UNGASS COUNTRY PROGRESS REPORT 2010

STATE OF QATAR

Narrative Report

January 2008-December 2009

Glossary of terms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral Therapy
CSO	Civil Society Organization
CSW	Commercial Sex Worker
HIV	Human Immunodeficiency Virus
HMC	Hamed Medical Corporation
GCC	Gulf Cooperation Council
!DU	Injecting Drug Use
IEC	Information, Education and Communication
ILO	International Labor Organization
KAPB	Knowledge, Attitudes, Practices, Behaviors
MARPs	Most at risk populations
M&E	Monitoring and Evaluation
MENA	Middle East and North Africa
MOH	Ministry of Health, State of Qatar
MSM	Men Having Sex With Men
MTCT	Mother to Child Transmission
NGOs	Non governmental Organizations
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RCA	Red Crescent Authority
STD	Sexually Transmissible Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	The United Nations Joint Programme on HIV/AIDS.
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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II. Status at a glance

a- The inclusiveness of the stakeholders in the report writing process

The report had been elaborated in a consultative process with the following steps:

- Meeting with responsible from the Supreme Council of Health for debriefing about the UNGASS process; and selection of UNGASS indicators that are relevant for the country and for which there is data;
- Different interviews conducted for the National Composite Policy Index (Supreme Council of Health and the Qatari Red Cressent);
- Visit to different stakeholders (health care services and the Blood Bank)for Data Compilation;
- Validation, analysis and interpretation of data;
- Writing of the report and its approval.

b- The status of the epidemic

Qatar is epidemiologically classified as a country with low HIV prevalence with an average of 10 new cases diagnosed per year. The cumulative number of HIV/AIDS cases reported through 2009 was 247. The number of people living with HIV followed up by health delivery services are 78.

From 1999 to 2009, the main modes of HIV transmission was blood products (35%),followed by heterosexual (28%), mother to child transmission(6%), homosexual transmission (2,8%), and unknown (28%).

Although the current HIV prevalence rate, estimated less than 0.02% [14-15] of the total population (WHO/UNAIDS Working Group Estimation, 2007), is quite low, there is very limited data in Qatar for a proper situation analysis and planning.

c- The policy and programmatic response

The national response to HIV has been essentially focused on the medical aspect of the disease, and much less attention given to the social and preventive measures at community levels.

The AIDS response has thus so far focused on efforts to control HIV spread, including health delivery services, working closely with the industry to limit HIV spread in the work

place, holding several intensive workshops on HIV targeting community leaders from the media, the religious sector and others community sectors.

Despite the high level of political commitment and progress made in the national AIDS response, several challenges remain in Qatar, which are mainly related to the focus on medical and curative aspects at the expense of preventive and preemptive measures, surveillance remains scattered and focused mainly on case reports and screening ,inadequate epidemiological data to inform HIV programming, limited human resource skills base, , as well as limited involvement of civil society organizations (community based organizations including networks of people living with HIV) and the private sectors in the national response.

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

- Increased political support from key national stakeholders and decision makers at the Supreme Council of Health and expressed political commitment
- interest and awareness of the private sector and Civil Society
- efforts towards sensitizing religious and community leaders already initiated
- a continuously developing large array of medical services
- facilities to diagnose and monitor treatment (lab tests and rigorous protocols for testing) and post testing advice readily available
- treatment with ARV available free of charge to all Qatari and non Qatari residing in the country
- diversified condoms outlets (pharmacies and supermarkets) a national HIV/AIDS committee already established and is functioning
- surveillance is already initiated: pre-recruitment, armed forces pre-enrolment, pregnant women, pre-marital, frequently transfused patients, before some selected medical interventions (cardiac oath.), blood and organ donors, tuberculosis patients.

d- UNGASS indicator data in an overview table

#	Indicator	Remarks
1	Indicator 1: Domestic and International AIDS Spending	No data available, however all AIDS programs are financed by the government
2	Indicator 2: National Composite Policy Index	Part A: Completed Part B: there is not any civil society working for

