

UNGASS COUNTRY PROGRESS REPORT

Kingdom of Bahrain

Reporting period: January 2010 – December 2011

Submission date: March 31, 2012

Acknowledgements

This report was made possible with the support and commitment of the Government of the Kingdom of Bahrain and the Ministry of Health, especially His Excellency Sadiq Abdulkarim Al-Shehabi, Minister of Health; Dr. Mariam Al Jalahma, Assistant Undersecretary for Primary Health Care and Public Health; and Dr. Khairya Moosa, Director of Public Health.

Technical support was provided by Dr. Adel Salman Alsayyad, Chief of the Disease Control Section, Public Health Department; and members of his team, including Dr. Kubra S. Nasser, Dr. Wafa Al Sahrbati, and Mr. Mohammed Ali. Special appreciation is extended to Dr. Somaya Al-Jowder, Member of the Council of Representatives and former Head of the National Committee for the Prevention of AIDS, for offering her time and invaluable insights into the national response.

Special thanks is also extended to those who participated in interviews and/or the NCPI process, including Dr. Jameela Al-Salman (Head of Medical Department, Salmaniya Hospital), Dr. Safa Al-Khawaja (Consultant, Infectious Diseases, Salmaniya Hospital), Dr. Zahra (Head of Medical Commission Ministry of Interior), Dr. Abdul Nabi (Head of Al-Muayyad Addiction Unit, Psychiatric Hospital), Dr. Mariam Al-Shetti (Member of National Committee on AIDS Prevention), Dr. Kadhim J. Al Halwaji (Head of Health Promotion Programs, Health Promotion Directorate), Dr. Mariam Al-Hajeri (Chief of Department of School Health, MOH), Dr. Ashwaq Abdalla Sabt (Department of School Health, MOH), Mr. Ali Salman Saleh (Programme Analyst, United Nations Development Program), and Dr. Tawfeeq Naseeb (President, Bahrain Reproductive health Association). A person living with HIV, who will remain anonymous, also generously offered his time and insights into the national response and contributed to the NCPI.

The NCAP also recognizes and thanks UNAIDS MENA for the assistance provided in writing this report.

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I. Status at a glance

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

The preparation of the Kingdom of Bahrain's 2012 United Nations General Assembly Special Session (UNGASS) Progress Report involved the participation of a broad range of stakeholders, both governmental and non-governmental. The process for compilation of relevant information for this report was led by the Public Health Department of the Ministry of Health (MOH).

A one-day meeting was held with representatives from sections of the Ministry of Health, including the Communicable Disease Unit of the Public Health Department, the Health Promotion Directorate, the Addiction Unit, and the Department of School Health. In addition, individual meetings were held with the former Head of the National Committee for the Prevention of AIDS (NCAP), the Ministry of Interior, the United Nations Development Program (UNDP), non-governmental organizations (NGOs) and PLHIV (persons living with HIV).

The objectives, process and outcomes of the 2012 UNGASS reporting were shared with His Excellency, Sadiq Abdulkarim Al-Shehabi, Minister of Health, Dr. Mariam Al-Jalahma, Assistant Undersecretary for Primary Care and Public Health, and Dr. Khairy Moosa, Director of Public Health.

Data for reporting on indicators were collected from the Kingdom of Bahrain's robust Health Information System. The administration of the National Policy Composite Index (NCPI) was carried out during the meetings and interviews described above. The results were combined and Part A was validated by the Public Health Department of MOH, while Part B was circulated to all respondents for review and comments.

After the initial background desk review, the process of data collection, interviews and meetings was carried out over a one-week period. The final report was reviewed by Dr. Adel Al-Sayyad, Chief of the Disease Control Section, to ensure that it comprehensively and accurately represents the national situation and response to HIV/AIDS in the Kingdom of Bahrain.

(b) The status of the epidemic

The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that approximately 500,000 people are living with HIV in the Middle East and North Africa region. The rate of new infections has increased steadily since 2001 in the region, in contrast to the declining epidemics described in most other parts of the world.

Few data are available on the scope of the epidemic in the Kingdom of Bahrain due to the absence of systematic HIV surveillance. Information is limited to case-finding, primarily through mandatory screening. The number of infections detected through screening has remained relatively constant at a low level. Low-risk general population screening (e.g. ANC women and blood donors) points to a prevalence of <0.1%. The highest prevalence is found among drug users. Mandatory screening data on admission to rehabilitation programmes indicate a prevalence of 3.3-4.6%.

However, it should be noted that case reporting data do not provide a complete picture of the full scope of the epidemic because individuals who are screened are not necessarily representative of the entire population group. Pockets of infection among persons who are not subjected to screening would not be detected by this monitoring method. The low CD4 counts among newly diagnosed cases indicates that people are being diagnosed at a late stage and suggests that a relatively low proportion of PLHIV know their status.

Historically, the overwhelming majority of identified HIV cases were due to injecting drug use. More recently, the proportion due to heterosexual transmission has increased, suggesting that the epidemic has spread beyond the drug user community. As in the past, most identified infections are among males and about three-quarters of newly identified PLHIV are non-Bahraini migrants who are deported at the time of diagnosis.

(c) The policy and programmatic response

Political commitment to the national HIV response remains high in the Kingdom of Bahrain. The Bahrain ambassador delivered a speech at the United Nations General Assembly Plenary in June 2011 stating that although HIV remained at low prevalence in Bahrain, his Government shared the international community's concerns regarding HIV and AIDS.¹ The Minister of Health gave a speech about AIDS at the World Health Assembly in 2010. In addition, the Head of the NCAP participated in the Gulf Cooperation Council (GCC) meeting culminating in the Riyadh Charter, which re-affirmed Bahrain's commitment to respond effectively to HIV. On the domestic front, public statements originate primarily from within the Ministry of Health. For example, the Minister of Health delivered a speech on World AIDS Day and the Director of Public Health has been interviewed in the newspaper about AIDS.

Despite such indications of high-level commitment, the multi-sectoral response has not gained strength in Bahrain. HIV/AIDS is viewed primarily as a health issue and is largely left to the Ministry of Health to manage. Attendance at the National Committee for Prevention of AIDS (NCAP) meetings is low and the committee has not met for over one year. There is no governmental budget allocated specifically for HIV/AIDS activities. Only a small number of NGOs are active in HIV/AIDS activities, since most are more concerned with other issues.

Over the past two years, an active policy debate has centered on a proposed HIV Law, which was submitted to Parliament in 2009. The originally proposed version (submitted in 2009) included several elements that were inconsistent with the National Strategy for the Prevention of AIDS, including immediate notification of employers of a worker's positive HIV status. After discussion, the law was revised in line with a rights-based approach and a decision is still pending in Parliament. It has been recently withdrawn for further revisions and planned re-submission.

The political unrest over the past year has slowed the implementation of the programmatic and policy response. In addition to difficulties faced in implementing community-based programmes and convening meetings, the political situation has

¹ United Nations Sixty-fifth General Assembly Plenary (11 June 2011). GA/11093. Adoption of political declaration promises 'bold and decisive action' to wipe out what remains of global human tragedy of HIV/AIDS, as high-level meeting concludes. <http://www.un.org/News/Press/docs/2011/ga11093.doc.htm> (accessed 9 March 2012).

dominated the attention of most stakeholders for the past several months. Another challenge has been the decision of the Head of the National Committee for the Prevention of AIDS (the only full-time dedicated position) to seek election to Parliament and her subsequent resignation from the NCAP in mid-2011. Her replacement is imminent, but has not yet been announced at the time of preparation of this report.

