COUNTRY PROGRESS REPORT

STATE OF KUWAIT

Reporting period: 1 January 2012 – 31 December 2013

Submission Date: 31 March, 2014

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I. STATUS AT A GLANCE

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

The development of the Kuwait Global AIDS Response Progress Report 2014 was undertaken under the auspices of His Excellency Dr. Ali Al Obaidi, the Minister of Health. Initial consultation meetings took place with high level officials within the Ministry of Health to endorse and provide support to the entire data collection, validation and review processes.

The development of the Kuwait Global AIDS Response Progress Report 2014 was led by the National AIDS Programme (NAP) within the Department of Public Health, Ministry of Health. The process took place through broad consultations with key stakeholders involved in Kuwait's national response to HIV. The Ministry of Health (MOH) contracted an international consultant to assist in the overall process of data collection and consolidation of the final report.

Data collection for the indicators and the NCPI took place through review of policy documents, programme reports, health statistics, health facility reports, research reports and studies, as well as site visits to key facilities and interviews with national stakeholders and key informants from government, civil society and UN agencies. Interviews and site visits included policy makers at MOH and other ministries, hospitals and health facilities involved in ART service delivery, the drug rehabilitation centre and UN agencies. In addition, focus group discussions with female and male university students were held to get first-hand inputs from these populations.

A roundtable discussion meeting was held at the Ministry of Health with the National AIDS Committee to present and discuss the preliminary findings of the data-collection process. The Committee consists of representatives of key national stakeholders from the Ministry of Health, Ministry of Information, Ministry of Education, Ministry of Awqaf and Islamic Affairs, Public Authority for applied Education and Training, Kuwait University, UN agencies (UNDP and UNESCO), ART service providers, and the National Laboratory. This roundtable not only served to validate all data with key stakeholders, but also engendered a discussion with stakeholders from all sectors and constituencies with regard to priority issues to be addressed in the next period. These discussions will also serve as inputs for the revision and development of the National Strategic Plan, which is set to be developed in the course of 2014.

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

(b) Status of the epidemic

The HIV situation in Kuwait can be characterised as low-prevalence. Since the late 1980s, when the first Kuwaiti HIV case was reported, till the end of 2013, a cumulative total of 252 Kuwaiti HIV cases has been reported, 72.6 percent male, 27.4 percent female. In the reporting period 2012-2013 46 new Kuwaiti HIV cases were reported (12 in 2012; 34 in 2013).

Most HIV cases are detected through mass screening programmes. About two-thirds of the Kuwaiti population consists of expatriates: in 2011 the total population was 3,632,009, with

1,164,449 (32.1%) Kuwaitis and 2,467,560 (67.9%) non-Kuwaitis. The vast majority (88%) of all HIV tests is conducted among non-Kuwaitis, mainly in the context of residency permits or food handling. However, most Kuwaitis are tested in the context of blood donations (38-39%), pre-marital (26-27%) or pre-employment testing (18-19%).

While limited research has been done among key populations, including sex workers, men who have sex with men (MSM) and people who inject drugs (PWID), available data and information from focus group discussions and key informants in Kuwait show that these groups are all present in the country, engaging in HIV-risk behaviours, including unprotected sex with multiple sex partners in the context of sex workers and their clients; MSM; PWID, as well as young people, especially males. Reports from the Addiction Treatment Centre reveal that sharing of injection equipment by PWID presents a real HIV risk, as is evidenced by very high Hepatitis C rates among them.

In addition to key populations, specific groups of the general population may be particularly vulnerable to HIV. Especially among young men, but increasingly also among young women, changing sexual norms and practices, injecting drug use, as well as international travel and increased exposure to other cultures place young people increasingly at risk of HIV infection. Furthermore, the large expatriate population workers who make up a considerable proportion of the Kuwaiti population may face special vulnerabilities regarding unsafe sex.

(c) Policy and programmatic response

The national response distinguishes the two levels of: 1) national *commitment* and 2) actual programme *implementation*. While implementation is key, it is dependent on adequate support from high level policy- and decision-makers.

1) In terms of national commitment, there has been some progress in the last two years (2012-2013), particularly through the successful reactivation of the National AIDS Control Committee *(see next)*. However, overall there is limited political support for HIV/AIDS. This is reflected at the *institutional and organisational* level; in *policy and programme development*; and in terms of *allocation of human and financial resources*.

- At the *institutional level*, progress was made with the re-activation of the National AIDS Control Committee in 2012, which is tasked with overall policy guidance. The NACC has membership from the Ministries of Health and Ministry of Awqaf and Islamic Affairs , Ministry of Education, Ministry of Information, Kuwait University, Public Authority for applied Education & Training ,UNDP and UNESCO. The NACC has two subcommittees, one is the technical committee that looks into technical issues, such as treatment, rights of PLHIV and operational policy, and the Information and Education Subcommittee that looks into mass-media communication. Furthermore, the National AIDS Programme continues to receive limited support in terms of financial and human resources and needs urgent strengthening.
- In terms of *policy and programme development*, NAP has been without an updated NSP and operational plan (OP) since the late 1980s, and this situation has continued in 2012-2013, although the development of an NSP and OP was already planned two years ago. The MOH leadership and the National AIDS Committee have recently shown commitment to develop an NSP in 2014 or 2015: this is expected to provide the much-needed guidance to the national response in the next few years.
- The limited national commitment is most concretely seen in the limited *allocation of financial and human resources*. The NAP has continued to be under-resourced in 2012-2013, and apart from screening and ART, which are financed through existing MOH budgets, no specific budget has been allocated to HIV interventions, especially in the prevention field.

2) Without the overall guidance of a commonly agreed HIV/AIDS national strategic and operational plan, the national response has remained scattered and ad-hoc, with most HIV-

related interventions taking place in the context of other existing public health policies, mainly HIV screening – especially of expatriates (88% of all tests) – and ART for Kuwaiti HIV patients. Other general HIV prevention efforts have mainly been confined to the health sector, e.g. infection control in health-care settings; and PMTCT measures for pregnant women known to be HIV-infected. The National AIDS Committee is currently (March 2014) discussing the modalities for introducing opt-out provider-initiated testing and counselling for all pregnant women attending antenatal care and screening of STI patients.

More focused HIV-prevention activities have taken place on a limited scale, in the absence of funding allocations and work plans. In 2013, innovative approaches to communication and education were implemented for the last year: these included text messages on HIV prevention (in both languages Arabic and English), HIV testing, transmission routes and other general information, which reached approximately 2 million people for 2 months.

In addition, short video films were shown in all supermarkets in the country (in 100 sites for 2 months), with people being offered an opportunity to anonymously ask the NAP manager specific questions about HIV and AIDS via Twitter account of the NACC which is @KNAC2012.

Furthermore, HIV-related issues were discussed in a number of TV and radio programmes, with interactive questions and answers for viewers and listeners. Similarly, short educational films were shown in city buses in various languages (Arabic, English, Tagalog, Bengali and others).

Other activities include World Aids Day activities and general education in schools and universities. A legal framework that will allow VCT centres was already developed two years ago, but VCT centres have still not been implemented.

Targeted HIV prevention for key populations has remained a gap in 2012-2013, like two years ago: the planned National Strategic Plan on HIV/AIDS will need to identify the priority interventions in this field, and build national consensus and support for more concerted action in this area. While there have been no programmes for sex workers and MSM, detox and rehabilitation programmes for PWID exist, but little specific attention is given to HIV/AIDS. A pilot Opioid Substitution Therapy (OST) programme with *Suboxone* (a combination of buprenorphine and naloxone) is planned to be implemented in 2014; however, needle-and-syringe-exchange programmes (NSEP) are not available. Condom promotion and distribution remain highly-sensitive topics in Kuwait, and no policy changes have taken place in this field in 2012-2013. While condoms are widely available for contraception among married couples, condom promotion for HIV-prevention purposes has not been implemented in 2012-2013; but could be considered as part of future targeted programmes for key populations.

In the field of *treatment, care and support*, existing antiretroviral treatment (ART) programmes have continued. All Kuwaiti nationals have access to ART and HIV care and support, including the right to early medical retirement. By the end of 2013, 238 Kuwaiti patients were on ART, a 28-percent increase (n=52) compared to the 186 HIV patients who were on ART by the end of 2011. In 2013, a first attempt was made to organise PLHIV self-help groups: a limited number of PLHIV are meeting on an irregular basis. Organising PLHIV remains a major challenge, due to strong (self) stigma and discrimination of PLHIV, and the fact that many patients indicate they don't need the support of other HIV patients. Furthermore, more attention is still needed for comprehensive care and support, including psychological counselling, social and legal support, e.g. with regard to employment rights.
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(d) GARPR Indicator data in an overview table

NO.	INDICATOR	REPORTED DATA AND COMMENTS
		SEXUAL TRANSMISSION
1.1	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	NO DATA ON INDICATOR – The only KABP study on HIV among young people was conducted as far back as 1995; since then no new studies have been done. While there is no accurate data on HIV knowledge in this age group, the result from focus group discussions held in the context of GARP reporting in 2012 and 2014 suggest that overall knowledge on HIV transmission routes is high, but this does not translate in protective behaviours, as a relatively large proportion of young men in particular engage in risky behaviours.
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	NO DATA ON INDICATOR – No study has ever been conducted on sex before the age of 15, as this is a highly sensitive topic, and formal research will be hard to conduct. However, anecdotal evidence from a focus group discussion held among female and male University students in Kuwait City in 2014 as part of the GARP reporting process, suggests that as much as 10-20% of young men had their first sexual experience before the age of 15. No information is available for young women regarding sex before the age of 15. Reportedly, the first sexual contacts of young males often take place abroad with sex workers. Furthermore, boys report that first sexual contacts -- although not necessarily penetrative sex -- may occur between boys, especially in public schools where there is segregation of sexes. First sexual contacts between boys and girls in Kuwait are often limited to oral and/or anal sex in order to preserve the girls' virginity, but this will usually be after 15 years of age.
1.3	Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	NO DATA ON INDICATOR – In the absence of any data from surveys or other studies, it is not possible to provide an accurate picture on the “Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months”. However, focus group discussions with male university students (18-25) held in the context of data collection for this GARP report, revealed the presence of high-risk sexual behaviours with multiple partners, mainly unprotected sex with foreign sex workers, particularly during trips abroad to some countries . These behaviours were reportedly quite common for young Kuwaiti males. In addition, respondents mentioned the presence of commercial sex in Kuwait as well. This highlights the importance of conducting a systematic survey among young people and adults regarding multiple sexual partnerships.
1.4	Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse	NO DATA ON INDICATOR – In the absence of any data from surveys or other studies, it is not possible to provide an accurate picture on the “Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse”. However, focus group discussions with female and male university students (18-25) held in the context of data collection for this GARP report, revealed the presence of many high-risk sexual behaviours with multiple partners, mainly foreign sex workers abroad . These behaviours were reportedly quite common for young Kuwaiti males. In addition, respondents mentioned the presence of commercial sex in Kuwait as well. Respondents indicated that condom use depended on the location and nationality of the sex worker, as well as her “overall appearance”. Overall, respondents said no condoms were used in about one-quarter (25%) of these sex contacts. Condoms were more likely to be used with women perceived to be “higher risk”, especially Asian or East European women, while condoms would be less used with those women perceived to be “lower risk”, especially women from the region. These FGD