		HIV
3	Indicator 3: Percentage of donated blood units screened for HIV in a quality assured manner	100% of donated blood units are screened in a quality assured manner.
4	Indicator 4: Percentage of Adults and Children with advanced HIV Infection receiving ART	According to the Communicable Disease Unit, in 2009, the total number of adults and children with advanced HIV infection who are currently receiving ART is 70. Estimated number of adults and children with advanced HIV infection is not available.
5	Indicator 5: Percentage of HIV-positive pregnant women who receive ARV to reduce the risk of MTCT.	In the period between January and December 2009, data reported on 1 women receiving ART medication in order to reduce the risk of mother to child transmission. Estimated number of HIV-infected pregnant woman in the last 12 months is not available.
6	Indicator 6: Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	According to the Communicable Disease Unit, in 2008, there was 1 case of advanced HIV infected patient receiving antiretroviral therapy and who started TB treatment, Estimated number of incident TB cases in people living with HIV is not available for the country.
7	Indicator 7: Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	The indicator is irrelevant to Qatar's epidemic context as the country has a low prevalence of HIV.
8	Indicator 8: Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results	No data available to report on this indicator.
9	Indicator 9: Percentage of most-at-risk populations reached with HIV prevention programs	No data available to report on this indicator.
10	Indicator 10: Percentage of orphans and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	The indicator is irrelevant to Qatar's epidemic context as the country has a low prevalence of HIV.
11	Indicator 11: Percentage of schools that provided life-skills based HIV education within the last academic year	No data available to report on this indicator.
12	Indicator 12: Current school	Indicator is irrelevant to the epidemic context in

	attendance among orphans and non-orphans aged 10–14	Qatar.
13	Indicator 13: Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	A cross-sectional study conducted among 781 universities students in Qatar revealed that around 95% of the respondents had correctly identified the main modes of HIV/AIDS transmission (unprotected sexual activities, sharing same needle).But some misconceptions still exist, around 62 % of the respondents reported that AIDS can be transmitted through mosquitoes and more than 50% believed that transmission can occur through public toilets or swimming pools or by chairing food utensils of an infected person clothes of an infected person.
14	Indicator 14: Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	No data available to report on this indicator.
15	Indicator 15: Percentage of young women and men who have had sexual intercourse before the age of 15	No data available to report on this indicator.
16	Indicator 16: Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	The indicator is irrelevant to Qatar's epidemic context as the country has a low prevalence of HIV.
17	Indicator 17: Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last sexual intercourse	The indicator is irrelevant to Qatar's epidemic context as the country has a low prevalence of HIV.
18	Indicator 18: Percentage of female and male sex workers reporting the use of a condom with their most recent client	No data available to report on this indicator.
19	Indicator 19: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No data available to report on this indicator.
20	Indicator 20: Percentage of injecting drug users reporting the use of a condom the last	No data available to report on this indicator.

	time they had sexual intercourse	
21	Indicator 21: Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	No data available to report on this indicator.
22	Indicator 22: Percentage of young people aged 15-24 who are HIV-infected	The indicator is irrelevant to Qatar's epidemic context as the country has a low prevalence of HIV.
23	Indicator 23: Percentage of most at risk populations who are HIV-infected	No data available to report on this indicator.
24	Indicator 24: Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of ART	Survival rate 12 months after initiation of therapy is reported to be 100 %
25	Indicator 25: Percentage of infants who are born to HIV-infected mothers who are infected	In the period between February and December 2009, it was reported that there is not any infant born to HIV infected mothers who was infected.

III. Overview of the AIDS epidemic

The HIV epidemic in Qatar is currently at a low level with a national prevalence rate less than 0.02%. The cumulative number of HIV/AIDS cases through 2009 was about 247.

Number of Reported HIV/AIDS Cases per year

UP to 1999	**00**	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**Total**
154	**07**	**03**	**15**	**08**	**11**	**14**	**09**	**10**	**11**	**05**	**247**

According to the Communicable Disease Unit of the Rumaila hospital, Based on statistics for 2009, the number of PLVIH registered are 78 persons, 6.4% of them are young men and women aged between 15-24 and 60% are aged between 25-44. The number of HIV cases among men was 53 (68%) while the number of cases among women was 25 (32%). The same trends are seen for the cumulative HIV infected cases.