(d) Indicator data in an overview table

Table 1: UNGASS Indicators Overview Table

Indicator	Status 2010	Status 2012	Comments
Target 1. Reduce sexual transmission of HIV by 50 per cent by 2015			
General population			
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	Not available.	Not available.	2006 KABP survey among 2,145 university students (aged 18-25): 73% knew that the risk of HIV transmission can be reduced by having sex with only one uninfected partner who has no other partner 60% knew that a person can reduce the risk of getting HIV by using a condom every time they have sex 69% knew a healthy person could have HIV 60% believed that HIV can be transmitted by mosquito bites 44% believed that HIV can be transmitted through sharing food Proportion answering all 5 questions correctly not reported.
1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Not relevant.	Not relevant.	Not relevant to low prevalence concentrated epidemics.
1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	Not available.	Not available.	Not relevant to concentrated epidemics.
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	Not available.	Not available.	Not relevant to concentrated epidemics.
1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	Not available.	Not available.	Not relevant to concentrated epidemics.
1.6 Percentage of young people aged 15-24 who are living with HIV	Not relevant.	Not relevant.	Screening criteria for pregnant women varies between sites – some physicians screen all pregnant women and others screen only high-risk pregnant women. An estimated 11% of pregnant women were screened in 2010.

			ANC data indicates <0.1% prevalence overall and no cases found among 15-24 year old women. 2010: 0 positive pregnant women; 2,394 tested (age breakdown not available, both Bahraini and non-Bahraini) 2011: 2 positive pregnant women - both over 24 years; 2150 tests (age breakdown not available, both Bahraini and non-Bahraini).
Sex workers			
1.7 Percentage of sex workers reached with HIV prevention programmes	Not available.	Not available	There are no prevention programmes for sex workers.
1.8 Percentage of sex workers reporting the use of a condom with their most recent client	Not available.	Not available.	
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	Not available.	Not available.	
1.10 Percentage of sex workers who are living with HIV	Not available.	Not available.	No prevalence surveys undertaken. In 2010/2011, 724 FSW (11 Bahraini/713 non-Bahraini) were tested at time of detainment by police, 6 (0.8%) tested positive.
Men who have sex with men			
1.11 Percentage of men who have sex with men reached with HIV prevention programmes	Not available.	Not available.	There are no prevention programmes for MSM.
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Not available.	Not available.	
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	Not available.	Not available.	
1.14 Percentage of men who have sex with men who are living with HIV	Not available.	Not available.	No prevalence surveys undertaken.
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 programmes		Not available.	There are no needle and syringe exchange programmes.
2.2 Percentage of people who inject drugs who	80%, n=61	Not available.	2006 KABP survey data (among drug users enrolled in

report the use of a condom at last sexual intercourse	(2006 IDU KABP Survey)		psychiatric care and rehabilitation programme) reported in 2010 on use of condoms with commercial partners is not specific to those having sex and injecting drugs within the last month.
2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	Not available.	Not available.	KABP survey among drug users in 2006 found that 25.0% of injecting users shared needles in the past month. Among those who reported sharing, only 61.3% reported cleaning the needles every time. Most did not adequately sterilize the needles and syringes before re-use.
2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	Not available.	Not available.	
2.5 Percentage of people who inject drugs who are living with HIV	Not available.	Not available.	No prevalence surveys undertaken. Data from mandatory testing on admission to rehabilitation program: 2010: 3.3% (6/181); 2011: 4.6% (7/151)
Target 3.			
Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths			
3.1 Percentage of HIV-positive pregnant women who receive anti-retrovirals to reduce the risk of mother-to-child transmission	No HIV positive cases identified.	Not available.	2 HIV-positive pregnant women were identified in 2011, none in 2010. Both were non-Bahraini. One was deported. The other was treated with ARVs because she identified after 36 weeks gestation. No denominator data (requires modeling).
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth		Not available.	
3.3 Mother-to-child transmission of HIV (modelled)	Not available.	Not available.	No modeling has been carried out.
Target 4.			
Have 15 million people living with HIV on antiretroviral treatment by 2015			
4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy	40 PLHIV on ART -38 adults -2 children	Not available.	ART monitoring data indicate 38 PLHIV on ART - 38 adults and 1 child. No denominator data available (requires modeling).
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	No new cases in previous 12 months	Not available.	

Target 5.			
Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015			
5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	2 persons received treatment for both HIV and TB in 2009. Denominator not available.	0% (2010) 9% (2011)	Numerator: 2010: 6 cases of co-infection identified. 3 non-Bahraini deported. 3 Bahrainis not treated. 2011: 7 cases of co-infection identified. 4 non-Bahraini deported. 3 Bahrainis: 1 died; 1 already on ART, 1 not treated. Denominator = 11 (range <10 – 21) based on WHO estimate for 2010, includes Bahraini and non-Bahraini cases.
Target 6.			
Reach a significant level of annual global expenditure (US\$22-24 billion) in low- and middle-income countries			
6.1 Domestic and international AIDS spending by categories and financing sources	Not available.	Not available.	NASA not carried out.
Target 7.			
Critical Enablers and Synergies with Development Sectors			
7.1 National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	8 NCPI questionnaires Part A: 4 government sectors Part B: 6 PLHIV, 2 CSOs, 1 UNDP	13 respondents Part A: 10 respondents, all from MOH Part B: 1 PLHIV, 1 NGO, 1 UNDP	
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		Not available.	2009 study of domestic violence among ANC women found 49.4% ever experienced domestic violence from spouse. Data were not analyzed for violence experienced in past 12 months.
7.3 Current school attendance among orphans and non-orphans aged 10–14	Not relevant.	Not relevant.	Not relevant to concentrated epidemic.
7.4 Proportion of the poorest households who received external economic support in the last 3 months		Not available.	

II. Overview of the AIDS epidemic

The Kingdom of Bahrain appears to be maintaining a very low prevalence HIV epidemic. In the absence of surveillance data, the monitoring of the epidemic is based on mandatory screening programmes and case-finding. However, the lack of community-based prevalence surveys among key affected populations means that some pockets of infection may be undetected and the full scope of the epidemic is unknown.

Since the first case was identified in 1986, a total of 1,856 cases have been reported: 399 Bahrainis and 1457 non-Bahrainis.² Among the 399 Bahraini cases, 195 are living. The identified cases are mostly male (85.2%). Few children have been diagnosed: 9 cases, 4 living. Among those currently living with HIV, 19.5% (38) are receiving antiretroviral treatment (ART).

Each year, about 15-20 Bahraini cases are identified, with a fairly stable trend in recent years. See Table 1 and Figure 1. Non-Bahrainis account for about three-quarters of cases identified in the past six years and have nearly all been deported. The ratio of Bahraini to non-Bahraini reported cases has remained stable.

