KINGDOM OF SAUDI ARABIA

MINISTRY OF HEALTH

GLOBAL AIDS RESPONSE PROGRESS REPORT

COUNTRY PROGRESS REPORT 2014

KINGDOM OF SAUDI ARABIA

Submission date:

MARCH 31, 2014

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Acknowledgements

This Global AIDS Response Progress Reporting for 2014 (GARPR) on the progress made in the national response between January 2013 and December 2013 highlights the achievements, challenges and best practices under the various intervention areas of HIV prevention, care, treatment and response as contained in the KSA's National Strategic Plan on HIV/AIDS 2013/2017 as well as the guidelines for global reporting.

The GARPR 2014 report was compiled through an inclusive consultative and participatory process involving desk reviews and extensive consultations with the Scientific Committee and key HIV/AIDS stakeholders of the National AIDS Program of Kingdom of Saudi Arabia. The successful reporting depends largely on the encouragement and guidance received by many others. On this note, the National AIDS Program would like to express its sincere thanks all the partners who have been instrumental in the successful completion of this report.

The guidance and support received from Dr Abdullah Al-Rabiah, Minister of Health, Dr Mansoor Al Hawasi, Deputy Health Minister, Dr. Ziad Ahmed Memish, Deputy Minister of Public Health, and Dr. Raafat Faisal Al Hakeem, Director of General Directorate of Infectious Disease Control, was vital for carrying the process forward and the National AIDS Program is grateful for their constant support and help received all through the process and most importantly for providing strategic direction to the national program.

Words are inadequate in offering sincerest thanks to the community members, volunteers, people living with HIV and AIDS and their family members, NGOs- Saudi AIDS Charity Association, Halfway House and their staff members for their encouragement, cooperation and valuable inputs in the report, with especial reference to the questionnaires in NCPI Part B section. NAP staff would also like to thank the Saudi AIDS Charity Association for enabling their visit to their offices and observe their daily operations and interact with the community members.

Sincere thanks are extended to all those who responded to the questionnaires and provided their perspective into the reporting process. National AIDS Program acknowledges any possible shortcoming that may appear in the report and is entirely responsible for it.

Finally, an honorable mention goes to the members of the Scientific AIDS Committee and International and Regional Organization especially UNAIDS and Regional Arab Network Against AIDS (RANAA) for providing much needed technical support in developing this report.

ACRONYMS

AIDS……...…… Acquired Immune Deficiency Syndrome

ART…….…… Antiretroviral Therapy

ARVs……...…….…… Antiretrovirals

CSO ……Civil Society Organization

FSW …… Female Sex Workers

GARPR ……Global AIDS Response Progress Reporting

HBV ……. Hepatitis B Virus

HCV ……...…….. Hepatitis C Virus

HIV…….……Human Immuno-deficiency Virus

IC …….. Infection Control

IDU ……...Injecting Drug User

IEC ……Information, Education and Communication

KSA …….Kingdom of Saudi Arabia

MARPS …….....Most at Risk Populations

MSM……Men who have sex with men

NAP ……National AIDS Program

NCPI…….……..National Commitments and Policy Instruments

NSP ……National Strategic HIV/AIDS Plan

PHC ……...…...Primary Health Care

PITC …….…… Provider-Initiated Testing and Counseling

PMTCT…….……..Prevention of Mother to Child Transmission

PWID ……..People who inject drugs

PLHIV …….People living with HIV

RANAA …….....Regional Arab Network Against AIDS

RCH ……Reproductive and Child Health

SAC……...Scientific AIDS Committee

SACA……..…… Saudi AIDS Charity Association

STIs ……...Sexually Transmitted Infections

TB …….Tuberculosis

UNAIDS…….....Joint United Nations Programme on HIV/AIDS

UNGASS…….……..United Nations General Assembly Special Session

UNICEF ……...…….United Nations Children Fund

VCT ……...Voluntary Counseling and Testing

WHO ……World Health Organization

I. Status at a glance

a. Inclusiveness of the stakeholders in the report writing process

The process of data collection for the 2014 Global AIDS Response Progress (GARP) report was undertaken between December 2013 and March 2014. The report writing for the Kingdom of Saudi Arabia (KSA) was guided by the leadership of the National AIDS Program Manager for KSA, along with guidance and support of the senior Ministry of Health Officials, and intensive inputs from the NAP staff. All key stakeholders involved in the AIDS response in KSA, were consulted and gave inputs through a series of meetings and interviews over a four month period that dovetailed with the National Strategic Planning process including NGOs such as The Saudi Charity Association for AIDS Patients, Halfway House for IDUs in Riyadh, and PLHIV and former IDU support groups.

b. Status of the epidemic

To date, Saudi Arabia remains a low-HIV-prevalence country, with approximately 1.5 newly detected HIV infections per 100,000 per year among Saudi nationals, and 1.2 per 10,000 among non-Saudis. In the period between 1984, when the first HIV tests were conducted, and December 2013, a total of 20,539 HIV cases were reported, of which 5,890 (28.7%) were Saudi citizens, and 14,649 (71.3%) were foreigners. Most of these non-nationals HIV cases were found among workers who were tested for obtaining or renewing their work permit (iqama, 34%); or foreigners who were suspected HIV cases (23%), or prisoners (17%)- in general get more opportunities for testing, unlike Saudi-nationals. Incidence can be expected to be significantly higher among vulnerable subsets of the population, and in general, reported infections will underestimate true infections.

The trend of officially reported HIV cases among Saudi nationals has been a clearly increasing over time, from a mere 125 HIV cases in 2000, to 542 in 2013. This trend, however, needs to be interpreted with caution, and is not necessarily indicative of the actual HIV situation, as it is based on HIV testing among a limited number of specific groups – especially blood donors and premarital testing– while other groups are likely under-represented in HIV testing. The introduction of premarital HIV screening in 2008 may have contributed to the increasing trend (as can be seen by the small peak that year). In 2013 a total of 313,352 Saudi Nationals have been tested for HIV through the pre-marital screening programme which contributing by 14 percent for the newly detected HIV cases in that year.

To date, the HIV epidemic in Saudi Arabia is predominantly male, with a male-to-female ratio of 5 in 2013 (445 males vs. 97 females). Reliable data is lacking on the actual modes of transmission and underlying risk behaviors. However, data from the officially reported cases among nationals and non-nationals suggest predominance of heterosexual transmission.

The ability to estimate of the number of people living with HIV in KSA remains a challenge. The program relies mainly on reported HIV case data to track the epidemic. These data reflect a combination of people seeking medical treatment for HIV-related conditions or suspected HIV, and infections that are found through routine testing. There are several routine testing groups in KSA, some which provide proxy information for lower risk groups (e.g. pre-marital screening and blood donors), and higher risk groups (STI patients, prisoners, and IDUs in rehabilitation centers). The prevalence in these populations ranges between 0.02% in the lower risk proxy groups to between 0.1% and 1.67% in the higher risk proxy groups.

c. Policy and programmatic response

Since the first case of HIV/AIDS was detected in KSA, fight to prevent and control the spread of HIV has received increasingly the highest political commitment and continues to remain high among the national development agenda priorities.

At the end of 2011, the Ministry of Health and the National AIDS Program, in close collaboration with national stakeholders, decided to prioritise the development of a five-year National Strategic HIV/AIDS Plan (NSP) for the period of 2013-2017, to Saudi Arabia's national HIV response for the 5-year period of January 2013 till December 2017.

The (NSP) aimed to provide overall policy and programmatic guidance to all stakeholders involved in HIV prevention, care, support and treatment. In addition, a 5-year Operational Plan (OP) for implementing the NSP's priorities into specific activities and with roles and responsibilities has been developed.

The NSP has two overall goals to prevent the further spread of HIV and mitigate the impact of AIDS on society:

1. To halt the further spread of HIV among the Saudi Arabian population and maintain HIV prevalence rates below 1.0 percent among all most-at-risk populations and below 0.1 percent among the general population by 2017
2. To improve the quality of life, health and wellbeing of people living with HIV by providing universal access to comprehensive HIV treatment, care and support services of high quality.

