COUNTRY PROGRESS REPORT

STATE OF KUWAIT

Reporting period: January 2010-December 2011

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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 2012 was undertaken under the auspices of His Excellency Dr. Ali Saad Al-Obaidi, Minister of Health. Initial consultation meetings took place with high level officials within the Ministry of Health to endorse and provide support to the entire data collection, validation and review processes.

The development of the Kuwait Global AIDS Response Progress Report 2012 was led by the National AIDS Programme (NAP) within the Department of Public Health, Ministry of Health. The process took place through broad consultations, over the course of two months, with key stakeholders involved in Kuwait's national response to HIV. UNAIDS MENA provided an international consultant to assist in the overall process of data collection and consolidation of the final report.

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

A roundtable discussion meeting was held at the Ministry of Health to present and discuss the preliminary findings of the data-collection process, whereby all key national stakeholders were invited and were given an opportunity to provide inputs, raise concerns and ask for further clarifications. This roundtable not only served to validate all data with key stakeholders, but also engendered a discussion with stakeholders from all sectors and constituencies with regard to priority issues to be addressed in the next period. These discussions will also serve as inputs for the revision and development of the National Strategic Plan, which is set to be developed in the course of 2012.

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

(b) Status of the epidemic

The HIV situation in Kuwait can be characterised as low-prevalence. Since the 1980s, when the first Kuwaiti HIV case was reported, till the end of 2011, a cumulative total of 206 Kuwaiti HIV cases has been reported, 72 percent male, 28 percent female. In the period 2010-2011, 36 new Kuwaiti HIV cases were reported (11 in 2010; 25 in 2011).

Most HIV cases are detected through mass screening programmes. 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. The vast majority (87-90%) of all HIV tests is conducted among non-Kuwaitis, mainly in the context of residency permits. However, most Kuwaitis are tested in the context of blood donations (36-42%), pre-marital (26-30%) or pre-employment testing (19-20%).

While limited research has been done among the most-at-risk populations, including sex workers, men who have sex with men (MSM) and injecting drug users (IDUs), available data and information from focus group discussions and key informants in Kuwait show that these MARP 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; IDUs, as well as young people, especially males. Reports from drug rehabilitation centres reveal that sharing of injection equipment by IDUs presents a real HIV risk, as is evidenced by high Hepatitis C rates among IDUs.

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

(c) Policy and programmatic response

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

1) In terms of national commitment, Kuwait has made limited progress in the last two years (2010-2011). While there are signs of more involvement of some Cabinet ministers, members of Parliament and other high-level decision-makers, overall there is limited political support for HIV/AIDS. This is reflected at the *institutional and organisational* level; in *policy and programme development*; and in terms of *allocation of human and financial resources*.

- At the *institutional level*, there has been little progress with the re-establishment of the National AIDS Committee, which is tasked with overall policy guidance. Furthermore, the National AIDS Programme has received limited support in terms of financial and human resources and needs urgent strengthening.
- In terms of *policy and programme development*, NAP has been without an active NSP and operational plan (OP) since the 1980s, and this situation has continued in 2010-2011th. The MOH leadership has recently shown commitment to develop an NSP in 2012: this is expected to provide the much-needed guidance to the national response in the next few years.
- The limited national commitment is most concretely seen in the limited *allocation of financial and human resources*. The NAP has continued to be under-resourced in 2010-2011, 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 policy, 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 (90% 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, although ANC women are not systematically screened for HIV.

More focused HIV-prevention activities have not taken place, in the absence of funding allocations and work plans. Education has largely been limited to ad-hoc activities such as World Aids Day, and general education in schools and universities. Positive steps include the

recent creation of a legal framework that will allow VCT services, which will allow people to be tested confidentially.

Targeted HIV prevention for MARPs has remained a gap in 2010-2011: the planned NSP 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, rehabilitation programmes for IDUs exist, but little specific attention is given to HIV/AIDS. Syringe-exchange programmes and Opioid substitution therapy is not available. Condom promotion and distribution remain highly-sensitive topics in Kuwait, and no policy changes have taken place in this field in 2010-2011. While condoms are widely available for contraception among married couples, condom promotion for HIV-prevention purposes has not been implemented in 2010-2011; but could be considered as part of future targeted programmes for MARPs.

In the field of *treatment, care and support*, existing ART programmes have continued. All Kuwaiti nationals have access to RT and HIV care and support, including the right to early medical retirement. By the end of 2011, 186 Kuwaiti patients were on ART. However, stigma and discrimination of PLHIV remains a big problem, and PLHIV support groups cannot be organised due to self-stigma of PLHIV. 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) 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	The only KAP study on HIV among young people was conducted as far back as 1995; since then no new studies have been done. While there is no accurate data on HIV knowledge in this age group, anecdotal evidence suggests that even if knowledge is relatively high, this does not translate in protective behaviours, as a relatively large proportion of young men in particular engage in risky behaviours.
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	No 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 male University students in Kuwait City in 2012 as part of the GARP reporting process, suggests that as much as 10-20% of young men has had their first sexual experience before the age of 15. This may have been with a female or male partner.
1.3	Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	NO DATA ON INDICATOR. However, focus group discussions with male university students (18-25) held in the context of data collection for this GARP report, revealed the presence of many high-risk sexual behaviours with multiple partners, mainly 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.
1.4	Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse	NO DATA ON *INDICATOR*. However, focus group discussions with male university students (18-25) held in the context of data collection for this GARP report, revealed the presence of many high-risk sexual behaviours with multiple partners, mainly 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.