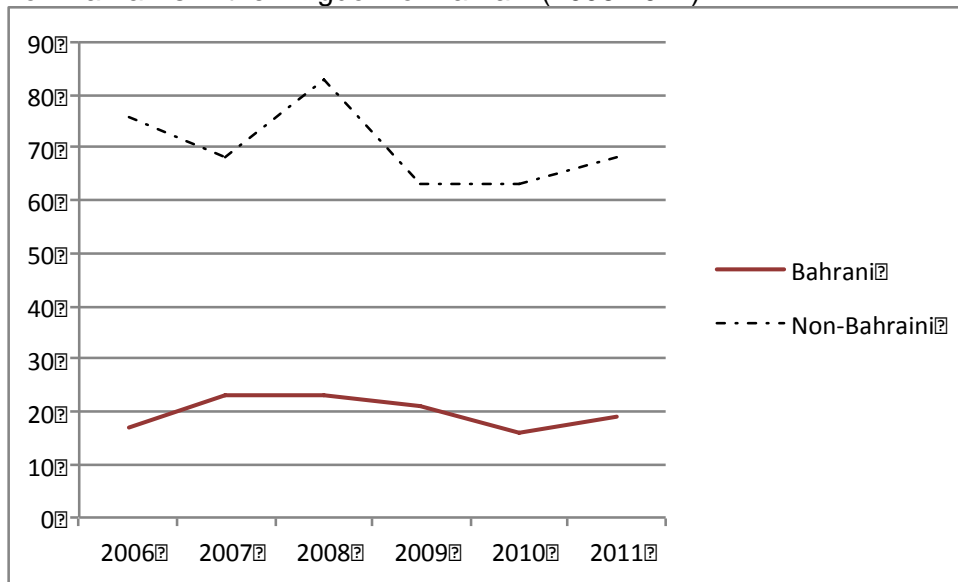
Table 1. Annual HIV case reporting in Kingdom of Bahrain (2006-2011).

Year	Bahraini	Non-Bahraini	Total	Ratio of Bahraini to non-Bahraini
2006	17	76	93	0.22
2007	23	68	91	0.33
2008	23	83	106	0.28
2009	21	63	84	0.33
2010	16	63	79	0.25
2011	19	68	87	0.28

Source: Public Health Department, MOH.

² Public Health Department data, MOH.

Figure 1. Trend in number of annual new HIV cases identified among Bahrainis and non-Bahrainis in the Kingdom of Bahrain (2006-2011).



Source: Public Health Department, MOH.

There are no official estimates of the total number of PLHIV in the country. Based on CD4 counts at time of diagnosis, many PLHIV are identified late in the course of their disease and therefore, the reported cases are a relatively low proportion of the total number of PLHIV. In the past two years, CD4 counts at time of diagnosis were available for 25 newly diagnosed Bahraini PLHIV. Among these, nearly half (12) had CD4 counts less than 350 cells/mm³ at time of diagnosis and three were less than 100 cells/mm³.

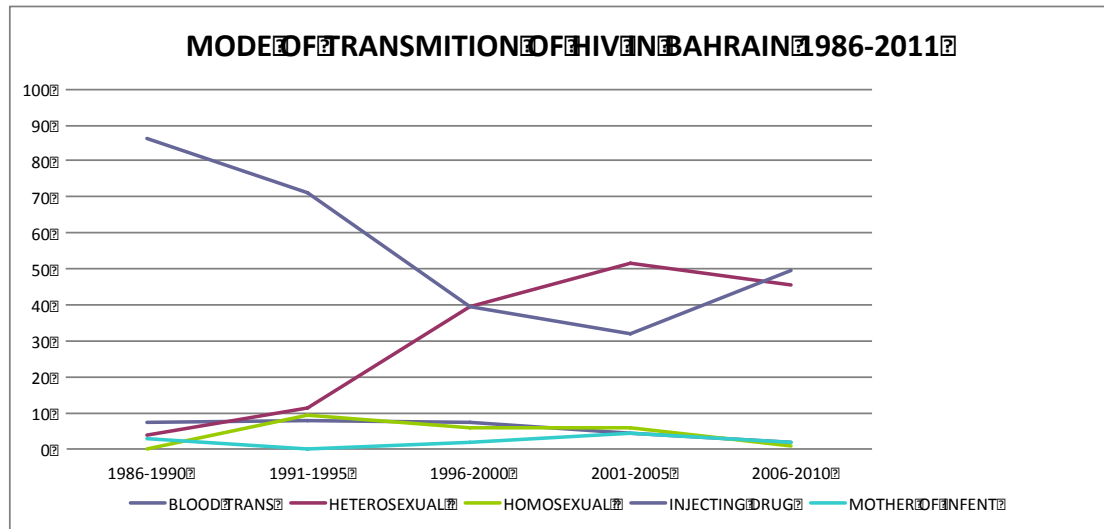
Primary risk data is available for reported cases among Bahrainis. The primary mode of transmission overall is injecting drug use, accounting for 58.1% of the total identified cases (Table 2). However, the proportional contribution of heterosexual transmission has increased, from less than 10% in the early years of the epidemic (pre-1995) to roughly equivalent to the proportion of transmission due to injecting drug use over the past 15 years (Figure 2).

Table 2. Mode of transmission of total cumulative cases of HIV reported.

Primary risk factor	Number	% of total
Injecting drug use	232	58.1%
Heterosexual	119	29.8%
Blood transfusion	21	5.3%
Homosexual	13	3.3%
Mother to child	9	2.3%
Unknown	5	1.3%
Total	399	100%

Source: Public Health Department, MOH.

Figure 2. Trends in mode of transmission in Bahrain.*



* Data are grouped in five-year increments due to low overall number of cases.
 Source: Public Health Department, MOH

During the last two years' reporting period (2010 and 2011), all of the Bahraini newly diagnosed cases were reported to be due to either heterosexual transmission or injecting drug use, with over half due to heterosexual transmission. The proportion attributed to heterosexual transmission was 62.5% (10 out of 16) in 2010 and 52.6% (10 out of 19) in 2011.

Although non-citizens account for over half (54%) of the estimated population of Bahrain, limited information is available on HIV among non-Bahraini migrants. Pre-employment communicable disease screening is carried out for selected labor categories (mostly laborers and housemaids, mainly from South Asia) within one to two months after arrival into the country. All those with hepatitis B, hepatitis C, tuberculosis, and HIV are repatriated on diagnosis. HIV risk factor data is not collected for non-Bahrainis and CD4 counts are not done.

Indicator 1.6: HIV prevalence in young people³

Among 4,544 antenatal women screened over two years (2010 and 2011), only 2 (<0.01%) tested positive for HIV and 0.1% for syphilis (VDRL). Although the age breakdown is not available for all women screened, neither of the two HIV-positive cases were between 15 and 24 years. Therefore, the HIV prevalence among young people is reported to be <0.1%.

Bahrain has not implemented a routine ANC surveillance system where all pregnant women are tested at specific sites. The reported cases are from routine clinical practice with non-uniform screening criteria. Some physicians follow national guidelines to screen only high-risk women, but some physicians screen all women.

Results from other general population mandatory screening support a very low prevalence in Bahrain. Only 2 persons tested positive out of 21,428 screened for

³ Public Health Department, MOH.

premarital clearance in the past 2 years (<0.01%). Among blood donors, none of the 34,007 (all ages) screened in the past 2 years tested positive.

Overall, 15.7% (63/399) of the cumulative Bahraini HIV cases were in the 15-24 years age group.

Indicator 1.10: HIV prevalence in sex workers

No prevalence surveys have been carried out among sex workers. However, HIV testing is done within 24 hours on all women detained for prostitution. In the past two years (2010 and 2011), a total of 724 female sex workers were tested (11 Bahraini and 713 non-Bahraini) and 0.8% (6) tested positive. All six HIV-positive sex workers were non-Bahraini and were deported.⁴

Indicator 1.14: HIV prevalence in men who have sex with men

No information is available.