These two goals are further operationalized in six strategic objectives that address the five key intervention areas. The strategic objectives address the key priority areas based on the comprehensive analysis of the state of the HIV epidemic and the national response to date. The six strategic objectives have been described in depth along with provision of a clear direction of activities to be undertaken under each of them. The six strategic objectives are:

1. To strengthen the availability, sharing and utilisation of strategic information on HIV/AIDS that will guide the development and implementation of evidence-informed policies, programmes and services;
2. To scale up and improve the quality of HIV-prevention programmes and services for most-at-risk populations (MARPs) with the aim to reach universal access;
3. To scale up and improve the quality of key HIV-prevention programmes and services for the general population, with a special focus on vulnerable groups;
4. To strengthen the quality, and scale up coverage and utilization of comprehensive treatment, care and (self) support for PLHIV, in accordance with international standards;
5. To promote supportive social, legal and policy environments that enable a multi-sectoral national response to HIV/AIDS, with special attention for PLHIV, and key populations at risk and vulnerable to HIV;
6. To strengthen and build technical, organizational and institutional capacity for the coordination, implementation and monitoring and evaluation of an effective, decentralized, multi-sectoral response to HIV/AIDS.

In addition to the National Strategic Plan on HIV/AIDS 2013-2017, many other policies and guidelines are in place that focus on specific aspects of the national response to HIV and AIDS, including blood safety, infection control in health-care settings, HIV testing and counselling, antiretroviral treatment, and care and support for PLHIV. While the Ministry of Health has played a major role in the national response to date, other sectors have been actively involved in prevention, care and treatment programmes and services as well. The multi-sectoral Scientific AIDS Committee (SAC) was established to provide technical advice to NAP with regard to HIV/AIDS policies and programmes. SAC membership includes members from the Ministries of Health, Interior, Defense, Education and Social Affairs, representatives from the corporate sector, faith based organizations, civil society and from people living with HIV and AIDS. The SAC meets regularly to discuss emerging programmatic and policy issues.

In the legal field, a special bylaw to protect the rights of PLHIV was drafted and is currently in the process of being endorsed by the 'Shoura' Council, the highest policy-making body in the Kingdom.

In addition, the Saudi government has shown high-level political commitment at both national and regional levels. Recent examples include the active involvement in regional initiatives, such as the Saudi MOH called for a regional meeting of Government, non-Government and UN agencies under the umbrella of Arab League in October 2011 with representation from 22 countries for "Uniting Arab Countries to unify efforts Fight Against AIDS" and recommended to have a common strategic plan for the Arab region and align the regional strategy with the global strategy on HIV/AIDS.

d. GARPR Indicator data in an overview table

Table 1 GARPR Indicators Overview Table

Indicator	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.	A study was carried in 2012 to assess the knowledge, attitudes and behavior of youth in the Kingdom towards HIV and AIDS. A total of 925 youth participated in the study (66% males and 34% females). The percentages of respondents who correctly answered the questions on HIV prevention were: • A healthy-looking person can have HIV: 59% • A person can get HIV from mosquito bites: 34% • A person can get HIV by sharing food with someone who is infected: 54%
1.2. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.	Not relevant for low and concentrated epidemic.
1.3. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months.	No population based surveys have been carried out to supply the needed data for this indicator. However, there are plans to conduct KABP survey amongst general population in the year 2014.
1.4. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse.	No population based surveys have been carried out to supply the needed data for this indicator. However, there are plans to conduct KABP survey amongst general population in the year 2014.
1.5. Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results.	No population based surveys have been carried out to supply the needed data for this indicator. KABP survey amongst general population is planned for the year 2014. However, as part of the premarital health screening program which is regularly carried in the Kingdom, a total of 313,352 Saudi citizens

	(approximately 50% females and 50% males) received HIV test and were able to know their results.
1.6.Percentage of young people aged 15-24 who are living with HIV.	Not relevant for low and concentrated epidemic.

TARGETS 1 and 2 **SIZE ESTIMATIONS FOR KEY POPULATIONS**			
Key population	**Size estimation performed (yes/no)**	**If yes, when was the latest estimation performed? (year)**	**If yes, what was the size**
a) Men who have sex with men	The term -men who have sex with men- is not relevant in the socio-cultural and religious context of Kingdom of Saudi Arabia. For men who are vulnerable and at higher risk of acquiring HIV, the need for prevention services is recognized.		
b) People who inject drugs	No		
c) Sex workers	The term sex worker is not relevant in the socio-cultural and religious context of Kingdom of Saudi Arabia. For women and men who are vulnerable and at higher risk of acquiring HIV, the need for prevention services is recognized.		
d) Other key populations− please specify which key population in the comments box.	No		
e) Comments:			

Sex Workers	
1.7.Percentage of sex workers reached with HIV prevention programs	The term sex worker is not relevant in the socio-cultural and religious context of Kingdom of Saudi Arabia. For women and men who are vulnerable and at higher risk of acquiring HIV, the need for prevention services is recognized and provided accordingly. Qualitative behavioral studies are currently in the planning stages which will provide a better understanding of this population and facilitate the ability to provide adequate services.

1.8. Percentage of sex workers reporting the use of a condom with their most recent client	The term sex worker is not relevant in the socio-cultural and religious context of Kingdom of Saudi Arabia. For women and men who are vulnerable and at higher risk of acquiring HIV, the need for prevention services is recognized. Condoms are distributed among people living with HIV, in ART treatment centers, PHC and STI clinics.
1.9. Percentage of sex workers who have received an HIV test in the past 12 months and know their results	The term sex worker is not relevant in the socio-cultural and religious context of Kingdom of Saudi Arabia. For women and men who are vulnerable and at higher risk of acquiring HIV, the need for prevention services is recognized. Provision of services to higher risk men and women will increase utilization of VCT services and enable people to know their current status and referral to specialized centers are done for further managements.
1.10. Percentage of sex workers who are living with HIV	The term sex worker is not relevant in the socio-cultural and religious context of Kingdom of Saudi Arabia. As the proportion of higher risk men and women utilizing VCT services increases, proxy information on prevalence of HIV in higher risk populations will become available.
Men who have Sex with Men	
1.11. Percentage of men who have sex with men reached with HIV prevention programs	The term men who have sex with men are not relevant in the socio-cultural and religious context of Kingdom of Saudi Arabia. For women and men who are vulnerable and at higher risk of acquiring HIV, the need for prevention services is recognized. Qualitative behavioral studies currently in the planning stages will provide a better understanding of this population and facilitate the ability to provide adequate services.
1.12. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	The term -men who have sex with men- is not relevant in the socio-cultural and religious context of Kingdom of Saudi Arabia. For men

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

2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	During the year 2013, a total of 571 Intravenous Drug Users were tested for HIV and knew their results. Qualitative behavioral studies currently in the planning stages to provide a better understanding on this indicator.
2.5 Percentage of people who inject drugs who are living with HIV	Data from the largest drug detoxification centers in Riyadh, Jeddah and Damam shows 20 cases were found to be HIV positive out of 571 Intravenous Drug Users tested during the year 2013. Qualitative behavioral studies currently in the planning stages will provide a better understanding the prevalence of HIV among PWID.
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 ARVs to reduce the risk of mother-to-child transmission	A total of 41 pregnant women were found to be HIV positive in 2013, All of them were enrolled in ARV treatment to reduce the risk of mother-to-child transmission.
3.1.a. Percentage of women living with HIV who are provided with antiretroviral medicines for themselves or their infants during the breastfeeding period.	Not applicable to KSA, as Women living with do not breastfeed. Formula feeding is provided to newborn instead.
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth.	41 infants were born to HIV-positive women in 2013. 97.5% of them (40 infants) received a virological test for HIV within 2 months of birth.
3.3 Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months.	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	The total of 2388 PLHIV was on ARV treatment, 600 females and 1788 males.

