UNGASS COUNTRY PROGRESS REPORT 2010

MINISTRY OF HEALTH
UNITED ARAB EMIRATES

Narrative Report

January 2008–December 2009

Submitted on: Tuesday March 30, 2010

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I. Glossary of terms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral Therapy
DHA	Dubai Health Authority
HAAD	Health Authority of Abu Dhabi
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communiction
MARPs	Most at Risk Populations
MENA	Middle East and North Africa
MOH	Ministry of Health, United Arab Emirates
MOHE	Ministry of Higher Education
MSM	Men Having Sex With Men
NAP	National AIDS Program – Ministry of Health, United Arab Emirates
NGOs	Non Governmental Organizations
NSP	National Strategic Plan
PEP	Post Exposure Prophylaxes
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RST	Regional Support Team
STI	Sexually Transmitted Infection
UNAIDS	The United Nations Joint Programme on HIV/AIDS.
UAE	United Arab Emirates
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VCT	Voluntary Testing and Counseling
WHO	World Health Organization

II. Status at a glance

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

This report was prepared with extensive input from the various HIV/AIDS stakeholders involved in the prevention, surveillance, education, treatment and advocacy efforts at the UAE. The MOH at UAE led the efforts with the support and patronage of H.E. the MOH at UAE, Dr. Haneef Hassan, and the CEO for Health Policies at the MOH, Dr. Mahmoud Fikri. Support was also extended by the Director of Preventive Medicine Department at the MOH, Dr. Ibrahim Al-Qadi and Dr. Rola Abdul Jabbar from Preventive Medicine Department. The NAP manager at the UAE, Dr. Nada Al-Marzouqi was instrumental in charting the UNGASS 2010 reporting journey towards successful completion. The reporting process was significantly enhanced by the valuable information provided by Dubai Health Authority (special thanks to Drs. Abdullah Ustadi, Layla Al-Dabl and Ali Al-Marzooqi), the Health Authority of Abu Dhabi (special thanks to Drs. Jamal Al-Mutawa and Farida Al-Hosani) and Zayed Military Hospital at Ministry of Defense (special thanks to Dr. Saif Al-Bedwawi). In addition to the information provided by the MOH and other governmental organizations, the report incorporates input from non-governmental stakeholders to enhance inclusiveness and improve the validity and accuracy of reported findings.

The input of civil society organizations was also pivotal in this report and has complemented the information reported by MOH and other governmental agencies. The valuable contribution of Colonel Dr. Mohamed Abdalla AlMur and Captain Khaled Saleh from Dubai Police are worthy of acknowledgement. Special regards are also extended to the representatives of the civil society, namely Mrs. Fathiyya Al-Nizari and Dr. Abdul Rahman Azzazy from Red Crescent and Mrs. Ahlam Al Lamki from Women's Union.

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

(b) the status of the epidemic

UAE currently has a very low incidence and prevalence of HIV. Two main factors have contributed to this; the first is the rigorous testing (including HIV test) that UAE foreign workers are subjected to as a prerequisite for issuance of work permit at the country and the second is due to the conservative society that rejects practices contributing to the spread of the infection.

The country's national response to the HIV/AIDs epidemic has been scaled up over the last few years. Economic prosperity, coupled to an exponential increase in the number of expatriate workers in the country, each bringing forward their habits, practices and cultural beliefs, have alarmed UAE official to the need to increase investment in HIV surveillance, prevention and treatment. Yet, a significant proportion of investments and programming have been focused on the passive surveillance of HIV.

The total number of HIV positive cases among UAE nationals in 2009 was 49; which is comparable to the number of incident cases reported in previous years. In contrast, the number of incident HIV positive cases among UAE expatriates has been increasing over the last few years with the increase in the number of foreign workers employed in the country. Yet, discovered cases among UAE expatriates are not reflected in the national reports since these cases are repatriated for proper care treatment and support at the country of origin, unless serving a jail term at UAE.

Note that in 2009, 39% and 35% of incident cases among UAE nationals, were discovered in the Emirates of Dubai and Abu Dhabi respectively; the 2 emirates have indeed the highest number of incident cases compared to the 5 other Emirate of the UAE. Many governmental and non-governmental stakeholders agreed that the discovered and reported incident cases might under estimate the true incidence of HIV at the UAE. Anecdotal evidence, backed up by stakeholders' opinion indicate that an undetermined number of UAE nationals prefer to test HIV status and seek care, treatment and support services outside UAE out of fear of stigma and discrimination.