Indicator 2.5: HIV prevalence in people who inject drugs

Estimates of HIV prevalence among injecting drug users (IDU) in the Kingdom of Bahrain are out-dated and vary widely from 0.3% in 2000⁵ to 21.1% among enrollees in a rehabilitation programme in 1994.⁶

The prevalence of HIV on mandatory screening for admission to rehabilitation was 3.3% in 2010 (6 HIV positive out of 181 screened) and 4.6% in 2011 (7 HIV positive out of 151 screened). However, these data are not representative of the total population of IDU and no community-based prevalence studies have been carried out.

A situation analysis conducted by UNDP in 2006 reported that the official number of registered drug users enrolled in out-patient treatment in 2006 was 3,200.⁷ No updated figure is available. The same report estimated the total number of drug users in Bahrain to be 20,000-30,000. In the period prior to the report (2000-2004), increasing rates of drug use were noted, based on increasing amounts of drugs seized by law enforcement and an increase in the number of deaths due to drug overdose.

More recently, the cost of opioids has decreased and drug users are beginning to inject earlier in their drug use history. Heroin is the primary drug used for injection, although amphetamines and cocaine are used to a lesser extent.⁸

⁴ Ministry of Interior, Police Clinic.

⁵ Mathers et al (2008). "Global Epidemiology of Injecting Drug Use and HIV among People Who Inject Drugs: A Systematic Review." *Lancet* 372: 1733–45.

⁶ Al-Haddad et al. (1994) "HIV Antibodies among Intravenous Drug Users in Bahrain." *J Commun Dis* 26: 127–32. All were enrolled in rehabilitation programmes.

⁷ Kingdom of Bahrain & UNDP (2006). *Multisectoral Drug Control Assistance to the Government of Kingdom of Bahrain*.

⁸ Personal communication, Dr. A. Nabi, Head of Al-Muayyad Addiction Unit, Psychiatric Hospital

III. National response to the AIDS epidemic

Programmatic response

The national response to HIV/AIDS in Bahrain is coordinated and monitored by the National Committee for the Prevention of AIDS (NCAP). The NCAP is a multi-sectoral committee, which reports to the Assistant Undersecretary for Primary Care and Public Health in the Ministry of Health. The NCAP was established in 1995 in accordance with the Cabinet Decree #20 of the Council of Ministers and membership was updated in 2004 (Cabinet Decree #8).

The NCAP is made up of ten members, including representatives from Ministry of Health, Ministry of Interior, Ministry of Information, Ministry of Education, Ministry of Social Development, Ministry of Defense, Organization of Youth and Sports, and UNDP. In addition, there are four subcommittees: (1) counseling and health education, (2) treatment, (3) research, and (4) data collection and public health. The subcommittees are multi-sectoral and also include representatives from the private sector, universities, civil society, and PLHIV.

The director of the NCAP is the only dedicated full-time person working on the HIV national response in Bahrain. Implementation of the national response is integrated into the job responsibilities of other members of the NCAP and its subcommittees, as well as the Communicable Diseases Unit of the Disease Control Section of the Department of Public Health (MOH).

The NCAP and its subcommittees have met irregularly in recent years and attendance has been low for scheduled meetings. Multi-sectoral commitment has not been strong. Members do not receive remuneration for their participation and the director of the NCAP does not have authority to ensure they are released from their other duties to attend meetings. Due to political unrest in 2011, the committee has not met for over one year.

In mid-2011, the longtime Head of the NCAP, Dr. Somaya Al Jowder, resigned to successfully seek election as a Member of Parliament and her replacement has not yet been appointed. However, at the time of writing (March 2012), the Minister of Health indicated that the replacement director has been identified and will be announced in the near future.

To improve the management and coordination of the national response, Dr. Al-Jowder has submitted a proposal to Parliament for a two-tiered re-organization of the NCAP with higher-level representation on the HIV/AIDS Committee and establishment of a National AIDS/STD Programme with full-time staff to assist with coordination, implementation and monitoring of activities. The proposal is still under consideration.

The National Strategy for AIDS Prevention (2008-2010) is the first and most recent national strategy. There is strong political commitment to the strategy, which was developed with inputs from line ministries, community-based organizations, faith-based organizations and UNDP. However, there is a general consensus that an updated, revised strategy developed with more participation from stakeholders that includes a detailed, costed operational plan are needed to improve the national response. The planned programme assessment has not been carried out.

Civil society

Several NGOs contribute to the implementation of the national HIV response, including the Bahrain Reproductive Health Society, Red Crescent Society, Bahrain Development Society (women's group), youth groups, and religious groups. Their contribution is primarily for general population and youth awareness and education activities. At least one NGO, Bahrain Reproductive Health Association, has adopted a rights-based HIV/AIDS workplace policy.

In 2009, the Friendly Addiction People's Society was registered as a new NGO. Comprised of health care workers, the NGO is working with 18 former drug addicts to train them as peer educators to decrease demand for drugs among youth. HIV education messages will also be included.

As reported in the 2010 Country Progress Report, the PLHIV support group applied for registration as an NGO. However, it was denied NGO status because it is led by a former drug addict. Although PLHIV continue to assist with post-rehabilitation support groups for drug users, the PLHIV support group has not met for over one year due to the political unrest.

Policy update

An HIV Law has been proposed for the first time in the Kingdom of Bahrain. The first draft submission to Parliament in 2009 included several elements that were inconsistent with National AIDS Control policies, including immediate notification of employers of HIV status if positive. After discussion, the law was revised with a rights-based approach, including non-discrimination for PLHIV, confidentiality of HIV status at the workplace with an option for workplace modifications as needed, non-discrimination in schools, provision of VCT with anonymous HIV testing, active partner notification (giving first option for notification to the primary case), and re-organization of the coordination of the national HIV response to a 2-level system, including establishment of a National AIDS Programme.

The proposed law has not yet been approved by Parliament. Discussions were interrupted by last year's political unrest and it has recently been withdrawn by Dr. Al-Jowder (former Head of the NCAP) for further revisions and re-submission.

Indicator 6.1: AIDS Spending

Funds for HIV/AIDS activities are included in the general government budget without specific allocation for the HIV response. Since the Kingdom of Bahrain is a high-income country, international funding for HIV/AIDS activities is limited to technical assistance from UN agencies. In addition, a small (USD 60,000) one-time UNAIDS Programme Acceleration Funds grant was obtained by UNDP for 2011.

The National Strategy for the Prevention of AIDS (2008-2010) includes a two-year budget in the amount of USD 458,580. However, expenditure data for HIV/AIDS activities are not tracked and no National AIDS Spending Assessments (NASA) have been carried out.

a) Prevention

Prevention programs are a priority area in the National Strategy for AIDS Prevention, with the goal of maintaining the level of HIV among the general and target populations at less than 1%. Despite political unrest since early 2011, many prevention programmes have continued and new programmes have been instituted. Prevention programmes focus on awareness and education messages and are targeted primarily to the general population and youth.

In general, there is very little condom promotion, even for family planning. However, the Ministry of Trade reports increasing condom imports in recent years.⁹ Social constraints for the discussion of HIV/AIDS and sexual behaviors are reportedly loosening in Bahrain. Two TV talk shows recently featured a person living with HIV (appearing anonymously). The Head of the National Committee on AIDS Prevention was also interviewed on TV, and she promoted condom use on the air.

HIV/AIDS education continues to be integrated into the school curriculum and reproductive health and workplace education programmes are continuing. Workshops with government, community and religious leaders, supported by UNDP, have continued with the most recent workshop conducted in December 2011. Religious leaders are now reportedly adding HIV/AIDS topics to Friday talks and speaking in schools, even including messages about condom use.