		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.
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	In the absence of any data from surveys or other studies, it is not possible to provide an accurate picture on the *INDICATOR.* However, results from such a survey would likely reveal very low percentages of people who had been tested "and knew their results", since there are no confidential and voluntary counselling and testing (VCT) services available in Kuwait. Most HIV testing takes place in the context of massive, mandatory screening, e.g. in the context of pre-marital and pre-employment testing, or blood transfusions and major invasive operations. Pre- or post-test counselling is not done; only those who test positive are informed of their status. Hence, surveys among the general population regarding knowledge of HIV status would reveal very low percentages.
1.6	Percentage of young people aged 15–24 who are living with HIV".	In the absence of any data from surveys among young people or ANC attendees, it is not possible to provide an accurate picture on the *INDICATOR.* Although massive HIV screening is done among several population groups, antenatal clinic attendees are not routinely screened for HIV in Kuwait, unlike many neighbouring countries. However, data from ANC women would not yield reliable data, as Kuwait has a very low-prevalence HIV epidemic, with a male-female ratio of approximately 3:1. Regardless of the absence of survey data, HIV prevalence in Kuwait is extremely low still. Results from mass screening among Kuwaiti citizens in 2009 revealed 12 new HIV cases out of a total of 62,260 tested; in 2010, 11 new cases were found among 153,581 Kuwaitis tested; in the first 6 months of 2011, 25 new cases were found (total No. tested unknown). These figures indicate that overall HIV prevalence is still very low. However, experiences in neighbouring countries have shown that massive screening tends to miss specific HIV cases (who are found through VCT), as certain groups are typically less likely to be screened. Also, persons who suspect they may have engaged in high-risk behaviours (sexual or injection drug use) tend to avoid screening (e.g. premarital), and thus especially those at higher risk may be missed through screening. Therefore, screening data do not necessarily give an accurate picture. As was highlighted in the comments on previous indicators, there is reason to believe that sexual behavioural patterns in Kuwait are changing dramatically, with a considerable proportion of young people – especially young men – engaging in high-risk sexual contacts with multiple partners, especially during visits outside Kuwait; as well as injecting drug use. Hence, the currently low numbers are no reason for complacency, also because the screening data do not provide a reliable picture.
1.7	Percentage of sex workers reached with HIV prevention programmes (condom distribution; HIV testing)	Despite the fact that no surveys or other studies have ever been conducted among sex workers in Kuwait, it is safe to say that the *INDICATOR* will be extremely low to zero, because no such programmes exist or have ever existed in Kuwait. While sex work does exist in Kuwait, it is illegal and punishable by law, and extremely hidden. Overall, there is very little information available on sex work in Kuwait, as no qualitative research, mapping or size estimations, or any other type of study or survey has ever been conducted among sex workers. Nevertheless, reports from focus group discussions conducted among male Kuwaiti university students, as well as press reports reveal that sex work exists in Kuwait, and is in part linked to human trafficking. The illegal character, extreme social rejection, and the possible relation to organised crime and

		human trafficking make it extremely challenging to reach these women with HIV-prevention programmes.
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	As mentioned regarding the previous indicator (1.7), although sex work in Kuwait is present, it is extremely hidden and no HIV-prevention programmes are available for these women. In the absence of any data from surveys among sex workers, it is not possible to provide an accurate picture on this indicator. Anecdotal evidence from focus group discussions held in the context of this GARP report with male university students indicates that condom use with sex workers depends on the client, and is based on his assessment of the overall "cleanliness" of the sex worker, as well as her nationality (as this is perceived to be related to higher HIV/STI risks). However, reportedly, condoms are not systematically used and unprotected sex is common with sex workers. 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.
1.9	Percentage of sex workers who received an HIV test in the past 12 months and know their results	As mentioned regarding the previous indicators (1.7 and 1.8), although sex work in Kuwait is present, it is extremely hidden and no HIV-prevention programmes are available for these women. In addition, no (voluntary) counselling and testing services are available for the general population in Kuwait, let alone for sex workers. Hence, there is no data on the *INDICATOR.* While safe and confidential VCT services for sex workers would be important, it is doubtful whether any sex workers would go for VCT, since many might not trust the confidentiality of a positive test result and fear arrest and imprisonment and/or deportation, as most sex workers in Kuwait are said to be foreign women, some of whom may have been trafficked.
1.10	Percentage of sex workers who are living with HIV	As mentioned for previous sex worker indicators (1.7-1.9), although sex work is present in Kuwait it is extremely hidden and little is known about the exact scope and nature of the phenomenon. To date, there has been no research, nor HIV-prevention programmes for sex workers in Kuwait. In this context, it is extremely difficult to conduct a sero-survey to assess HIV-prevalence rates among sex workers, as this requires trust and confidentiality. Hence, no data is available to provide any insight into the *INDICATOR.* There is anecdotal evidence that most sex workers in Kuwait have foreign nationalities: thus, the majority would at some point have been tested for HIV before they received a residency permit for the country, and most were therefore not HIV-infected when they arrived. However, others may have been trafficked illegally into the country and may therefore not have been tested. Experiences with sero-surveillance studies among sex workers in other countries in the region, such as Jordan and Syria, suggest that HIV prevalence among sex workers may be low, despite frequent unprotected sex with many different sex partners.
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	Despite the fact that no surveys or other studies have ever been conducted among sex workers in Kuwait, it is safe to say that the *INDICATOR* will be extremely low to zero, because no such programmes exist or have ever existed in Kuwait. MSM and homosexuality are highly rejected by society and surrounded by severe stigma and discrimination. Therefore, MSM is hidden from the public eye and it is very difficult to reach them with HIV-prevention, or any other type of programme, in the absence of political support, allocated resources, and organisations willing and capable of effectively reaching and working with them. The development of a National Strategic Plan on HIV/AIDS and a costed Operational Plan need to provide the basis for HIV prevention among MSM in the near future. This also requires the availability of voluntary counselling and testing services, which provide confidential services that are MSM-friendly. Effective outreach to MSM will depend on peer education approaches, and requires partnerships between the NAP and individual MSM willing to collaborate on this.