(c) the policy and programmatic response

Good efforts have been exerted in response to the AIDS epidemic at UAE including:

1- Offering a comprehensive and unlimited care treatment and support services to UAE nationals living with HIV and AIDS patients. Many hospitals now offer ARV treatment and have designated infectious diseases specialists with experience in the management of AIDS patients.
2- Political support to a new draft bylaw protecting the society from the spread of the infection and guaranteeing the rights of PLHIV& AIDs patients. The bylaw is currently going through the formal processes for approval and should be at the agenda of the Cabinet of Ministers this year. Note according to this bylaw VCT clinics will be legalized and promoted at UAE.
3- Expanded routine AIDS passive surveillance efforts which comprise multiple sub-groups, including: premarital, antenatal care, TB patients, prisoners, IDUs, residency applications and renewal, military recruits, job applications and university applications. Although these screening efforts might be deemed inefficient and costly they are effective in detecting incident HIV cases in the country.
4- A good partnership with the civil society and international organizations to help raise awareness, dispel misconceptions and decrease the stigma against PLHIV and AIDS patients. The successful partnership on raising HIV awareness between Dubai Police, UNAIDS, UNDP and UNICEF is a good example that will be highlighted under the best practices section in this report.

(d) UNGASS indicator data in an overview table

Serial	Indicator	Remarks
Reported Indicators		
1	Indicator 1: Domestic and International AIDS Spending	Approximately 17.6 million dollars in public funding; 82% of which are dedicated to involuntary testing (e.g. for employment, premarital, etc.) and an additional 15% dedicated to ARV therapy for UAE nationals. Note that there is difficulty is getting the exact spending figures on AIDS at the UAE since there is no clear allocated budget for AIDS programs from the MOH or local health authorities. Thus, the reported number is an underestimation of the actual amount spent on AIDS programs at the UAE
2	Indicator 2: National Composite Policy Index	Completed
3	Indicator 3: Percentage of donated blood units screened for HIV in a quality assured manner	All donated blood units in the country are screened for HIV in labs following documented standard operating procedures and participating in external quality assurance scheme. The total number of donated blood units in 2009 was 19388 all were screened as described above. Only one donated blood unit was tested HIV positive in year 2009.
Indicators with no information to report on/ Irrelevant to UAE		
4	Indicator 4: Percentage of Adults and Children with advanced HIV Infection receiving ART	There are no denominator estimates generated for this indicator. The total number of UAE nationals receiving ARV therapy in 2009 was 121 divided as follows: 51 patients receiving ARV at MOH hospitals and 70 at Dubai Health Authority (DHA) hospitals (note that DHA does not only treat Dubai AIDS patients but rather nationals coming from all across the UAE). DHA patients are divided as follows: 60 (85.7%) are males and 10 (14.3%) are females. Among DHA AIDS patients receiving ARV, only one female patient was less than 15 years old. Note that 17 additional non-UAE patients are receiving ARV treatment at DHA hospitals. These are mostly completing jail terms and will be repatriated upon the conclusion of their jail terms.
5	Indicator 5: Percentage of HIV-positive pregnant women who receive ARV to reduce the risk of MTCT.	Denominator estimates are not available. Note that the total number of HIV-infected pregnant women who received ARV to reduce MTCT in 2009 was one.

6	Indicator 6: Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Denominator estimates are not available for this indicator. There is one HIV incident TB case that received treatment for TB and HIV among UAE nationals in 2009. As for expatriates, DHA reported 15 HIV positive patients with open pulmonary TB in 2009. According to country law, these patients were either repatriated to their home countries or to jail if they were referred from Jail Clinic. Note that all HIV and TB management costs are provided by MOH and health authorities free of charge to both UAE nationals and expatriates (until they are repatriated); including inpatient fees all through admission period, and a stock of at least 2 weeks supply of medications from DHA and one month supply from MOH is handed out to co-infected patients upon discharge.
7	Indicator 7: Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	Indicator is relevant but there are no population based surveys to populate it. Note that there is currently a bylaw, going through official approval channels, which would legislate the establishment of VCT clinics. Perhaps the establishment of VCTs could help with data collection for this indicator.
8	Indicator 8: Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results	There are no behavioral surveys providing the required data for this indicator. It should be noted though that prostitution and homosexuality are believed to be rare at UAE in light of the religious, social and cultural fabric of the country. Yet, this needs to be confirmed by bio-behavioral surveys.
9	Indicator 9: Percentage of most-at-risk populations reached with HIV prevention programs	There are no behavioral or special surveys to provide the necessary data for this indicator. Note that the future plans to legislate and establish VCT clinics might help provide a venue for individuals with risky behavior to test their HIV status. Note that there are socio-cultural sensitivities to condom distribution at UAE, since this might be viewed as a strategy to encourage extra-marital relationships. Yet, condoms are widely available for purchase in all pharmacies as well as many hotels, gas stations & supermarkets. In addition, it is not permitted to run needle exchange programs at UAE. Drug addicts are referred to rehabilitation facilities for appropriate treatment.
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 UAE'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	There are no school surveys providing relevant information regarding this indicator. Note that there is evidence that education about AIDS is integrated into the curricula of all secondary schools at UAE but the number of educational hours is less than 30 and the education is focused on raising awareness and is not life-skill based.
12	Indicator 12: Current school attendance among orphans and non-orphans aged 10–14	Indicator is irrelevant to the epidemic context at the UAE.
13	Indicator 13: Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	No population based surveys have been carried out to supply the needed data for this indicator. Evidence of serious misconceptions about AIDS risk factors and modes of transmission surfaced in a number of studies carried out at schools, universities and healthcare facilities.
14	Indicator 14: Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	There has been no special behavioral surveys carried out at UAE to help populate this indicator. Note that it is very difficult to identify FSWs and MSMs as a sub-category of MARPS since prostitution and homosexuality are criminalized and are highly stigmatized at UAE.
15	Indicator 15: Percentage of young women and men who have had sexual intercourse before the age of 15	According to Islamic Jurisprudence prevailing in the country, sex is illegal outside the wedlock. Religious, cultural, social and legal restrictions prevent sexual activity for individuals younger than 15 years. Future surveys of school children and youth could help verify the aforementioned assumptions.
16	Indicator 16: Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	Indicator is irrelevant to UAE's epidemiologic context. In addition, it is illegal at the UAE to have sex with multiple partners unless within the boundaries of marriage. Individuals found guilty of adultery will be prosecuted and penalized.
17	Indicator 17: Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last sexual intercourse	Indicator is irrelevant to UAE's epidemiologic context. In addition, it is illegal to have sex with multiple partners at UAE unless within the boundaries of marriage. Promoting the use of condoms among the youth or the general population is deemed culturally unacceptable, though condoms are widely available for purchase.

