, there has been very limited experience with targeted HIV programmes, especially with regard to prevention. These programmes require specific experience and skills to work with often hard-to-reach groups in sensitive areas, which can often not be offered through government institutions. The lack of experience in UAE is further compounded by a weak civil society, with few CSOs experienced or interested in working in HIV prevention with MARP groups.

Remedial action: Training and capacity building in the field of a) Technical expertise and skills; and b) Institutional and organisational capacity, especially for the weak civil society. This also includes support to establish a PLHIV association with international support from

PLHIV networks. Additional activities may include site visits to successful programmes in the region, attending international conferences and organising national or regional ones in UAE; training and on-the-job technical support.

7. Lack of supportive legal, social and policy environments, including stigma and discrimination – In addition challenges already mentioned above, existing legal and policy frameworks, and social norms and values often hamper specific HIV/AIDS programmes and services. Criminalisation of MARPs hampers effective outreach or may not allow certain interventions, such as opioid substitution therapy, safe injection programmes, condom promotion or explicit HIV education for young people. In the absence of more supportive environments, none of the above challenges can be effectively addressed.

Remedial action: the creation of supportive environments is complex and may typically meet resistance from different groups. Therefore, HIV programmes need to be culturally and religiously sensitive, and actively involve political, community and religious leaders. This requires involving them in research, programme development, implementation and evaluation. Furthermore, lobbying and advocacy strategies need to focus on gaining support from political leaders. Overall, emphasis needs to be placed on mobilising support for effective HIV prevention, care and treatment programmes.

VI. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

UAE is high-income country with excellent medical and other infrastructure. In this regard it is not in need of external financial support. However, development partners, especially local and international civil society organisations and NGOs, and UN agencies, can play an important role in strengthening the national response to HIV/AIDS through technical assistance and exchange of experiences, and cooperation in joint planning and implementation of programmes and services. Examples of excellent collaboration between government agencies, UN agencies, civil society organisations and private sector– such as with NAP, Dubai police and UNICEF; Red Crescent, UNFPA and local health authorities – already exist, but need to be further systematised and consolidated into sustainable programmes.

However, UN presence is very limited, and restricted to a UNDP office and UNICEF presence. However, the UNDP can mobilise technical assistance from UN agencies, such as for the revision and development of a National Strategic Plan (ASAP, World Bank/ UNAIDS); National M&E Plans (UNAIDS); HIV prevention among MARPs (UNAIDS, UNODC); HIV treatment and care, including ART and PMTCT (WHO, UNICEF); HIV education for young people, children, in and out-of-schools (UNFPA, UNICEF, UNESCO); and HIV workplace programmes and employment rights (ILO); and strengthening civil society organisations (UNDP).

VII. MONITORING AND EVALUATION ENVIRONMENT

(a) Overview of the current monitoring and evaluation (M&E) system

To date, UAE has not had a proper ***system*** for monitoring and evaluation of HIV/AIDS, nor has it developed a joint national M&E ***plan*** to systematise the collection, reporting, storage and utilisation of all HIV-related data for planning and programming purposes. Overall, effective surveillance and monitoring are challenged by the presence of parallel data-management systems at the national MOH and the health authorities of Abu Dhabi and Dubai, which hampers effective data flows and sharing.

The available HIV-related data is mainly based on large-scale HIV screening of selected population groups (large majority for residency permits) and specific settings, as well as data from clinical monitoring of HIV patients. However, there is no HIV-surveillance system that accurately assesses HIV prevalence among the general population, nor among most-at-risk groups, such as sex workers, MSM and IDUs, although IDUs are tested to some extent through police, prisons and drug-treatment facilities (but this does not represent systematic data).

In addition, no behavioural surveillance studies have been conducted, and there is no national research agenda that identifies research priorities in the HIV field.

Furthermore, given the limited experience with HIV-prevention programmes among the general population or MARP groups, programmatic M&E data is mainly restricted to clinical monitoring of HIV patients. All those enrolled in pre-ART care and ART are regularly tested for CD4 and viral load.

Adequate financial monitoring of HIV interventions is difficult, as there is no central overview of HIV expenditures; most HIV-related expenditures are not earmarked as such. Therefore it is difficult to get an accurate overview of expenses made in the context of HIV/AIDS. Most of these costs are for HIV screening, ARV treatment and ART monitoring (laboratory), while much smaller amounts are spent on other interventions, especially in the field of HIV prevention.

(b) Challenges faced in the implementation of a comprehensive M&E system and remedial actions to be taken

Specific challenges with regard to current M&E systems include the following issues:

1. Absence of overall national HIV strategy and framework
2. Inaccuracies and gaps in data collection
3. Availability, accessibility and utilisation of HIV-related data
4. Adequate human resources and infrastructure for HIV-related data management

1) In the absence of an up-to-date NSP, the current national response to HIV in UAE lacks a clear focus on clearly identified priorities. With the development of a new NSP, it is expected that more attention will be given to HIV prevention, besides the current priority attention for ART and screening. Therefore, a priority *remedial action* is the development of a national M&E plan and system in conjunction with the development of the new National Strategic Plan (foreseen for 2012). This revised NSP should specify the national priorities in the field of HIV/AIDS, with M&E and surveillance as a priority component.

2) Inaccuracies and gaps in data collection: Official HIV data rely mainly on reporting of HIV cases found through health services and screening activities. However, this system does not give an accurate picture of the overall UAE population, and especially with regard to HIV rates among MARP groups. People with high-HIV-risk behaviours typically tend to screen themselves out for blood donations, or may get tested abroad to avoid being identified. Similar self-selection mechanisms may occur for pre-employment testing. Hence, the number of people found to be HIV-infected through the current screening mechanisms is likely to reflect an *underestimation* of the true number of HIV-infected persons.

In addition to inaccuracies with regard to HIV surveillance among the general population, there are *significant gaps* with regard to data on MARP groups and other vulnerable populations. Due to the currently extremely low HIV rates, HIV/AIDS continues to be seen as a low priority, and there is no overall HIV research agenda for MARPs. In addition, and as a result of the lack of interventions in the prevention field, there is no specific experience or systems for monitoring of interventions in this field.

Hence, remedial actions in this area involve the establishment of a system of integrated biological and behavioural surveillance (IBBS) studies, specifically focusing on MARP groups. Furthermore, the improved roll-out of confidential VCT services will promote people to get tested, who would otherwise not easily be found through screening. A research agenda is needed to ensure that priority research topics are identified and systematically addressed.

3) Apart from the gaps in data *collection*, there are also problems regarding the *availability and accessibility of data*. While most HIV data is collated and available at the NAP, there is no true central database that contains all HIV-related data. E.g., financial data collection is hampered due to a lack of clear financial monitoring systems. A priority *remedial action* in this field is the establishment of a central data base on HIV at the MOH-NAP. To this effect, clear data-collection- and reporting protocols are needed, which ensure a smooth flow of data from the facility level, as well as between the different sectors and health authorities (i.e. MOH, Abu Dhabi and Dubai health authorities). A major challenge is the accessibility and use of this data for policy and programme decisions and resource allocation: even if one national database exists, the data may not be easily accessible for all stakeholders.

4) The lack of a unified national HIV/AIDS surveillance and M&E system is further compounded by the *absence of a special M&E unit or dedicated, trained data-management staff in the NAP* at MOH. More capacity building is needed in this field to ensure adequate operation of M&E systems; while a special unit should be considered for management of HIV data. However, before strengthening human resources in this field, the current staffing level of the NAP should be strengthened.

ANNEXES

ANNEX 1: National Commitments and Policy Instrument (NCPI)