New programmes initiated in the past two years include theater, social media, etc, carried out by the Youth Peer Programme, sponsored by the United Nations Population Fund (UNFPA). Youth members have attended regional meetings. In addition, UNDP has collaborated with the Ministry of Interior for awareness and prevention programs in prisons with prisoners and prison guards.

Indicator 1.5 HIV testing in the general population

HIV testing in Bahrain is either provider-initiated through health centers or by mandatory screening. The current policy of mandatory reporting of all notifiable diseases, including HIV, precludes anonymous testing.

In 2010, about 90% of all tests carried out in the country (84,960 in 2010 and 73,684 in 2011; Bahraini and non-Bahraini combined) were for mandatory screening for various reasons, including STD patients, high-risk antenatal, drug users entering rehabilitation, TB patients, blood donors, blood transfusion/organ donation recipients, dialysis patients, pre-employment (for specific occupations, predominantly laborers and housemaids), pre-marital, pre-operative, and prisoners.¹⁰ Pre-test counseling is not carried out for mandatory screening and Bahrainis who test positive are notified and counseled. Non-Bahrainis do not receive counseling and are deported.

HIV testing is carried out at two laboratories, one in the Public Health Department (PHD) of the Ministry of Health and the other at a private laboratory. However, all positive results from the private laboratory are confirmed at PHD. Blood is drawn from health centers and sent to PHD for testing. Pre-test counseling is provided by family physicians at the health centers. Counseling training is included in the family physician residency program curriculum, but no refresher courses or assessment of

⁹ Personal communication, Dr. Al-Jowder, former Head of NCAP.

¹⁰ Public Health Department, MOH. The total number of tests does not include Ministry of Interior data on testing of prisoners.

quality and consistency of counseling have been carried out. Prior to mid-2011, all persons testing positive for HIV were sent to Dr. Somaya Al-Jowder for post-test counseling and care. Since her recent election to Parliament, all Bahraini citizens testing positive are being referred directly to Salmaniya Medical Complex for assessment in the Infectious Disease Clinic.

On World AIDS Day in 2010, HIV and Hepatitis C virus (HCV) rapid testing was made available at general population awareness events at five locations (shopping malls, health centers, and NGOs) using test kits donated by the manufacturers. Demand for client-initiated testing was higher than expected and exceeded the 200 available test kits. This suggests that the current system of provider-initiated testing is not meeting the demand for testing, even among the general population. Of note, one case of HCV was diagnosed and all HIV tests were negative.¹¹

The policy of deporting HIV-positive non-Bahrainis reportedly creates a barrier to testing for expatriates and prevents them from seeking treatment if they suspect they are at risk for HIV. Human rights activist groups have called for revision of this policy and demanded a migrant-friendly testing approach to HIV testing.

Indicator 1.7: Sex workers: prevention programmes

There are no prevention programmes for sex workers despite their inclusion as a priority group in the National HIV Strategy. Prostitution is illegal and taboo in Bahrain, limiting engagement with this key affected population.

Indicator 1.9: HIV testing in sex workers (SW)

Sex workers (SW) are tested only at the time of detention by the police. In the two year reporting period (2010/2011), 724 female SW (11 Bahraini and 713 non-Bahraini) were tested.¹² There are no available estimates of the total number of sex workers in the country. Most SW are non-Bahraini and are deported when they test positive for HIV.

Indicator 1.11: Men who have sex with men (MSM): prevention programmes

There are no prevention programmes for men who have sex with men (MSM) and they are not included in the National Strategy for the Prevention of AIDS. Attempts to meet with MSM who were HIV positive found them unwilling to engage or to organize peer support groups. Most MSM are married and are not publically gay.¹³ Although male-to-male sexual behavior is not technically illegal in Bahrain, it is prohibited under Islamic Law and can be punished by the State as an immoral act.¹⁴ Culturally, male-to-male sex is taboo and highly stigmatized.

Indicator 1.13: HIV testing in men who have sex with men

No information available.

Indicator 2.1: People who inject drugs: prevention programmes

People who inject drugs account for the majority of HIV infections overall in Bahrain

¹¹ Personal communication, Dr. Somaya Al-Jowder.

¹² Ministry of Interior, Police Clinic.

¹³ Personal communication, Dr. Somaya Al-Jowder.

¹⁴ Article 345 of Bahrain Penal Code.

and are a priority group for targeted prevention in the National Strategy for AIDS Prevention. There are no harm reduction interventions and therefore no data for reporting on indicator 2.1.

Interventions among drug users are limited to those who are enrolled in rehabilitation programs or incarcerated, as well as an addiction support group for post-rehabilitation support. The intervention focus is on remaining drug free. HIV awareness and education messages are included, but without information on safe injection and safe sex. There are currently no programmes for community-based outreach to actively injecting drug users.

Needles and syringes are easily accessible only by diabetics. All others must have a prescription to obtain them from a pharmacy and drug users have been arrested for possession of drug paraphernalia, including new needles and syringes. Nevertheless, 83.6% of injecting drug users reported access to new needles and syringes in 2006, even though only 34.6% were able to obtain them from a pharmacy. Other common sources were from friends, other drug users, and relatives.¹⁵

Methadone maintenance therapy is not available in Bahrain. Methadone is used only for detoxification on an inpatient basis. It was also used for outpatient detoxification in the past, but cases of abuse led to the recent discontinuation of this practice.

Indicator 2.4: HIV testing in people who inject drugs

HIV testing for drug users is mandatory on entry into a rehabilitation programme. Testing data from admission to the rehabilitation programme in Manama found 3.3% (6 out of 181 tested) of drug users to be HIV positive in 2010 and 4.6% (7 out of 151 tested) in 2011.

Indicator 3.1: Prevention of mother-to child transmission

Only 2 HIV-positive pregnant women were identified in the past two years: none in 2010 and two in 2011.¹⁶ Both were non-Bahraini. One was already receiving ART (from her home country) at the start of her pregnancy and returned to her home country for delivery. The other was past 36 weeks gestation at time of diagnosis, so was allowed to remain in Bahrain until delivery and was given AZT prophylaxis.

All pregnant women are screened for syphilis using VDRL. In 2010 (the last year data are compiled for), 0.1% tested positive. ANC guidelines recommend screening for HIV "if indicated" or if there is a history of blood transfusion before 1990. Practices vary, with some physicians screening only high-risk women and others screening all women. The definition of high risk is not well defined for HIV testing.

The total number of pregnant women tested for HIV in 2010 was 2,394, compared to 22,590 tested for syphilis. Considering that the accepted practice is to screen all pregnant women for syphilis, the number of VDRL tests is a reasonable proxy for the total number of pregnant women. Using that as a denominator, it appears that approximately 11% of pregnant women are tested for HIV.

¹⁵ Ministry of Health and UNDP (2006). HIV/AIDS Knowledge Attitudes Behaviors Survey among Bahraini Injecting Drug Users.

¹⁶ Public Health Department, MOH.

Indicator 3.2: Early infant diagnosis

Although no national written policy is in place for early infant diagnosis, international guidelines are followed. One baby reportedly delivered to an HIV positive mother in the past two years and was tested within the first two months. The baby tested negative.¹⁷

Indicator 3.3: Mother-to-child transmission of HIV (modeled)

No modeling has been carried out.

b) Care, treatment and support

Care and treatment is a priority area in the National Strategy for the Prevention of AIDS, with the goal of reducing the impact of HIV/AIDS on individuals, families and communities.

