

COUNTRY PROGRESS REPORT

STATE OF KUWAIT

Reporting period: 1 January 2014 – 31 December 2014

Submission Date: 15 June, 2015

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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 2015 was done 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 process.

The development of the Kuwait Global AIDS Response Progress Report 2015 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 took place through review of policy documents, programme reports, health statistics, health facility reports, 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 Addiction Treatment Centre; the central prison and prison hospital and the Preventive Health Department of the prison system; the Premarital Screening Centre; the main STI Treatment Department; the AIDS Patients Support Group; and UN agencies. In addition, interviews with key informants included men who have sex with men and people who inject drugs. Furthermore, information from focus group discussions with female and male university students held in 2012 and 2014 was used to complement information on sexual behaviours among young people.

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 (National AIDS Office; Legal Section; Head of the Information Department); 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); HIV treatment service providers; National Laboratory; Central Blood Bank; Head of the STI Department; and the Head of the Addiction Treatment Centre. 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 first National Strategic Plan on HIV and AIDS, which is set to be developed in the course of 2015.

After incorporation of all inputs that were received through the data-collection process described above, final data entry was done by the NAP manager and the international 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 2014, a cumulative total of 274 Kuwaiti HIV cases has been reported, 74.5 percent male and 25.5 percent female. In the

reporting period of 1 January till 31 December 2014 22 new Kuwaiti HIV cases were reported (21 male and 1 female).

Most HIV cases are detected through large-scale health-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. In 2014, a total of 884,250 HIV tests were conducted among Kuwaiti and non-Kuwaiti nationals. The vast majority (n=791,280; 89.5%) of these HIV tests was conducted among non-Kuwaitis, mainly in the context of residency permits (including new arrivals and renewals) (53.5%) or food handling (38.9%). However, most Kuwaitis (n=92,970; 10.5%) were tested in the context of blood donations (39.7%), pre-marital (25.2%) or pre-employment testing (24.6%). In 2014 screening of antenatal care attendees (pregnant women) had not yet been introduced; however, as of April 2015, all ANC attendees will be screened for HIV and other infections and health conditions.

While no systematic 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 interviews with 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 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. Changing sexual norms and practices, injecting drug use, as well as international travel and increased exposure to other cultures place young people – especially young men, but increasingly also young women – increasingly at risk of HIV infection. Furthermore, the large population of expatriate workers who make up more than half 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 2014, particularly through the continued active involvement of the National AIDS Control Committee, which was reactivated only in 2012 (see *next*). Overall, however, in 2014 political support for HIV/AIDS continued to be limited. 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*, a positive achievement was the active engagement of the National AIDS Control Committee in policy and programmatic discussions and 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, in 2014 the National AIDS Programme (NAP) has been active in providing overall coordination, policy guidance and promotion of key HIV education activities, but in 2014 continued to receive limited support in terms of financial and human resources and hence needs urgent strengthening.

- In terms of *policy and programme development*, NAP has been without an updated National Strategic Plan (NSP) on HIV and AIDS and an associated costed Operational Plan (OP) since the late 1980s, and this situation has continued in 2014, although the development of an NSP and OP was already planned three years ago. On the positive side, in 2014 the MOH leadership and the National AIDS Control Committee have shown firm commitment to support the development an NSP in 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 evident in the limited *allocation of financial and human resources*. The NAP has continued to be under-resourced in 2014, 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 (NSP), 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 (89.5% 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. In 2014, the National AIDS Control Committee has successfully advocated for the introduction of *opt-out* provider-initiated testing and counselling for all pregnant women attending antenatal care and screening of STI patients. Implementation of these new measures is expected to start in March 2015.

More focused HIV-prevention activities have taken place on a limited scale, in the absence of funding allocations and work plans. In 2014, 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 2014, like in previous years: 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. The introduction of Opioid Substitution Therapy (OST) with *suboxone* (a combination of buprenorphine and naloxone) which was planned to be implemented in 2014, has been postponed till September 2015; 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 2014. While condoms are widely available for contraception among married couples, condom promotion for HIV-prevention purposes has not been implemented in 2014; but could be considered as part of future targeted programmes for key populations. This will require in-depth discussion of the benefits vs. the prevailing objections to condom promotion.

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. The latter may need to be revised, as people living with HIV who are successfully enrolled in ART are in principle fit to continue their work rather than being retired on medical grounds. By the end of 2014, 248 Kuwaiti patients were on ART. In 2014, the recently established AIDS Patients Support Group met a limited number of times, but on an irregular basis. Actively involving 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 and prefer to remain anonymous. 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.

(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	<p>NO DATA ON INDICATOR – The only KABP study on HIV among young people was conducted as far back as 1995; since then, no systematic studies have been conducted to assess the percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. While there is no accurate data on HIV knowledge in this age group, the results from focus group discussions held in the context of GARP reporting in 2012 and 2014 suggest that overall knowledge on HIV transmission routes is relatively high, but does not translate in protective behaviours, as a relatively large proportion of young men reported engaging in high-risk sexual behaviours.</p> <p>In 2014, a short questionnaire on HIV-related knowledge was given to approx. 100 students, of whom 34 responded. The results revealed considerable levels of misconceptions on HIV transmission and other aspects of HIV. E.g. 17.7% thought HIV could be transmitted by shaking hands with an infected person; 26.5% could not correctly identify key populations at higher HIV risk; 67.7% did not know how HIV transmission from mother to child could be prevented; 23.5% did not know common complications of HIV infection. These results highlight the need to conduct more systematic research on HIV awareness and knowledge and strengthen HIV education among young people and other population groups.</p>
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	<p>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, suggested 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.</p> <p>In addition, anecdotal evidence from interviews with key informants held in 2015 (in the context of the 2014 GARP report) confirmed that sexual debut of young men and women often takes place at young ages, as early as 12-14 years of age. However, no accurate data is available on the proportion of men and women who have sex before the age of 15.</p>
1.3	Percentage of women	NO DATA ON INDICATOR – In the absence of any data from surveys or other