18	Indicator 18: Percentage of female and male sex workers reporting the use of a condom with their most recent client	There are no special surveys to help populate this indicator. Prostitution is a crime that leads to prosecution and punishment. Although the presence of prostitution can not be ruled out in UAE, it is uncommon and is hidden in the society. It is extremely difficult to map out the existing cases of FSWs.
19	Indicator 19: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	There are no special surveys to help populate this indicator. Homosexuality is deemed as a criminal act that is highly stigmatized. MSMs are prosecuted and penalized. The cases of MSMs are usually hidden and are extremely difficult to map out.
20	Indicator 20: Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	There are no special surveys to help populate this indicator.
21	Indicator 21: Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	No behavioral surveys have been carried out to gather relevant information for this indicator. Note that needle exchange programs are not allowed at the UAE.
22	Indicator 22: Percentage of young people aged 15-24 who are HIV-infected	The indicator is irrelevant to the epidemiologic context of the UAE.
23	Indicator 23: Percentage of most at risk populations who are HIV-infected	Prostitution and homosexuality are illegal at UAE. FSWs and MSMs are not acknowledged as a sub-category of MARPs. HIV prevalence among FSWs and MSMs was never assessed.
24	Indicator 24: Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of ART	99.17% of individuals that started ARV therapy in 2009 were still on therapy 12 months after initiating treatment. They are divided as follows: 51 individuals who initiated ARV therapy 12 months prior to reporting period were still on ARV after 12 months of treatment initiation. The source of this information is the MOH ARV registers and pharmacy records in 2009. The records of Dubai Health authority indicate that out of 70 individuals that are receiving ARV in 2009, 69 were still alive on ART at 12 months after initiating treatment.
25	Indicator 25: Percentage of infants who are born to HIV-infected mothers who are infected	There are no denominator estimates for this indicator. Program monitoring data indicate that only one baby was delivered to an HIV positive mother with no information on the HIV status of this baby.

III. Overview of the AIDS epidemic

Overview of Literature

According to the WHO, the UAE and neighboring countries are classified among the world's least affected countries by the HIV epidemic as evidenced by the number of incident and prevalent cases (WHO, 2006). This low prevalence was traced back to cultural, social and behavioral norms that may have contributed to keeping the epidemic at low levels. Indeed, a 2007 UNDP report states that: *"AIDS is a rare disease in the UAE, for two major reasons: the conservative nature of UAE's national society rejects practices that help spread the disease; permanent expatriates are subjected to rigorous tests"* (UNDP/MOE, 2007).

However, another contributing factor to this low prevalence is the UAE AIDS control program, the first of its kind in the region. The program, established in 1989, was initiated in order to control and monitor the spread of HIV in the country and to protect the community against its dangers. According to UNDP (2007), the program has established controls and measures aiming at preventing entry of the disease, ensuring its preliminary prevention and early detection, as well as providing health insurance for all workers.

The program concentrated on early case detection, follow-up of patients for counseling and compliance, health education campaigns and other strategies (WHO, 2006). The joint program launched by the government and private institutions greatly helped in curbing the disease, especially that the UAE counts a large number of expatriates.

The first HIV positive case was detected at UAE in 1980. Consequently, the UAE was the first country in the region to stop importing blood in 1984. It was reported that starting 1985, no more cases of AIDS transmission through blood transfusion were recorded. In 1990, the government established a national blood transfusion program; it

took legislative and policy measures to move to a system of 100% voluntary unpaid blood donation (WHO, 2008).