Indicator 4.1: HIV treatment: antiretroviral therapy

There are currently 38 PLHIV receiving ART: 37 adults and one child. There are no national estimates available for the total number of eligible adults and children.

All HIV treatment is centralized at Salmaniya Hospital in Manama and is provided by infectious disease specialists according to US CDC guidelines. Patients are eligible for ART when CD4 counts reach 350 cells/mm³ or below. PLHIV are treated in the general Infectious Disease Clinic to minimize stigma, however integration makes coordination and follow up more difficult. HIV treatment, including all medications (ART, OI prophylaxis and treatment) and laboratory testing, is free for Bahraini nationals.

Improvement of HIV treatment is included in the MOH strategic plan and much progress has been made. Genotyping and viral load testing are now available for all patients. More medical residents are being trained in HIV management and a new nurse coordinator position for HIV treatment has been approved, but is not yet filled. There is also an increased focus on quality of treatment. The infectious disease team has recently developed indicators to improve quality of care, including for hepatitis C and/or hepatitis B co-infection with HIV. However, a monitoring and reporting system is not currently in place to systematically track patient progress.

A wider range of antiretroviral drugs are now available for first line treatment, although stock-outs still result in treatment interruptions. In NCPI discussions, feedback from PLHIV indicated that many people are experiencing side effects from their initial drug regimen and have not been offered an alternative. Although the national strategy describes a comprehensive package of care and support for PLHIV, including psychosocial support, pre- and post-initiation adherence counseling, and palliative and home-based care, the current system focuses primarily on ART and OI treatment and prophylaxis. Psychosocial support services are only available on request and patients are referred to the psychiatric hospital for counseling. Adherence counseling is done only by physicians during the patient visit. Palliative and home-based care are not available. Nutritional services are not available since dietitians are not aware of HIV-related needs.

¹⁷ Personal communication, Dr. Jameela Al-Salman, Salmaniya Hospital.

Both doctors and PLHIV voice a need for more accessible psychosocial support services. The PLHIV support group provided some services in the past, but is not currently active. Sensitization training for dentists and hygienists conducted in 2010 has resulted in improved access to dental services for PLHIV. In addition, an informal list of HIV-friendly physicians has been prepared for non HIV-related illnesses.¹⁸

Linkages between HIV testing and treatment are being re-organized. In the past, all patients testing positive were referred to the Head of the NCAP (a family physician) for counseling, follow-up, and eventual referral to Salmaniya Hospital when eligible for ART. Since mid-2011, PLHIV will be referred directly to the Salmaniya Hospital Infectious Disease Clinic at the time of diagnosis for assessment and treatment (either pre-ART management or initiation of ART, according to eligibility). It is hoped that by streamlining the referral system, ART can be started earlier. Doctors report that many patients are presenting at the Salmaniya Hospital clinic at an advanced stage with very low CD4 counts, and PLHIV describe persistent barriers to treatment accessibility, including fear of stigma and discrimination and lack of confidentiality. More information is needed on the barriers to testing and treatment. As reported in an earlier section, many PLHIV are initially tested at a late stage of disease.

Indicator 4.2: Twelve month retention on antiretroviral therapy

Not available.

Indicator 5.1: Co-management of tuberculosis and HIV treatment

Table 3. Indicator 5.1 on co-management of TB and HIV treatment.

Year	Estimated no. of co-infections (WHO estimate) ¹⁹	No. co-infections identified	No. treated	Proportion receiving treatment*
2010	11 (range <10–21)	6 (3 Bahraini, 3 non-Bahraini)	0	0%
2011	11 (range <10–21)	7 (3 Bahraini, 4 non-Bahraini)	1	9%

*Based on WHO estimated number of infections
 Source: Public Health Department, MOH

The WHO estimate of 2010 annual incidence of HIV-TB co-infections is 11 (range <10-21). The estimate is based on a population of 1 million, which includes non-Bahrainis. In 2010, six cases of HIV/TB co-infection were identified. Three were non-Bahrainis who were deported. The remaining three Bahrainis did not receive ART. In 2011, seven cases of HIV/TB co-infection were identified. Four were non-Bahrainis who were deported. Among the three Bahraini co-infections: one died, one was already on ART, and one did not receive ART.

In practice, physicians report that all PLHIV are screened regularly for TB and receive treatment if infected. Isoniazid prophylaxis is provided to those without active TB infection.

¹⁸ Personal communication, Dr. Somaya Al-Jowder.
¹⁹ <http://www.who.int/tb/country/en>, accessed 9 March 2012.

c) Knowledge and behavior change

Results of recent KABP surveys in the Kingdom of Bahrain are summarized in Table 4. Three KABP surveys were carried out in 2006 to provide background for the development of the National Strategy for Prevention of AIDS, including studies among university students (aged 18-25 years), ANC women and drug users enrolled in a rehabilitation program. A follow-up survey among ANC women was conducted in 2009.²⁰⁻²³

Overall knowledge of condom use for HIV risk reduction was low and a high proportion of respondents held misperceptions about HIV transmission. Of note, a high proportion of ANC women (85% in 2010; 88% in 2006) were aware of the possibility of vertical transmission during pregnancy, but less than half (34% in 2010; 44% in 2006) knew that HIV could be transmitted through breastfeeding.

Table 4. Results of recent KABP surveys in the Kingdom of Bahrain.

	University students 2006 ²⁰ n=2145	ANC women 2006 ²¹ n=388	ANC women ²² 2010 n=207	Drug users 2006 ²³ n=523
Knew that the risk of HIV transmission can be reduced by having sex with only one uninfected partner who has no other partners	73%	91%	84%	67%
Knew that a person can reduce the risk of getting HIV by using a condom every time they have sex	60%	39%	37%	72%
Knew a healthy person could have HIV	69%	>50%	66%	86%
Believed that HIV can be transmitted by mosquito bites	60%	60%	--	77%
Believed that HIV can be transmitted through sharing food	44%	40%	38%	33%

Indicator 1.1: Young people: Knowledge about HIV prevention

All knowledge questions relating to Indicator 1.1 were asked in the 2006 survey of university students, aged 18-25 (see Table 4). Although analysis of the proportion answering all five questions correctly was not carried out, it can be inferred that it would be less than 40% (the proportion who knew that HIV could not be transmitted

²⁰ Ministry of Health and UNDP (2006). HIV/AIDS Knowledge Attitudes Behaviors Survey among Bahraini University Students.

²¹ Ministry of Health and UNDP (2006). HIV/AIDS Knowledge Attitudes Behaviors Survey among Bahraini Pregnant Women Attending Public Antenatal Clinics.

²² Al-Arab E, Abbas F, Khalil S, et al (2010). Knowledge and attitude about HIV/AIDS among pregnant women in Bahrain. Arabian Gulf University College of Medicine.

²³ Ministry of Health and UNDP (2006). HIV/AIDS Knowledge Attitudes Behaviors Survey among Bahraini Injecting Drug Users.

by mosquitoes). Despite a long-standing HIV education programme in schools, misperceptions were held by over half of the students and only 60% knew that consistent condom use could reduce the risk of HIV transmission.

Knowledge data from the ANC surveys in 2006 and 2010 was not stratified by age. The mean age in the surveys was over 24 years (27.6 in 2006 and 28.7 in 2010). Of note, there was no improvement in knowledge noted over the five years between ANC surveys.

Indicator 1.2: Sex before the age of 15

Indicator 1.3: Multiple sexual partnerships

Indicator 1.4: Condom use at last sex among people with multiple sexual partnerships

Questions for the above three indicators were not asked in KABP surveys due to cultural constraints.