NO.	INDICATOR	REPORTED DATA AND COMMENTS
	and men aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	<p>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 and female university students (18-25) held in the context of data collection for previous GARP reports, revealed the existence of high-risk sexual behaviours with multiple partners, mainly unprotected sex with foreign sex workers, particularly during trips abroad. These behaviours were reportedly quite common for young Kuwaiti males. In addition, respondents mentioned the presence of commercial sex in Kuwait as well. Interviews with key informants held in 2015 confirmed these findings regarding sex with multiple partners.</p> <p>These findings highlight the importance of conducting more systematic research among young people and adults regarding multiple sexual partnerships.</p>
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	<p>NO DATA ON INDICATOR – In the absence of any data from systematic surveys or other studies, it is not possible to provide accurate data 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 previous GARP reports (2013-2014), revealed the presence of many high-risk sexual behaviours with multiple partners, mainly foreign sex workers, particularly during trips abroad to South-East Asia or the Middle East. These behaviours were reportedly quite common for young Kuwaiti males. In addition, respondents mentioned the presence of commercial sex in Kuwait as well, mainly with foreign sex workers, but also local sex workers, in particular stateless people. 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.</p> <p>Interviews with key informants in 2015 confirmed the presence of sexual contacts of Kuwaiti men with multiple partners, but condom use was reported to be relatively high.</p> <p>These findings from focus group discussions and key informant interviews highlight the importance of more systematic research among young people and adults regarding condom use during sex with non-regular partners before or outside marriage.</p>
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	<p>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 in 2014 voluntary counselling and testing centres (VCT) were still not available in Kuwait. Efforts have been underway for many years now to introduce VCT using rapid test kits, but its approval is hampered by the fact that by law, non-Kuwaitis with HIV have to leave the country.</p> <p>However, many people are tested for HIV each year, both Kuwaiti and non-Kuwaiti. In 2014, a total of 884,250 HIV tests were conducted, most among non-Kuwaiti citizens: 791,280 HIV tests (89.5%) were done among foreigners, mainly in the context of renewal of work or residency permits, or among specific categories of employees (e.g. food handlers). Furthermore, 92,970 (10.5%) HIV tests were done among Kuwaiti citizens, mainly in the context of premarital HIV screening (23,479 tests), pre-employment testing (15,566 tests), and blood donations (36,991 tests). Post-test counselling is usually provided in case of positive tests results and also for some negative test results if they come for the test on their own, given the very low numbers of HIV found. In 2014, a total of 447 positive</p>

NO.	INDICATOR	REPORTED DATA AND COMMENTS
		tests results were found, 22 (4.9%) among Kuwaitis and 425 (95.1%) among non-Kuwaiti citizens.
1.6	Percentage of young people aged 15–24 who are living with HIV”.	<p>NO DATA ON INDICATOR – Measurement of this indicator is done through HIV testing among antenatal clinic (ANC) attendees (aged 15-24). In 2014, however, no HIV testing was in place for ANC attendees. HIV testing among ANC attendees will only be introduced in the course of 2015, based on Ministerial Decree #46, which stipulates screening of ANC attendees for HIV and other STIs.</p> <p>Hence, in the absence of HIV testing among ANC attendees or HIV studies 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”.</p> <p>However, the results of large-scale screening among more than 92,970 Kuwaiti citizens in 2014 revealed only 22 new HIV cases (21 male and 1 female): 19 (86.4%) were above 25 years of age; and only 3 (13.6%) were 15-24 years old, while no cases under 15 years of age were found. These figures indicate that overall HIV prevalence is still very low.</p>
1.7	Percentage of sex workers reached with HIV prevention programmes (condom distribution; HIV testing)	<p>NO DATA ON INDICATOR – To date, no prevention programmes or services for sex workers have been available in Kuwait. Sex work is illegal and punishable by law, which makes it very difficult to offer programmes for sex workers.</p> <p>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 in 2012 and 2014 among male Kuwaiti university students, interviews with migrant workers in 2014 and with key informants in 2015, as well as press reports reveal that sex work exists in Kuwait, and is in part linked to human trafficking. According to key informants consulted in 2014 and 2015, most sex workers are foreign citizens. However, local residents are also reported to be active in sex work, including for MSM. The illegal character, extreme social rejection, and the possible relation to organised crime and human trafficking make it extremely challenging to reach sex workers with HIV-prevention programmes.</p>
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	<p>NO DATA ON INDICATOR – As mentioned in the context of the previous indicator (1.7), sex work is present in Kuwait, but 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 with male university students and interviews with key informants held in the context of this and previous GARP reports indicates that condom use with sex workers depends on the client, and is based on his assessment of the overall perceived “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. 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. It should be noted that most contacts of Kuwaiti men with sex workers are reported to take place outside Kuwait.</p>
1.9	Percentage of sex workers who received an HIV test in the past 12 months and know their results	<p>NO DATA ON INDICATOR – As mentioned in the context of the previous indicators (1.7 and 1.8), although sex work in Kuwait is present, it is extremely hidden and no HIV-prevention programmes for sex workers are available. Reportedly, most sex workers in Kuwait are foreign citizens.</p> <p>Currently, most HIV testing takes place in the context of large-scale screening programmes for foreign citizens (e.g. for renewal of residency or work permits) as well as for Kuwaiti citizens (e.g. premarital and pre-employment testing and blood donation in blood bank). To date, no voluntary counselling and testing (VCT) services are available in Kuwait, nor have rapid HIV test kits been officially allowed on the market. Thus, there are few options to offer anonymous and confidential</p>

NO.	INDICATOR	REPORTED DATA AND COMMENTS
		<p>HIV testing to key populations such as people having heterosexual acts abroad. Efforts have been going on for several years to introduce VCT centres and rapid testing. However, even if voluntary HIV testing services are available, it is unlikely that sex workers could be easily reached, as most are foreign women, and any foreign person (outside GCC) found to be HIV-positive has to be deported from Kuwait by law with the exception if they are married or related to Kuwaiti nationals.</p> <p>In September 2014, the Kuwait Ministry of Health participated in the 61st session of the WHO Regional Committee for the Eastern Mediterranean, and officially committed itself to data collection for the “Eastern Mediterranean Region Framework for Health Information Systems and Core Indicators for Monitoring Health Situation and Health System Performance 2014”. This framework comprises indicators on key populations, including on HIV testing among sex workers. Hence, it is expected that more HIV data will be available on sex workers and other key populations in Kuwait in the coming years.</p>
1.10	Percentage of sex workers who are living with HIV	<p>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. 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 are expatriates, 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 arrived or been trafficked illegally into the country and may therefore not have been tested for HIV.</p> <p>In September 2014, the Kuwait Ministry of Health participated in the 61st session of the WHO Regional Committee for the Eastern Mediterranean, and officially committed itself to data collection for the “Eastern Mediterranean Region Framework for Health Information Systems and Core Indicators for Monitoring Health Situation and Health System Performance 2014”. This framework comprises indicators on key populations, including sex workers. Hence, it is expected that more HIV data will be available on sex workers and other key populations in Kuwait in the coming years.</p>
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	<p>NO DATA ON INDICATOR – To date, no prevention programmes or men who have sex with men (MSM) have been available in Kuwait. Homosexuality is illegal and MSM keep a very low profile, which makes it very difficult to offer HIV-prevention programmes for MSM, especially by government institutions.</p> <p>Overall, there is very little information available on MSM in Kuwait, as no qualitative research, mapping or size estimations, or any other type of study or survey has ever been conducted among MSM. MSM and homosexuality are highly rejected by Kuwaiti society and surrounded by strong stigma and discrimination. Hence, 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 planned 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 services. Effective outreach to MSM will depend on peer-education approaches, and requires partnerships between the National AIDS Programme and individual MSM willing to collaborate on this. Programmes will need to primarily build on the use of social media, considering that these are the main channel for MSM to communicate and meet each other.</p>
1.12	Percentage of men	NO DATA ON INDICATOR – As mentioned in the context of indicator 1.11, although