among all adults and children living with HIV.	Disaggregation by gender and age: • < 1 year: 1 PLHIV (1 M and 0 F); • 1 – 4 years: 7 PLHIV (4 M and 3 F); • 4-15 years: 4 PLHIV (2 M and 2 F); • >15 year: 2376 PLHIV (1781 M & 595 F);
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	A cohort of 530 PLHIV were enrolled on ARV treatment on 2012, 126 females and 404 males. All of them completed 12 months of treatment by 2013. Disaggregation by gender and age: • < 1 year: 0 PLHIV (0 M and 0 F); • 1 – 4 years: 3 PLHIV (2 M and 1 F); • 4-15 years: 4 PLHIV (1 M and 3 F); • >15 year: 523 PLHIV (401 M & 122 F);
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.	In 2013, a total of 27 PLHIV were found to be having TB (5 females and 22 males). All of them were enrolled on treatment for both TB and HIV.
Target 6 **Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries**	
6.1 Domestic and international AIDS spending by categories and financing sources	National Funding Matrix- 2014 was completed and submitted through the Global AIDS Progress online reported tool. During the year 2013 an equivalent to US$ 34,023,464 (SAR 127,587,900) was spent on HIV and AIDS prevention, care treatment intervention. HIV and AIDS Care and treatment programs received 62.6% of the allocated funds (US$ 21,308,906), while 27.4%, 5.6%, and 4.1% of the funds were spent on Prevention, Human Resources management, and System Strengthening respectively. All the funds allocated to the HIV and AIDS national response were allocated by the Government of KSA.

Target 7 **Eliminating gender inequalities**	
7.1 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.	Data on Gender based violence currently not available
Target 8 **Eliminating stigma and discrimination**	
Percentage of women and men aged 15–49 who report discriminatory attitudes towards people living with HIV	In study carried in 2012 to assess the knowledge, attitudes and behavior of 925 youth in the Kingdom towards HIV and AIDS; 71% mentioned that they would not buy fresh vegetables from a shopkeeper or vendor if they knew that this person had HIV, while 19 percent were sure. 27% said that children living with HIV should not be able to attend school with children who are HIV negative, while 24% were not sure.
Target 9 **Eliminate travel restrictions**	
NA	Data on this indicator are collected directly by the Human Rights and Law Division at UNAIDS.
Target 10 **Strengthening HIV integration**	
10.1 Current school attendance among orphans and non-orphans aged 10‑14	Not relevant. Applicable for concentrated epidemic.
10.2 Proportion of the poorest households who received external economic support in the last 3 months	PLHIV and the family members receive economic support from the Ministry of Social Affairs (SAR 2000/- per person /per month). In addition unemployed PLHIV receive SAR 2000/- per month like other unemployed individuals from the Government. The civil society through the community / home based care and support for PLHIV and their family

	members provide nutritional support, income generating activities, household / electrical goods (especially for the newly married PLHIVs) and other material support as required.
Government HIV and AIDS policies	
National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programs, stigma and discrimination and monitoring and evaluation)	National Commitments and Policy Instruments - 2014 was completed and submitted through the Global AIDS Progress online reporting tool.

II. Overview of the AIDS Epidemic

Estimated number of people living with HIV

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

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

Figure 1: Reported HIV infections among Saudi Nationals (2000-2013)

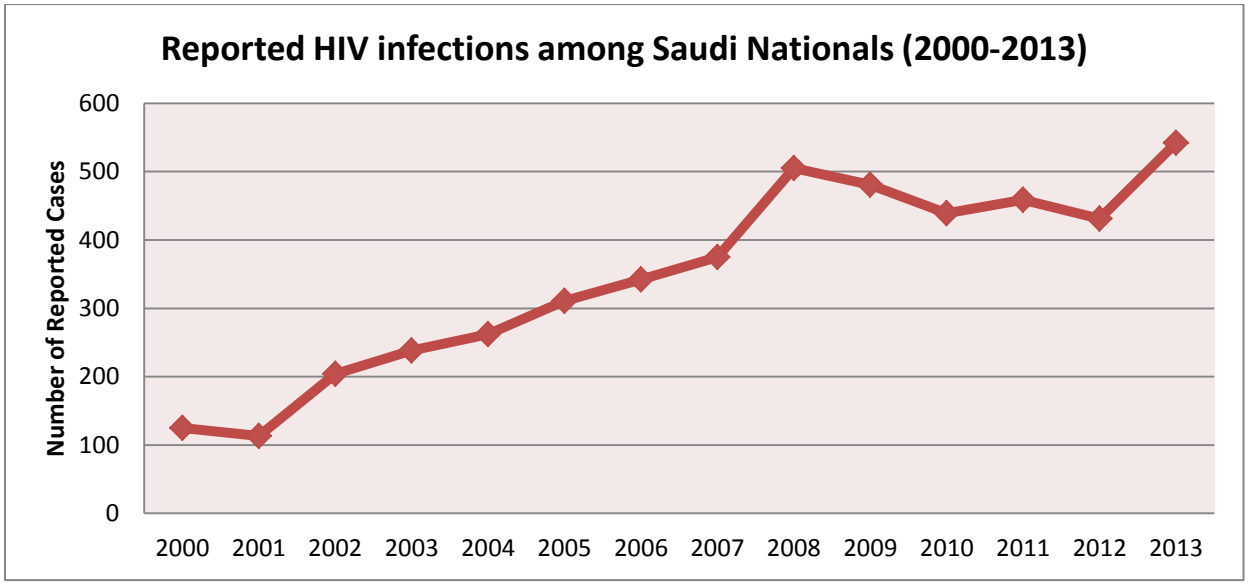
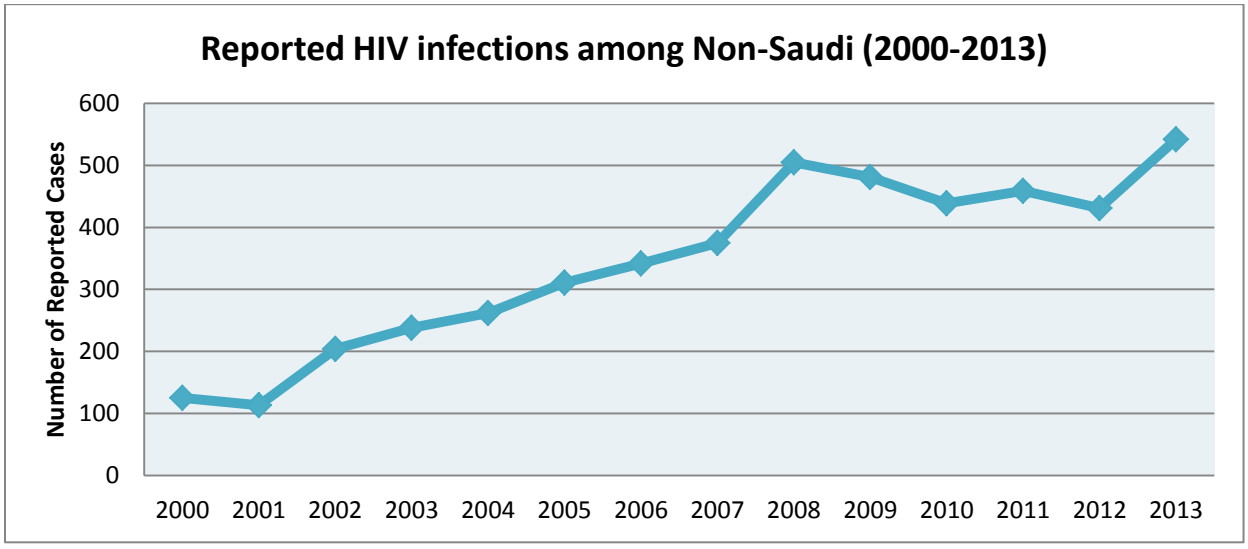


Figure 2: Reported HIV infections among Non-Saudi (2000-2013)



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

Table 2: HIV Prevalence among Key and Proxy Populations in 2012/2013

Group	Number Tested	Number Positive	Prevalence
Blood Donors (2012)	445,000	85	0.019
Premarital Test (2013)	313,352	69	0.02%

The data in (Table 2) represent the prevalence of HIV among those people who undergo premarital testing or who donate blood. They do not represent the true prevalence in the population at-large. Nonetheless, at a population level, they point to prevalence close to 0.02% (two per 10,000) among the general population, which can be expected to be higher after adding infections from higher risk groups.