Condom promotion for HIV prevention is limited in Bahrain. Condoms are freely available in pharmacies but are not provided in family planning clinics. However, Dr. Somayya Al-Jowder describes publically promoting condoms during her TV interview.

Indicator 1.8: Sex workers: condom use

No surveys have been carried out among sex workers.

Indicator 1.12: Men who have sex with men: condom use

No surveys have been carried out among men who have sex with men.

Indicator 2.2: People who inject drugs: condom use

The most recent information on condom use among people who inject drugs is available from the 2006 KABP survey of 523 drug users enrolled in psychiatric care and rehabilitation at Al-Muayyad addiction center in the Psychiatric Hospital in Manama.²⁴ The majority (n=421, 80.5%) reported a history of injecting drugs, 225 within the past month.

The survey report did not provide an analysis of condom use among respondents who reported both having injected drugs and having had sexual intercourse during the last month, which would be required satisfy criteria for reporting on Indicator 2.2. The analysis did, however, calculate indicator data separately for those who reported sex within the past month for three categories of partners: regular partner, irregular partner, and commercial partner (Table 5).

Table 5. Condom use at last sex among drug users who reported sexual contact in the past month, by type of sexual partner.

	Regular partner	Non-regular partner	Commercial sex partner
Proportion of drug users			

²⁴ Ministry of Health and UNDP (2006). HIV/AIDS Knowledge Attitudes Behaviors Survey among Bahraini Injecting Drug Users.

reporting condom use at last sex	16%	89%	89%*
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* Among drug users who had sex with a commercial partner in the past 12 months, only 75% had ever used a condom.

Source: HIV KABP survey among Bahraini Injecting Drug Users (2006).

Sexual contact with sex workers was fairly common among drug users, with 22% reporting sex with a commercial partner in past 12 months. Although the reported condom use among drug users reporting sexual contact with commercial partners in the past month is high (Table 5), the study also found that only 75% of drug users who reported sexual contact with a commercial partner in the past year had ever used a condom. Among those, 85% used condoms regularly with commercial partners during the year prior to the survey.

Condom promotion is not included in HIV education for drug users and accounts for the particularly low use with regular partners.

Indicator 2.3 People who inject drugs: safe injecting practices

The 2006 KABP survey results²⁵ highlighted high rates of needle sharing. Among 421 injecting drug users enrolled in a rehabilitation programme, over half (53.4%) had injected in the month prior to the survey and 25.0% reported sharing needles in the past month. Among those who reported sharing, only 61.3% reported cleaning the needles every time. Most did not adequately sterilize the needles and syringes before re-use. Over half (55.7%) of those who reported ever cleaning needles said they used only hot (not boiling) or cold water. The survey did not ask about use of sterile equipment at last injection as required for reporting on Indicator 2.3.

While information on safe injecting practices is not included in community education or rehabilitation programmes, it is provided during physician counseling sessions with HIV-positive drug users, who are then encouraged to act as peer educators in the community.²⁶

d) Impact alleviation

Indicator 7.2: Prevalence of recent intimate partner violence

A study of domestic partner violence among married Bahraini women attending primary care clinics was carried out in 2009 by Family Practice residents. Overall, 49.4% had ever experienced violence from a spouse or previous spouse. Among those, 90% had experienced two or more types of violence. The most commonly reported spousal behaviors were demanded sex (29.8%), shouted at or threatened the children (29.8%), forced wife to have sex (25.8%), and punched or kicked walls or furniture (24.2%). More serious violent incidents were also reported, including being threatened with a weapon (5.0%), attempted burning, strangling or drowning (6.1%), being injured with an object (7.2%), threatened to be killed (8.1%), and being

²⁵ Ministry of Health and UNDP (2006). HIV/AIDS Knowledge Attitudes Behaviors Survey among Bahraini Injecting Drug Users.

²⁶ Personal communication, Dr. Somaya Al-Jowder.

choked (9.2%).²⁷

Although the survey questionnaire included a question about violence within the past 12 months, the responses were not reported and therefore the required data for Indicator 7.2 are not available.

Indicator 7.3: Orphans school attendance

The Royal Charity Organization (established by the King in 2001) supports Bahraini orphans and widows. Currently, 680 orphans aged 1-10 years and 3100 orphans aged 11-20 years are receiving support, including education. Al Sanabil, an NGO, is currently supporting an additional 225 orphans (aged 0-14 years), all of whom are in school. Information on the total number of orphans in Bahrain is not available for reporting on Indicator 7.3.

Indicator 7.4 External economic support to the poorest households

In 2011, 14,214 Bahraini families received a total of 16.8 million dinars (USD 44.6 million) in social assistance from the Ministry of Human Rights and Social Development. Beneficiaries included needy families, families of prisoners, widows, divorced women, the elderly, the disabled, and orphans.²⁸

II. Best practices

Bahrain's prison programme continues to be a best practice in the region. A PLHIV support group for prisoners, established in 2009, continues to meet regularly. The leader of the group (also a prisoner) has attended regional workshops on peer education. Feedback from the families of support group members is that the group has improved the mood and outlook of the prisoners. In addition, linkages are in place with the central hospital to provide ART for eligible prisoners.²⁹

More recently, the prison programme has added an additional component. UNDP, in collaboration with the Ministry of Interior, is working with a community-based organization (non-registered) to conduct four workshops with guards and prisoners on HIV awareness, prevention and reduction in stigma and discrimination.

III. Major challenges and remedial actions

a) Progress made on key challenges reported 2012 Country Progress Report

²⁷ Mohammed B, Al-Jalahma E, Al-Saffar H, et al (2010). Prevalence of spouse abuse among Bahraini women attending government health centres in the Kingdom of Bahrain. Family Practice Residency Programme, MOH.

²⁸ Mohammed al-Jayousi. Thousands of Bahrainis benefit from social assistance programme. Al-Shorfa. 27 January 2012.

http://alshorfa.com/cocoon/meii/xhtml/en_GB/features/meii/features/main/2012/01/27/feature-01 (accessed 9 March 2012)

²⁹ Personal communication, Dr. Somaya Al-Jowder.

The 2010 Country Progress Report for the Kingdom of Bahrain lists four challenges: information and programming for key affected populations, treatment of PLHIV, lack of assessment of current programme effectiveness, and capacity of the National AIDS Programme. Updates on progress for each challenge are presented below.

Information and programming for key affected populations: The situation has not substantially changed since the 2010 Country Progress Report. No new surveys have been carried out. Limited information is available on knowledge and behaviors among people who inject drugs, based solely on one study carried out in 2006 among drug users enrolled in a rehabilitation programme. No information is available for MSM and FSW.

Currently, outreach programmes are not in place for key affected populations. As described earlier in the report, people who inject drugs are reached through post-rehabilitation or prison programs. However, community-based interventions with actively injecting users are not in place, except for informal training of drug injecting PLHIV on safe injecting during counseling sessions.³⁰

MSM and FSW remain hidden populations. Attempts to make contact with groups of MSM and FSW have been unsuccessful because they were reluctant to attend meetings.³¹

More biological and behavioral surveys are needed to be able to “know your epidemic” and plan an appropriate and targeted national response.

Treatment of PLHIV: Although Salmaniya Hospital remains the sole point of service for ART, the quality of services has improved. As described earlier in the report, laboratory monitoring and treatment options have expanded and there has been an increased focus on quality of treatment. Efforts are being made to reduce treatment interruptions due to drug stock-outs. Pre-ART management has recently been re-located to Salmaniya Hospital in an effort to consolidate treatment at one site and begin ART earlier in the course of the disease. Co-infections with Hepatitis C and B are being systematically addressed.