NO.	INDICATOR	REPORTED DATA AND COMMENTS
	reporting the use of a condom the last time they had anal sex with a male partner	<p>MSM and homosexuality exist in Kuwait, 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”.</p> <p>However, interviews with key informants in the context of this GARP report reveal that Kuwait has an active MSM community, including with heterosexual men engaging in MSM contacts. Contacts are mostly made through dating apps and social media; in addition there are cruising areas and other meeting places known to MSM. Condom use is reported to be the exception rather than the rule. This may be due to limited awareness and knowledge on HIV transmission and prevailing misconceptions. In addition to same-sex contacts between MSM, male sex workers are reported to offer services to MSM in Kuwait.</p>
1.13	Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results	<p>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, voluntary counselling and testing services are not available for the general population in Kuwait, let alone special HIV testing services 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 reported HIV cases are attributed to heterosexual contacts, while almost no cases are reported as due to MSM contacts. Out of 22 new reported HIV cases among Kuwaiti nationals in 2014, none were attributed to MSM contacts. Rather than the actual percentage of MSM transmission, this reflects the extreme stigma associated with MSM behaviour. Hence, the true role of MSM contacts in HIV transmission is likely to be underestimated.</p> <p>In September 2014, the Kuwait Ministry of Health participated in the 61st session of the WHO Regional Committee for the Eastern Mediterranean, and officially committed itself to data collection for the “Eastern Mediterranean Region Framework for Health Information Systems and Core Indicators for Monitoring Health Situation and Health System Performance 2014”. This framework comprises indicators on key populations, including MSM. Hence, it is expected that more HIV data will be available on MSM and other key populations in Kuwait in the coming years.</p>
1.14	Percentage of men who have sex with men who are living with HIV	<p>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”. However, interviews with key MSM informants in Kuwait reveal that MSM often engage in unprotected sex with many different sex partners. This includes contacts with male sex workers in Kuwait. Furthermore, many Kuwaiti MSM have the financial means to travel in and outside the region, and 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 Kuwait, the reported risk behaviours indicate the potential for a rapid spread of HIV within the MSM community.</p> <p>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. In September 2014, the Kuwait Ministry of Health participated in the 61st session of the WHO Regional Committee for the Eastern</p>

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		<p>Mediterranean, and officially committed itself to data collection for the “Eastern Mediterranean Region Framework for Health Information Systems and Core Indicators for Monitoring Health Situation and Health System Performance 2014”. This framework comprises indicators on key populations, including MSM. Hence, it is expected that more HIV data will be available on MSM and other key populations in Kuwait in the coming years.</p>
		PEOPLE WHO INJECT DRUGS (PWID)
2.1	Number of Syringes distributed per person who injects drugs per year by Needle and Syringe Programmes	<p>NO DATA ON INDICATOR – No prevention programmes involving needle-and-syringe exchange (NSEP) 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 Treatment Centre and include detoxification and rehabilitation services. In 2014, a total of 1,492 patients were admitted to the Addiction Centre (1,417 male and 75 female).</p> <p>In 2014, opioid substitution therapy (OST) was not yet available, but OST services are expected to start in September 2015 using <i>suboxone</i>. However, NSEP programmes are more controversial in Kuwait and are not expected to be introduced any time soon. At the same time, syringes and needles are not easily available on the market, hence sharing of injecting equipment continues to be common.</p> <p>The current services are insufficient to meet the needs of PWID. A thorough discussion and revision of the policies, programmes and services for (injecting) drug users is urgently 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 Addiction Centre is often seen as a temporary refuge from law-enforcement agencies, and it cannot keep most patients against their will. As a result, 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. Out of 1,492 patients admitted in 2014, 1,186 (79.5%) were repeat patients. A problem is that the Addiction Centre 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 total women. Heroin is the second-most common drug among clients of the Addiction Centre, and 80% inject the drug.</p> <p>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. In recent years, the majority of drug users have been shifting towards crystal meth, which is usually inhaled and cheap. However, most people are poly-drug users, and heroin remains the number 1 drug, with most drug users using it by the age of 20.</p> <p>Injecting drug use typically takes place in social groups, including within the family: it is common for PWID to have brothers, uncles or even parents who also use drugs, which makes it extremely difficult to quit the habit. While most PWID start sniffing heroin initially, they soon move to injection. Sharing of injection equipment is common, as evidenced by high prevalence rates of Hepatitis C infection among PWID: out of 98 patients tested for hepatitis between May 2013 and December 2014, 53 (54%) were positive for HCV and 4 for HBV and no HIV cases among them. Compounding the needle-exchange problem is the fact that many PWID are imprisoned, where access to syringes is difficult: there is anecdotal evidence of sharing of injection equipment in prisons, which may contribute to the future spread of HIV among PWID.</p>
2.2	Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse	<p>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, interviews with key informants (staff and patients at drug treatment services) reveal that high-risk sex behaviours – including unprotected sex with sex workers abroad – are common, especially</p>

NO.	INDICATOR	REPORTED DATA AND COMMENTS
		<p>among young men. Although there is no direct evidence about condom use among (male) PWID, results from studies in the Middle East reveal that PWID are more likely to engage in unprotected sex with multiple partners than the general population. 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.</p> <p>In September 2014, the Kuwait Ministry of Health participated in the 61st session of the WHO Regional Committee for the Eastern Mediterranean, and officially committed itself to data collection for the <i>“Eastern Mediterranean Region Framework for Health Information Systems and Core Indicators for Monitoring Health Situation and Health System Performance 2014”</i>. This framework comprises indicators on key populations, including PWID. Hence, it is expected that more HIV data will be available on PWID and other key populations in Kuwait in the coming years.</p>
2.3	Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected	<p>NO DATA ON INDICATOR – In the absence of 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 in the context of indicator 2.1, reports from the Addiction Treatment Centre reveal that heroin and other injectable drugs are commonly used in groups, and that sharing of injection equipment is common; this is exacerbated by the fact that clean injection equipment is not easily available from pharmacies or other places. Sharing of injection equipment 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. 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.</p> <p>In September 2014, the Kuwait Ministry of Health participated in the 61st session of the WHO Regional Committee for the Eastern Mediterranean, and officially committed itself to data collection for the <i>“Eastern Mediterranean Region Framework for Health Information Systems and Core Indicators for Monitoring Health Situation and Health System Performance 2014”</i>. This framework comprises indicators on key populations, including PWID. Hence, it is expected that more HIV data will be available on PWID and other key populations in Kuwait in the coming years.</p>
2.4	Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results	<p>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 <i>“Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results”</i>. All PWID (and other drug users) are tested for HIV when they are arrested and imprisoned, but not if they are admitted to the Addiction Treatment Centre, and it is unknown what percentage of the total PWID population in Kuwait they represent. In 2014, a total of 1,321 PWID were tested for HIV, but no HIV-positive cases were found.</p> <p>The HIV-screening practices for PWID 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 PWIDs 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.</p> <p>In September 2014, the Kuwait Ministry of Health participated in the 61st session of the WHO Regional Committee for the Eastern Mediterranean, and officially committed itself to data collection for the <i>“Eastern Mediterranean Region Framework for Health Information Systems and Core Indicators for Monitoring Health Situation and Health System Performance 2014”</i>. This framework</p>