Cumulative HIV infected cases by age group, Qatar, 2009

Percentage	Number	AGE
5.3%	13	0-4
2.4%	6	5-9
3.6%	9	10-14
6.1%	15	15-19
8.9%	22	20-24
14.6%	36	25-29
14.2%	35	30-34
12.2%	30	35-39
13.4%	33	40-44
7.7%	19	45-49
2.8%	7	50-54
4%	10	55-60
3.7	9	60+
1.2%	3	Unknown
100%	**247**	**Total**

According to Point–prevalence surveys, up to the early 1990s, the majority of HIV cases in Qatar were linked to blood or blood products or exposures abroad. Transfusions or other blood products were behind a large fraction of reported cases. More than 75% of reported HIV infections up to 1989 were acquired via transfusion of imported blood [5]. However with the adoption of universal precautions in handling blood or blood products and the universal blood screening [4], it is believed that such parenteral infections are currently rare as in most other MENA countries [1].

Available data from the Communicable Disease Unit of the Rumaila hospital indicate the following numbers and percentages of HIV infection by mode of transmission.

Cumulative HIV infected cases by mode of transmission, Qatar

HIV Mode of Transmission	Hetero	Homo	Blood/Blood products	From mother to child	Unknown	Total
Number	68	7	90	14	68	247
Percentage	27.53%	2.83%	36.44%	5.67%	27.53%	100%

The risk of infection by HIV depends on the mode of transmission, HIV prevalence, and behavioral attributes of the population. Human populations exhibit widely variable sexual and injecting drug risk behaviors, a heterogeneity in risk conventionally conceptualized in terms of three population groupings.[3] The first is the priority or high-risk group which experiences the highest risk of exposure to HIV and which typically include injecting drug use(r) (IDUs), men who have sex with men (MSM) including male sex work(ers), and female sex workers (FSWs); the second group is the bridging populations, such as truck drivers and clients of FSWs, who bridge HIV infections from priority populations to the third group of low risk which is the general population and which encompasses most of the population in any community.

Data on priority populations and HIV are virtually absent in Qatar. The number of IDUs in Qatar is estimated at 1,190 with a range of 780 to 1,600 [4].Prevalence of drug injection in the population is estimated at 0.22% with a range of 0.15% to 0.30% which is in the intermediate range in comparison to other MENA countries [1-2]. There are also limited data on HIV prevalence among bridging populations and the general population in Qatar. However, available data from HIV point-prevalence measures among different population groups in Qatar suggest that the prevalence levels of HIV are very low in the general population.

Sexually transmitted infections (STIs) can be used as proxy biological markers of sexual risk behavior. Very limited data are available on STIs in Qatar. Syphilis antibody prevalence among blood donors was reported at 1.1% [6]. The age-standardized rate (ASR) of cervical cancer incidence, a disease caused by human papillomavirus, is at 3.9 per 100,000 women per year with a mortality of 2.2 per 100,000 women per year [7]. These data suggest low levels of sexual risk behavior in the general population in Qatar.

Point-prevalence surveys on STI patients show prevalences of 4.49% HIV for the year 1999 [9-11].

Others Point–prevalence surveys from 1993 and 1996 indicate a 0% and 0.78% HIV prevalence among TB patients respectively [9-11].

The HIV epidemic in Qatar is currently at a low level, however, Qatar is witnessing an impressive economic and development boom, opening the country to a large influx

of labor force creating a cultural mix and some rapid demographic changes. This rapid socio-demographic transition the country is going through has driven attention to the risk of HIV epidemic. For the local community the risks of HIV/AIDS associated with large communities of single male expatriate workers, was perceived as an area of concern needing to be addressed.

An unpublished A cross-sectional study conducted among 781 universities students in Qatar revealed that around 95% of the respondents had correctly identified the main modes of HIV/AIDS transmission (unprotected sexual activities, sharing same needle).But some misconceptions still exist, around 62 % of the respondents reported that AIDS can be transmitted through mosquitoes and more than 50% believed that transmission can occur through public toilets or swimming pools or by chairing food utensils of an infected person clothes of an infected person. (dr Abdulhameed Alkhenji, unpublished study)

Because of the limited epidemiological data and lack of information in Qatar, the magnitude of HIV and STIs cannot be accurately defined in the absence of a reliable surveillance system.

IV. National response to the AIDS epidemic

a- Political leadership & supportive policy environment

In 2006, Qatar established its National AIDS Committee under the auspice of the National Health Authority. The members of the committee come from different governmental and non governmental sectors, including the acute care, the public health, the governmental planning department, the Islamic Affairs, the Human Rights, Qatar University, Ministry oflnterior, Ministry of Education, etc. Since it was formed, the committee undertook major steps forward in the efforts to control HIV spread.