1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	As mentioned regarding the previous indicator (1.11), although MSM and homosexuality exist in Kuwait as in all other countries of the world, it is extremely hidden and no HIV-prevention programmes are available for these men. In the absence of any data from surveys among sex workers, it is not possible to provide an accurate picture on the *INDICATOR.* Research and experiences in other countries in the Middle East and North Africa have revealed that most MSM try to hide their sexual orientation and preferences, and will marry and have a family in order to meet societal expectations and avoid being identified as homosexual. Sexual contacts with other men usually take place in secret, and rather than having a steady sex partner, MSM may prefer the services of male sex workers, as this is considered to be more anonymous and safer than having an actual relationship with another man, which could be discovered. These MSM contacts are often high-risk, with unprotected anal sex with many casual, unstable partners. A recent study conducted by a regional MSM organisation on the Internet among MSM in the wider Middle East and North Africa also included respondents from Kuwait: 64% of Kuwaiti respondents reported always having safe sex, while the remaining 36% said condom use depended on the circumstances, or gave an ambiguous answer. The researchers indicate that the 64% "always safe sex" most likely represented an exaggerated percentage, with few MSM consistently using condoms. Nevertheless, these data reveal that unprotected sex among Kuwaiti MSM is frequent. This high-risk behaviour implies HIV-infection risks not only for these MSM themselves, but also for their (potential) spouses and children.
1.13	Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results	As mentioned regarding the previous indicators (1.11 and 1.12), although MSM are present in Kuwait, they are extremely hidden and no HIV-prevention programmes are available for these men. In addition, no (voluntary) counselling and testing services are available for the general population in Kuwait, let alone special VCT services for MSM. Hence, there is no data on the *INDICATOR.* While large numbers of Kuwaiti citizens undergo mandatory HIV screening every year (511,796 in 2009; 818,246 in 2010 and 279,729 in the first 6 months of 2011), most HIV cases found report heterosexual contacts as the route of transmission, while almost no cases are linked to MSM. Rather than the actual percentage of MSM transmission, this reflects the extreme stigma associated with MSM behaviour. As a result, the true role of same-sex relations in HIV transmission is highly underestimated. While safe and confidential VCT services for MSM would be important, it is doubtful to what extent MSM would feel free to use these services, since many might not trust the confidentiality of a positive test result and fear public disclosure of their HIV status and/or homosexuality, as both are associated with high stigma, especially in a small community such as Kuwait, where this would bring shame to their whole family. Instead, MSM who want to know their HIV status may go for VCT in other countries.
1.14	Percentage of men who have sex with men who are living with HIV	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 *INDICATOR.* As mentioned for indicator 1.12 (condom use among MSM), however, research in the wider Middle East and North Africa has revealed that MSM often engage in high-risk sex with many different sex partners. This includes contacts with male sex workers, often younger men who sell sex to other men for pleasure and income. Furthermore, many Kuwaiti MSM have the financial means to travel in and outside the region, and may go for MSM sex in other countries, where the

		social climate around homosexuality is more liberal. This may also involve sexual contacts with local male sex workers. While there is no conclusive evidence of HIV rates among MSM in the region, these risk behaviours indicate the potential for a rapid spread of HIV within the MSM community. In this context, it is a priority to conduct studies among MSM to better understand the HIV risks in this community, and guide future policies and programmes for HIV prevention among MSM. This includes mapping, size-estimation studies and socio-anthropological research.
		INJECTING DRUG USERS
2.1	Number of Syringes distributed per person who injects drugs per year by Needle and Syringe Programmes	Despite the fact that no surveys or other studies have ever been conducted among IDUs in Kuwait, it is safe to say that the *INDICATOR* is zero, because no such programmes exist or have ever existed in Kuwait. Needle-and-syringe-exchange programmes (NSEP) are not available in Kuwait, as there is no political support for NSEP, which is seen to promote injecting drug use. The only services for (injecting) drug users are provided through the Addiction and Psychiatric Hospital (APH), and include detoxification and rehabilitation services. Opioid substitution therapy (OST), however, is not available. Current APH services are insufficient to meet the service needs of IDUs. A thorough discussion and revision of the policies, programmes and services for (injecting) drug users is highly needed, as current policies are outdated, and services ineffective. Many patients come on a voluntary basis, but lack real motivation to stop using drugs: the APH is often seen as a temporary refuge from law-enforcement agencies, and the APH cannot keep most patients against their will, Subsequently, relapse is very high: out of approximately 300-400 IDU clients per year, less than 10% abstain for more than 2 years, and many relapse within a week after detox. A problem is that the APH can only accept patients who are 17 years and older, while drug problems often start at an earlier age. The proportion of female IDUs is surprisingly high with 10-20% of IDUs being women. Heroin is the second-most common drug among APH clients, and 80% inject the drug. The typical background of IDUs 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 and cocaine. Usually people are poly-drug users. Injecting drug use typically takes place in social groups, including within the family: it is common that IDUs have brothers, uncles or even parents who also use drugs, which makes it extremely difficult to quit the habit. While most IDUs start sniffing heroin initially, they soon move to injection. Sharing of injection equipment is common, as evidenced by high prevalence rates of Hepatitis B and C infection among IDUs. Compounding the needle-exchange problem is the fact that many IDUs are imprisoned, 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 IDUs.
2.2	Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse	In the absence of any data from surveys among injecting drug users (IDUs), it is not possible to provide an accurate picture on the *INDICATOR*. However, as mentioned with regard to indicator 1.4, high-risk sex behaviours – including unprotected sex with sex workers abroad – are common, especially among young men. Although there is no direct evidence about condom use among (male) IDUs, research from studies in the Middle East reveal that IDUs 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 IDUs 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 IDU respondents (56%) reported