NO.	INDICATOR	REPORTED DATA AND COMMENTS
		comprises indicators on key populations, including PWID. Hence, it is expected that more HIV data will be available on PWID and other key populations in Kuwait in the coming years.
2.5	Percentage of people who inject drugs who are living with HIV	<p>NO DATA ON INDICATOR – To date, no HIV sero-surveillance studies have been conducted among PWID in Kuwait. PWID are more frequently seen in HIV-screening programmes, e.g. on admission to prisons or drug-treatment facilities. While these data from screening programmes among PWID reveal high levels of Hepatitis B and C, to date they have shown few HIV cases: no HIV cases were found among the 1,321 PWID tested in 2014; similarly, 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. Therefore, in the absence of sero-surveys among PWID, no data is available to provide any insight into the “percentage of people who inject drugs who are living with HIV”. However, 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 HCV rates among PWID, show that the risk of a rapid spread of HIV in the near future is real. Experiences from other countries in the Middle East with high HIV rates among PWID have shown that there is no room for complacency in the face of a looming HIV cases among PWID.</p> <p>In September 2014, the Kuwait Ministry of Health participated in the 61st session of the WHO Regional Committee for the Eastern Mediterranean, and officially committed itself to data collection for the “Eastern Mediterranean Region Framework for Health Information Systems and Core Indicators for Monitoring Health Situation and Health System Performance 2014”. This framework comprises indicators on key populations, including PWID. Hence, it is expected that more HIV data will be available on PWID and other key populations in Kuwait in the coming years.</p>
		PMTCT
3.1	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	<p>NO DATA ON INDICATOR – In the absence of estimations for the total number of HIV-positive pregnant women within the past 12 months, accurate data on the “Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission” is not available, although their number is expected to be extremely low.</p> <p>No sentinel surveillance studies have been conducted among ANC attendees in Kuwait, nor were they routinely screened for HIV in 2014. Hence, there is no accurate information on the total number of HIV-infected pregnant women. HIV testing will be introduced as part of screening of antenatal care attendees as of April 2015, in accordance with Decree #46 which became effective in March 2015. In 2014, all pregnant women known to be HIV-positive (total of 4) were followed up and received antiretroviral treatment throughout their pregnancy; in addition, prophylactic treatment was given to all children born to HIV-positive women.</p>
3.1a	Percentage of women living with HIV who are provided with antiretroviral medicines for themselves or their infants	This indicator is irrelevant in the Kuwaiti context: all women known to be HIV-infected have access to ART, regardless of their pregnancy and abstain from breastfeeding.

NO.	INDICATOR	REPORTED DATA AND COMMENTS
	during the breast-feeding period	
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	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 infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth” is not available. In 2014, ANC attendees were not yet routinely screened for HIV, although HIV testing for ANC women will be introduced in March 2015. However, there is 100% coverage with ART of mothers KNOWN to be HIV-infected. All women <i>known</i> to be HIV-infected and on ART who became pregnant in the 2014 period (total of 4) were treated accordingly and their newborn infants received a virological test for HIV at birth and after 3 months and after 6 months. None of the children born to known HIV-infected women in 2014 were infected.
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 <i>known</i> to be HIV-infected (all of whom were on ART) were followed and none were HIV-positive. In 2014, ANC attendees were not yet routinely screened for HIV, although HIV testing for ANC women will be introduced in March 2015. However, there is 100% coverage with ART of mothers KNOWN to be HIV-infected. All women <i>known</i> to be HIV-infected and on ART who became pregnant in the 2014 period (total of 4) were treated accordingly: none of the children born to these known HIV-infected women in 2014 were infected. However, in the absence of HIV screening of ANC attendees in 2014, some 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.
ANTIRETROVIRAL TREATMENT		
4.1	Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV	NO DATA ON INDICATOR – In the absence of estimations of the number of people living with HIV (PLHIV) in Kuwait, there is no accurate data on the denominator. Hence, no value can be provided on the “Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV”. Regarding the numerator: by the end of 2014, a total of 248 PLHIV were on antiretroviral treatment (ART), including 4 children under 10 years of age. Among the 244 patients older than 10 years, 229 were on first-line treatment; 13 on second line; and 2 on third line. All under-10 years patients were on first-line treatment. The total number of reported HIV cases among Kuwaiti nationals since the beginning of registration till the end of 2014 (who are still alive) is 274. As mentioned, 248 (90.5%) of them are currently on ART, while the remaining 26 people refuse to take treatment although it is offered to them free of charge.
4.2a	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	In 2013, 34 new HIV patients were reported; all were enrolled in ART. After 12 months, 2 patients had discontinued their treatment; thus the 12-month retention rate in 2014 was 94.1 percent (32/34).
TB-HIV CO-INFECTION		
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	NO DATA ON INDICATOR – All TB patients are screened for HIV and get treatment if positive and all HIV positive cases are screened for TB and receive treatment. However, in 2014 no cases of TB were found among newly diagnosed HIV patients.
AIDS SPENDING		
6.1	Domestic and	The total cost of HIV/AIDS-specific spending in 2014 was KWD 6,396,534

NO.	INDICATOR	REPORTED DATA AND COMMENTS
	international AIDS spending by categories and financing sources	(approximately USD 22,365,504) However, this is based on the following available financial information: <ul style="list-style-type: none"> • HIV screening & testing: KWD 3,697,174 (USD 12,927,181) • ART drugs: KWD 1,059,260 (USD 3,703,706) • Staffing costs: KWD 1,640,100 (USD 5,734,615) Additional HIV/AIDS-related financial data for education, communication; HIV testing by the Faculty of Medicine WHO Collaborating Centre (Min. of Education); and in the context of drug treatment centres is not available. Hence, the total HIV/AIDS-related spending is higher than the KWD 6,396,534 that can be reported.
		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 – No data is available on intimate partner violence in Kuwait.
8.1	Percentage of women and men aged 15-49 who report discriminatory attitudes towards people living with HIV	NO DATA ON INDICATOR – To date, no systematic surveys have been conducted to assess discriminatory attitudes towards PLHIV in Kuwait. However, HIV-related stigma and discrimination are widespread and most PLHIV will only disclose their HIV status to their partner, with most not even informing their close family members. Negative attitudes to PLHIV are closely related to the taboo on extramarital sex and/or homosexuality, and PLHIV are commonly blamed for their HIV infection, including by health-care professionals. Furthermore, there are many misconceptions regarding the risk of HIV transmission among health-care professionals.
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. Hence, this indicator is irrelevant.
10.2	Proportion of the poorest households who received external economic support in the past 3 months	IRRELEVANT – The indicator is not relevant for context of Kuwait, as it is a high-income country with very few HIV cases, good social services and high socio-economic status of most people.