NO.	INDICATOR	REPORTED DATA AND COMMENTS
		findings highlight the importance of conducting a systematic survey among young people and adults regarding condom use during high-risk sex.
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 DATA ON INDICATOR – In the absence of any data from surveys or other studies, it is not possible to provide an accurate picture on the "Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results". However, results from such a survey would likely reveal very low percentages of people who had been tested "and knew their results", since there are no confidential and voluntary counselling and testing (VCT) centres available in Kuwait. Most HIV testing takes place in the context of massive, mandatory screening, e.g. in the context of pre-marital and pre-employment testing, or blood transfusions and major invasive operations. Pre- or post-test counselling is done in AIDS office by the NAP. Hence, surveys among the general population regarding knowledge of HIV status would reveal very low percentages.
1.6	Percentage of young people aged 15–24 who are living with HIV".	NO DATA ON INDICATOR – In the absence of any data from surveys among young people, it is not possible to provide an accurate picture on the "Percentage of young people aged 15–24 who are living with HIV". Although massive HIV screening is done among several population groups, antenatal clinic attendees are not routinely screened for HIV in Kuwait. ANC screening is expected to be introduced in 2014 or 2015. Regardless of the absence of survey data, HIV prevalence in Kuwait is extremely low still. Results from mass screening among Kuwaiti citizens in 2012 revealed 12 new HIV cases out of a total of 89,379 tested; 2 of these were 15-24 years old. In 2013, 34 new cases were found among 94,086 Kuwaitis tested; 5 of these were 15-24 years old. These figures indicate that overall HIV prevalence is still very low.
1.7	Percentage of sex workers reached with HIV prevention programmes (condom distribution; HIV testing)	NO DATA ON INDICATOR – Despite the fact that no surveys or other studies have ever been conducted among sex workers in Kuwait, it is safe to say that the INDICATOR will be zero, because no such programmes exist or have ever existed in Kuwait. While sex work does exist in Kuwait, it is illegal and punishable by law, and extremely hidden. Overall, there is very little information available on sex work in Kuwait, as no qualitative research, mapping or size estimations, or any other type of study or survey has ever been conducted among sex workers. Nevertheless, reports from focus group discussions conducted among male Kuwaiti university students, interviews with migrant workers, as well as press reports reveal that sex work exists in Kuwait, and is in part linked to human trafficking. The illegal character, extreme social rejection, and the possible relation to organised crime and human trafficking make it extremely challenging to reach these women with HIV-prevention programmes.
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	NO DATA ON INDICATOR – As mentioned regarding the previous indicator (1.7), although sex work in Kuwait is present, it is extremely hidden and no HIV-prevention programmes are available for these women. In the absence of any data from surveys among sex workers, it is not possible to provide an accurate picture on the *"Percentage of sex workers reporting the use of a condom with their most recent client".* Anecdotal evidence from focus group discussions held in the context of this GARP report with male university students indicates that condom use with sex workers depends on the client, and is based on his assessment of the overall "cleanliness" of the sex worker, as well as her nationality (as this is perceived to be related to higher HIV/STI risks). However, reportedly, condoms are not systematically used and unprotected sex is common with sex workers.
1.9	Percentage of sex workers who received an HIV test in the past 12 months and know their results	NO DATA ON INDICATOR – As mentioned for previous sex worker indicators (1.7-1.9), although sex work is present in Kuwait it is extremely hidden and little is known about the exact scope and nature of the phenomenon. To date, there has been no research, nor HIV-prevention programmes for sex workers

NO.	INDICATOR	REPORTED DATA AND COMMENTS
		in Kuwait. In this context, it is extremely difficult to conduct a sero-survey to assess HIV-prevalence rates among sex workers, as this requires trust and confidentiality. Hence, no data is available to provide any insight into the *"Percentage of sex workers who are living with HIV".* There is anecdotal evidence that most sex workers in Kuwait have foreign nationalities: thus, the majority would at some point have been tested for HIV before they received a residency permit for the country, and most were therefore not HIV-infected when they arrived. However, others may have been trafficked illegally into the country and may therefore not have been tested. Experiences with sero-surveillance studies among sex workers in other countries in the region, such as Jordan and Syria, suggest that HIV prevalence among sex workers may be low, despite frequent unprotected sex with many different sex partners.
1.10	Percentage of sex workers who are living with HIV	NO DATA ON INDICATOR – As mentioned for previous sex worker indicators (1.7-1.9), although sex work is present in Kuwait it is extremely hidden and little is known about the exact scope and nature of the phenomenon. To date, there has been no research, nor HIV-prevention programmes for sex workers in Kuwait. In this context, it is extremely difficult to conduct a sero-survey to assess HIV-prevalence rates among sex workers, as this requires trust and confidentiality. Hence, no data is available to provide any insight into the *INDICATOR.* There is anecdotal evidence that most sex workers in Kuwait have foreign nationalities: thus, the majority would at some point have been tested for HIV before they received a residency permit for the country, and most were therefore not HIV-infected when they arrived. However, others may have been trafficked illegally into the country and may therefore not have been tested. Experiences with sero-surveillance studies among sex workers in other countries in the region, such as Jordan and Syria, suggest that HIV prevalence among sex workers may be low, despite frequent unprotected sex with many different sex partners.
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	NO DATA ON INDICATOR – Despite the fact that no surveys or other studies have ever been conducted among sex workers in Kuwait, it is safe to say that the "Percentage of men who have sex with men reached with HIV prevention programmes" (condom distribution; HIV testing)" will be extremely low to zero, because no such programmes exist or have ever existed in Kuwait. MSM and homosexuality are highly rejected by society and surrounded by severe stigma and discrimination. Therefore, MSM activity is hidden from the public eye and it is very difficult to reach them with HIV-prevention, or any other type of programme, in the absence of political support, allocated resources, and organisations willing and capable of effectively reaching and working with them. The development of a National Strategic Plan on HIV/AIDS and a costed Operational Plan need to provide the basis for HIV prevention among MSM in the near future. This also requires the availability of voluntary counselling and testing centres, which provide confidential services that are MSM-friendly. Effective outreach to MSM will depend on peer education approaches, and requires partnerships between the NAP and individual MSM willing to collaborate on this.
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	NO DATA ON INDICATOR – As mentioned regarding the previous indicator (1.11), although MSM and homosexuality exist in Kuwait as in all other countries of the world, it is extremely hidden and no HIV-prevention programmes are available for these men. In the absence of any data from surveys among MSM, it is not possible to provide an accurate picture on the "Percentage of men reporting the use of a condom the last time they had anal sex with a male partner". Research and experiences in other countries in the Middle East and North Africa have revealed that most MSM try to hide their sexual orientation and preferences, and will marry and have a family in order to meet societal expectations and avoid being identified as homosexual.

NO.	INDICATOR	REPORTED DATA AND COMMENTS
		Sexual contacts with other men usually take place in secret, and rather than having a steady sex partner, MSM may prefer the services of male sex workers, as this is considered to be more anonymous and safer than having an actual relationship with another man, which could be discovered. These MSM contacts are often high-risk, with unprotected anal sex with many casual, unstable partners. A study conducted by a regional MSM organisation on the Internet among MSM in the wider Middle East and North Africa also included respondents from Kuwait: 64% of Kuwaiti respondents reported always having safe sex, while the remaining 36% said condom use depended on the circumstances, or gave an ambiguous answer. The researchers indicate that the 64% "always safe sex" most likely represented an exaggerated percentage, with few MSM consistently using condoms. * Nevertheless, these data reveal that unprotected sex among Kuwaiti MSM is frequent. This high-risk behaviour implies HIV-infection risks not only for these MSM themselves, but also for their (potential) spouses and children.
1.13	Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results	NO DATA ON INDICATOR – As mentioned regarding the previous indicators (1.11 and 1.12), although MSM are present in Kuwait, they are extremely hidden and no HIV-prevention programmes are available for these men. In addition, no voluntary counselling and testing centres are available for the general population in Kuwait, let alone special VCT centres for MSM. Hence, there is no data on the *"Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results".* While large numbers of Kuwaiti citizens undergo mandatory HIV screening every year, most HIV cases found report heterosexual contacts as the route of transmission, while almost no cases are reported as due to MSM contacts. Rather than the actual percentage of MSM transmission, this reflects the extreme stigma associated with MSM behaviour. As a result, the true role of same-sex relations in HIV transmission is likely to be underestimated. While safe and confidential VCT centres for MSM would be important, it is doubtful to what extent MSM would feel free to use these services, since many might not trust the confidentiality of a positive test result and fear public disclosure of their HIV status and/or homosexuality, as both are associated with high stigma, especially in a small community such as Kuwait, where this would bring shame to their whole family. Instead, MSM who want to know their HIV status may go for VCT in other countries.
1.14	Percentage of men who have sex with men who are living with HIV	NO DATA ON INDICATOR – As mentioned for previous MSM indicators (1.11-1.13), although MSM are present in Kuwait, they remain extremely hidden and little is known about the exact scope and nature of the phenomenon. To date, there has been no research, nor HIV-prevention programmes for MSM in Kuwait. In this context, it is extremely difficult to conduct a sero-surveillance study to assess HIV-prevalence rates among MSM, as this requires trust and confidentiality. Hence, no data is available to provide any insight into the *"Percentage of men who have sex with men who are living with HIV*". As mentioned for indicator 1.12 (condom use among MSM), however, research in the wider Middle East and North Africa has revealed that MSM often engage in high-risk sex with many different sex partners. This includes contacts with male sex workers, often younger men who sell sex to other men for pleasure and income. Furthermore, some Kuwaiti MSM have the financial means to travel in and outside the region, and may go for MSM sex in other countries, where the social climate around homosexuality is more liberal. This may also involve sexual contacts with local male sex workers. While there is no conclusive evidence of HIV rates among MSM in the region, these risk behaviours indicate the potential for a rapid spread of HIV within the MSM community. In this context, it is a priority to conduct studies among MSM to better understand the HIV risks in this community, and guide future policies and programmes for HIV prevention among MSM. This includes mapping, size-