		never or only sometimes using condoms with non-regular partners. While these data cannot be extrapolated to the Kuwaiti IDU population, it provides an indication of elevated high-risk sexual practices among IDUs, which may further exacerbate the future spread of HIV among IDUs and their sexual partners (including wives). Therefore, more research on (injecting) drug use in Kuwait is needed to better understand the HIV risks among this population. This includes mapping, size-estimation studies and socio-anthropological research.
2.3	Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected	In the absence of any data from surveys among injecting drug users (IDUs), it is not possible to provide an accurate picture on the *INDICATOR.* However, as mentioned under indicator 2.1, reports from the Addiction and Psychiatric Hospital (APH) reveal that heroin and other injectable drugs are commonly used in groups, and that sharing of injection equipment is common. Needle sharing may be particularly high in prisons, since access to clean injecting equipment is restricted and IDUs are forced to share. The fact that sharing of injection equipment is common among IDUs is evidenced by high Hepatitis C rates among IDUs, which is typically associated with sharing of injection equipment. A small study conducted in prison settings in 2009 revealed 398 cases of HCV, approximately 10% of the total prison population; 75% of whom were IDUs. Reportedly, sharing of equipment does not occur due to the unavailability or difficult access to syringes and needles, but mainly in settings and at moments when the IDU wants to inject but clean syringes or needles may not be immediately available, including in prisons.
2.4	Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results	In the absence of any behavioural surveillance studies or surveys among IDUs on the issue of HIV status, there is no data on the *INDICATOR.* Injecting drug users are tested for HIV when they are arrested and imprisoned, as well as when they are admitted to the Addiction and Psychiatric Hospital (APH), but it is unknown what percentage of the total IDU population in Kuwait they represent. Furthermore, these HIV screening practices typically do not involve counselling, and IDUs 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 IDUs' 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 IDUs. Furthermore, the absence of voluntary counselling and testing (VCT) services in Kuwait does not allow IDUs to get tested outside the screening programmes in prisons and the APH.
2.5	Percentage of people who inject drugs who are living with HIV	To date, no HIV sero-surveillance studies have been conducted among IDUs in Kuwait. In contrast to sex workers and MSM – who remain largely hidden from the public eye – IDUs are more frequently seen in HIV screening programmes, e.g. on admission to prisons or the APH drug-treatment facility. While these data from screening programmes among IDUs reveal high levels of Hepatitis B and C, to date they have shown few HIV cases: in 2010 only one new HIV case was found among 545 IDUs tested, while in 2009 no HIV cases were found among 255 tested. However, these screening data do not provide a reliable picture of the true HIV prevalence rates among the overall IDU 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 IDUs 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 IDU population in Kuwait. Therefore, in the absence of sero-surveys among IDUs, no data is available to provide any insight into the *INDICATOR.* However, despite the seemingly low HIV rates among IDUs 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 IDUs, 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 IDUs – such as Iran, Egypt and Libya – have shown that there is no room for complacency in the face of a looming HIV epidemic among IDUs.
		PMTCT
3.1	Percentage of HIV-positive pregnant women who received anti-retrovirals to reduce the risk of mother-to-child transmission	In the absence of estimations for the number of HIV-positive pregnant women within the past 12 months, accurate data on the *INDICATOR* is not available. No sentinel surveillance studies have been conducted among ANC attendees in Kuwait, nor are they routinely screened for HIV (unlike the many other population groups that are screened, e.g. premarital, pre-employment, foreign residents). Hence, there is no information on the total number of HIV-infected pregnant women. However: * In 2010, 5 women known to be HIV-infected and on ART became pregnant; all 5 were treated accordingly and their infants received a virological test for HIV within 2 months of birth: none were infected. * In 2011, 6 women known to be HIV-infected and on ART became pregnant; all 6 were treated accordingly and their infants received a virological test for HIV within 2 months of birth: none were infected.
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	In the absence of estimations for the number of HIV-positive pregnant women within the past 12 months, accurate data on the *INDICATOR* is not available. No sentinel surveillance studies have been conducted among ANC attendees in Kuwait, nor are they routinely screened for HIV (unlike the many other population groups that are screened, e.g. premarital, pre-employment, foreign residents). Hence, there is no information on the total number of HIV-infected pregnant women. However : * In 2010, 5 women known to be HIV-infected and on ART became pregnant; all 5 were treated accordingly and their infants received a virological test for HIV within 2 months of birth: none were infected. * In 2011, 6 women known to be HIV-infected and on ART became pregnant; all 6 were treated accordingly and their infants received a virological test for HIV within 2 months of birth: none were infected. So 100% coverage with EID of mothers known to be HIV-infected.
3.3	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	In the absence of an estimation of the number of HIV-infected women who delivered in the previous 12 months, all 6 children born to those women known to be HIV-infected (all of whom were on ART) were followed and none were HIV-positive. Although infants may have been born to HIV-positive women whose HIV status was unknown, it is possible that their infants were infected through mother-to-child transmission. However, in the last more than 10 years, no paediatric HIV cases were found; the only known paediatric case is now 13 years old. Since HIV-infected children born in 2010 would by now have developed HIV disease, it can be assumed that no new infants born to HIV-infected mothers were infected. Hence the "estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months" is zero.
		ANTIRETROVIRAL TREATMENT
4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy	186 HIV patients were receiving ART by 31 Dec. 2011: 133 men, 52 women and 1 child (sex unknown) There is no accurate estimation for the Denominator (estimated No. of adults and children with advanced HIV infection)
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	12-month retention rate for 2010 is 88% 12-month retention rate for 2010 is 89%