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 2014, a cumulative total of 274 Kuwaiti HIV cases has been reported: 204 men (74.5%) and 70 women (25.5%). In 2014, 22 new Kuwaiti cases were identified (see Table 1), considerably less than in 2013. However, there is no clear trend over time and data need to be interpreted with caution, as they are based on results from screening programmes that do not necessarily provide an accurate picture of the true HIV trends.

Table 1. Number of reported Kuwaiti HIV cases, 2009-2014

	2009	2010	2011	2012	2013	2014
MALE	8	7	21	11	24	21
FEMALE	4	4	4	1	10	1
TOTAL	12	11	25	12	34	22

HIV statistics for Kuwaiti and non-Kuwaiti nationals are based on large-scale screening of selected groups. To date, there has been no HIV screening of women attending antenatal care (ANC), but HIV testing of ANC women will be introduced in April 2015. All foreign nationals 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 three 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 2014, a total of 884,250 HIV tests were conducted among Kuwaiti and non-Kuwaiti nationals: 791,280 tests (89.5%) among foreign nationals and 92,970 (10.5%) among Kuwaiti nationals.

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 2014, a total of 425 HIV cases was found among expatriates.

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 2014 and the number of positive test results per category.

The table shows that the vast majority (n=791,280; 88%) of all HIV tests is conducted among non-Kuwaiti nationals, mainly in the context of expatriate residency permits (n=423,600; 53.5%) or for people handling food (n=307,930; 38.9%). However, most Kuwaiti nationals are tested in the context of blood donations (n=36,991; 39.8%), pre-marital (n=23,479; 25.3%) or pre-employment testing (n=15,566; 16.7%).

Table 2: Numbers of Kuwaiti & Non-Kuwaitis tested for HIV and number of HIV-positive cases, 2014

	HIV TESTING CATEGORIES	# Kuwaiti tested	# Non-Kuwaiti tested	TOTAL No. tested	# HIV+ Kuwaiti	HIV+ Non-Kuwaiti	TOTAL No. HIV+	Overall HIV %
1	Expatriates	0	423.600	423.600	0	368	368	0,087%
2	Blood bank	36.991	40.149	77.140	4	2	6	0,008%
3	Premarital	23.479	2.546	26.025	3	0	3	0,012%
4	Pre Employment	15.566	7.368	22.934	1	0	1	0,004%
5	Food handlers	1.654	307.930	309.584	0	20	20	0,006%
6	Drug users	419	902	1.321	0	0	0	0,000%
7	Hospitals	1.605	2.409	4.014	10	30	40	0,997%
9	Army & Police	6.180	3.454	9.634	3	0	3	0,031%
10	Prisons	562	1.078	1.640	1	5	6	0,366%
11	Other	6.514	1.844	8.358	0	0	0	0,000%
	TOTAL	92.970	791.280	884.250	22	425	447	0,051%

In 2014, a total of 447 HIV cases was officially reported: 22 among Kuwaiti nationals and 425 among non-Kuwaiti nationals. This indicates that the overall HIV-infection rate is still extremely low, at 0.05% of all people tested, and 0.02% of all Kuwaiti nationals tested. However, this data needs to be interpreted with great caution, as the persons tested are not necessarily representative of the total Kuwaiti and non-Kuwaiti population. In addition, no accurate HIV data is available for key populations: while 419 drug users were tested in 2014, these included injecting and non-injecting drug users who were admitted to the Addiction Treatment Centre: this group is unlikely to be representative of the total population of people who inject drugs (PWID), hence no conclusions regarding the HIV-prevalence rate among PWID can be derived from these figures. In addition, no data is available on HIV among men who have sex with men (MSM) or sex workers.

Most of the 22 Kuwaiti HIV cases were identified in hospitals (n=10, 45.5% of all Kuwaiti cases), while others were identified in blood banks (n=4; 18.2%), premarital testing (n=3; 13.6%), uniformed services (n=3; 13.6%) and one case in pre-employment testing and in prisons each. Among non-Kuwaiti nationals, most of the 425 HIV-positive cases were found through testing for residency permits (n=368; 86.6% of all non-Kuwaiti cases), in hospitals (n=30; 7.1%), among food handlers (n=20; 4.7%) or prisons (n=5; 1.2%), and 2 cases in blood banks.

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 HIV cases, and the overall HIV prevalence rate 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 key populations, such as sex workers and their clients, MSM and people who inject drugs (PWID) are typically under-represented. In the absence of VCT centres or special programmes for key populations, it is not easy for persons at higher risk to get information about their HIV status anonymously, although their HIV test result is kept in privacy and it is confidential by law. In addition, persons who suspect they may have a higher risk of HIV infection (e.g. due to engaging in high-risk sex), may avoid being screened through the existing mass-screening programmes, out of fear of HIV-related stigma and discrimination. The National AIDS Control Committee, which was reactivated in 2012, is

currently looking into the possibility of introducing voluntary counselling and testing centres and the introduction of rapid HIV test kits.

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 a considerable number of Kuwaiti nationals with HIV may be missed.

HIV risks and vulnerabilities among key and other vulnerable populations

As mentioned above, the mass screening of foreigners and certain categories of Kuwaiti nationals (in 2014, almost 8% of the total Kuwaiti population was tested for HIV) does not provide an accurate picture of the HIV epidemic in the general Kuwaiti population. It gives an even less reliable picture of HIV among key 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 network dynamics and risk behaviours of these groups, which makes it very difficult to assess the HIV risks among these key populations, or among vulnerable groups such as young people.

Behavioural risks among young people

Although no formal studies among young people in Kuwait have been conducted to date, anecdotal evidence from focus group discussions with young people and interviews with key informants reveals that sexual behavioural patterns among young people in Kuwait have been 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 in 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 in those years suggested 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, young men are also reported to 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 the 2012-2014 period are found among men above the age of 25, approximately 15 percent of all new cases among Kuwaiti citizens in this period were 15-24 years old. In 2014, 82 percent of the 22 newly reported HIV infections were among males above 25 years of age; however, three HIV cases (13.6%) were among men 15-24 years. These may be associated with the unprotected sex behaviours described above.