Other groups tested routinely for HIV include STI patients, prisoners, and IDU patients at rehabilitation centers. These populations give us some "window" into levels of infection among populations at higher risk, although the extent to which these routine testing groups represent the larger risk groups cannot be quantified. As seen in Table 3 different data sources in these populations suggest different levels of HIV prevalence. The prevalence of 1.67% among a large sample of STIs patients is quite high and it would be informative for the program to have more information about how those infections occurred.

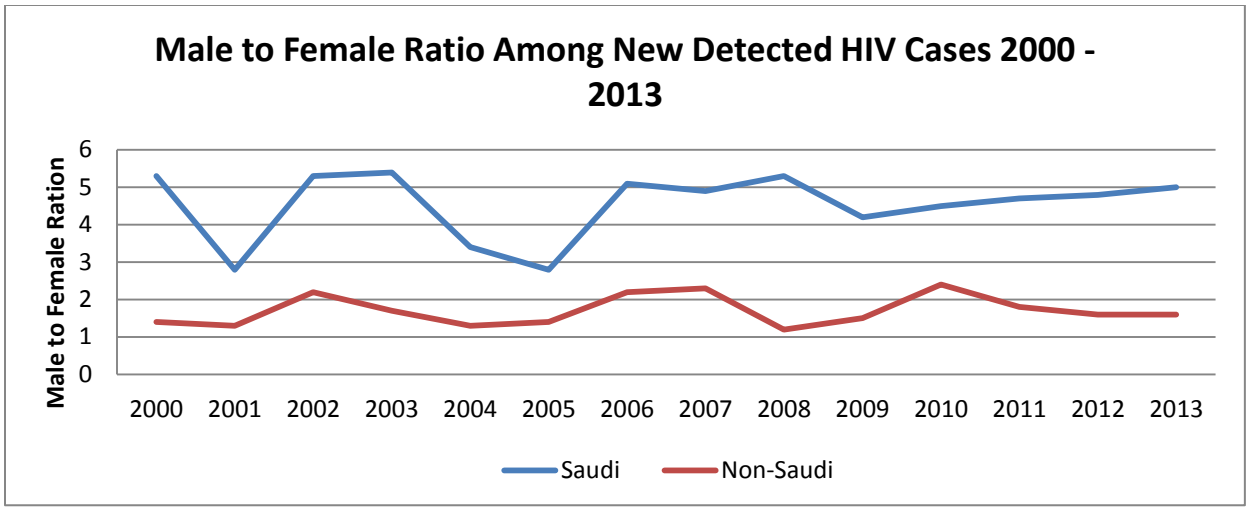
Table 3: HIV Sero-prevalence among sentinel surveillance groups in 2012

Group	Number Tested	Number Positive	Prevalence
STIs Patients	1200	20	1.67%
Prisoners	1200	16	1.16%
TB Patients	1200	26	2.16%
Pregnant Women	2400	3	0.1%

HIV by gender:

To date, the HIV epidemic in Saudi Arabia is predominantly male, with a male-to-female ratio of 5 in 2013 (445 males vs. 97 females). In KSA, the trends of male-to-female ratio of HIV detected among Saudi nationals over the past twelve years imply that there are more males than females infected. Over time it is expected that the male to female ratio will decrease, as more infected males infect their female sexual partners, unless transmission is predominantly among male PWID and/or same sex behavior among them. However, more information on the number of males vs. females tested over time is necessary to better interpret these figures. Figure 3 shows the trends among Saudi men and women between 2000 and 2013.

Figure 3: Male to female ratio over time

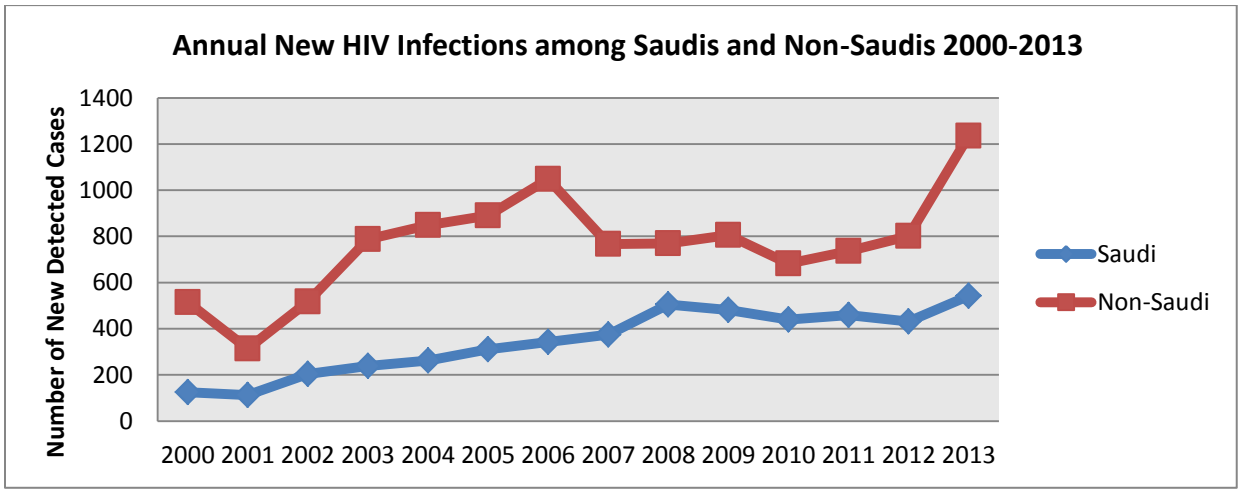


The ratio of infected males to females among non-Saudis is lower than that of Saudis, and has also remained constant over time. This could be because heterosexual transmission is more common among non-Saudis, or because the number of males and females tested is more equal.

Infections among Saudis vs. non-Saudis:

The number of reported HIV cases in KSA during the twelve year period between 2000 and 2013 indicates more cases among non-Saudis than among Saudis. However, the pattern over the past ten years is changing, with a declining number of new cases among non-Saudis over time, and an increasing number of cases among Saudis (although there is a downward dip among both Saudis and non-Saudis after 2009).

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



It is important to interpret the data from Figure 5 in light of the data source, and the number of Saudis and non-Saudis who are tested each year. Non-Saudis are tested systematically when they migrate to KSA legally for work. Those who are positive are generally deported back to their country of origin except for individuals legible for treatments e.g. born in KSA or being spouse of nationals plus other cases. Some of the cases are detected when the person renews their residence status. Others are detected through routine testing of suspected cases, blood donors, STI patients, TB patients, prisoners, IDUs, etc. (which applies to both Saudis and non-Saudis).

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

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

III. National response to the AIDS epidemic

The Kingdom of Saudi Arabia has maintained a continued response to the AIDS epidemic since 1984 through a close collaboration between the National AIDS Program (NAP) at national and central levels, UN agencies, and local civil society organizations (CSO).

During this reporting period the National AIDS Program has been significantly scaled up. It now has a central unit with more staff and better capacity. The NAP operates through a strong, well-managed central unit at the national level, with NAP departments in each of the 20 health regions in the country. Central and regional NAP departments meet regularly to discuss local priorities and programme implementation. This, combined with increased political support, have resulted in more visibility for the program, more involvement of civil society, and ultimately more open discussion of HIV.

Establishment of the multi-sectoral Scientific AIDS Committee (SAC) resulted in effective multi-sectoral coordination. While SAC members are responsible for spearheading sectoral HIV approaches in their own ministries or constituencies, they meet regularly to discuss emerging programmatic and policy issues.