		TB-HIV CO-INFECTION
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	
		AIDS SPENDING
6.1	Domestic and international AIDS spending by categories and financing sources	Total amount 2010 USD 56,791,096 Lab commodities: USD 30,368,924 ARVs: USD 6,001,083 Programme management (Salaries, Other costs Laboratories): USD 20,421,067
		CRITICAL ENABLERS & SYNERGIES
7.1	National Commitments and Policy Instruments (NCPI) (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and M&E)	Overall ratings (1-10) 1. Civil Society involvement: 2 2. Strategic Planning: 1 3. Political Support & Leadership: 2 4. Human Rights: 6 5. Prevention: 5 6. Treatment, care & support: 9 7. M&E: 0
7.2	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 available
7.3	Current school attendance among orphans and non-orphans aged 10–14	Kuwait is a high-income country with no HIV-related orphan cases; All children attend school. Hence this indicator is irrelevant.
7.4	Proportion of the poorest households who received external economic support in the past 3 months	Indicator not relevant for context of Kuwait. Kuwait is a high-income country with very few HIV cases, good social services.

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 2011, a cumulative total of 206 Kuwaiti HIV cases has been reported: 147 men (71%), 58 women (28%) and one child. In 2010, 11 new Kuwaiti cases were found, and in 2011 25 *(see Table 1)*. These 36 new Kuwaiti cases represent an increase of 21 percent of the cumulative number in the last two years only.

Table 1. Number of new Kuwaiti HIV cases, 2009-2011

	2009	2010	2011
MALE	**8**	**7**	**21**
FEMALE	**4**	**4**	**4**
TOTAL	**12**	**11**	**25**

HIV statistics for Kuwaiti and non-Kuwaiti nationals are based on mass screening of selected groups. However, there is no HIV screening of ANC attendees. All foreigners seeking employment or residency in Kuwait have to get screened for HIV, first in their country of origin: if they test positive, they are not allowed entry into the country. Those who test negative are tested again within 2 months after arrival in Kuwait, and deported if found HIV-positive. Foreign workers are typically tested again every two or 3 years on renewal of their work contracts, while nationals of some countries considered higher-risk are tested every year. Thus, the vast majority of all HIV tests is conducted in the context of screening of expatriates (72% of all tests in 2010 and 57% of all tests in the first half of 2011).

As a consequence, ***non-Kuwaiti HIV cases*** mainly consist of persons tested before they get their permanent residency in the country, and who were never allowed in. In 2011, a total of 97 HIV cases was found among expatriates: 53 had visas but were never allowed into permanent residency in Kuwait; however, 44 of them were foreigners who had residency permits and were subsequently deported.

It is important to note that more than two-thirds of the Kuwaiti population consists of expatriates. In 2010 the total population was 3,566,437 of whom 1,133,214 (31.8%) were Kuwaitis and 2,433,223 (68.2%) foreign nationals. 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 2010 and the first 6 months of 2011.

The table shows that the vast majority (87-90%) of all HIV tests is conducted among non-Kuwaitis, mainly in the context of residency permits. However, most Kuwaitis are tested in the context of blood donations (36-42%), pre-marital (26-30%) or pre-employment testing (19-20%).

Table 2: Numbers of Kuwaiti & Non-Kuwaitis screened for HIV, 2010 and first half 2011

	2010					Jan-June 2011				
	Kuwaiti		Non-Kuwaiti		Total	Kuwaiti		Non-Kuwaiti		Total
	No.	%	No.	%	No.	No.	%	No.	%	No.
Expatriates	-	-	609,755	78.8	609,755	-		166,664	65.6	166,664
Blood donors	31,168	36.4	32,717	4.2	63,885	15,965	41.6	16,966	6.7	32,931
Pre-marital	21,980	25.7	2,297	0.3	24,277	11,449	29.9	1,276	0.5	12,725
Pre-employment	16,789	19.6	9,883	1.3	26,672	7,203	18.8	5,099	2.0	12,302
Food handlers	1,611	1.9	110,460	14.3	112,071	96	0.3	60,337	23.7	60,433
Police	4,123	4.8	372	0.05	4,495	658	1.7	63	0.02	721
Prisons	1,187	1.4	2,577	0.3	3,764	227	0.6	435	0.2	662
Army	3,780	4.4	957	0.1	4,737	938	2.5	506	0.2	1,444
Other	4,889	5.7	4,484	0.6	9,373	1,812	4.7	2,760	1.1	4,572
TOTAL	**85,527**		**773,502**		**859,029**	**38,348**		**254,106**		**292,454**

The available data on the number of known HIV cases among Kuwaiti nationals do not allow providing an accurate estimation of the true number of cases, and the overall HIV prevalence among nationals, since the available HIV data is mainly based on mass screening among blood donors, premarital and pre-employment screening, in which most-at-risk populations are typically under-represented. In the absence of VCT services, it is not easy for persons at higher risk to get information about their HIV status anonymously but their HIV test result is kept in privacy and it is confidential by law.

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

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

As mentioned above, the mass screening of foreigners and certain categories of Kuwaiti nationals (in 2010, 7.5% of the total Kuwaiti population was tested for HIV) does not provide an accurate picture of the HIV epidemic in the general population. It gives an even less reliable picture of HIV among most-at-risk populations, such as sex workers, MSM and IDUs. 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 at all*** on the size, sexual networks dynamics and risk behaviours of these groups, which makes it impossible to assess the HIV risks among these MARP groups, or among vulnerable groups such as young people.