Published and official data on the prevalence, prevention, treatment, care and support at the UAE are scarce. A comprehensive report characterizing the HIV / AIDS epidemiology in the MENA region reported that there are no available estimates of the number of PLHIV or AIDS patients at the UAE. The limited available data, studies and estimations could not substantiate whether a concentrated epidemic among IDUs, FSWs and MSMs is likely. Yet, a generalized epidemic in the UAE is improbable (MENA HIV/AIDS Epidemiology Synthesis Project, 2008).

The 2005 and 2008 UNAIDS global reports did not include any data on the number of cases of HIV / AIDS and routes of transmission of the disease in the UAE as this information were not reported by the country's authorities. The exact prevalence of HIV among UAE citizens is still not reported and it is anticipated that any reported numbers might not be accurate due to fear of stigma. Although treatment is available free of charge to all UAE citizens, many choose to seek treatment overseas out of fear of stigma surrounding people who are HIV positive.

Nowadays, UAE has become a major touristic destination and a host country for expatriate communities. Awareness and advocacy efforts are hence now more important than ever. National health authorities have joined hands with the UNDP in order to strengthen AIDS awareness programs throughout the UAE (UNDP, 2008).

A number of studies have been carried out investigating the HIV knowledge levels, attitudes, believes and practices. Most of these studies were carried out among school/university students and all unearthed an evidence of some serious misconceptions about HIV and modes of transmission among surveyed individuals. In that regard, researchers from the department of Community Medicine at the Faculty of Medicine and Health Sciences at UAE University conducted a number of surveys to investigate knowledge levels, attitudes, beliefs and practices related to AIDS and HIV between 1996

and 2006. These studies surveyed the youth in schools and universities and health workers in hospitals in different regions of the nation. We hereby report on the studies that were carried out over the last 5 years.

In 2006, a group of researchers surveyed 378 female students in the last grade of the secondary stage from the schools of the Emirate of Abu Dhabi. They concluded that there is a low basic knowledge concerning AIDS and HIV coupled to serious false beliefs concerning its mode of transmission (69% believed that the virus could be transmitted through insects). Study findings exhibited a need to promote, among the youth, the various methods that can help protect them from contracting virus, and to organize educational interventions on all secondary school students at UAE, as well as use media outlet as one mean to reach the general public (Al-Muhairy et al., 2006).

Another study also conducted in 2006 surveyed 505 male students in the last grade of the secondary school, aged 16 to 19 years, in Al-Ain region. A low level of basic knowledge concerning AIDS and HIV was also reported in this study, as well as false beliefs concerning its mode of transmission. The study recommended working on changing the existing attitudes among the youth, towards promoting a positive attitude in dealing with AIDS and HIV (two thirds of respondents exhibited a negative attitude), and in facing the stigma that inhibits people carrying the virus from seeking care, support and treatment services. The study pointed out to the necessity to unite the efforts of the different sectors of the population to awareness about HIV and decrease stigma, starting with media outlets and reaching physicians and health workers (Al-Shamsi et al., 2006).

These findings were in conformity with the findings of two other studies also conducted in 2006, one including 538 female students (Al-Kaabi et al., 2006) and the other included 482 female students in the last grade of the secondary stage from the schools of Al-Ain region (Al-Dhahri et al., 2006). The first study pointed out to the fact that UAE youth are exposed to the danger of drugs and unprotected /unsafe sexual intercourse. It pointed out to the responsibility of the society to build a context in which youth can discuss sensitive topics that might affect them such as AIDS, and the necessity

to face the shame that inhibits infected people from seeking testing , counseling and treatment services. The second study showed that the majority of the girls represented in the sample obtain the bulk of their information on the topic from media outlets and view physicians and health workers as the most knowledgeable source of information.

Another study conducted in 2005 surveyed 217 students from the UAE University. It showed an imbalance in the knowledge of students about AIDS and HIV. While 99.5% realized the seriousness of the virus, they were not sure about its reasons and its nature, and its modes of transmission and modes of prevention. This explains the false beliefs and attitudes towards it. The survey respondents pointed out to the fact that they rely on books and magazines and media outlets as sources of information on methods of prevention from the virus. The majority (79%) stated their need to learn more about the virus, 56% said that the focus on it in schools was not enough, 95% declared that it is a duty to educate the youth on how to protect themselves from the virus. The study concluded that there is a need to provide accurate and detailed information about HIV/AIDS to students and their families through health programs. The study confirmed the role of the media especially when it comes to providing information in a way that attracts the general public and educates it (Obeid et al., 2005). Finally, Gańczak et al. (2007) reported that UAE university students had a low comprehensive knowledge about HIV and were identified as a population with high levels of misinformation on the subject. University students were further identified as a population holding negative attitudes towards people living with HIV /AIDS.

It is difficult to specify with certainty the exact risk factors at UAE before conducting field studies to investigate it. But given the experience from some neighboring countries and based on the givens available, principally through the analysis of the means of transmission of the virus among the known cases, the main risk factors among UAE nationals is reported to be extra marital heterosexual relations & IDU for men and infection from the spouse for the women. Other risk groups, given the experience from some neighboring countries, might include MSMs, FSWs, prisoners, young males, illegal migrants and foreign workers.