Inclusion of PLHIV through their active organization (the Saudi AIDS Charity Association) has also been a feature of this response.

Prevention

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

HIV-prevention programmes for the general population focus on general HIV awareness-raising through mass-media IEC messages informing on basic information on HIV along with modes of transmission and dispelling the present myths and misconceptions. The NAP also supports a 24-hour hotline call-centre system that provides HIV information and counseling services for the general population. HIV-prevention programmes for adolescents and youth focus on basic HIV knowledge in the curriculum of secondary schools.

In addition to general awareness-raising, other HIV-prevention interventions include condom promotion among discordant couples within PLHIV groups, as well as at STI clinics and in primary health-care centers. IEC materials are also disseminated and VCT services promoted at STI, TB and ART clinics.

Activities implemented through NGO and CSO collaborations

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

They provide many services including:

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

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

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

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

Integration of HIV Services into Health Facilities

HIV prevention in the health-care system has been one of the earliest priorities and involves the implementation of internationally accepted protocols and guidelines in key services.

Ministry of Health has put strict measures in place to ensure the safety of blood and blood products. The National Blood Transfusion Service focuses on total quality management of all donated blood and blood products at all facilities in Saudi Arabia.

Infection Control (IC) measures are strictly observed and monitored in the public and private health-care sectors to prevent nosocomial infections – including with HIV, HBV and HCV. Regular training courses on infection control and supervisory visits take place in all regions. All

hospitals have IC teams to ensure the strict implementation of IC standards, and all health-care facilities use disposable, single-use injection equipment.

Syndromic management of STIs has been strengthened at STI clinics in more than 2,000 Primary Health-Care (PHC) Centers and in a limited number of hospitals where etiologic diagnostic facilities are not available. Furthermore, intensive training and capacity-building initiatives on syndromic and etiological STI treatment and case management have been implemented for physicians at PHC centers and hospitals. Since the introduction of STIs syndromic management approach in 2009, the number of identified and treated STIs has persistently increased from 22,708 cases in 2009 to 45,300 cases in 2012. A total of 139,146 STIs cases were identified and treated, 58% of them (80,986) were identified using STIs syndromic management approach.

Engagement with multi-sectoral partners:

The National AIDS Program has increased its collaboration with civil society and private sector partners to address stigma and discrimination, e.g. with the media, faith-based organisations and NGOs, the Saudi Islamic Bank and different pharmaceutical companies working on supporting HIV/AIDS awareness-raising. These collaborative efforts have resulted in activities such as the dissemination of IEC materials through a range of channels, e.g. school education programmes; among health providers, and at traveller exit-points (e.g. airport and border-crossings), as well as at mosques, prisons, traffic signal points, supermarkets and malls.

Examples of these types of engagements include:

- Collaboration with the Ministry of the Interior to run detoxification and rehabilitation programs for IDUs (e.g. at Al Amal hospital in Riyadh). These programs offer social and psychological support, medications to reduce cravings. (Note: although legal obstacles to oral substitution therapy for IDUs were removed several years ago, logistical challenges to dispensing OST still remain);
- Provision of IEC materials for school education programs, health providers, at traveler exit-points (e.g. airport and border-crossings), and at mosques, prisons, traffic signal points, supermarkets and malls, etc;
- Technical support and vocational opportunities for an open discussions on HIV/AIDS with parent-teacher, and teacher-youth meetings;
- Technical support for “Media and HIV” workshops on HIV awareness, rights and elimination of stigma;
- Technical and material support for mobile VCT services at soccer match in Jeddah (Ministry of Youth and Sports Affairs);
- Promotion of the concept of ‘Volunteerism” through involvement of e.g. PLHIV, ex-IDUs, medical students and nurses …etc., for outreach work and peer support groups to create awareness on HIV/AIDS. For example, current campaign for volunteering by medical students in many different cities “Get to Zero New Infections, Zero

Discrimination, and Zero AIDS related deaths" was a great success and thus greater effort is being made in encouraging volunteer work in the overall program.

- Support to civil society including:
    - Different campaigns to increase awareness.
    - Leadership development.
    - Establishment of peer support programs for PLHIV, semi drop-in centers, and care and support programs (CSOs cannot offer treatment). For example, PLHIV have formed many small support groups and network e.g. with "Al-hosen", which is an active PLHIV network in Saudi Arabia having separate networks for men and women).
    - Economic support and training facilities to PLHIV and their families.
    - Unemployment financial benefits.

Voluntary Counseling and Testing:

Voluntary counseling and testing services are extended to all 20 regions of the Kingdom. Most of these VCT centers are attached to a health facility (central hospital) where facilities of advanced testing are available. In some cases, the VCT facility is located near ARV treatment facilities, which hampers their effective utilisation, since most clients prefer to go to more confidential locations, which are not directly associated with HIV/AIDS. A local NGO service organisation for PLHIV in Jeddah also provides VCT services at their premises in a suburb, which lowers the threshold for people to seek HIV testing.

As part of the VCT scale-up effort, mobile voluntary counseling and testing (MVCT) services were introduced in eight big cities (Jeddah, Riyadh, Medina, Damamm, Jazan, Makkah, Altaif, and Aseer). This service mainly targets people at high risk by operating in areas where both vulnerable and Most at Risk Populations (MARPS), both Saudi and non-Saudi, are more likely to be found. It can also reach illegal residents, who are particularly hard to reach by regular VCT or screening programmes.

VCT services are being promoted through mass media, websites and the internet. There is a special website for VCT that provides general information about HIV, services available and modes of transmission, along with the names, locations, hours of operation, and contact information for the VCT centers. Services at the VCT include individual pre-test and post testing counseling. VCT clients are given an anonymous code and those with a positive test result are then referred to one of the testing and treatment centers for further diagnosis and eventual ARV treatment if necessary.

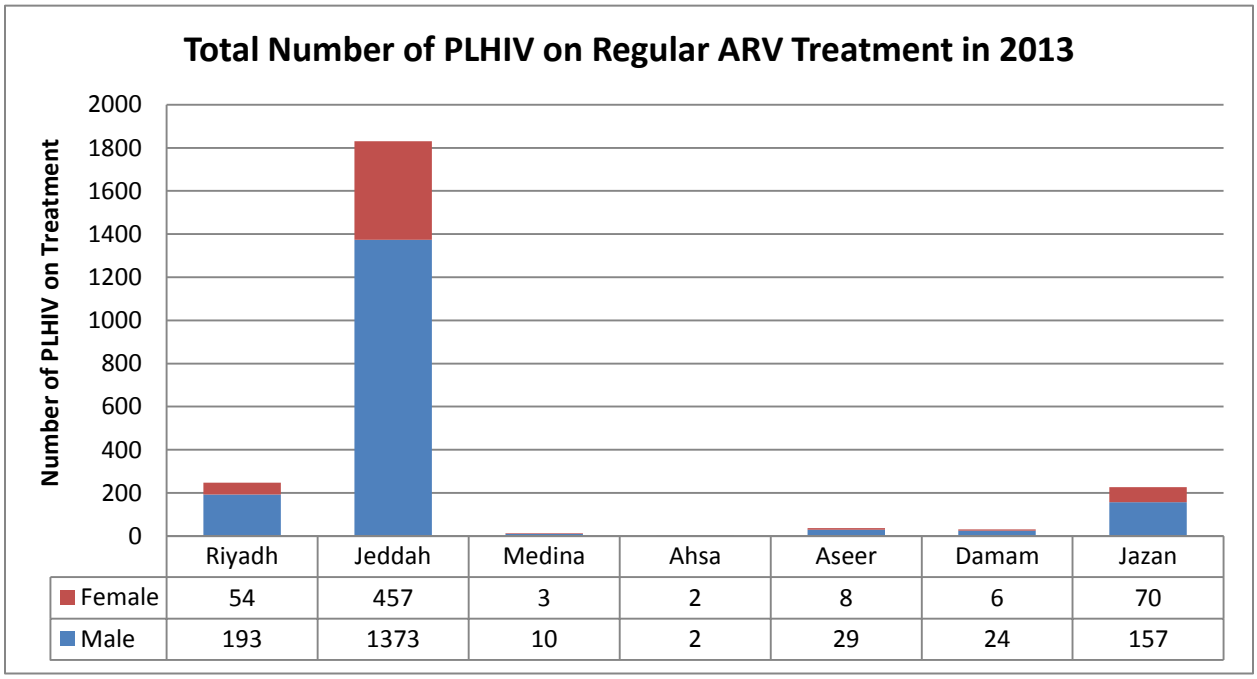
The completely anonymous nature of the service provides increased access for illegal foreigners, who would otherwise face deportation if discovered to be HIV positive.