Behavioural risks among young people

While no formal studies have been conducted, there is reason to believe that sexual behavioural patterns in Kuwait are changing dramatically, with a considerable proportion of young people – especially young men – engaging in high-risk sexual contacts with multiple partners, especially during visits outside Kuwait; as well as injecting drug use.

Anecdotal evidence from a focus group discussion (FGD) held among male University students (18-25 years of age) in Kuwait City in 2012 as part of the GARP reporting process,

suggests that as much as 10-20% of young men has had their first sexual experience before the age of 15, either with a female or male partner. In addition, FGD participants reported many high-risk sexual behaviours among young men, particularly during trips abroad to countries in South-East Asia as well as the Middle-East region: this included unprotected sex with multiple partners, mainly foreign sex workers. Respondents also mentioned the presence of commercial sex in Kuwait as well. 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 East European women, while condoms would be less used with those women perceived to be "lower risk", especially women from the region.

The results from this focus group discussion 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.

HIV risks among female sex workers

As mentioned in focus group discussions by male University students (see previous section), sex work in Kuwait is present, but it is extremely hidden and no HIV-prevention programmes are available for these women. However, in the absence of any research on sex work in Kuwait, little is known about the exact scope and nature of the phenomenon.

There is anecdotal evidence that most sex workers in Kuwait have foreign nationalities, and that sex work is not necessarily their main source of income: they may have regular jobs and engage in sex work or transactional sex with multiple boyfriends 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. However, others may have been trafficked illegally into the country and may therefore not have been tested.

The results from focus group discussions held in the context of this GARP report with male university students indicates that condom use with sex workers depends on the client, and is based on his assessment of the overall "cleanliness" of the sex worker, as well as her nationality (as this is perceived to be related to higher HIV/STI risks). However, reportedly, condoms are not systematically used and unprotected sex 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.

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.

Research and experiences in other countries in the Middle East and North Africa have revealed that most MSM try to hide their sexual orientation and preferences, and will marry and have a family in order to meet societal expectations and avoid being identified as homosexual. Sexual contacts with other men usually take place in secret, and rather than

having a steady sex partner, MSM may prefer the services of male sex workers, as this is considered to be more anonymous and safer than having an actual relationship with another man, which could be discovered. These MSM contacts are often high-risk, with unprotected anal sex with many casual, unstable partners. Furthermore, many 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, where the social climate around homosexuality is more liberal. This may also involve sexual contacts with local male sex workers.

A recent study conducted by a regional MSM organisation on the Internet among MSM in the wider Middle East and North Africa also included respondents from Kuwait: 64% of Kuwaiti respondents reported always having safe sex, while the remaining 36% said condom use depended on the circumstances, or gave an ambiguous answer. The researchers indicate that the 64% "always safe sex" most likely represented an exaggerated percentage, with few MSM consistently using condoms. Nevertheless, these data reveal that unprotected sex among Kuwaiti MSM is frequent. This high-risk behaviour implies HIV-infection risks not only for these MSM themselves, but also for their (potential) spouses and children.

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

HIV risks among injecting drug users

To date, no HIV sero-surveillance or behavioural studies have been conducted among IDUs in Kuwait. In contrast to sex workers and MSM – who remain largely hidden from the public eye – IDUs are more frequently seen in HIV screening programmes, e.g. on admission to prisons or the drug-treatment facility of the Addiction and Psychiatric Hospital (APH). While these data from screening programmes among IDUs reveal high levels of Hepatitis B and C, to date they have shown few HIV cases: in 2010 only one new HIV case was found among 454 IDUs tested, while in 2009 no HIV cases were found among 255 tested. However, these screening data do not provide a reliable picture of the true HIV prevalence rates among the wider IDU population. Many IDUs 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 IDU population in Kuwait.

More information is also needed about the total size of the IDU population and in what settings injecting drug use takes place. APH experts report that most injecting drug use takes place in private locations, such as private houses, and sometimes even within the family. Reportedly, heroin is the second-most common drug among IDU clients at APH, with 80 percent injecting the drug. Most IDUs 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 and cocaine. Usually people are poly-drug users.

While most IDUs 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 IDUs 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 IDUs in prisons.

Compounding the needle-sharing problem is the fact that many IDUs 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

IDUs. 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 IDUs. Reportedly, sharing of equipment does not occur due to the unavailability or difficult access to syringes and needles, but mainly in settings and at moments when the IDU wants to inject but clean syringes or needles may not be immediately available, including in prisons.

Hence, despite the seemingly low HIV rates among IDUs 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 IDUs, show that the risk of a rapid spread of HIV among IDUs in the near future is real. Experiences from other countries in the Middle East with high HIV rates among IDUs – such as Iran, Egypt and Libya – have shown that there is no room for complacency in the face of a looming HIV epidemic among IDUs.

In addition to unsafe injecting practices, high-risk sexual practices by IDUs may also play a role in HIV transmission. Although there is no direct evidence about condom use among (male) IDUs, research from studies in the Middle East reveal that IDUs 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 IDUs 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 IDU respondents (56%) reported never or only sometimes using condoms with non-regular partners. While these data cannot be extrapolated to the Kuwaiti IDU population, it provides an indication of elevated high-risk sexual practices among IDUs, which may further exacerbate the future spread of HIV among IDUs and their sexual partners (including wives). Therefore, more research on (injecting) drug use in Kuwait is needed to better understand the HIV risks among this population. This includes mapping, size-estimation studies and socio-anthropological research.