Overview of the AIDS epidemic at UAE nowadays[1]

The UAE has one of the lowest reported HIV rates globally. This could be attributed to deep rooted religious, cultural and social beliefs rejecting the practices that help spread the disease (e.g. homosexuality, prostitution, etc.), it is also partially attributable to the strong screening programs that UAE expatriates are mandated to go through prior to the issuance of their residency in the country.

Table1: Reported HIV/AIDS Positives Cases Among UAE Nationals by Age, Sex & Medical District (2009)

Medical District	Age group														Unspecified Sex	Total			
	0-15		15-24		25-34		35-44		45-54		55+		Unspecified age						
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female		Male	Female	Unspec.	Total
Abu Dhabi	1		2	2	3		4		3	1			1			**14**	**3**		**17**
W. Region																**0**	**0**		**0**
Al Ain				1	2			2	1	1	1					**4**	**4**		**8**
Dubai					3	1	3						1		**11***	**7**	**1**	**11**	**19**
Sharjah			1						1							**2**	**0**		**2**
Ajman																**0**	**0**		**0**
UAQ																**0**	**0**		**0**
RAK							1		1							**2**	**0**		**2**
Fujairah							1									**1**	**0**		**1**
Total	**1**	**0**	**3**	**3**	**8**	**1**	**9**	**2**	**6**	**2**	**1**	**0**	**2**	**0**	**11**	**30**	**8**	**11**	**49**

*These 11 cases were diagnosed at DHA but were not disaggregated by sex. Four cases belonged were 25-34 years old, three were 35-45 years old, 2 were 45-55 years old and 2 had not specified age.

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

According to the 2008 UAE population census (the latest available), the total number of UAE national was 892,000, including 439,000 females and 453,000 males. The cumulative number of living HIV positive cases among nationals in 2009 was 636 (476 males, 160 females). This translates into an estimated 2009 prevalence rate of 0.071% amongst the general population, 0.1% amongst UAE males and 0.036% amongst UAE females.

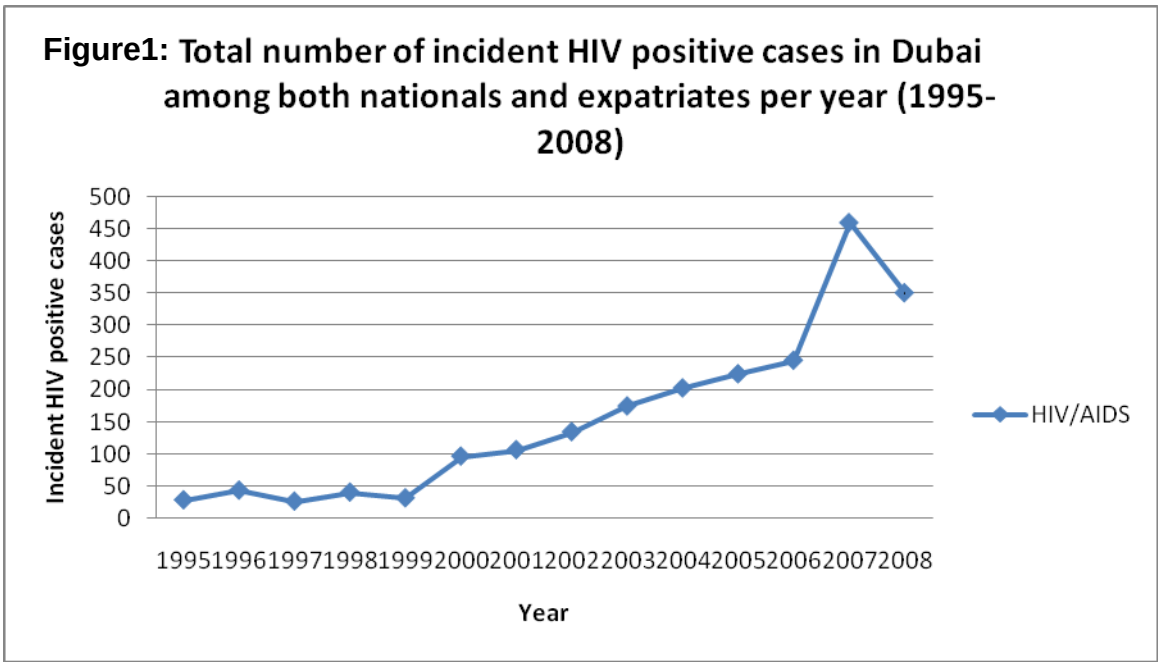
In 2009, a total of 49 incident HIV cases among UAE nationals were reported (Table 1). This resembles a 9% growth in the number of incident cases compared to 2008 (45), conversely, it resembles an 8% decrease in the number of incident cases compared to 2007 (52). The number of incident cases reported in 2006 and 2005 were 42 and 59; respectively. Therefore, although there has been some minor fluctuations in the numbers of incident HIV cases at UAE over the last few years, this number remains small and is generally comparable across the years.