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.

Sexually transmitted infections

In addition to the data on reported HIV cases, data on sexually transmitted infections (STIs) among Kuwaiti nationals provide some insight into the presence of unprotected sex with multiple sex partners. Table 3 shows the incidence of the most frequent STIs in Kuwait in the 2011-2014 period.

Table 3: Comparison of the Number of STI cases between years 2011 to 2014
(STI Department, MOH, Kuwait City, 2014)

	2011			2012			2013			2014		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Syphilis	10	2	12	7	1	8	7	1	8	5	0	5
Chancroid	32	9	41	49	15	64	31	8	39	37	11	48
HSV-2	52	28	80	74	26	100	58	32	90	50	29	79
Gonorrhoea	925	14	939	819	25	844	1089	13	1102	884	33	917
Chlamydia	994	33	1027	955	36	991	972	29	1001	1025	46	1071
Trichomoniasis	3	34	37	4	42	46	2	30	32	4	57	61
Venereal warts	114	26	140	105	37	142	140	25	165	119	34	153
Hepatitis C	2	1	3	5	0	5	1	0	1	2	0	2
Total	2132	147	2279	2018	182	2200	2300	138	2438	2126	210	2336

The data show that STIs are much more frequent among men than women, with men representing between 91.0 and 94.3 percent of all STI cases in the 4-year period of 2011-

2014. In 2014, the most common STIs were chlamydia (45.8% of all STI cases) and gonorrhoea (39.3%). Anecdotal evidence from an interview with the chief STI specialist in early 2015 reveals that there are two notable peaks in the age distribution of STIs: the first is in the 12-16 year age group; and the second peak is found in the 28-40 year age group. The presence of STIs in the first (young) age group may reflect young people's involvement in the high-risk sexual behaviours described above, which include sexual experimenting with sex workers in neighbouring countries, as well as with multiple sex partners in Kuwait.

HIV risks among female sex workers

The results from focus group discussions with male and female university students in 2012 and 2014, as well as from interviews with key informants (including leading health professionals) in 2015, reveal that young men visit sex workers abroad, but also show that sex work is present in Kuwait. Individual interviews with migrant workers in 2014 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 who engage in sex work, it is extremely hidden and no HIV-prevention programmes are available for these women or their clients. 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 entered the country illegally and may therefore not have been tested for HIV. However, commercial sex is also reported to be offered by local women.

The results from focus group discussions with male university students indicate 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. In 2014, no cases were reported among MSM. However, due to the extreme stigma regarding homosexuality, the actual number of HIV infections through same-sex contacts is likely to be underestimated.

Anecdotal evidence from an in-depth interview with an MSM in Kuwait City in 2015 provides an insight into the MSM scene in the country. A distinction is made between homosexual *identity* (“being gay”) on the one hand and MSM *behaviour* on the other hand: not all men engaging in sex with other men are homosexual: heterosexual men may also have sex with

other men. In this regard a distinction is also made between the so-called “active” (penetrative) partner and the “passive” (receptive) partner: most MSM who do not identify themselves as homosexual will only take on the “active” role, while the “passive” role is associated with the female gender. This has important implications for HIV prevention, as most non-homosexual men who engage in MSM behaviour are likely to have female sex partners as well.

The MSM scene in Kuwait is largely “underground”: while there are certain cruising and meeting areas for MSM, most contacts are made via cell-phone dating apps targeting MSM, such as “*scruff*” and “*grindr*”. These apps are safer and more difficult to control than MSM websites. These apps are also used by male sex workers – both Kuwaiti and non-Kuwaiti – to offer their services. Meeting areas include certain beaches, parking lots, massage parlours and rented apartments. In addition, “invitation only” MSM parties allow people to meet other men.

Condom use is reported to be the exception. While general awareness of HIV may be high, specific knowledge on HIV transmission and prevention is not adequate, and there are many misconceptions. In addition, most MSM do not think of HIV risks, and the overall risk perception is low.

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 region also included respondents from Kuwait: 64 percent 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 percent “always safe sex” was most likely 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.

Research and experiences in other countries in the Middle East and North Africa reveal that most MSM try to hide their sexual orientation and preferences, and a considerable proportion may 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 (see above), 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.

While there is no conclusive evidence of HIV rates among MSM in the region, these risk behaviours indicate the potential for the further 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, socio-anthropological and bio-behavioural 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 Treatment Centre in Kuwait City report that injection

drug use has been increasing, and has become common. Reasons mentioned for this increase include the easy availability of drugs, financial means and time. Experts of the Addiction Treatment Centre report a trend of an increasing number of new drug users among students – especially those who have studied abroad for some time – and higher levels of education.

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 Addiction Treatment Centre (ATC) of the Kuwait Centre for Mental Health. The ATC has some 6,000-7,000 active files of drug users, with approximately 60 percent (approx. 4,000) injecting drugs. ATC experts estimate that the actual total number of drug users may be three times higher than those seen at the ATC; hence there may be some 20,000 drug users, of whom an estimated 12,000 inject drugs.

While the data from screening programmes among PWID reveal high levels of Hepatitis C (approximately 60% of PWID is HCV-infected), to date they have shown few HIV cases: *no new HIV cases* were found among PWID in 2014, nor in the 2012-2013 reporting period among a total of 419 Kuwaiti and 902 non-Kuwaiti drug users tested. Currently, three patients at the ATC are HIV-positive (old cases). 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 drug-treatment 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. ATC 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 ATC, 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. While *opioid substitution therapy* with *suboxone* has recently been allowed and is expected to start in September 2015, *needle-and-syringe-exchange programmes* are not available in Kuwait, and are not expected to be introduced any time soon.

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 data on 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, socio-anthropological and bio-behavioural research.

III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

1. National Commitment

In terms of national commitment, compared to previous years, Kuwait has seen some progress in 2014, with increased political support and leadership. This 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 continued active functioning of the Kuwaiti National AIDS Control Committee (KNACC) as a multisectorial policy body with the mandate to provide overall coordination and follow-up of the national response. The KNACC was reactivated in 2013, and meetings have continued in 2014, with discussions focusing on the introduction of voluntary counselling and testing, and the use of rapid testing. The membership of the KNACC includes technical people from Ministries, governmental facilities and UN agencies, and the KNACC has been receiving high-level political support from the Assistant Undersecretary of Public Health. However, 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 in 2014 has continued to be the lack of a national strategic plan on HIV and AIDS, which was already mentioned in the last two GARP Reports. 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 no longer available. In the absence of an updated NSP there are also no operational plans, M&E frameworks or budgets. The lack of an updated NSP since the 1980s reflects the limited attention that HIV/AIDS has been receiving for many years. However, increasing political support in late 2014 has resulted in the decision by the Ministry of Health to develop a National Strategic Plan in the course of 2015. As will be discussed more in-depth in the next section, in 2014 the national response continued to be characterised by large-scale screening programmes for different population groups, especially expatriates (89.5% of all HIV tests) and ARV treatment for HIV-positive Kuwaiti nationals. While the NAP conducts regular lectures and other educational activities, to date HIV *prevention* has never been systematically developed or implemented. This is one of the priorities for the national strategic plan to be developed in 2015.