NO.	INDICATOR	REPORTED DATA AND COMMENTS
		estimation studies and socio-anthropological research.
1.16	Number of people who received HIV testing and counselling in the past 12 months and know the results	NO DATA ON INDICATOR – Currently, there are no VCT centres in Kuwait, although the possibility of voluntary counselling and testing is being discussed by the National HIV/AIDS Committee. Most HIV tests are conducted in the context of mandatory screening without giving information about the test and no counselling. Hence, the numbers reported below reflect the number of Kuwaiti citizens who tested HIV-positive, but who did not receive systematic counselling and testing. Most HIV testing for Kuwaitis is done in the context of mandatory premarital testing, pre-employment testing, or blood donations.
		PEOPLE WHO INJECT DRUGS (PWID)
2.1	Number of Syringes distributed per person who injects drugs per year by Needle and Syringe Programmes	NO DATA ON INDICATOR – No prevention programmes involving needle-and-syringe exchange are available in Kuwait. No accurate data or estimations are available regarding the number of PWID in Kuwait. The only services for PWID are provided through the Addiction and Psychiatric Hospital (APH), and include detoxification and rehabilitation services. Opioid substitution therapy (OST) is not available, but plans exist to start an OST pilot with Suboxone in 2014. Current APH services are insufficient to meet the service needs of PWID. A thorough discussion and revision of the policies, programmes and services for (injecting) drug users is highly needed, as current policies are outdated, and services ineffective. Many patients come on a voluntary basis, but lack real motivation to stop using drugs: the APH is often seen as a temporary refuge from law-enforcement agencies, and the APH cannot keep most patients against their will, Subsequently, relapse is very high: out of approximately 300-400 PWID clients per year, less than 10% abstain for more than 2 years, and many relapse within a week after detox. A problem is that the APH can only accept patients who are 17 years and older, while drug problems often start at an earlier age. The proportion of female PWID is surprisingly high with 10-20% of PWID being women. Heroin is the second-most common drug among APH clients, and 80% inject the drug. The typical background of PWID is a friend or brother who introduces him/her to drugs at a young age (< 15), starting with hashish and alcohol, and gradually moving to heavier drugs such as heroin.
2.2	Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse	NO DATA ON INDICATOR – In the absence of any data from surveys among people who inject drugs (PWID), it is not possible to provide an accurate picture on the *"Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse".* However, as mentioned with regard to indicator 1.4, high-risk sex behaviours – including unprotected sex with sex workers abroad – are common, especially among young men. Although there is no direct evidence about condom use among (male) PWID, research from studies in the Middle East reveal that PWID are more likely to engage in unprotected sex with multiple partners than the general population. E.g. data from a bio-behavioural study in 2008 among PWID in Jordan show that almost half had had more than one sex partner in the last year, and one-third with a sex worker. More than half of the PWID respondents (56%) reported never or only sometimes using condoms with non-regular partners. While these data cannot be extrapolated to the Kuwaiti PWID population, it provides an indication of elevated high-risk sexual practices among PWID, which may further exacerbate the future spread of HIV among PWID and their sexual partners (including wives).
2.3	Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected	NO DATA ON INDICATOR – In the absence of any data from surveys among people who inject drugs (PWID), it is not possible to provide an accurate picture on the *"Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected".* However, as mentioned under indicator 2.1, reports from the Addiction and Psychiatric Hospital (APH) reveal that heroin and other injectable drugs are commonly used in groups, and that sharing of injection equipment is common. Needle

NO.	INDICATOR	REPORTED DATA AND COMMENTS
		sharing may be particularly high in prisons, since access to clean injecting equipment is restricted and PWID are forced to share. The fact that sharing of injection equipment is common among PWID is evidenced by high Hepatitis C rates among PWID, which is typically associated with sharing of injection equipment. A small study conducted in prison settings in 2009 revealed 398 cases of HCV, approximately 10% of the total prison population; 75% of whom were PWID. Sharing of injection equipment may be due to difficult access to adequate needles and syringes; as well as the result of situations in which unused injecting equipment is not readily available.
2.4	Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results	NO DATA ON INDICATOR – In the absence of any behavioural surveillance studies or surveys among people who inject drugs (PWID) on the issue of HIV status, there is no data on the *"Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results".* PWID are tested for HIV when they are arrested and imprisoned, as well as when they are admitted to the Addiction and Psychiatric Hospital (APH), but it is unknown what percentage of the total PWID population in Kuwait they represent. Furthermore, these HIV screening practices typically do not involve counselling, and PWID tested will only be informed of their HIV status when they are HIV-positive. Hence the majority of those who are not tested through these screening programmes or whose test result is negative will not be aware of their HIV status. In order to increase PWID's awareness of their HIV status, more attention needs to be given to counselling and the systematic sharing of test results (from screening), including negative results, with PWID. Furthermore, the absence of voluntary counselling and testing (VCT) centres in Kuwait does not allow PWID to get tested outside the screening programmes in prisons and the APH.
2.5	Percentage of people who inject drugs who are living with HIV	NO DATA ON INDICATOR – COMMENT: To date, no HIV sero-surveillance studies have been conducted among PWID in Kuwait. In contrast to sex workers and MSM – who remain largely hidden from the public eye – PWID are more frequently seen in HIV screening programmes, e.g. on admission to prisons or the APH drug-treatment facility. While these data from screening programmes among PWID reveal high levels of Hepatitis B and C, to date they have shown few HIV cases: in 2013 only one new HIV case was found among 976 PWID tested, while in 2012 no HIV cases were found among 560 PWID tested. However, these screening data do not provide a reliable picture of the true HIV prevalence rates among the overall PWID population, as it is not known how large this group is, or where they can be found. Most injecting drug use takes place in hidden locations, such as private houses, and sometimes even within the family. Furthermore, many PWID may go for drug treatment outside the country, and are thus not screened through Kuwaiti health or security facilities. This makes it very difficult to get a true picture of the scale and nature of the PWID population in Kuwait.
		PMTCT
3.1	Percentage of HIV-positive pregnant women who received anti-retrovirals to reduce the risk of mother-to-child transmission	NO DATA ON INDICATOR – In the absence of estimations for the number of HIV-positive pregnant women within the past 12 months, accurate data on the *"percentage of HIV-positive pregnant women who received anti-retrovirals to reduce the risk of mother-to-child transmission"* is not available. No sentinel surveillance studies have been conducted among ANC attendees in Kuwait, nor are they routinely screened for HIV (unlike the many other population groups that are screened, e.g. premarital, pre-employment, foreign residents). Hence, there is no information on the total number of HIV-infected pregnant women. Plans to introduce standard testing of ANC women in 2014 will strengthen PMTCT coverage. The only information available is the number of pregnant women who are already known to be HIV positive previously.
3.1a	Percentage of women	NO DATA ON INDICATOR – All women known to be HIV-infected have access

NO.	INDICATOR	REPORTED DATA AND COMMENTS
	living with HIV who are provided with antiretro-viral medicines for them-selves or their infants during the breastfeeding period	to ART, regardless of their pregnancy .and when the woman get pregnant she will be followed up to protect the child from getting the infection.
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	In the absence of estimations for the number of HIV-positive pregnant women within the past 12 months, accurate data on the *"Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth"* is not available. No sentinel surveillance studies have been conducted among ANC attendees in Kuwait, nor are they routinely screened for HIV, although PITC for ANC women is expected to be introduced in the course of 2014/15. Hence, there is no information on the total number of HIV-infected pregnant women in Kuwait in the 2012-2013 period. However: * There is 100% coverage with EID of mothers KNOWN to be HIV-infected. All women known to be HIV-infected and on ART who became pregnant in the 2012-2013 period were treated accordingly and their newborn infants received a virological test for HIV within 2 and 4 and 6 months of birth. The protocol includes 6 weeks of oral ZDV for the child, with 3 virological tests and an HIV test after 6 months. None of the children born to HIV-infected women in 2012-13 were infected. * However, pregnant women who are NOT known to be HIV-positive are not standardly tested for HIV, and infants born to these women will not receive EID.
3.3	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	NO DATA ON INDICATOR – In the absence of an estimation of the number of HIV-infected women who delivered in the previous 12 months (denominator), all children born to those women known to be HIV-infected (all of whom were on ART) were followed and none were HIV-positive. Although infants may have been born to HIV-positive women whose HIV status was unknown, it is possible that their infants were infected through mother-to-child transmission. However, any new paediatric cases in the 2012-2013 period would most likely have been found: as no new paediatric cases were found, it is likely that there have been no child infections from HIV-positive women delivering in the 2012-2013 period.
		ANTIRETROVIRAL TREATMENT
4.1	Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV	238 HIV patients were receiving ART by 31 Dec. 2013: 167men, 68 women,3 children. There is no accurate estimation for the Denominator (estimated No. of adults and children with advanced HIV infection), but most HIV-infected Kuwaiti citizens will eventually be identified and offered ART; hence coverage is expected to be high, although late diagnosis presents a problem in some cases.
4.2a	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	The 12-month retention rate for 2012 is 92.0% (23 still on treatment in 2012 of 25 enrolled in 2011) The 12-month retention rate for 2013 is 91.7% (11 still on treatment in 2013 of 12 enrolled in 2012)
		TB-HIV CO-INFECTION
5.1	Percentage of estimated HIV-positive incident TB cases that received treat-ment for both TB and HIV	NO DATA ON INDICATOR
		AIDS SPENDING
6.1	Domestic and international AIDS spending by categories	ONLY DATA FOR 2012: • Total amount 2012 KWD 17,021,420 (Approx. USD 59,515,455) • Blood bank: KWD 6,399,770 (USD 22,376,818)