Challenges remain, including the need for better coordination and follow up of PLHIV. This is made more difficult by the integration of services into the Infectious Disease Clinic. The recent approval of a nurse coordinator position will help with coordination and follow-up of PLHIV, but it is not yet filled. In addition, a monitoring and reporting system is needed. There is also a need for more accessible and comprehensive psychosocial services for PLHIV.

More sensitization of health care workers is needed. PLHIV describe persistent stigmatization at the central hospital, for example, routine labeling of laboratory request forms with “HIV” in large letters. Some PLHIV report reluctance to access services due to stigma and discrimination.

Lack of assessment of current programme effectiveness: The effective period for the National Strategy for AIDS Prevention ended in 2010 and it has not been updated. Although the planned assessment was not carried out, it is clear that many of the indicative activities in the current strategy’s results framework were not implemented as planned. Many stakeholders expressed the need to evaluate and revise the current strategy through a strategic planning process that incorporates

³⁰ Ibid.

³¹ Ibid.

inputs of all key stakeholders. A realistic and manageable plan with strong multi-sectoral ownership is needed to guide the national response. Development of a detailed, costed operational plan and a monitoring and evaluation framework are needed for successful implementation of the strategy.

Capacity of National AIDS Programme: The National Committee for the Prevention of AIDS (NCAP) and its sub-committees have not met for over one year. In mid-2011, the long-standing Head of the NCAP resigned to successfully seek election to Parliament. Appointment of a new director has not yet been announced. However, the newly appointed Minister of Health indicated in a meeting that the selection has been made and an announcement is imminent.

As described in the 2010 Country Progress Report, the coordination of the national HIV response continues to be challenged by insufficient human resources, an over-ambitious national strategy and lack of a monitoring and evaluation system.

b) Challenges faced throughout the reporting period (2010-2011) that hindered the national response

The greatest challenge faced during this reporting period was the recent political unrest, which began in early 2011. Community-based activities could not be carried out and meetings could not be held for over one year. Civil society priorities have generally shifted to political issues.

In addition, the lack of a replacement Head of the National Committee on Prevention of AIDS following the resignation of Dr. Somaya Al-Jowder in mid-2011 has limited the coordination and leadership of the response. This is especially challenging since the Head of the NCAP is the sole full-time position dedicated to the HIV/AIDS response in the country. Another challenge facing the NCAP is its lack of authority over its members. HIV/AIDS is generally viewed as a health problem by most sectors and therefore, they believe the primary responsibility lies with MOH. Other ministries and NGOs afford it a low priority, making a truly multi-sectoral response difficult to coordinate. In addition, the lack of a dedicated budget for planned HIV/AIDS activities further constrains implementation of the national strategy.

Cultural barriers to obtaining information and conducting outreach to key affected populations and social constraints on condom promotion continue to pose a challenge for HIV prevention activities, especially among those at highest risk. In addition, the lack of adequate human and financial resources to conduct studies has been a constraining factor.

A rights-based approach is not universally accepted, with an over-reliance on mandatory screening for case detection and lack of availability of anonymous VCT services. Most cases of HIV are identified among non-citizens who are deported.

c) Remedial actions that are planned to ensure achievement of agreed targets.

- Passage of a rights-based HIV law as described in an earlier section of this report.
- Re-organization and re-invigoration of the coordination of the national HIV response. A two-tiered structure is recommended in the proposed HIV legislation: a high level committee led by the Minister of Health with members at the undersecretary level from line ministries for strategy, political and

budget support; and a National AIDS/STD Programme consisting of dedicated staff for management of HIV/AIDS/STD-related activities.

- Revision and update of National HIV/AIDS Strategy, with development of a costed, operational plan and a national M&E plan.

IV. Support from the country's development partners

The national AIDS response is supported by the United Nations organizations. UNDP is the leading the UN organization in Bahrain and is the only one with a residential office. UNDP coordinates the efforts of other UN non-residential organizations, including UNAIDS, WHO, UNODC and UNFPA.

UNDP has been engaged with the national HIV response for many years and worked with the National Committee for Prevention of AIDS to develop the first National Strategy for AIDS Prevention. All costs for UNDP's presence and work in Bahrain, whose programmes and projects delivered US \$1,621,000 in 2010, are contributed by the Government.³² UNDP has signed a new agreement with the Government of Bahrain covering the period 2012-2016. HIV/AIDS is included, but not as a priority area. Other initiatives, such as the planned regional initiatives for migrants, will contribute to the HIV response.

UNDP is currently working with the Government of Bahrain on the proposed HIV law to ensure concordance with human rights conventions. As a one-time grant, UNDP, in collaboration with the HIV/AIDS Regional Programme in the Arab States (HARPAS), applied for and received USD 60,000 from the UNAIDS Programme Acceleration Funds in 2011 to enhance awareness of HIV/AIDS/STI. Activities include HIV capacity building for community workers (religious leaders, university professors, Parliament members, and youth) and HIV prevention in prisons.

UNFPA is currently sponsoring Youth Peer Groups, including attendance of representatives at regional workshops.

V. Monitoring and evaluation environment

The national monitoring and evaluation system has not changed since the last Country Progress Report in 2010. A National M&E Plan with indicators to monitor the National Strategy for AIDS Prevention is not in place. M&E capacity remains a critical challenge for implementing the National Strategy for Prevention of AIDS.

The Public Health Department of the Ministry of Health collects national HIV testing and treatment statistics through Bahrain's robust computerized health information system (HIS) linking 24 hospitals and health centers through the country. HIV statistics are included in the Annual Health Report prepared by the Health Information Department. However, there is no mechanism for implementing partners to submit reports on HIV/AIDS activities and share data. Programme data are not available to be used for programme planning or quality improvement.

The National Committee on Prevention of AIDS includes two related sub-committees:

³² <http://content.undp.org/go/newsroom/2011/april/undp-defers-upcoming-five-year-programme-for-syria.en> (accessed 9 March 2012).

research, and data collection & public health. Both committees include representatives from the Public Health Department, but neither are fully functional.

Epidemiological and behavioral information related to HIV is limited in general, especially for key affected populations. Behavioral information required for modeling estimates and projections is not available. The surveys carried out to date have omitted key questions on sexual behavior due to cultural constraints. Nevertheless, participants in a recent study on domestic partner violence surprised researchers with their willingness to answer difficult and potentially stigmatizing questions.³³

Behavioral and prevalence surveys have not been carried out among sex workers and men who have sex with men. Some information is available on drug users, particularly from a KABP survey conducted in 2006. However, the survey was conducted among drug users enrolled in a rehabilitation programme and is not likely to be representative of the total population of drug users. More information on sexual behaviors and HIV prevalence among key affected populations is needed.

The key challenges to implementing a comprehensive M&E system are lack of human resource capacity, as well as lack of a designated budget. An updated National HIV/AIDS Strategy with indicators and targets is needed to form the basis of a National M&E Framework. A designated focal point for comprehensive monitoring of the HIV national response will also be required.

Technical assistance will be required to assist in the strategy development process and for development of the M&E framework. In addition, technical assistance will be needed to assist in defining priority information needs and for capacity building in the area of behavioral and biological survey methodology, especially among hard to reach populations.

ANNEX 1: National Commitments and Policy Instrument (NCPI)

³³ Personal communication, Dr. Adel Salman Alsayyad.