3) In 2014, HIV/AIDS programmes continued to receive very 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 continued to be understaffed and under-resourced in 2014. 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 key obstacle for effective programme implementation in 2014 has been the lack of an updated national strategic plan and operational plan since the mid-1980s. Commitments made to developing an updated NSP since 2012 still did not materialise in 2014. 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. As mentioned above, however, since late 2014 there has been increased political support in the MOH for developing the NSP and for the introduction of voluntary counselling and testing.

While the reactivation of the National AIDS Control Committee in 2012 has marked an important step towards strengthening the national response to HIV/AIDS, in 2014 this still did not materialise in concrete changes in terms of a more comprehensive delivery of programmes and services, especially in the field of HIV prevention. The national response has largely remained limited to large-scale, mandatory HIV screening in various contexts, and clinical treatment and care for HIV/AIDS.

HIV prevention

In 2014, 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 (89.5% of all HIV tests in 2014), while the remaining 10.5% are Kuwaitis who are mainly screened in the context of blood transfusions and pre-marital and pre-employment HIV testing. However, in 2014, *voluntary counselling and testing* (VCT) centres had still not been established, 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 creation in 2013 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. In 2014, the NACC has continued to discuss the modalities to implement VCT and the use of rapid HIV tests 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, in 2014, *there was 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 2014, no new cases of HIV were found among young children.

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 2014. Furthermore, all pregnant HIV-positive women were on ART throughout the pregnancy, as well as 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. In 2014, the National AIDS Control Committee has successfully addressed this issue and screening of all ANC women will be introduced in early 2015.

HIV education – In the field of HIV education, IN 2014, the NAP gave lectures on key aspects of HIV transmission and prevention to students at various universities, colleges and secondary schools; medical professionals (e.g. doctors at the Preventive Medicine Department). Furthermore the NAP organised open days and exhibitions on HIV/AIDS, and conducted a wide range of activities around World AIDS Day 2014 as well as on World Health Day (April 2014).

Furthermore, SMS awareness messages were sent to the mobiles of more than 2 million people and a short film was broadcast in 100 locations in 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 manager in cooperation with UNESCO regarding the way in which the education sector addressed the AIDS topic: this study revealed that the old curricula about HIV/AIDS were still used since 1980s in schools. 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 and the Ministry of Education was supplied with the materials to be included in curricula.

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 2014 include text messages on HIV at a national level; short video messages in supermarkets countrywide; interactive programmes on radio, TV and Twitter; lectures in universities and for family doctors; KAP questionnaires for university students; involvement in open days and exhibitions; conferences and other health occasions and celebrations.

Targeted interventions for key populations and other vulnerable groups – In 2014, the limited political support and the lack of 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 2014, there has still 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 Treatment Centre (ATC), but their coverage is limited (approx. 30% of all drug users) 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 ATC does not offer specific HIV-prevention programmes, such as HIV education. A positive development is the planned introduction of *opioid-substitution therapy* (OST) with *suboxone* (buprenorphine and naloxone) in September 2015. 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.

Although local experts report that sharing of injection equipment is common among PWID, to date, *needle-and-syringe-exchange programmes* (NSEP) remain unavailable and remain considered to be unacceptable to society, 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 ATC 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 2014, 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 2014, 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 reported 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 2014 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: for Kuwaiti MSM, going public 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 2014. However, the results from focus-group discussions with male university students in the context of previous GARP reports, as well as interviews with STI experts in 2015 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 revealed 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 pre- and 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 2014. 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 feasible.

HIV treatment, care and support

HIV treatment, care and support have been, and remained the strongest component of the national response to HIV in 2014. 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.

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 2013 was 90.5 percent.

In 2014, 22 new HIV cases were found among Kuwaiti citizens. By the end of 2014, a total of 248 Kuwaiti PLHIV were on antiretroviral treatment (ART), including 4 children under 10

years of age. Among the 244 patients older than 10 years, 229 were on first-line treatment; 13 on second line; and 2 on third line. All under-10 years patients were on first-line treatment. The total number of reported HIV cases among Kuwaiti nationals since the beginning of registration till the end of 2014 was 274. As mentioned, 248 (90.5%) of them are currently on ART, while the remaining 26 people refuse to take treatment, although it is offered to them and free of charge.

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 most 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 (with the exception of GCC citizens) 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. Foreign non-GCC citizens who are married to a Kuwaiti national are entitled to life-long ARV treatment and are not deported to their country of origin. Current deportation policies of HIV-infected individuals are harmonised with other GCC countries, and are not expected to be changed any time soon.

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 an AIDS Patient Support Group (APSG). In 2014, the APSG still lacked a clear mission statement and workplan. In 2014, members included health-care professionals, UN staff and youth representatives, but it remained a challenge to actively involve people living with HIV. Still most PLHIV do not want to organise themselves and meet 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 2014. 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 – as in previous years, the main success to date has been attained in the field of **antiretroviral treatment for Kuwaiti HIV patients**. 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.

Another achievement has been the **continued functioning of the National AIDS Control Committee** in 2014, after its successful re-establishment in 2012, with multisectoral membership from various government and UN sectors. The Committee has two subcommittees and is meeting regularly. Priority issues that the Committee has been promoting in 2014 include: 1) Voluntary counselling and testing centres; 2) Introduction of rapid HIV test kits; and 3) Provider-initiated testing and counselling of all pregnant women at antenatal care facilities and STI patients: the latter will be introduced in early 2015. 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.

The **AIDS Patients Support Group** is one of the professional groups under the umbrella of Kuwait Medical Association and it includes physicians, technicians and professional interested people in prevention and control of HIV. It supports HIV patients and their families through evidence-based health education and social and psychological support for HIV patients and their families to alleviate the burden of HIV infection. The AIDS Patients Support Group is encouraging and supporting studies and projects aiming at exploring the social, psychological, economic and health aspects of HIV infection as well as assessing the burden of HIV infection on patients, families and community. The activities of the support group include cooperation with NGOs and civil society within Kuwait, as well as with other NGOs in the GCC and other Arab countries and at the global level for exchanging experiences and encouraging joint activities and initiatives.

In 2014, the National AIDS Programme has continued to collaborate with, and support the **Standing Committee on Reproductive Health and AIDS** (SCORA), which is based at the Kuwaiti Association of Medical Students. SCORA is affiliated to a larger international umbrella organisation for medical students. The collaboration between NAP and SCORA provides a good basis for further strengthening (peer) education to young people.