In regards to the age and sex distribution among HIV positive cases at UAE, it should be noted that close to 75-80% are among males and close to 20-25% are among females. The same sex distribution is recorded in the incident HIV positive cases at UAE in 2009 (Table 2).

Table 2. Incident HIV cases among UAE nationals by age group & Emirate (2009)

Age distribution of incident HIV positive cases among UAE nationals (2009)	Number (%)
<15 years	1 (2.0)
15-44 years	33 (67.4)
≥ 45 years	11 (22.4)
Unspecified	4 (8.2%)
Total	49 (100)
Percent distribution of incident HIV positive cases among UAE nationals by Emirate (2009)	Number (%)
Dubai	19 (38.8)
Abu Dhabi	17 (34.7)
Al-Ain	8 (16.3)
Remaining UAE Emirates	5 (10.2)
Total	49 (100%)

Figure 1 exhibits the total number of diagnosed HIV cases at the Emirate of Dubai, for both UAE nationals and expatriates, from years 1995 to 2008. The figure portrays two distinctive trends; a period of stability at low number of incident HIV positive cases (below 50) from 1995 to 1999; followed by a period of steady growth in the number of incident HIV positive cases that went along with the exponential growth in the number of expatriate workers residing in Dubai from 2000 till 2007. In these seven years, the number of incident HIV positive cases grew seven folds, from around 50 to 450. Note that the sudden spike in the number of cases recorded in 2007 (from 250 to 450) is worthy of investigation. In 2008, the total number of incident cases in Dubai decreased to 350. The numbers for 2009 were not ready at the time of the preparation of this report but there are some early indications of a significant drop in the total number of incident cases in 2009 due to the decrease in the number of expatriate workers in Dubai precipitated by the global financial crisis. In that regard, DHA records indicate that the total number of incident HIV positive cases for the first ten months of 2009 was 147.



IV. National response to the AIDS epidemic

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

(a)Political leadership & supportive policy environment

There is 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 favorably about HIV efforts in major domestic forums.

Political support and endorsement of MOH leadership in the period extending from 2006 to 2008 resulted in the drafting of a multi-sectoral national strategic framework and operational plan. The hallmark of this plan was the broad involvement of multiple governmental and non-governmental stakeholders in planning the future of UAE's response to the HIV/AIDS epidemic. Although, regretfully, an assortment of challenges prevented the drafted NSP from being finalized, approved or endorsed, it still presents a good basis nowadays to summon the multiple stakeholder and work collaboratively on updating this plan for an updated NSP and operational plan.

Perhaps the clearest evidence of political support to scale up the country's response to the epidemic relies in the drafting a bylaw to protect the society from the spread of the disease and to guarantee the rights of PLHIV and AIDS patients. This bylaw is currently going through formal legislative channels for endorsement and approval and is expected to be reviewed by the Cabinet of Ministers in 2010 before the final approval of the President of the country. Note that should this bylaw be endorsed, it would not only protect and guarantee the civil and human rights of PLHIV and AIDS patients, including the right for employment, education, care, treatment and support,

among others, but it also legalizes and regulates the establishment of VCT clinics at the UAE.

(b) Prevention programs

HIV prevention programs at the UAE have been scaled up over the last two years. Multiple governmental and non-governmental agencies joined efforts in order to improve the UAE residents' awareness about HIV, enhance their knowledge about prevention methods and decrease their fear and stigma directed at PLHIV and AIDS patients. Worth noting is the "Unite for Children, Unite Against AIDS" program co-organized by Dubai Police and UNICEF. This program concentrated on spreading AIDS awareness using multiple communication techniques across different social forums to have maximum outreach and impact on the population.

Also worth noting is the peer education program led by the Emirati Red Crescent which recruits, empowers and trains ambassadors for AIDS education and prevention. AIDS prevention efforts also included awareness, advocacy and capacity building workshops organized in 2008 and targeting healthcare workers, media, civil society and religious organizations.

Implemented HIV prevention programs at UAE include: Blood safety, Universal precautions in health care settings, Prevention of mother-to-child transmission of HIV, IEC on risk reduction, provider initiated HIV testing and counseling, Reproductive health services including sexually transmitted infections prevention and treatment and School-based HIV education for young people.

Despite the aforementioned progress reported, there is a consensus among all HIV stakeholders at UAE that HIV/AIDS prevention programs still need additional scaling up with collaborative effort from multiple governmental and non-governmental stakeholders. Special attention need to be dedicated to designing targeted prevention programs for the

youth, designing awareness raising and stigma reduction campaigns and establishing VCT clinics across the UAE.

(c) Care, treatment and/or support programs

UAE offers a universal free, comprehensive and unlimited access to AIDS treatment for all UAE nationals. Note that most non-nationals diagnosed with HIV/AIDS are repatriated to their country of origin. The logic for repatriation of UAE expatriates diagnosed with HIV/AIDS relates to the fear that they might develop resistance should treatment be initiated in UAE and discontinued upon return to home country.