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

Treatment:

Antiretroviral treatment (ART) and other HIV-related medication are provided free of charge to all eligible Saudi nationals at twelve ARV treatment centers throughout the country. 2388 PLHIV had been enrolled in regular ARV treatment in 2013 (600 females and 1788 males). The majority of ART patients are treated in the King Saud Hospital in Jeddah, which also has the highest number of newly detected HIV cases, as can be seen in Figure 5. Provision of ART is based on North American DHSS standards and guidelines, with treatment starting when CD4 counts drop below 500, and includes first, second, and third-line ARV drugs. Treatment is monitored on a regular basis through CD4 and CD8 tests, viral load testing, while genotyping is done at a number of central laboratories.

Figure 5: Total Number of PLHIV on Regular ARV Treatment in 2013

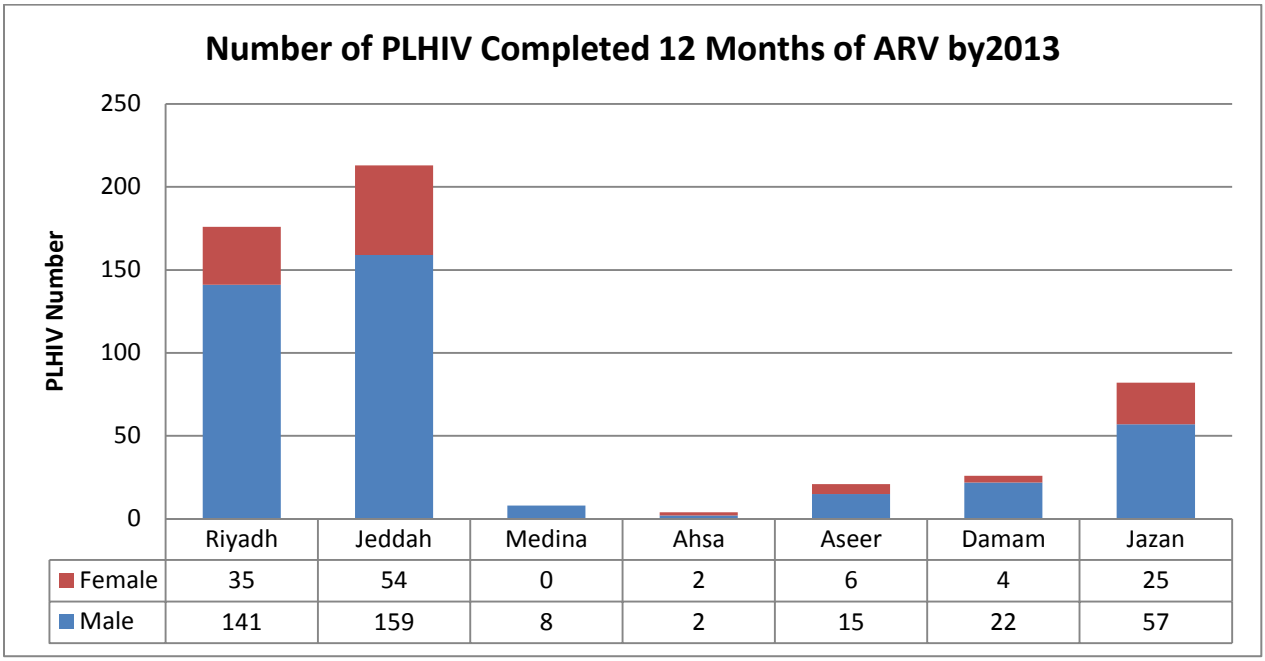


	Riyadh	Jeddah	Medina	Ahsa	Aseer	Damam	Jazan
Female	54	457	3	2	8	6	70
Male	193	1373	10	2	29	24	157

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

Almost all detected cases that are eligible for treatment are receiving ART and adherence is very good. In 2012 a cohort of 530 PLHIV were enrolled on ARV treatment (126 females and 404 males) and all completed 12 months of treatment by 2013 (figure 6).

Figure 6: Total Number of PLHIV Completed 12 month on ARV Treatment by 2013



	Riyadh	Jeddah	Medina	Ahsa	Aseer	Damam	Jazan
Female	35	54	0	2	6	4	25
Male	141	159	8	2	15	22	57

Prevention of Mother to Child Transmission

Prevention of mother-to-child transmission of HIV (PMTCT) is mainly restricted to pregnant women who were known to be HIV-positive, and has therefore been limited to a very small number of pregnant women. However, efforts are currently underway to reach more HIV-infected pregnant women with PMTCT services through provider-initiated testing and counseling (PITC), which will allow identifying new HIV cases among pregnant women, in addition to already known cases.

The so-called 4Ps initiative, which aims at zero paediatric HIV cases in the country, includes four key components:

1. Primary prevention of HIV infection among women of childbearing age; this involves a number of components: accurate surveillance data; HIV testing and counseling of pregnant women; education of adolescent girls in schools and universities; and public awareness campaigns on PMTCT;
2. Preventing unintended pregnancies among women living with HIV; this involves family planning and PMTCT services, with a key focus on reducing the unmet need for family planning among HIV-positive women;

3. Preventing HIV transmission from a woman living with HIV to her infant; this involves a standard PMTCT protocols and guidelines; adequate monitoring of HIV-infected pregnant women and their newborns; Male involvement; and support groups of HIV-positive women;
4. Providing appropriate treatment, care and support to mothers living with HIV and their children and families; this involves comprehensive approaches to care and treatment by a multidisciplinary team approach.

Adequate implementation of this 4Ps initiative will improve HIV-prevention among children born to HIV-infected mothers, as well as offer an entry point to early detection and treatment for more HIV-infected women and their husbands. In this context, unified national PMTCT protocols and guidelines are being developed.

Care and Support

In addition to ART and other clinical services, PLHIV have access to psychological, social and economic support if needed.

With financial support from the Ministry of Social Affairs, the Jeddah-based Saudi Charity Association for AIDS Patients provides a range of programmes and services to PLHIV and their dependents, including: psychological counseling through individual and group sessions; peer support groups; spiritual support; (treatment) education; food support for PLHIV in need; income-generating activities and trainings; small loans; as well as facilitation of marriage for PLHIV.

The marriage programme for PLHIV is one of the good initiatives implemented through the Association for AIDS Patients. To date, it has resulted in marriage of nearly 100 individuals and the healthy deliveries of many babies.

Adequate collaboration and referral mechanisms between the local NAP office and the Association ensure effective linkages between fixed and mobile VCT, ARV treatment, care and support services.

Civil society has established strong linkages with regional and sub-regional networks, such as the Regional Arab Network against AIDS (RANAA). These partnerships resulted in capacity building and technical support to local NGOs (e.g. leadership development training programmes for PLHIV). Civil society also accesses funding for HIV activities from corporate sector including oil companies, and other private institutes as well as pharmaceutical companies.

In addition to the care and support services provided through civil society as mentioned above, government ministries outside the health sector provide a range of social and economic support services to PLHIV and their families, including unemployment benefits. The Ministry of Social Affairs provides economic support and unemployment benefits to PLHIV and their families.

Other services include: loans and micro-finance programmes to assist PLHIV in pursuing self-employment opportunities and/or to start-up small businesses; vocational training for better employment opportunities; and priority admission for educational opportunities e.g., schooling and university education for students from families with PLHIV.