NO.	INDICATOR	REPORTED DATA AND COMMENTS
	and financing sources	• HIV screening: KWD 4,204,372 (USD 14,700,602) • ART drugs: KWD 4,855,278 (USD 16,976,497.-) • Staffing costs: KWD 1,562 (USD 5,461,538)
		CRITICAL ENABLERS & SYNERGIES
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	NO DATA ON INDICATOR
8.1	Percentage of women and men aged 15-49 who report discriminatory attitudes towards people living with HIV	NO DATA ON INDICATOR – Overall there is strong and widespread stigma regarding HIV. As all PLHIV keep their HIV status to themselves, except for informing their direct partners, stigma does mostly not translate to discrimination, but attitudes are discriminatory.
10.1	Current school attendance among orphans and non-orphans aged 10–14	IRRELEVANT – Kuwait is a high-income country with no HIV-related orphan cases; All children attend school. Hence this indicator is irrelevant.
10.2	Proportion of the poorest households who received external economic support in the past 3 months	Indicator not relevant for context of Kuwait. Kuwait is a high-income country with very few HIV cases, good social services.
NCPI	National Commitments and Policy Instruments (NCPI) (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and M&E)	Overall ratings (1-10) 1. Civil Society involvement: 1 2. Strategic Planning: 5 3. Political Support & Leadership: 3 4. Human Rights: 8 5. Prevention: 8 6. Treatment, care & support: 10 7. M&E: 0

II. OVERVIEW OF THE AIDS EPIDEMIC

Number of reported HIV cases

The HIV situation in Kuwait can be characterised as low-prevalence. Since the 1980s, when the first Kuwaiti HIV case was reported, till the end of 2013, a cumulative total of 252 Kuwaiti HIV cases has been reported: 183 men (72.6%), 69 women (27.4%). In 2012, 12 new Kuwaiti cases were found, and in 2013 34 *(see Table 1)*. These 46 new Kuwaiti cases represent an increase of 22.3 percent of the cumulative number in the last two years only.

Table 1. Number of new Kuwaiti HIV cases, 2009-2013

	2009	2010	2011	**2012**	**2013**
MALE	8	7	21	**11**	**24**
FEMALE	4	4	4	**1**	**10**
TOTAL	12	11	25	**12**	**34**

HIV statistics for Kuwaiti and non-Kuwaiti nationals are based on mass screening of selected groups. To date, there has been no HIV screening of women attending antenatal care (ANC), but HIV testing of ANC women is expected to be introduced in 2014: current discussions focus on whether this will be standard screening or provider-initiated with an opt-out possibility. All foreigners seeking employment or residency in Kuwait have to get screened for HIV, first in their country of origin: if they test positive, they are not allowed entry into the country. Those who test negative are tested again within 2 months after arrival in Kuwait, and deported if found HIV-positive. Foreign workers are typically tested again every two or 3 years on renewal of their work contracts, while nationals of some countries considered higher-risk are tested every year. Thus, the vast majority of all HIV tests is conducted in the context of screening of expatriates. In 2012 and 2013, a total of 751,999 and 792,296 HIV tests were conducted respectively. Testing of expatriates in the context of residency and work permits represented 45.4 and 45.6 percent of the total number of HIV tests in 2012 and 2013 respectively.

As a consequence, ***non-Kuwaiti HIV cases*** mainly consist of persons tested before they get their permanent residency in the country, or who had to bet their work permits renewed. Thus, most non-Kuwaiti positive cases represent persons who were never allowed into the country. In 2012 and 2013, a total of 105 and 138 HIV cases was found among expatriates respectively.

It is important to note that more than two-thirds of the Kuwaiti population consists of expatriates. In 2011 the total population was 3,632,009, with 1,164,449 (32.1%) Kuwaitis and 2,467,560 (67.9%) non-Kuwaitis.

Table (2) below presents an overview of the numbers of Kuwaitis and expatriates screened for HIV in 2012 and 2013.

The table shows that the vast majority (88%) of all HIV tests is conducted among non-Kuwaitis, mainly in the context of residency permits (52%) or for people handling food (40%).

However, most Kuwaitis are tested in the context of blood donations (38-39%), pre-marital (26-27%) or pre-employment testing (18-19%).

Table 2: Numbers of Kuwaiti & Non-Kuwaitis screened for HIV, 2012 and 2013

	2012					2013				
	Kuwaiti		Non-Kuwaiti		Total	Kuwaiti		Non-Kuwaiti		Total
	No.	%	No.	%	No.	No.	%	No.	%	No.
Expat residency	0	0	341,390	51.5	341,390	0	0	361,595	51.9	361,595
Blood donors	34,129	38.2	39,191	5.9	73,320	36,186	38.5	38,858	5.6	75,044
Pre-marital	23,820	26.7	2,647	0.4	26,467	24,490	26.0	2,721	0.4	27,211
Pre-employment	16,430	18.4	7,306	1.1	23,736	17,642	18.8	9,268	1.3	26,910
Food handlers	2,486	2.8	262,939	39.7	265,425	2,566	2.7	275,646	39.5	278,212
Drug users	106	0.1	454	0.07	560	304	0.3	672	0.1	976
Hospitals	2,026	2.3	3,905	0.6	5,931	1,920	2.0	3,161	0.5	5,081
Army & Police	6,532	7.3	1,869	0.3	8,401	5,138	5.5	2,585	0.4	7,723
Prisons	444	0.5	803	0.1	1,247	254	0.3	1,047	0.15	1301
Other	3,406	3.8	2,116	0.3	5,522	5,586	5.9	1,681	0.2	7,267
TOTAL	89,379		662,620		**751,999**	94,086		697,234		**791,320**

The available data on the number of known HIV cases among Kuwaiti nationals do not allow providing an accurate estimation of the true number of cases, and the overall HIV prevalence among nationals, since the available HIV data is mainly based on mass screening among blood donors, premarital couples, pre-employment screening and people who inject drugs, in which most-at-risk populations are typically under-represented. In the absence of VCT centres, it is not easy for persons at higher risk to get information about their HIV status anonymously but their HIV test result is kept in privacy and it is confidential by law. The National AIDS Control Committee, which was reactivated in 2012, is currently looking into the possibility of introducing voluntary counselling and testing centres.

Hence, despite the fact that many Kuwaitis and especially foreigners are screened for HIV each year, this does not provide a reliable picture of the epidemic, as many Kuwaiti persons with HIV may be missed.

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

As mentioned above, the mass screening of foreigners and certain categories of Kuwaiti nationals (in 2013, almost 8% of the total Kuwaiti population was tested for HIV) does not provide an accurate picture of the HIV epidemic in the general population. It gives an even less reliable picture of HIV among most-at-risk populations, such as sex workers, men who have sex with men and people who inject drugs. However, in the absence of special sero-surveillance studies, there are no reliable estimates of HIV rates among these groups.

Furthermore, there has been ***no research*** on the size, sexual networks dynamics and risk behaviours of these groups, which makes it very difficult to assess the HIV risks among these key populations groups, or among vulnerable groups such as young people.

Behavioural risks among young people

While no formal studies have been conducted, there is reason to believe that sexual behavioural patterns in Kuwait are changing dramatically, with a considerable proportion of

young people – especially young men, but also young women – engaging in high-risk sexual contacts with multiple partners, as well as injecting drug use.

Results from a number of focus group discussions (FGD) held among female and male University students (18-25 years of age) in Kuwait City in 2012 and 2014 as part of the GARP reporting process, suggest that a considerable proportion of male and female Kuwaiti students is sexually active before marriage. Young men indicate that many have their first sexual contact at age 16, while as much as 10-20% of young men had their first sexual experience before the age of 15, either with a female or male partner. Sex between boys is said to be more common in public schools, where boys and girls are separated, and same-sex contacts are easier.

During FGDs, male university students reported that the majority of young men (80-90%) have several local girlfriends at the same time, with frequent changes to other girlfriends, and young men often passing girl friends on to their friends after some time. Respondents indicated that two-thirds of young men have regular oral and/or anal sex (in order to protect the girls' virginity) with these local girlfriends. The most common locations for sex include cars, as well as apartments or beach houses, which a group of young men rent jointly, with the specific purpose of having a place to be alone with their girlfriends.

In addition to sexual relations with local girls, many young men also have sex with sex workers, mainly abroad: most young men (80-90%) start travelling abroad – often in groups – at a young age, as young as 15 to 16. Young men say it is typical to have their sexual debut with sex workers abroad, while they report that 50-75 percent travel with the specific aim to have sex with sex workers. Condom use is reported to be high, with 75-90 percent using condoms, although respondents also report frequent alcohol use as a risk factor for unprotected sex.

Reported condom use with sex workers depended on the location and nationality of the sex worker, as well as her "overall appearance". Overall, respondents said condoms were *not* used in about one-quarter (25%) of these sex contacts. Condoms were more likely to be used with women perceived to be "higher risk", especially Asian or Eastern European women, while condoms would be less used with those women perceived to be "lower risk", especially women from the MENA region.

While most newly reported HIV cases in 2012 and 2013 are found among men above the age of 25, approximately 15 percent of all new cases among Kuwaiti citizens are 15-24 years old.

The results from these focus group discussions reflect the rapid changes in sexual behaviour patterns among young generations, especially among young men, and highlight the importance of conducting further research to identify the scale and scope of risk behaviours among Kuwaiti youth, and develop appropriate HIV-prevention programmes. Young men and women alike mention the absence of any sexual education in schools, and indicate that their main source of information on sexuality are other young people who already have sexual experience. Knowledge on other STIs is reported to be even lower than on HIV.

In this context, sexual education is an important priority. In addition to basic sex education in schools, peer education programmes supported by experts in this field will be more effective in providing adequate information on HIV, STIs, protective measures and life skills than educational programmes through teachers.