In 2014, a short **questionnaire** on HIV-related knowledge was distributed among 100 students, of whom 34 responded. The results revealed the need to improve accurate knowledge of key HIV facts among these young people.

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 Reports in 2012 and 2014, and few of them were adequately addressed in 2014.

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.

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 to deal with those infected on an individual basis, rather than developing a true *public* health approach, including a specific HIV-prevention strategy. The two main approaches taken to “*keep HIV out*” are large-scale HIV 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 have been the continued meetings of the National AIDS Control Committee (NACC) in 2014, which has opened the discussion on a number of key challenges, such as HIV screening and PMTCT programmes for ANC women; the introduction of VCT services and rapid testing; as well as more attention for human rights aspects related to HIV/AIDS.

Lack of systematic HIV prevention, especially for key populations

While the main focus of the national response in 2014 has continued to be on large-scale HIV screening and antiretroviral treatment (ART), *HIV-prevention* efforts have continued to lack a systematic approach due to a lack of political and financial support for addressing the often sensitive issues related to HIV prevention. These include 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 – extramarital or homosexual relations, drug use – and hence people with HIV face severe social stigma and discrimination, even from their own families.

In this context, a key challenge continues to be the development of a ***national strategy*** that will 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 on the drivers of the HIV epidemic, 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 existing national response on the other hand, requires addressing the following specific challenges:

1. Strengthening political support – Throughout 2014, HIV continued to be low on the list of public health priorities in Kuwait. The low number of newly reported HIV infections as well as the sensitivities surrounding HIV make it easy to downplay its importance as a public health problem. Therefore, stronger political support is needed 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 National AIDS Control Committee has a key role to play in advocacy and lobbying for more political and financial support for a comprehensive national response to HIV.

2. In the absence of an updated National Strategic Plan (NSP) and costed Operational Plan (OP) since the 1980s, still in 2014 the national response has been 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 (2015) 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.

3. Inadequate institutional support systems and 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 with technical and secretarial assistance. In order to further strengthen the mandate of the NAP, and ensure better integration of policies and programmes, its focus should include HIV/AIDS and sexually transmitted infections (STIs).

Remedial action: Strengthening of NAP through: 1) Reinforcement of its institutional position as a separate HIV/STI Department; 2) Increasing the number of *technical* and administrative staff, with clearly described mandates and terms of reference (TORs) that allow NAP to act accordingly; 3) Adequate budgets, that allow NAP to implement the priority interventions identified in the updated National Strategic Plan; and 4) Establishment of electronic data

systems and networking between the AIDS Office and the departments involved in HIV testing, including laboratories, the Infectious Disease Hospital and the Premarital Screening Centre, to ensure access to accurate data for decision making at all levels.

4. 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 National Strategic Plan (NSP) that needs to be developed in 2015 – 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; the introduction of rapid HIV test kits; specific programmes to reduce HIV-related stigma and discrimination; peer education and outreach for key populations and young people; workplace programmes; ‘Client-friendly’ STI treatment for key populations; PLHIV support groups; Legal support for PLHIV; harm reduction programmes for PWID, including opioid substitution therapy; advocacy for and involvement of social, political and religious leaders in HIV prevention; regional collaboration with GCC and other countries in the Middle East and North Africa (MENA) region.

5. Lack of evidence regarding the potential drivers of the HIV epidemic, the nature and scale of high-risk behaviours, and regarding the effectiveness of 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 monitoring and evaluation (M&E) systems hampers an evidence-informed approach that comprises effective national policies and strategic frameworks, as well as adequate budget allocations.

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 opioid substitution therapy (OST) programme.

6. Lack of experience and capacity in HIV prevention and weak civil society – as discussed, to date there has been 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 civil society organisations (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. Insufficiently supportive legal, social and policy environments, including the presence of widespread stigma and discrimination – In addition to all the challenges mentioned above, legal and policy frameworks and social and cultural norms and values may often not be supportive of specific HIV/AIDS programmes and services. Legal restrictions with regard to key populations and their behaviours may hamper effective outreach or may not allow certain interventions, such as safer injection programmes, condom promotion for key populations, 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 resistance from different constituencies. 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 Kuwaiti 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 2015 (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

In 2014, Kuwait still lacked a 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 in specific settings (see details below), as well as data from clinical and laboratory monitoring of HIV patients. However, there is no functioning *HIV-surveillance system* to assess the HIV prevalence among the general population, nor among key populations, 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.

Large-scale 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 (predominantly 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 Addiction Treatment Centre (ATC)
- 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 2014, a total of 884,250 people were tested respectively; 10.5% were Kuwaiti nationals, while 89.5% 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 47.9% of all HIV tests in 2014. Other large groups tested were food handlers (35.0% of all HIV tests in 2014); blood transfusion services (8.7%); pre-employment testing (2.6%); and premarital testing (2.6%).

As mentioned, **Kuwaiti nationals** only represented 10.5 percent of all HIV tests conducted in 2014. In 2014, approximately 8 percent of the Kuwaiti nationals (92,970) were tested for HIV. Among *Kuwaiti nationals*, the largest numbers of people screened for HIV were *blood donors* (accounting for 39.8% of all Kuwaitis tested in 2014); *pre-marital* (25.3% of total in 2014); and *pre-employment* testing (16.7% of total in 2014).

Clinical monitoring of HIV patients

Clinical and laboratory 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; as a result, the retention rate for 2014 (i.e. the percentage of HIV patients enrolled in ART in 2013 who were still on ART 12 months after their enrolment) was 90.5 percent.

(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 strategic plan (NSP) on HIV/AIDS and a costed operational plan (OP)
2. Inaccuracies and gaps in data collection
3. Ineffective availability, accessibility and utilisation of HIV-related data for programme planning and management
4. Inadequate human resources and infrastructure for HIV-related data management

1) As mentioned, Kuwait has been without an updated national strategic plan (NSP) on HIV/AIDS since the late 1980s. In addition, there is no costed Operational Plan, nor a 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 2015. M&E (including measurable indicators and targets) and surveillance will be a priority component for this new NSP.

2) Inaccuracies and gaps in data collection: as mentioned, the existing large-scale HIV screening system is skewed towards testing of *non-Kuwaitis*, while Kuwaiti nationals account for only 10.5 percent of those tested, with some 8 percent of Kuwaiti nationals 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.

Despite the lack of accurate data, interviews with key informants show that 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.

Remedial actions in these areas involve the establishment of a system of *integrated biological and behavioural surveillance (IBBS) studies*, specifically focusing on key populations. Furthermore, the future implementation of *confidential VCT centres* and the use of *rapid HIV testing* as the first HIV test (with subsequent confirmation of positive test results with additional tests, in accordance with national protocols and standards) 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 electronic 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.