Impact Mitigation

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

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

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

Supportive political environment

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

Engagement with regional institutions

- Minister of Health, KSA at the GCC Ministerial Meeting (April 2011) urged each country in the region to budget separately for HIV prevention and care activities and to have a unified Regional HIV/AIDS strategy for GCC countries on issues concerning the region.
- The ministry of health under the umbrella of Arab League called for a regional meeting of Government, non-Government and UN agencies in October 2011 with representation from 22 countries for "Uniting Arab Countries to unify efforts Fight Against AIDS" and recommended to have a common strategic plan for the Arab region and align the regional strategy with the global strategy on HIV/AIDS
- Further, there was a Launch of recommendations during the regional ' Saudi Forum on HIV/AIDS' uniting the Arab countries in November 2011 which was approved by all Arab health ministries and initiatives are to be taken forward and headed by Saudi Arabia.

Perhaps of most note is the drafting of a bylaw to protect the rights of PLHIV in KSA, in relation to human and civil rights, (i.e. employment and work, right to education, and right to marriage), which has been working its way through the legal system. The strong advocacy efforts led by NAP in the last two years moved the process to the point where it is now awaiting final approval from the highest body, the "Shoura Council". Meanwhile, if any complaints are received by the Ministry, either directly or through the local courts, they are investigated promptly and corrective actions are taken.

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

- Some rights accorded to PLHIV include:
    - PLHIV youth receive unemployment benefits like any other.
    - Rights to education, marriage, work opportunities, and all other benefits same as others not infected with HIV.
    - Rights to access and receive proper care, treatments and health support.
    - Prison inmates can receive treatment and care at ART centers.
    - IDUs in detention are not sent to prisons but to hospitals for treatment and rehabilitation services (unless there is concomitant criminal office).
- Agencies such as the Human Rights Commission, Women's Rights Commission, National NGO on Human Rights in Saudi Arabia, and civil society representatives in the Law Reform Commission work for the protection and promotion of human rights including that of HIV positive individuals.
- Increased involvement of civil society
    - Involvement of civil society on the National Steering Committee and the National Scientific Committee, which is the highest body taking technical and policy decisions.
    - Involvement of civil society in multi-sectoral strategy development for current National Strategic Plan, Operation Plan and M&E Framework.
    - Engagement with regional initiatives e.g. GCC Ministerial Meeting, Arab League meetings for "Uniting Arab Countries to fight against AIDS" and at the Saudi Forum on HIV/AIDS' for the Arab countries in 2011 and bringing in inputs from the grass root to the regional strategy and the forum.

IV. Best Practices

Facilitation of marriages between PLHIV

Eight years ago the NAP launched a project to facilitate marriage between HIV positive individuals. The project was implemented through the Saudi Charity Association for AIDS Patients; the project has resulted in marriage of nearly 100 individuals that gave way for healthy

deliveries of many babies. The quality of life for these couples has been improved through economic support for home furnishing, support for finding employment, trainings, and a sense of "well-being" that comes from being part of a family. The project has also provided health education, treatment & counseling services, drop in center facilities, and peer group support, and helped to minimize stigma and discrimination.

VCT for vulnerable populations

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

Mobile voluntary counseling and testing (MVCT) services were introduced in eight big cities (Jeddah, Riyadh, Medina, Damamm, Jazan, Makkah, Altaif, and Aseer). This service mainly targets people at high risk by operating in areas where both vulnerable and Most at Risk Populations (MARPS), both Saudi and non-Saudi, are more likely to be found. It can also reach illegal residents, who are particularly hard to reach by regular VCT or screening programmes.

Integration of HIV services with health services

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

Use of Social Media for HIV Awareness and Promotion of VCT Services

The National AIDS Program has been using mass media campaigns to expose high proportions of its target population to health HIV awareness messages. In addition to the traditional awareness raising methods of publishing, TV, radio and events; NAP started putting more effort into targeting social media channels like YouTube, Twitter, and Facebook. During the World AIDS Day campaign in 2013, NAP launched its website and developed a mobile application to disseminate HIV/AIDS related information. In a very short time, website attracted more than 55,000 visitors.

V. Major Challenges and Remedial Actions

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

Reaching all illegal migrants and MARPS in KSA and engage them in needed prevention interventions targeting this two groups is a challenge for NAP and other NGOs/CBOs working with these communities, The usual stigma that causes people with risky behavior to remain hidden is a challenge . Naturally this deters access to preventive or counseling and testing services, although there are anonymous VCT services available. As efforts to reach out to at risk populations is more expanded, special attention on how to include different illegal migrants and other at risk populations will be imperative.

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

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

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

Other issues of concern include the following:

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

VI. Support from the Countries Development Partners

Not Relevant

VII. Monitoring and Evaluation Environment

The National AIDS Program (NAP), by statutory mandate, is responsible for the overall coordination of the HIV response nationally, including monitoring and evaluating the national response to HIV/AIDS. In this regard, the National Strategic Plan on HIV/AIDS 2013-2017 NSP included a specific objective on strategic information management which aimed at strengthen the availability, sharing and utilization of strategic information on HIV/AIDS that guides the development and implementation of evidence-informed policies, programmes and services. Monitoring and evaluation (M&E) is a key, integrated element of the National Strategic Plan (NSP) at all level: impact, outcomes, outputs and activities (inputs/process). For each level, annual targets have been set, the attainment of which will be monitored using objectively verifiable indicators (OVIs), which are in accordance with international M&E standards and local priorities.

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

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

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

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

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

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

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

There have been limited biological or behavioral researches studies conducted among high-risk populations, and provide little information about the transmission dynamics of HIV. However, qualitative behavioral studies for men and women at higher risk are currently in the planning stages. Given the sensitivities and stigma around these risk behaviors in KSA, planning such research will be challenging, but critically important.

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

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

Efforts will be made to get information on age and sex disaggregated data of the groups that undergo routine HIV testing (blood donors, pre-marital testing) as they can serve as proxy groups for understanding the epidemic (HIV prevalence in general population).

Identification of a set of minimum indicators for routine reporting was suggested by the Scientific Committee members at the sharing meeting of GARPR draft report and this is to be worked out.

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

ANNEXES

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

The GARPR 2014 report for the Kingdom of Saudi Arabia (KSA) has been prepared with the inputs of all the key stakeholders involved in the AIDS response in KSA. The National AIDS Program Manager ably steered the whole process and provided leadership support in bringing the whole process towards a successful completion. The report preparing process received a major guidance from Dr Ziad Ahmed Memish, Deputy Minister for Public Health, Dr Raafat Al-Hakeem Director of Infectious Diseases Control Directorate at MOH, and the Scientific Committee members.

There has been an intense effort put in by the National AIDS Program in the last few months in engaging the stakeholders not only for the implementation of the overall program, but also for seeking inputs for the two key processes KSA is currently engaged in i.e. developing the National Strategic Plan for KSA (2013-2017) and GARPR 2014 reporting. Utilizing existing opportunities and creating some new initiatives was the strategy undertaken for reporting on the progress made since the last GARPR 2012 report. A focal point person was identified from within the central NAP team to coordinate all the efforts for this process. Technical assistance was provided by a consultant from RANAA in developing the report.

Efforts were made to collect data and information for the recommended indicators of GARPR, National Funding Matrix, National Commitment and Policy Instrument (Part A and B). This brought us to interact with stakeholders of other Governmental departments i.e. Genetic and Chronic Diseases Control Administration at MOH, National Department of Laboratories and Blood Banks, Al Amal Drug Rehabilitation Centers, Directors of Public Health Departments and HIV/AIDS Coordinators at regions and provinces, Members of the Scientific AIDS Committee, Members of the National Multi-Sectoral AIDS Committee, Infectious Diseases Consultants and Physicians at HIV/AIDS Treatment Centers.