HIV risks among female sex workers

The results from focus group discussions with male and female university students (see previous section), reveals that young men visit sex workers abroad, but also show that sex work is present in Kuwait. Individual interviews with migrant workers in the context of this GARP report also revealed the presence of sex workers in Kuwait City, who include women from the region who reside illegally in Kuwait. Due to the illegal nature of sex work and the illegal status of many women engaging in sex work, it is extremely hidden and no HIV-prevention programmes are available for these women. However, in the absence of any research on sex work in Kuwait, little is known about the exact scope and nature of the phenomenon.

There is anecdotal evidence that most sex workers in Kuwait have foreign nationalities, and that sex work is not necessarily their main source of income: they may have regular jobs and engage in sex work or transactional sex with multiple boyfriends – both Kuwaiti and non-Kuwaiti – to gain additional income. Thus, the majority of these women would at some point have been tested for HIV before they received a residency permit for the country, and most were therefore not HIV-infected when they arrived. As mentioned, however, others may have been trafficked illegally into the country and may therefore not have been tested for HIV.

The results from focus group discussions held in the context of this GARP report with male university students indicates that condom use with sex workers depends on the client, and is based on his assessment of the overall “cleanliness” of the sex worker, as well as her nationality (as this is perceived to be related to higher HIV/STI risks). However, reportedly, condoms are not systematically used and unprotected sex occurs with sex workers. More research is needed to better understand the scale and nature of sex work in Kuwait, and particularly the presence of high-risk, unprotected sex.

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

While MSM and homosexuality exist in Kuwait as in all other countries of the world, it is extremely hidden and little is known about the exact scope and nature of the phenomenon. To date, there has been no research, nor HIV-prevention programmes for MSM in Kuwait. In this context, it is extremely difficult to conduct a sero-surveillance study to assess HIV-prevalence rates among MSM, as this requires trust and confidentiality. Hence, no data is available on the HIV prevalence among MSM. Data from HIV testing in 2012 and 2013 reveal only one HIV case as a result of MSM sex in 2012; however, due to the extreme stigma regarding homosexuality, the actual number of HIV infections through same-sex contacts is likely to be underestimated.

Research and experiences in other countries in the Middle East and North Africa have revealed that most MSM try to hide their sexual orientation and preferences, and will marry and have a family in order to meet societal expectations and avoid being identified as homosexual. Sexual contacts with other men usually take place in secret, and rather than having a steady sex partner, MSM may prefer the services of male sex workers, as this is considered to be more anonymous and safer than having an actual relationship with another man, which could be discovered. These MSM contacts are often high-risk, with unprotected anal sex with many casual, unstable partners. Furthermore, most Kuwaiti MSM are likely to have the financial means to travel in and outside the region, and may go for MSM sex in other countries – including in Europe and Asia – where the social climate around homosexuality is more liberal. This may also involve sexual contacts with local male sex workers.

A rapid assessment conducted a few years ago by a regional MSM organisation on the Internet among MSM in the wider Middle East and North Africa also included respondents from Kuwait: 64% of Kuwaiti respondents in this assessment reported always having safe

sex, while the remaining 36% said condom use depended on the circumstances, or gave an ambiguous answer. The researchers indicate that the 64% "always safe sex" most likely represented an exaggerated percentage, with few MSM consistently using condoms. Nevertheless, these data reveal that unprotected sex among Kuwaiti MSM is frequent. This high-risk behaviour implies HIV-infection risks not only for these MSM themselves, but also for their (potential) spouses and children.

While there is no conclusive evidence of HIV rates among MSM in the region, these risk behaviours indicate the potential for a rapid spread of HIV within the MSM community. In this context, it is a priority to conduct studies among MSM to better understand the HIV risks in this community, and guide future policies and programmes for HIV prevention among MSM. This includes mapping, size-estimation studies and socio-anthropological research.

HIV risks among people who inject drugs (PWID)

To date, no HIV sero-surveillance or behavioural studies have been conducted among PWID in Kuwait. Experts from the Addiction and Psychiatric hospital (APH) in Kuwait City report that injection drug use is increasing, and has become common. Reasons mentioned for this increase include the easy availability of drugs, financial means and time.

In contrast to sex workers and MSM – who remain largely hidden from the public eye – PWID are more frequently seen in HIV screening programmes, e.g. on admission to prisons or the drug-treatment facility of the Addiction and Psychiatric Hospital (APH). The APH has 6,000 active files of drug users, with approximately 60 percent (approx. 3,600) injecting drugs.

While the data from screening programmes among PWID reveal high levels of Hepatitis C, to date they have shown few HIV cases: *no new HIV cases* were found among PWID in the 2012-2013 reporting period among a total of 1,536 PWID tested. However, these screening data do not provide a reliable picture of the true HIV-prevalence rates among the wider PWID population. Many PWID may go for drug treatment outside the country, and are thus not screened at Kuwaiti health or prison facilities. This makes it very difficult to get an accurate picture of the scale and nature of the PWID population in Kuwait.

More information is also needed about the total size of the PWID population and in what settings injecting drug use takes place. APH experts report that most injecting drug use takes place in private locations, such as private houses, and sometimes even within the family. Reportedly, heroin is the second-most common drug among PWID clients at the APH, with 80 percent injecting the drug. Drug use often starts as thrill-seeking behaviour among young people: most PWID are typically introduced to drugs at a young age (< 15) by a friend or brother, starting with hashish and alcohol, and gradually moving to heavier drugs such as heroin, Tramadol, methamphetamine and dextro-amphetamine (locally called *"shaboo"*). Usually people are poly-drug users. Methamphetamine is known to be associated with higher levels of sexual activity, which may increase the risk of HIV infection.

While most PWIDs start sniffing heroin initially, they soon move to injection. Injecting drug use typically takes place in social groups, including within the family: it is common that PWIDs have brothers, uncles or even parents who also use drugs, which makes it extremely difficult to quit the habit. Sharing of injection equipment is common, as evidenced by high prevalence rates of Hepatitis B and C infection among PWID in prisons. Experts report that as much as 80 percent of PWID share injection equipment. Reportedly, sharing of equipment mainly occurs in settings and at moments when the PWID wants to inject but clean syringes or needles may not be immediately available, including in prisons. Furthermore, the availability of the 'right" needles for injecting drug use is limited in Kuwait: available needles

and syringes are mainly for diabetes patients, but other injecting equipment is less readily available.

Compounding the needle-sharing problem is the fact that many PWID are imprisoned at some point in their lives, where access to syringes is difficult. There is anecdotal evidence of high sharing of injection equipment in prisons, which contribute to the future spread of HIV among PWID. A small study conducted in prison settings in 2009 revealed 398 cases of HCV, approximately 10% of the total prison population; 75% of whom were PWID.

Hence, despite the seemingly low HIV rates among PWID to date – based on limited and selective screening data from prisons and drug-treatment facilities – the common sharing of injection equipment as reported by Kuwaiti experts, and as evidenced by high HVC rates among PWIDs, show that the risk of a rapid spread of HIV among PWID in the near future is real. Experiences from other countries in the Middle East with high HIV rates among PWID – such as Iran, Egypt and Libya – have shown that there is no room for complacency.

In addition to unsafe injecting practices, high-risk sexual practices among PWID – especially those using methamphetamine – may also play a role in HIV transmission. Although there is no direct evidence about condom use among (male) PWID, research from studies in the Middle East reveal that PWIDs are more likely to engage in unprotected sex with multiple partners than the general population. E.g. data from a bio-behavioural study in 2008 among PWID in Jordan show that almost half had had more than one sex partner in the last year, and one-third with a sex worker. More than half of the PWID respondents (56%) reported never or only sometimes using condoms with non-regular partners. While these data cannot be extrapolated to the Kuwaiti PWID population, it provides an indication of elevated high-risk sexual practices among PWID, which may further exacerbate the future spread of HIV among PWID and their sexual partners (including their wives).

Therefore, more research on (injecting) drug use in Kuwait is needed to better understand the HIV risks among this population. This includes mapping, size-estimation studies and socio-anthropological research.

III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

1. National Commitment

In terms of national commitment, Kuwait has made limited progress in the last two years (2012-2013). However, overall political support for comprehensive HIV prevention, treatment, care and support programmes remains limited. This limited political support and leadership is reflected at the *institutional and organisational* level; in *policy and programme development*; and in terms of *allocation of human and financial resources*.

1) At the ***institutional level***, the most meaningful development has been the effective re-activation of the National AIDS Control Committee (NACC) as a multisectorial policy body with the mandate to provide overall coordination and follow-up of the national response. Membership of the NACC remains limited to technical people from Ministries, governmental facilities and UN agencies, without high-level political engagement (e.g. (deputy) Ministers). The functioning of the National AIDS Programme (NAP) continues to be hampered by limited technical staffing and unclear mandate and budget.

2) At the level of ***policy and programme development***, the most pressing challenge is the absence of an updated national strategic plan, which was already mentioned in the 2012 GARP Report. The national response to HIV started in the mid-1980s: at the time there was a general overview of priority areas, but hard copies of that first "national plan" are not available anymore. In the absence of an updated NSP there are also no operational plans, M&E frameworks or budgets. The lack of an updated NSP reflects the fact that HIV/AIDS has not been acknowledged as a public health priority, let alone as a priority for non-health sectors. As will be discussed more in-depth in the next section, the national response continues to be characterised by massive screening of different population groups, especially expatriates (88% of all HIV tests) and ARV treatment for Kuwaiti nationals found HIV-infected. As a consequence, HIV prevention has never been systematically developed or implemented. On the positive side, the MOH leadership and the National AIDS Control Committee have pledged their support for the development of a National Strategic Plan in the course of 2014 or 2015.

3) The lack of political commitment is most concretely seen in the limited ***allocation of financial and human resources***. Most HIV-related resources are spent on mass screening and ARV treatment for a limited number of people. However, these resources are not specifically earmarked for HIV, but are part of existing mass health-screening programmes for expatriate workers and Kuwaiti population groups such as premarital and pre-employment screening, which is not specifically aimed to control HIV. Similarly, ART provision takes place in the overall context of hospital treatment and care.