III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

1. National Commitment

In terms of national commitment, Kuwait has made very limited progress in the last two years (2010-2011). While Kuwait attended the UN High Level Meeting in June 2011 in New York and there are signs of more involvement of some Cabinet ministers, members of Parliament and other high-level decision-makers, overall there is limited political support. This limited political support and leadership is reflected at the *institutional and organisational* level; in *policy and programme development*; and in terms of *allocation of human and financial resources*.

1) At the ***institutional level***, there has been little progress with the re-establishment of the National AIDS Committee as a multisectoral, high-level policy body with the mandate to provide overall coordination and follow-up of the national response. However, the new political leadership in the MOH has indicated that this will be a priority for this year (2012), which shows an increased political awareness of the importance of a high-level involvement in the national response to HIV. Furthermore, the National AIDS Programme is given low priority as it is based at a lower administrative level within the MOH, as part of the Public health department.

2) At the level of ***policy and programme development***, the most pressing challenge is the absence of a national strategic plan ever since the national response to HIV started in the mid-1980s: at the time there was a general overview of priority areas, but hard copies of that first "national plan" are not available anymore. In the absence of an NSP there are also no operational plans, M&E frameworks or budgets. The lack of an NSP reflects the fact that HIV/AIDS still has not been acknowledged as a public health priority, let alone as a priority for non-health sectors. As will be discussed more in-depth in the next section, the national response has been characterised by massive screening of different population groups, especially expatriates (90% of all HIV tests) and ARV treatment for those found HIV-infected. This approach reflects the "externalisation" of HIV as a problem that affects "others" rather than the Kuwaiti population, and which is therefore of secondary importance. As a consequence, HIV prevention has never been systematically developed or implemented. On the positive side the new leadership in MOH has pledged full support for the development of a National Strategic Plan, which is expected to be developed in the course of 2012.

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

The lack of HIV-specific resource allocation is further evidenced by the extremely low budget for the *National AIDS Programme* (NAP), which is severely understaffed and under-resourced. There is only one technical staff, and no administrative or support staff, while there is no Internet access or adequate office infrastructure. The functioning of the NAP is further hampered by inadequate information systems and limited access to key HIV-related data. The NAP does not have its own budget, which severely hampers the national response, as will be described in the programme-implementation section below.

2. Programme Implementation

As mentioned in the previous section, a major stumbling block for programme implementation is the absence of a national strategic plan and operational plan since the mid-1980s. Without the overall guidance of a commonly agreed HIV/AIDS policy, the national response has remained scattered and ad-hoc, with most HIV-related interventions taking place in the context of other existing public health policies and strategies, without having a clear, specific vision on comprehensive HIV prevention, care, treatment and support.

While there are recent signs of a potential increase in political support for HIV – e.g. through the planned establishment of a National AIDS Committee and the development of a National Strategic Plan – in the 2010-2011 period, this political support has not yet materialised in concrete changes in terms of increased programmes and services. The national response has largely remained limited to massive, mandatory HIV screening in various contexts, and treatment and care for HIV/AIDS.

HIV prevention

In the last 2 years (2010-2011), 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 (90% of all HIV tests), while the remaining 10% are Kuwaitis who are mainly screened in the context of blood transfusions and pre-marital and pre-employment HIV testing. However, to date, voluntary counselling and testing (VCT) services are not available, which does not allow people to get to know their HIV status anonymously (they *can* get tested, but need to provide personal details). A positive step has been the recent creation of a legal framework that allows confidential and voluntary testing, without mandatory reporting, but this legal framework needs to be updated and still needs to translate into the actual availability of VCT services; and .

PMTCT – While PMTCT services are provided to pregnant women who are known to be HIV-infected, and who are mostly already on ART, there is no systematic screening of all ANC attendees. Therefore, HIV-positive pregnant women whose HIV status is unknown are unlikely to receive PMTCT interventions. In the last decade, however, there have been no new (known) cases of HIV-infected children. Hence, it is likely that most HIV-pregnant pregnant women are known previously. Nevertheless, in the absence of PITC in the context of ANC services, there remains a possibility of mother-to-child transmission in the future. The PMTCT protocol, which was introduced more than 15 years ago, involves ART for all mothers by the 4th month of pregnancy, avoiding 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. In 2010 and 2011, respectively five and six women were entered in this PMTCT regimen; and none of the infants were infected.

HIV education – In the field of HIV education, there have been no major changes in the 2010-2011 period. HIV has been part of the curriculum for intermediate and secondary school children since many years, but education is limited to factual knowledge, without attention for life skills or specific HIV-prevention methods. Furthermore, HIV is included in the curricula of some universities (especially medical). However, HIV 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.

Apart from the annual ad-hoc activities around World AIDS Day, there is no specific HIV-education strategy, and there are no specific changes towards targeted HIV education and prevention among most-at-risk and other vulnerable groups. 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.

Targeted interventions for MARPs and other vulnerable groups – The absence of a political support and a comprehensive vision on HIV prevention, coupled with stigma, discrimination and criminalisation of sex workers, IDUs and MSM continue to hamper targeted HIV-prevention programmes for these MARP groups. In the 2010-2011 period, there has been no progress even 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.

Injecting drug users are the (relatively) easiest-to-reach MARP group, as injecting drug use is not commonly associated with extramarital or MSM sex, and therefore less surrounded by stigma and discrimination. Furthermore, there are existing *drug-treatment services* provided by the Addiction and Psychiatric Hospital (APH), but their coverage is low and the current *detoxification and rehabilitation* programmes lack effectiveness, as evidenced by high drop-out and relapse rates. Access to IDUs 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 IDUs remains invisible to the Kuwaiti authorities.