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

Annex 2: List of Participants and Stakeholders involved in the consultative processes

2. 1.List of individuals consulted during the process of preparation of GARPR 2014 Report

1. Dr. Ziad Ahmed Memish, Deputy Minister for Public Health, MOH
2. Dr. Raafat Faisal Al Hakeem, Director General, General Directorate of Infectious Disease Control.
3. Dr Sanaa Mostafa Abbass Filemban, National AIDS Program Manager, MOH
4. Dr. Mohammed Bin Yahya Saidi, Director General, Genetic and Chronic Diseases Control Administration, MOH.
5. Dr. Ali Saad Al Shammari, Director General, General Department of Laboratories and Blood Banks
6. Dr. Abdulaziz Ahmed Alshotairy, Director, King Saud Hospital, Jeddah.
7. Dr. Abdullah Mohammed Al Qarni, Director of Vector and Infectious Disease Control, Jeddah.
8. Dr. Abdullah Ali Al Taifi, Director General for Health Affairs, Al Madinah Al Munawarah.
9. Dr. Hussamuldin Faroug Mohammed, HIV/AIDS Coordinator, Al Madinah Al Munawarah.
10. Dr. Abdullah Mohammed Al Shahrani, Assistant Director General for Public Health, Assir.
11. Dr. Fathal Aleem Mohammed Osman, HIV/AIDS Coordinator, Assir.
12. Dr. Abdul Muhsin Nasser Al-Mulhim, Director General of Health Affairs, Al-Ahsa.
13. Dr. Osama Hamid, HIV/AIDS and STIs Coordinator, Jazan.

14. Dr. Mohammed Swar Al Zahab, Al Sharqiyyah.

15. Dr. Mofeed Khamees Omar, HIV/AIDS Coordinator, Riyadh.

16. Mr. Saud Adil, King Saud Medical City, Riyadh.

17. Dr. Mohammed Mashoof Al Qahtani, Al Amal Complex for Mental Health, Riyadh.

18. Dr. Osamah Ahmed Ibrahim, Al Amal Hospital Program, Jeddah.

19. Dr. Mohammed Ali Al Zahrani, Al Amal Psychiatric Hospital, Al Damam.

20. Dr. Abdullah. I. Fidail, PH Consultant, HIV Health Education Counselling, NAP

21. Dr. Sayedgotb M Elrashied, HIV/AIDS Surveillance & Research Focal Point, NAP

22. Dr. Magdy Hamed Hussein, Infectious Disease Specialist, NAP STI Unit

23. Dr. Yasser AwadhallahYasein, Training Coordinator & STI, NAP

24. Dr. May Abdul Rahman Darwich, Program Officer, NAP.

25. Dr. Ahmed Salim Fadeel, Program Officer, NAP.

26. Board members of Saudi AIDS Charity Association.

2.2. List of the participants present during the Consultation Meeting with the National AIDS Multi-sectoral Committee members, Riyadh, March, 2014

1. Dr. Sanaa Mostafa Abbass Filemban, National AIDS Program Manager, MOH.
2. Ms. Samara Mostafa Zaza, Ministry of Social Affairs.
3. Mr. Adil Al Khaleel, Radio and Television Corporation.
4. Mr. Fahd Al Hadeeb, Radio and Television Corporation.
5. Mr. Mohammed Al Dakheel, Radio and Television Corporation.
6. Sheikh. Mohammed Al Babtain.
7. Mr. Sulaiman Fahd Al Khamees, Ministry of Islamic Affairs.
8. Mr. Sultan Al Harbi, Ministry of Labor.
9. Ms. Muna Al Juaid, Ministry of Labor.
10. Dr. Fahd Ahmed Hassan Arab, Ministry of Higher Education.
11. Dr. Adil Al Otaibi, School Health, Ministry of Education.
12. Dr. Hayel Abdul Fattah, School Health, Ministry of Education.
13. Mr. Abdullah Ahmed Al Dakheel, General Presidency of Youth Welfare.
14. Dr. Bandar Al Bakr, Preventive Medicine, Ministry of Interior.
15. Col. Ali Al Sagheer, General Directorate for Prisons, Ministry of Interior.
16. Maj. Mohammed Aayed Al Baqmi, General Directorate for Prisons, Ministry of Interior.
17. Mr. Sultan Al Firidi, Volunteer, Saudi AIDS Charity Association.
18. Mr. Ali Ahmed Al Gamdi, Ministry of Economy and Planning.
19. Mr. Abdul Rahman Rashid Al Hamd, Ministry of Economy and Planning.
20. Col. Abdullah Salem Al Nijem, General Directorate of Narcotics Control, Ministry of Interior.

21. 1st Lt. Ahmed Dakhelullah Al Malki, General Directorate of Narcotics Control, Ministry of Interior.
22. Mr. Abdul Rahman Aaida Al Zahrani, Preventive Affairs Administration, Ministry of Interior.
23. Mr. Abdul Aziz Mutaab Al harbi, Preventive Affairs Administration, Ministry of Interior.
24. Dr. Abdullah. I. Fidail, PH Consultant, HIV Health Education Counselling, NAP
25. Dr. Sayedgotb M Elrashied, HIV/AIDS Surveillance & Research Focal Point, NAP
26. Dr. Magdy Hamed Hussein, Infectious Disease Specialist, NAP STI Unit
27. Dr. Yasser AwadhallahYasein, Training Coordinator & STI, NAP
28. Dr. Ahmed Salim Fadeel, Program Officer, NAP.
29. Dr. May Abdul Rahman Darwich, Program Officer, NAP.
30. Dr. Shaimaa Mohammed Elkadi, Program Officer, NAP.
31. Dr. Ahmed Firaij, Program Officer, NAP.

2.3. Participant list of the consultative meeting with the physicians at HIV Management Centers (February 2014)

1. Dr Sanaa Mostafa Abbass Filemban, National AIDS Program Manager, MOH.
2. Dr. Batoul Suliman Ali, Infectious Diseases Consultant, King Saud Hospital, Jeddah.
3. Dr. Mohammed Mohammed Al Hazmi, Infectious Diseases Consultant, King Fahd Hospital, Jazan.
4. Dr. Tariq Abdullah Al Azraqi, Infectious Diseases Consultant, Asir Central Hospital, Asir.
5. Dr. Mamoon Al Jammal, Infectious Diseases Consultant, King Faisal Hospital, Makkah Al Mukarramah.
6. Dr. Fatin Imran, Infectious Diseases Consultant, King Faisal Hospital, Makkah Al Mukarramah.
7. Dr. Manal Mansour Al Quthami, Infectious Diseases Consultant, Al Nour Specialist Hospital, Makkah Al Mukarramah.
8. Dr. Foad Montasir, Infectious Diseases Consultant, Al Nour Specialist Hospital, Makkah Al Mukarramah.
9. Dr. Hussien Salih Ba'Eid, Infectious Diseases Specialist, King Faisal Hospital, Al Taif.
10. Dr. Mohammed Al Gamdi, Infectious Diseases Consultant, King Fahd Hospital, Jeddah.
11. Dr. Riyadh Abdul Aziz Al Khulaif, Infectious Diseases Consultant, King Saud Medical City, Riyadh.
12. Dr. Mubarak Mufrrah Al Shamrani, Paediatrics Consultant, King Saud Medical City, Riyadh.
13. Dr. Abdullah. I. Fidail, PH Consultant, HIV Health Education Counselling, NAP
14. Dr. Sayedgotb M Elrashied, HIV/AIDS Surveillance & Research Focal Point, NAP

15. Dr. Magdy Hamed Hussein, Infectious Disease Specialist, NAP STI Unit

16. Dr. Yasser AwadhallahYasein, Training Coordinator & STI, NAP

17. Dr. Ahmed Salim Fadeel, Program Officer, NAP.

18. Dr. May Abdul Rahman Darwich, Program Officer, NAP.

19. Dr. Shaimaa Mohammed Elkadi, Program Officer, NAP.

20. Dr. Ahmed Firaij, Program Officer, NAP.

21. Ms. Mariam Osman, Program Officer, NAP.