The lack of HIV-specific resource allocation is further evidenced by the limited budget for the *National AIDS Programme* (NAP), which continues to be understaffed and under-resourced. There is only one technical staff, and limited administrative and support staff. The functioning of the NAP is further hampered by inadequate information systems and limited access to key HIV-related data. The NAP does not have its own budget, which severely hampers the national response, as will be described in the programme-implementation section below.

2. Programme Implementation

As mentioned in the previous section, a major stumbling block for programme implementation is the absence of an updated national strategic plan and operational plan since the mid-1980s. Commitments made to developing an updated NSP in 2012 did not materialise so far. Without the overall guidance of a commonly agreed national HIV/AIDS plan, the national response has remained scattered and ad-hoc, with most HIV-related interventions taking place in the context of other existing public health policies and strategies, without having a clear, specific vision on comprehensive HIV prevention, care, treatment and support.

While there the reactivation of the National AIDS Control Committee has marked an important step towards strengthening the national response to HIV/AIDS, this has not yet materialised in concrete changes in terms of a more comprehensive delivery of programmes and services, especially in the field of prevention. The national response has largely remained limited to massive, mandatory HIV screening in various contexts, and treatment and care for HIV/AIDS.

HIV prevention

In the last 2 years (2012-2013), there have been no major changes in the field of HIV prevention. Most HIV-prevention activities continue to be part of wider public health measures, including mass screening of different population groups; infection control in health-care settings; and PMTCT measures for pregnant women known to be HIV-infected.

HIV screening and testing – As mentioned above, large numbers of people are screened for HIV each year, predominantly expatriate workers and other foreigners (88% of all HIV tests), while the remaining 12% are Kuwaitis who are mainly screened in the context of blood transfusions and pre-marital and pre-employment HIV testing. However, to date, voluntary counselling and testing (VCT) centres are not available, which does not allow people to get to know their HIV status anonymously (they *can* get tested, but need to provide personal details). A positive step has been the recent creation of a legal framework that allows confidential and voluntary testing, without mandatory reporting, but this legal framework needs to be updated and still needs to translate into the actual availability of VCT centres. The NACC is currently discussing the modalities to implement VCT in the near future.

PMTCT – While PMTCT services are provided to pregnant women who are known to be HIV-infected, and who are mostly already on ART, *there is still no systematic screening of all ANC attendees*. Therefore, HIV-positive pregnant women whose HIV status is unknown are unlikely to receive PMTCT services. In the 2012-2013 period, two (2) new cases of HIV were found among young children – both 4-years old – who were likely infected through mother-to-child transmission.

The current PMTCT protocol, which was introduced more than 15 years ago, involves a special protocol of ART for all mothers during pregnancy, avoiding some drugs that are not safe for the baby like *Efavirenz*; on delivery mothers receive intravenous AZT, and the infant 6 weeks of oral AZT. In the first 6 months, the infant is tested three times for p24 antigen and viral load. No newborn children of known HIV-infected mothers were infected in 2012 or 2013. And to mention that all HIV-positive women are on ART all over the pregnancy and before pregnancy and after delivery. However, in the absence of provider-initiated testing and counselling (PITC) in the context of ANC services, there remains a possibility of mother-to-child transmission in the future. The National AIDS Control Committee is currently addressing this issue and screening of all ANC women is expected to be introduced in 2014 or 2015.

HIV education – In the field of HIV education, there have been some changes in the 2012-2013 period. Prevention Program was implemented and the NAP gave lectures regarding HIV education and prevention (lectures to health care workers in private sector, lecture to pharmacology university students and nursing college students, and also lectures to the police academy students). SMS awareness messages were sent through the mobiles of 2 million people and a short film was broadcasted in 100 locations in the supermarkets in Kuwait. HIV has been part of the curriculum for intermediate and secondary schools, but education is limited to factual knowledge, without attention for life skills or specific HIV-prevention methods. In focus group discussions held in 2014, male and female university students reported having had no sexual education at all, as the topic remains taboo. While HIV is included in the curricula of medical schools as a clinical topic, HIV education is not included as a subject in the curricula for universities concerned with graduation of teachers. Most of the teachers in schools are expatriates from a wide variety of backgrounds and without any education about HIV/AIDS; this makes it difficult to teach students about HIV/AIDS with updated information, rather than depending on the old curricula available in the books of students. A study was done by the NAP in cooperation with UNESCO regarding the interaction of the education sector with the theme of AIDS: this study revealed that the old curricula about HIV/AIDS in schools were still used. Subsequently, a meeting was held between the NACC and the Ministry of Education, which resulted in an agreement to update the HIV curricula of schools.

Mass screening campaigns would provide a good opportunity to raise awareness among a large group of the Kuwaiti and expatriate community, but this has not been considered to date. Other HIV-communication activities implemented in the 2012-2013 period include text messages on HIV at a national level; short video messages in supermarkets countrywide, including links to a hotline; and interactive programmes on radio and TV.

Targeted interventions for key populations and other vulnerable groups – The absence of a political support and a comprehensive vision on HIV prevention, coupled with stigma, discrimination and criminalisation of sex workers, PWID and MSM continue to hamper targeted HIV-prevention programmes for these key populations. In the 2012-2013 period, there has been no progress towards addressing HIV risks among these groups: the current legal framework hampers research into the underlying dynamics of sexual and injecting drug use behaviours among these groups.

People who inject drugs (PWID) are the (relatively) easiest-to-reach key population, as injecting drug use is not commonly associated with extramarital or MSM sex, and therefore less surrounded by stigma and discrimination and moral rejection. Furthermore, there are existing *drug-treatment services* provided by the Addiction and Psychiatric Hospital (APH), but their coverage is low and the current *detoxification and rehabilitation* programmes lack effectiveness, as evidenced by high drop-out and relapse rates. Access to PWID is limited by the fact that many parents send their addicted children to other countries, such as Saudi Arabia, for drug treatment. Thus, a large proportion of PWID remains invisible to the Kuwaiti authorities.

Despite the relative good access to PWID the APH does not offer specific HIV-prevention programmes, such as HIV education. A positive development is the planned introduction of an *opioid-substitution therapy* (OST) pilot programme with *Soboxone* in 2014. While an earlier OST pilot was discontinued due to a lack of systematic monitoring of the results, the currently planned OST pilot will be carefully evaluated, and the results will be used to decide on its further continuation and scale-up. Furthermore, a treatment clinic for Hepatitis C was recently introduced in collaboration with a hepatologist of the Mubarak Hospital, which will provide services to selected HCV-infected patients.

Although local experts report that sharing of injection equipment is common among PWID, to date, *needle-and-syringe-exchange programmes* (NSEP) remain unavailable, although experts indicate NSEP services would be important to prevent HIV infection.

A considerable number of PWID may be tested for HIV through *mandatory testing* on admission to the APH drug-treatment facility, on arrest by the police, or when sentenced to prison: while this gives an idea about HIV prevalence among PWID, many PWID are never tested through any of these mechanisms.

Female sex workers – In the 2012-2013 period, there have been no HIV-prevention activities for sex workers, such as HIV education, peer outreach, condom distribution or special STI services and VCT centres for sex workers.

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

In the 2012-2013 reporting period there have been no changes with regard to existing policies towards sex workers, as they remain predominantly seen as persons engaging in illegal activities; hence HIV-prevention programmes are very hard to establish, especially through government agencies, while there are no civil society organisations with an expressed interest for working in this field. Outreach programmes for sex workers are further hampered by the fact that most of them are said to be foreign nationals – many illegally residing in the country without proper residency permits – who may offer paid sex services either on a full-time basis or as a source of additional income. In this context it is particularly difficult to establish relationships of trust and confidentiality, as the discovery of a person being engaged in sex work or as being HIV-infected might result in her deportation from the country or even imprisonment.

Men who have sex with men – For similar reasons as for sex workers, in the 2012-2013 period, there have been no HIV-prevention activities for MSM, such as HIV education, peer outreach, distribution of condoms and lubricants, or special STI services and VCT services for MSM.

MSM and homosexuality are highly rejected by society, criminalised by law, and surrounded by severe stigma and discrimination. Therefore, MSM is hidden from the public eye and it is very difficult to reach them with HIV-prevention, or any other type of programme, in the absence of political support, allocated resources, and organisations willing and capable of effectively reaching and working with them.

In addition, self-stigma may further hamper identifying and working with MSM: the fact that only one (1) out of 46 newly-found HIV cases in 2012-2013 reported MSM contacts seems to indicate that HIV-infected MSM will avoid at all cost being identified as MSM (in addition to being HIV-infected): for Kuwaiti men, this would lead to social ridicule and rejection by their own family, which has a particular impact in a small and closed society such as Kuwait.

Therefore, future HIV-prevention programmes for MSM need to build on confidentiality and peer outreach work. More research is needed to better understand the social and sexual networks of MSM in Kuwait, and the link with MSM communities in other countries in the region. A particularly important group for HIV-prevention may be male sex workers who cater to the needs of the MSM community, and who are at the highest risk of contracting and spreading HIV.

Clients of sex workers – Clients of sex workers are another important at-risk group, but very hard to identify; hence, no policy or programmatic attention has been given to this group in 2012-2013. However, the results from focus-group discussions with male university students in the context of this GARP report reveal that patterns of sexual behaviour are

rapidly changing among the predominantly young population of Kuwait, and that a considerable percentage may be clients of sex workers, both in Kuwait and in other countries. Furthermore, individual interviews with migrant workers in Kuwait reveal that some of them are clients of local sex workers.

However, targeted HIV-prevention programmes among clients of sex workers are particularly difficult, as this would require an acknowledgement of unprotected, extramarital sex with multiple partners among groups of the general population, including young people. This remains a politically and socially highly sensitive area, and therefore effective HIV-prevention programmes among clients of sex workers are difficult to establish and implement.

Nevertheless, effective HIV prevention requires an evidence-informed approach, which addresses identified public health priorities. To this effect, research is highly needed to better understand the dynamics of extramarital sexual behaviours in Kuwaiti society – both among nationals and expatriates – and develop effective programmes accordingly. Peer education and outreach programmes, possibly with condom promotion, are likely to be the most feasible and effective interventions.