The scaling-up of treatment and support programs at UAE is evident in the expansion of ARV treatment services to many hospitals across the UAE. This has resulted in the majority of UAE nationals in need having access to the following care, treatment and support services: Antiretroviral therapy, Pediatric AIDS treatment, Sexually transmitted infection management, Palliative care and treatment of common HIV-related infections, HIV testing and counseling for TB patients, TB screening for HIV-infected people, TB preventive therapy for HIV-infected people and Cotrimoxazole prophylaxis in HIV-infected people.

A few challenges in UAE's HIV/AIDS care, treatment and support programs remain to be addressed including: the standardization of care, treatment and support programs across the various clinical facilities and among the various emirates, the recruitment of additional qualified human resources to deliver services, promoting the use of generic drugs and enhancing homecare programs.

V. Best practices

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

(1) The inclusion of stakeholders in the planning efforts for HIV and their wide representation on national committees. The wide representation of the civil society has been a distinguishing characteristic in UAE's response to the AIDS epidemic. This has led to better collaboration and communication between stakeholders, better coordination of activities and programs and a stronger support for any planned for strategic direction.

(2) The role of Dubai Police in raising awareness about AIDS is commendable. Dubai Police has partnered with UNICEF and other community stakeholder to run AIDS awareness campaigns over the last 5 years. Dubai police currently has a unit with seven staff members dedicated to raising public awareness about AIDS. Awareness is raised through an assortment of activities taking place all around the year, including: setting up displays in exhibitions and shopping malls, holding workshops to decrease stigma, distributing educational material in various languages in supermarkets, carrying out school visits to enhance the awareness of students on AIDS and using the screen of ATM bank machines to send focused awareness messages about AIDS. Worth noting is Dubai Police's role in advocating for the rights of AIDS patients through the establishment of a dedicated unit for human rights within the organization.

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

VI. Major challenges and remedial actions

Despite the aforementioned progress in UAE's response to the AIDS epidemic, a few challenges remain on the agenda of decision and policy makers and will require, under the patronage of the MOH, a concerted effort between the various governmental and non-governmental stakeholders in the country, including:

1. Dedicating more resources to strengthen the functions and enhance the operations of the NAP office at the MOH, UAE. Of particular concern is the chronic understaffing at the NAP office. In fact, the office at the time of write up of this report had no full-time staff and no physical location. The single-handed NAP manager has no technical or administrative support staff working with her. Scaling up the response of the UAE to the AIDS epidemic mandates additional support to the NAP should be empowered to plan for, implement, coordinate, monitor and evaluate of programs. An additional human resources concern relates to the high turnover rate at the MOH and at UNDP/UNAIDS, which has prevented finalization and implementation of the draft NSP and led to dismantling the NSP taskforce.
2. HIV/AIDS needs to be viewed as a higher priority by stakeholders at the national and sub-national levels. Other priorities (e.g. non-communicable diseases, especially Diabetes and CVDs) although very important, should not divert attention from scaling up UAE's response to the AIDS epidemic.
3. The need to develop, endorse and implement a single national muti-sectoral strategic framework and plan to respond to HIV is an identified priority at UAE. The MOH intends to act on this priority in the near future in collaboration with governmental and non-governmental stakeholders and with help and support from international partners.
4. The role of NGOs needs to be strengthened. There are currently no NGOs at the UAE dedicated to addressing the needs or advocating for the rights of PLHIV & AIDS patients. Establishment of such NGOs could address these needs as well as help with the reach out to specific MARPS, especially IDUs, FSWs and MSMs.
5. Prevention programs need to be scaled up through the legalization and support of VCT clinics at the UAE. The draft bylaw for the protection of the community from the spread of HIV and the protection of the rights of PLHIV and AIDS patients acknowledge this need. Section 8 of the draft bylaw states:
    i. *"It is the right of every individual (at UAE) to check for their HIV status through voluntary, confidential and free test at the institutions and specialized centers that are*

approved by the NAP. Individuals and centers will not be obliged to disclose identity of tested individuals"

6. There is an urgent need for behavioral, BBS and/or population based studies to identify the main groups and behaviors associated with new infections, ensure a shared understanding of the "drivers" of the epidemic, and clearly link prevention interventions to this information. The MOH identifies the need for such surveys as a programmatic priority incorporated in the upcoming strategic plan for the NAP. The technical support from international partners, especially UNAIDS, will be highly appreciated in that regard.
7. There is a need to investigate, in collaboration with other sectors (health, education, social affairs, etc.); the socio-vulnerabilities that might influence further HIV transmission, and barriers to accessing and using HIV prevention services. The MOH appreciates that an Inter-sectoral collaboration is necessary to respond to this need.
8. Although there is a single national AIDS Program at the UAE, the services and functions of this program are fragmented under multiple health authorities with varying degrees of coordination. Standardizing and streamlining the processes related to the NAP is a necessity identified by the MOH. There is an agreement among the various stakeholders that the NAP office could spearhead national efforts provided it has the human resources, expertise and infrastructure to do so.
9. More effort could be exerted with respect to investigating the modes of transmission of HIV and identification of MARPs. Note that under Islamic penal code, prostitution and homosexuality are considered criminal acts that could lead to punishment and imprisonment. The MOH is fully aware for the need to map out MARPs. Yet, the acknowledgement of the presence of FSWs and MSMs will require a lot of time as they are related to deep rooted societal, cultural and religious values.
10. Optimal response to the AIDS epidemic requires the buildup of a stronger strategic alliance between the MOH, civil society organizations, educational /research facilities and international organizations. The MOH acknowledges the

need to strengthen the level of cooperation and coordination with non-governmental stakeholders and representatives of the civil society.