It resulted in an HIV law being drafted, production of HIV curriculum for schools , workshops for training of media personnel, religious and other opinion leaders and the design of studies to assess Knowledge, Attitudes and Behaviors of Youth and for determination of characteristics and needs of People Living with HIV and creation of a website. However, the activities of the committee were never funded (although its budgets were approved) and these activities have stalled of late with dispersion of the core group of its members.

The high level of political commitment expressed by responsibles of the Supreme Council of Health will lead to relaunch of this Committee.

b- Prevention programs

HIV screening takes place in the contexts of:

- Pre-marital HIV screening and counseling is undertaken to facilitate understanding of risks associated with pregnancy and birth whilst living with HIV/AIDS.
- Recruits entering the armed services and other governmental positions
- Women receiving ante-natal careI(VF)
- Intensive care unit admissions.
- Patients undergoing cardiac catheterization.
- Blood, tissue and organ transplant donors.
- Recipients of repeated transfusion of blood and blood products.
- TB patients
- Persons who marry individuals residing outside of Qatar
- Persons inflicted with Sexually Transmitted Diseases (STDs)
- Gulf Cooperation Council (GCC) Worker Recruitment Regulations who require an HIV test for all expatriates who intend to live and work in Qatar longer than one month

Voluntary counseling and testing via general medical consultation at hospitals and private clinics is available to nationals and expatriates. There is no legal requirement for HIV counseling, however post test counseling is routinely provided, especially in the event of an HIV+ diagnosis. World Health Organization standards are applied in testing which involves a preliminary Elisa test (Enzyme Linked Immunosorbent Assay) followed by a confirmatory Western Blot.

There are ongoing HV/AIDS awareness initiatives targeted at students enrolled in both public and private schools.The National Health Authority's Health Education section has developed some materials for HIV/AIDS education of young people, although limited educational material is present in the school curricula. There is no life skills development programmes for young people at risk available. HIV/AIDS education is primarily blo-medical in nature, focusing on routes of transmission without covering socio-behavioral determinants which create vulnerability to HIV of young people.

Condoms are widely available in Qatar in supermarkets and pharmacies, but there is no policy or programme for promotion of their use. Although sterile needles and syringes are available in clinical settings but there is no needle exchange programme in Qatar nor there is any outreach peer education efforts for IDUs

c- Care, treatment and/or support programs

Access to HIV treatment and care and other preventive HIV services such as testing and counseling, PMTCT and anti-retroviral (ARV) therapy (front-line and alternative triple therapy regimens), and treatment for opportunistic infections are centralized and are provided at no cost by the Qatar Government for nationals and expatriates who remain in the country living with HIV/AIDS. Actually the Hamad Medical Corporation Hospital provides HIV management for approximately 78 patients, 70 of them are under under ART.

There is not population modeling for the country that allow to calculate the PLVIH in need of ART.

The majority of expatriates who test HIV+ either on commencement of employment, during their contract period, or upon changing employer, are deported. Under extenuating circumstances such as where an expatriate has lived with his family for an extended duration, say ten to twenty years or more, he may be allowed to stay and receive treatment in Qatar_PLWH in the HMC are not attending any support groups, and apparently no self-help system exists on a continuous basis.

V. Major challenges and remedial actions

The few available data on HIV in Qatar indicate that there is no evidence for an HIV epidemic in the general population in Qatar and there appears to be very limited HIV transmissions within the general population. Most recent HIV infections appear to be due to exogenous exposures among nationals and residents, or HIV acquisitions among their sexual partners upon their return. There also seems to be limited HIV epidemic potential in the general population in Qatar as suggested by the low rates of proxy biological markers of sexual risk behavior**.**

With the limited epidemiological data in Qatar, the magnitude of HIV and STIs cannot be accurately defined in the absence of a reliable surveillance system Still, HIV surveillance in Qatar needs to be improved to track the evolution of the epidemic in the country and detect possible emerging epidemics among high-risk groups.

The national response to HIV has been scattered, poorly sustained, and essentially focused on the medical aspect of the disease, and much less attention given to the social and preventive measures at community levels.

VIII. Monitoring and evaluation environment

There is a significant need to implement a National M&E systems, supervision and monitoring, as well as to strengthen the capacities of program partners in monitoring and evaluation of the AIDS response in Qatar .

Surveillance remains scattered and focused mainly on case reports and screening information from available surveillance remains adequate and complete and behavioral surveillance is inexistent

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