Condom promotion & distribution – Condom promotion and distribution remain highly-sensitive topics in Kuwait, and no policy changes have taken place in this field in the 2012-2013 period. While condoms are widely available for contraception among married couples, condom promotion for HIV-prevention purposes is considered promotion of illegal extramarital sex. As already mentioned, public condom promotion among key populations, young people, or other segments of the general population is likely to remain socially unacceptable. However, condom education as part of wider HIV-prevention and peer-education programmes in more confidential settings may be a feasible approach.

HIV treatment, care and support

HIV treatment, care and support have been, and remain the strongest component of the national response to HIV in 2012-2013. However, no significant improvements in terms of coverage or quality of services have been attained in this period, as quality of care was already high in the previous reporting period.

Antiretroviral treatment (ART) is available to all eligible Kuwaiti citizens. Treatment is confidential, and special attention has been given to ensure there is no discrimination toward HIV patients at the treatment facility, and that their human rights are fully respected. In addition, HIV patients have access to HIV-related care and psychological and social support, including the right to full medical retirement, based on HIV status. Compared to HIV prevention, implementing effective HIV treatment is much easier, as Kuwait has excellent health-care facilities with free treatment for all Kuwaiti nationals, while medical interventions for PLHIV are much less controversial than behavioural change programmes in the field of sexual and drug-use behaviours.

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All HIV patients are regularly followed up, with quarterly CD4 and viral load tests, as well as pheno- and genotyping done since several years. Nevertheless, non-adherence is a problem for a small number of HIV patients, and the 12-month retention rate of those enrolled in 2012 was 91.7 percent.

In 2012 and 2013, 12 and 34 new HIV cases were found among Kuwaiti citizens respectively, and the total number of HIV patients on ART by the end of 2012 and 2013 was 218 and 252. In addition to loss to follow-up of some ART patients, other treatment problems are related to late diagnosis of HIV cases: these are Kuwaiti patients who were not identified through any of the HIV-screening programmes (which only screen approx. 8% of the Kuwaiti population per year), and presented with advanced clinical symptoms. According to the main ART facility in Kuwait, this is a significant proportion of new cases, which indicates that the

existing screening programmes are ineffective for identifying most Kuwaiti HIV cases; also because Kuwaiti nationals are screened only once in their life and it is usually not repeated (e.g. pre-employment). Another reason for late HIV diagnosis is the fact that most general practitioners in Kuwait have limited knowledge and experience in recognising HIV symptoms among their patients in an early stage, and patients are often referred in late stages. This shows there is a big gap between HIV specialists and GPs.

The major challenge with regard to access to treatment, however, is the fact that non-Kuwaitis who are found to be HIV-infected are deported to their home countries. Only a small proportion of them have temporary access to treatment if this is medically required to stabilise their condition before repatriation or if they are the married to a Kuwaiti then they get treatment forever and not deported. However, access to ART for expatriates working in Kuwait is linked to more general regional public health policies of GCC countries with regard to screening of foreign workers, which will not be easily changed on a country basis.

Social, psychological and legal position of PLHIV – Although the main health, employment and other legal rights of PLHIV are formally protected by laws and policies, PLHIV in Kuwait still face major challenges with regard to social stigma and discrimination, as well as their employment rights. Since several years, the NAP has been trying to facilitate the establishment of support groups or an association of PLHIV: in 2012 these efforts materialised in a small number of PLHIV forming a self-help group, but it remains a challenge to get more people to join: still most PLHIV do not want to organise themselves with other PLHIV due to social and self-stigma, and fear of public disclosure of their HIV status. Most PLHIV keep their status to themselves, or disclose it only to their closest family members and friends.

IV. BEST PRACTICES

As described in the previous sections, the national response to HIV in Kuwait still faces many challenges, particularly in the field of HIV prevention, including in the last two years (2012-2013). Among all aspects of a successful response – political leadership; a supportive policy environment; scale-up of effective prevention programmes; scale-up of care, treatment and/or support programmes; effective surveillance, research and M&E; capacity-building; infrastructure development – the main successes to date have been attained in the field of ***antiretroviral treatment for Kuwaiti HIV patients***. As mentioned, access to high-quality ART is free for all eligible Kuwaiti citizens, with adequate patient follow-up in place. Clinical treatment is complemented by psychological and social care and support, although this aspect still needs to be more systematised.

The ***reactivation of the National AIDS Committee*** in 2012, with multisectoral membership from various government and UN sectors, is another achievement. The Committee has two subcommittees and is meeting regularly. Priority issues that the Committee is currently promoting include voluntary counselling and testing centres and provider-initiated testing and counselling of all pregnant women at antenatal care facilities and STI patients. A legal framework for ***confidential, voluntary counselling and testing services*** had already been established in 2011. While this new legal framework law still needs to be operationalised into the establishment of VCT services, this is a key step towards strengthening people's right to know their HIV status without fear of repercussions in the social sphere, employment, or legal measures.

V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

HIV low on the national agenda

As described in previous chapters, there are many challenges facing the Kuwaiti response to HIV/AIDS. Most of these challenges were already reported in the previous GARP Report in 2012, and few of them were adequately addressed in the 2012-2013 period.

The main challenge is related to the fact that the numbers of Kuwaiti HIV cases have remained very low in the past 25 years, and that HIV has subsequently never been identified as a priority public health problem, let alone a problem that affects the country beyond the few individuals directly affected. In other words: *"HIV is not a problem",* or rather: *"HIV is not our problem".*

From this perspective, the main response to HIV has always been to treat it as an *external* threat, which has to be kept *out*, and if it cannot be kept out, to deal with those infected on an individual basis. The two main approaches taken to *"keep HIV out"* are massive screening and antiretroviral treatment of HIV-infected Kuwaitis. Massive HIV screening applies to all expatriate workers – who constitute more than two-thirds of the Kuwaiti population – and of selected Kuwaiti nationals – mainly through testing of blood donors and pre-marital and pre-employment screening. Foreigners identified with HIV are not allowed into the country or are deported to their home countries.

A positive step in this regard has been the reactivation of the National AIDS Control Committee (NACC) in 2012, which has opened the discussion on a number of key challenges, such as screening and PMTCT programmes for ANC women; introduction of VCT services and other services, as well as more attention for human rights aspects related to HIV/AIDS.

Lack of systematic HIV prevention, especially for key populations

Apart from the fact that the two main strategies – massive screening and ART – are considered *effective*, they are also *convenient*, as they don't require addressing the many sensitive issues related to HIV, such as sexual education for young people, condom promotion, needle-and-syringe-exchange programmes for PWID and programmes targeting other key populations – particularly sex workers and MSM – that are illegal. HIV continues to be associated with morally rejected behaviours – out-of-marriage or homosexual relations, drug use – and hence people with HIV face severe social stigma and discrimination, even from their own families.

The key challenge for the near future is to develop a national strategy that will also systematically address HIV prevention, specifically targeting key populations and other vulnerable groups, including young people. The rapidly increasing exposure to other countries and cultures, globalisation and changing cultural and sexual norms and practices make it clear that HIV can no longer be contained by labelling it as an *"external"* problem. Despite a serious lack of research into the drivers of HIV/AIDS, there is clear, albeit anecdotal evidence that Kuwaiti nationals, especially young people, are increasingly exposed to HIV. In consequence, the dual approach of screening and ART that seemed to have worked so far, may no longer be an effective response for the future.

Specific challenges, specific remedies

The *growing gap* between the factors that could drive a future HIV problem on the one hand, and the traditional national response on the other hand, requires addressing the following specific challenges:

1. Strengthening political support – HIV is still not considered a public health priority in Kuwait. The continuously low HIV-prevalence rates and sensitivities surrounding HIV make it easy to downplay its potential to become a serious public health problem. Therefore, political support needs to be strengthened for a more comprehensive national response to HIV – with specific attention for targeted HIV-prevention programmes for key populations and other vulnerable groups, including young Kuwaitis. In the absence of political support it is hard to mobilise support from within the health sector, as well as in other sectors for HIV-prevention efforts.

Remedial action: A combination of strong evidence *(see next)* and effective advocacy is needed to convince high-level decision-makers of the need to strengthen HIV prevention. In addition, leadership from the highest levels is needed to garner support at lower administrative levels. International experience and technical assistance may help highlight the priority issues. In this context, the reactivated National AIDS Control Committee should play a role in advocacy and lobbying to strengthen political and financial support for a comprehensive national response to HIV.

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

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

3. Inadequate institutional support systems an budgets – The current MOH-based *National AIDS Programme* (NAP) remains understaffed and under-resourced. A well-resourced NAP with adequate institutional and operational budgets and infrastructure is instrumental to oversee and support the implementation of the national response and to support the NACC.

Remedial action: 1) Strengthening of NAP through: a) Strengthened institutional position as a separate HIV/STI Department; Increased technical and administrative staff, with clearly described mandates and TORs that allow NAP to act accordingly; and adequate budgets.

4. The lack of an updated National Strategic Plan (NSP) and costed Operational Plan (OP) since the 1980s continues to leave the national response without a compass regarding the priority interventions. Without an updated NSP and specifically described priority strategies (OP) and allocated budgets the national response remains scattered, ad-hoc and ineffective.

Remedial action: Immediate development (2014) of an NSP and costed Operational Plan, with active involvement and participation of all key stakeholders – governmental, civil society including PLHIV, private sector and UN agencies.

5. Ineffective programmes and services, especially in the field of HIV prevention, PLHIV and stigma and discrimination, and expatriates fail to address priority issues and meet the service needs of the most-at-risk and vulnerable populations. As mentioned, the national response has been skewed towards HIV screening and ART, but lacks a vision particularly on HIV prevention from a human rights perspective: interventions need to be based on sound evidence, proven cost-effectiveness, and meet the needs of key populations with regard to information, skills, treatment, care and (social, legal) support.