11. IEC programs need to be expanded and strengthened in order to improve the awareness of the population about AIDS and help reduce the stigma against PLHIV and AIDS patients. Special attention needs to be dedicated to school children and teenagers who do not appear to be receiving optimal education about HIV. The MOH acknowledges this need and will be leading a concerted effort with other stakeholders to boost up IEC programs, especially those targeting the youth.
12. There is an obvious need to strengthen the HIV M&E capacity at UAE. This could be an area were capacity building efforts could be pooled. The help of international organizations and education institutions will be sought to build the M&E capacity at UAE (Please refer to section VIII).

VII. Support from the country's development partners

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

1- The proper Monitoring and Evaluation of AIDS in UAE requires the MOH to build a strategic alliance with three main stakeholders: International organizations (especially UNAIDS and WHO), civil society organizations with interest in AIDS and academic institutions. UNAIDS leadership could play an important role in bringing those strategic partners together to negotiate the terms of this strategic alliance.

2- The UAE does not have any special, behavioral or population based studies. All governmental and non-governmental stakeholders are convinced that initiating these studies is a national priority yet they are in need for external technical support to help initiate them. UNAIDS could help provide this technical support

to the MOH as well as organize training programs to build local capacity and expertise in M&E of HIV/AIDS.

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

4- UNAIDS could indeed extend much needed support to strengthen the M&E environment and capacity at the MOH, including but not limited to:

   a. Work with UAE's MOH and NAP to develop and implement a national M&E plan stemming from a national multi-sectoral strategic framework and plan to respond to HIV.
   b. Identification of a minimum dataset of indicators that both public and private institutions should be reporting on.
   c. Providing advise on the creation of proper committees and formal structures that could lead HIV/AIDS M&E activities at UAE
   d. Enhancing the M&E technical expertise by training staff members at the federal and sub-national levels
   e. Providing advice on the creating of proper monitoring tools and the means to ensure endorsement and standardization between the MOH and the various health authorities
   f. Extending support on the creation of an electronic reporting system that could boost M&E efforts

VIII. Monitoring and evaluation environment

Perhaps the weakest element in UAE's response to the AIDS epidemic lies in its HIV/AIDS monitoring and evaluation (M&E) system. The country does not currently have a unified M&E plan, nor does it have a national M&E committee/working group, there are no standardized monitoring forms and little is done to evaluate the implemented programs. Compounding these issues is the aforementioned chronic shortage of staff at the NAP office. Yet the future is not bleak, since all HIV/AIDS stakeholders at the country identified building the M&E system as a national priority. Below are some of the recommended steps that could help guide UAE's national efforts towards building its HIV/AIDS M&E system:

1- The establishment of a national M&E committee or working group with a clear mandate and terms of reference to coordinate M&E activities at UAE
2- Carrying out a national M&E system assessment to identify M&E priorities at UAE
3- The approval of a designated budget for the implementation of M&E plans and activities
4- There is an urgent need to hire M&E officer at the NAP office to plan for and coordinator national M&E efforts.
5- There is a need to design, disseminate and computerize standardized monitoring forms at both national and sub-national levels
6- It is important to enhance the M&E technical expertise of existing M&E officers at the national and sub-national levels
7- The existing national HIV database could be strengthened by the inclusion of information on the content, target population, geographical coverage of HIV services, as well as implementing organizations.
8- Need to strengthen relationships between the MOH and external stakeholders in order to ensure that all M&E data/reports are submitted to and compiled by the single national M&E unit at the MOH. Of particular importance, is the need to

coordinate with clinical facilities offering care, treatment and support programs to PLHIV and AIDS patients, for proper M&E of these programs.

9- Knowledge translation and transparency could be improved through the publishing of an annual M&E report on HIV, including HIV surveillance data.

Despite the limited number of indicators reported in the UNGASS report 2010, working on the report was a valuable exercise and an eye opener to decision/ policy makers and other stakeholder. An action plan to build up on the successes identified on this report and address identified shortcomings will be formulated in order to strengthen UAE's future response to the HIV/AIDS epidemic. An indirect, yet invaluable consequence of working on the UNGASS 2010 progress report is the revitalization of coordination and communication between various stakeholders in the country and the renewed commitment to scale up UAE's response to the AIDS epidemic. A synergistic role between the various governmental and non-governmental stakeholders will be a distinguishing characteristic of this response.

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