Remedial action: HIV programmes and services need to be developed and implemented – in line with the NSP that needs to be developed in 2014 – especially in the field of targeted HIV prevention for key populations. Decisions regarding priority interventions need to be based on proven (cost) effectiveness, social and cultural acceptability; and expressed needs of beneficiaries. Examples may include VCT centres; programmes to reduce stigma and discrimination; peer education and outreach for key populations and young people; workplace programmes for Kuwaitis and expatriates; availability of condom for key populations; 'Friendly' STI treatment for key populations; PLHIV support groups; Legal support for expatriate PLHIV; harm reduction programmes for PWID, including opiod substitution therapy; advocacy for and involvement of social, political and religious leaders in HIV prevention; regional collaboration.

6. Lack of experience and capacity in HIV prevention and weak civil society – as discussed, to date there has been very limited experience with comprehensive HIV programmes, particularly in the field of HIV prevention. Targeted HIV-prevention programmes require specific experience and skills to work with often hard-to-reach groups in sensitive areas, which can often not be offered through government institutions. The lack of experience in Kuwait is further compounded by a weak civil society, with very few CSOs capable or interested in working in HIV prevention with key populations.

Remedial action: Training and capacity building, including site visits to successful programmes in the MENA region, in the field of a) Technical expertise and skills; and b) Institutional and organisational capacity, especially for the weak civil society. This may include establishing a PLHIV association with international support from PLHIV groups. Additional activities may include site visits to successful programmes in the region, attending international conferences and organising national or regional ones in Kuwait; training and on-the-job technical support.

7. Lack of supportive legal, social and policy environments, including stigma and discrimination – In addition to all the challenges mentioned above, legal and policy frameworks and social norms and values may often not be supportive of specific HIV/AIDS programmes and services. Laws criminalising certain groups or behaviours may hamper effective outreach or may not allow certain interventions, such as opioid substitution therapy, safer injection programmes, condom promotion or life-skills-based HIV education for young people. Similarly, social and religious norms and values may stigmatise HIV-related sexual behaviours and hamper programmes for key populations. In the absence of these supportive environments, none of the above challenges can be effectively addressed.

Remedial action: the creation of supportive environments is complex and typically meets a lot of resistance from different groups. Therefore, HIV programmes need to be culturally and religiously sensitive, and mobilise the active involvement and support of political, community and religious leaders for key interventions. This requires involving them in HIV programmes from the start, in research, programme development and implementation. In addition, lobbying and advocacy strategies need to focus on gaining support from political leaders. Overall, emphasis needs to be placed on norms and values that support effective HIV prevention, care and treatment.

VI. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

Kuwait is high-income country with excellent medical and other infrastructure. In this regard it is not in need of external financial support. However, UN agencies including UNDP and UNESCO are active members of the recently reactivated National AIDS Control Committee, and can play an important role in strengthening the national response to HIV/AIDS through technical assistance.

UNDP may mobilise technical assistance from other UN agencies, such as for the development of a National Strategic Plan (UNAIDS); National M&E Plans (UNAIDS); HIV prevention among key populations (UNAIDS, UNODC); HIV treatment and care, including ART and PMTCT (WHO, UNICEF); HIV education for young people, children, in and out-of-schools (UNFPA, UNICEF, UNESCO); and HIV workplace programmes and employment rights (ILO). To date, this type of technical support has not been given, but if a national strategic plan and operational plan on HIV/AIDS will be developed in 2014 (as planned), this may provide a good context for technical support from UN agencies.

VII. MONITORING AND EVALUATION ENVIRONMENT

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

To date, Kuwait still has no proper ***system*** for monitoring and evaluation of HIV/AIDS, nor has it ever developed a national M&E ***plan*** to systematise the collection, reporting, storage and utilisation of HIV-related data for planning and programming purposes.

Available HIV-related data is mainly based on massive HIV screening among selected population groups and specific settings (see details below), as well as data from clinical monitoring of HIV patients. However, there is no HIV-surveillance system that assesses HIV prevalence among the general population, nor among most-at-risk groups, such as sex workers, MSM and PWID, although PWID are tested to some extent through police, prisons and drug-treatment facilities.

Similarly, no behavioural surveillance studies have ever been conducted, nor any other type of special study in the field of HIV/AIDS. The latest studies conducted date back to 2008 and before, and are primarily clinical studies. There is no national research agenda to prioritise research in the HIV field.

In the virtual absence of HIV-prevention programmes among the general population or key populations, programmatic M&E data is mainly restricted to clinical monitoring of HIV patients. All those enrolled in ART are regularly tested for CD4, viral load and drug resistance, although some 11 percent of ART patients are lost to follow-up each year. Furthermore,

Financial monitoring is poor: most HIV-related expenditures are not earmarked as such, therefore it is extremely difficult to get an accurate overview of expenses made in the context of HIV/AIDS. Most of these costs are for HIV screening, ARV treatment and ART monitoring (laboratory), while very little is spent on other interventions, especially in the field of HIV prevention.

Mass HIV-screening programmes

Kuwait has an extensive screening system, which applies to the following groups:

- Expatriates seeking employment of residency in Kuwait; this mainly includes foreign labour migrants;
- Blood donors;
- Pre-employment screening (nationals and expatriates)
- Pre-marital screening (Law No. 31 was established in 2008 and has been implemented since 2009)
- Food handlers (mainly expatriates)
- Patients admitted to hospitals for invasive procedures and organ transplants
- Prison inmates
- Army and police recruits and national guards
- STI patients
- PWID admitted to the Psychiatry hospital and Addiction clinic
- Others, including people who need AIDS certificates, contacts of HIV patients, foreign students coming on scholarships etc.

In the context of these screening programmes, in 2012 and 2013, a total of **751,999 and 791,320** people were tested respectively; 12% were Kuwaiti nationals, while 88% were non-Kuwaitis.

The largest percentage of people tested (nationals and expatriates) was through screening of expatriates seeking work and residency in Kuwait, which accounted for 45% of all HIV tests in 2012 and 2013. Other large groups tested were food handlers (35% of all HIV tests in both 2012 and 2013); blood transfusion services (10%); pre-employment testing (3%); and premarital testing (3.5%).

As mentioned, ***Kuwaiti nationals*** only represent 12 percent of all HIV tests. On a yearly basis, approximately 8 percent of the Kuwaiti nationals (approximately 90-95,000 per year) are tested for HIV. Among *Kuwaiti nationals,* the largest numbers of people screened for HIV were *blood donors* (accounting for 38-39% of all Kuwaitis tested in 2012 and 2013); *pre-marital* (26-27% of total in 2012 and 2013); and *pre-employment* (18-19% of total in 2012 and 2013) testing.

Clinical monitoring of HIV patients

Clinical monitoring of HIV patients is done in accordance with international standards, i.e. WHO. Patients are regularly followed up through CD4, viral load testing, genotyping, as well as clinical check-ups There are some problems with loss to follow-up and retention rates for 2012 and 2013 were 92.0 (23/25) and 91.7 (11/12) percent respectively.

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

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

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

1) As mentioned, Kuwait has been without an updated National HIV strategy since the late 1980s. Hence there is no national M&E plan for HIV either, and there are very few interventions to be monitored outside ARV treatment.

Therefore, a first key challenge for developing (and eventually implementing) a national M&E plan and system is related to the need to develop an updated National Strategic Plan with a costed Operational Plan that specifies the national priority interventions in the field of HIV/AIDS, which is foreseen for 2014-15. M&E and surveillance will be a priority component for this new NSP.

2) Inaccuracies and gaps in data collection: as mentioned, the current mass HIV screening system is skewed towards testing of *non*-Kuwaitis, while Kuwaiti nationals account for only 12 percent of those tested, with some 8 percent of Kuwaiti nationals s being tested each year.

The existing system does not give an accurate picture of the overall Kuwaiti population, as it mainly focuses on screening blood donors, pre-employment, pre-marital testing, PWIDs and

all military, while there is no systematic data collection among key populations. People with high-HIV-risk behaviours typically screen themselves out for blood donations, while the same applies to pre-marital and pre-employment testing: those who suspect they may be HIV-infected may get tested elsewhere (even abroad) to avoid being identified through premarital testing, as this would have major social implications for the would-be spouse as well as his/her family. Similar self-selection mechanisms may occur for pre-employment testing.

Hence, the number of Kuwaiti nationals found to be HIV-infected through the current screening mechanisms is likely to reflect a considerable *underestimation* of the true number of HIV-infected Kuwaitis.

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

All the same, key populations are present in Kuwait – including sex workers, MSM and PWID – and anecdotal evidence from focus-group discussions and interviews with local experts shows there are considerable high-risk behaviours especially among young men, including unprotected sex with sex workers (abroad), injecting drug use (young men and women) and unprotected anal sex between men and women and among men. The absence of more systematic data collection regarding the locations, population sizes and dynamics of sexual networks and risk behaviours among all these groups leaves the national response to HIV without a compass.

Hence, remedial actions in this area involve the establishment of a system of integrated biological and behavioural surveillance studies, specifically focusing on key populations. Furthermore, the future implementation of confidential VCT centres will promote people to get tested, who would otherwise not easily be found through screening. A research agenda is needed to ensure that priority research topics are identified and systematically addressed.

3) Apart from the gaps in data collection, ***availability and accessibility of data is a challenge***. There is a lack of clear and unified data-collection and –reporting protocols and guidelines, and HIV-related data are scattered and compartmentalised across different units and departments within the MOH. Not all data are adequately reported through the same reporting channels, and the NAP does not have systematic access to all data. E.g. data on pre-marital testing is kept separate from the other HIV-screening data and is difficult to access. In addition, HIV data is often considered sensitive and is therefore not easily published or shared.

Accessibility of data is further hampered by the absence of a ***central database***; e.g. data collection for this GARP report regarding the main HIV statistics and financial data was difficult and requests for information had to be made through different departments with different persons responsible for subsets of data. As said, much of the data was not readily available to the NAP. In addition to these problems with regard to availability and accessibility of available HIV-related data, HIV-related data is not systematically utilised for policy and programme development. This is evidenced by the absence of a national strategic plan since the 1980s. In this context, a priority remedial action to be undertaken in this context is the establishment of a central data base on HIV.

4) The lack of a unified national HIV/AIDS surveillance and M&E system is further compounded by the ***absence of a special M&E unit or dedicated, trained data-***

management staff in the NAP. There has been very limited training in M&E, with most capacity building being offered by multilateral partners such as UNAIDS and WHO.