Despite the relative good access to IDUs, the APH does not offer specific HIV-prevention programmes, such as HIV education or *opioid-substitution therapy* (OST) programmes. To date, OST remains seen to promote injecting drug use, and therefore remains unacceptable in Kuwait, although drug experts favour a political discussion on the benefits of OST.

Similarly, *needle-and-syringe-exchange programmes* (NSEP) remain unavailable. Although there is anecdotal evidence that sharing of injection equipment is common, this may not be due to difficult access to syringes. Hence, there is no proof that NSEP would be an effective HIV-prevention intervention.

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

Female sex workers – In the 2010-2011 period, there have been no HIV-prevention activities for sex workers, such as HIV education, peer outreach, condom distribution or special STI services and VCT services for sex workers.

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

In the 2010-2011 period there have been no changes with regard to existing policies towards sex workers, as they remain predominantly seen as persons engaging in illegal activities; hence HIV-prevention programmes are very hard to establish, especially through government agencies, while there are no civil society organisations with an expressed interest for working in this field. Outreach programmes for sex workers are further hampered by the fact that most of them are said to be foreign nationals who may offer paid sex services

either on a full-time basis or as a source of additional income. In this context it is particularly difficult to establish relationships of trust and confidentiality, as the discovery of a person being engaged in sex work or as being HIV-infected might result in her deportation from the country or even imprisonment.

Men who have sex with men – For similar reasons as for sex workers, in the 2010-2011 period, there have been no HIV-prevention activities for MSM, such as HIV education, peer outreach, distribution of condoms and lubricants, or special STI services and VCT services for MSM.

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

In addition, self-stigma may further hamper identifying and working with MSM: the fact that none of the newly-found HIV cases in 2010-2011 reported MSM contacts seems to indicate that HIV-infected MSM will avoid at all cost being identified as MSM (in addition to being HIV-infected): for Kuwaiti men, this would lead to social ridicule and rejection by their own family, which has a particular impact in a small and closed society such as Kuwait.

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

Clients of sex workers – Clients of sex workers are another important at-risk group, but very hard to identify; hence, no policy or programmatic attention has been given to this group in 2010-2011. However, anecdotal evidence from focus-group discussions with male university students in the context of this GARP report have shown 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. Similarly, an unspecified number of male HIV patients indicate that they were infected through contacts with female sex workers abroad.

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

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

Condom promotion & distribution – Condom promotion and distribution remain highly-sensitive topics in Kuwait, and no policy changes have taken place in this field in 2010-2011. 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 MARPs, young people, or other segments of the general population is likely to remain socially unacceptable. However, condom education as part of wider HIV-prevention and peer-education programmes in more confidential settings may be a feasible approach.

HIV treatment, care and support

HIV treatment, care and support have been, and remain the strongest component of the national response to HIV in 2010-2011. 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 2010 was 88 percent.

In 2010 and 2011. 11 and 25 new HIV cases were found among Kuwaiti citizens respectively, and the total number of HIV patients on ART by the end of 2010 and 2011 was 165 and 186 (133 men, 52 women and 1 child) respectively. The largest group of ART patients in 2011 was found in the 40-59 years age group (45.7%), while 40.3 percent was in the 20-39 years age group; and 13.4 percent 60-79 years old.

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. 7% of the Kuwaiti population per year), and presented with advanced clinical symptoms. According to the main ART facility in Kuwait, this is a significant proportion of new cases, which indicates that the existing screening programmes are ineffective for identifying most Kuwaiti HIV cases; also because Kuwaiti nationals are screened only once in their life and it is usually not repeated (e.g. pre-employment). Another reason for late HIV diagnosis is the fact that most general practitioners in Kuwait have limited knowledge and experience in recognising HIV symptoms among their patients in an early stage, and patients are often referred in late stages. This shows there is a big gap between HIV specialists and GPs.

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

Social, psychological and legal position of PLHIV – Although the main health, employment and other legal rights of PLHIV are formally protected by laws and policies, PLHIV in Kuwait still face major challenges with regard to social stigma and discrimination, as well as their employment rights. Although the NAP has been trying to facilitate the establishment of support groups or an association of PLHIV, to date, most PLHIV do not want to organise themselves with other PLHIV due to social and self-stigma, and fear of

public disclosure of their HIV status. Most PLHIV keep their status to themselves, or disclose it only to their spouse or closest family members and friends.

While PLHIV are entitled to employment, and cannot be dismissed from their job because of their HIV status, in some sectors, PLHIV are not allowed to work, such as in clinical health care, the military and oil business. Thus, the employment rights of (Kuwaiti) PLHIV are not fully protected, and there have been cases of Kuwaiti PLHIV who knew their HIV status and feared periodic workplace HIV screening, as they would be forced to leave their jobs. Thus, in some cases, the right to full medical retirement of PLHIV despite the fact that they are fit to work, masks the fact that they are not fully entitled to their employment rights. While this applies to Kuwaiti citizens with HIV, the consequences for foreign workers who are found HIV-positive are many times more severe: they face deportation, regardless of how they might have been infected with HIV: some may have been infected through occupational hazards (e.g. in health care), or through sexual abuse by their patrons.

IV. BEST PRACTICES

As described in the previous sections, the national response to HIV in Kuwait has had many challenges, and few achievements, including in the last two years (2010-2011). Among all aspects of a successful response – political leadership; a supportive policy environment; scale-up of effective prevention programmes; scale-up of care, treatment and/or support programmes; effective surveillance, research and M&E; capacity-building; infrastructure development – the main successes to date have been attained in the field of ***antiretroviral treatment for Kuwaiti HIV patients***.

As mentioned, access to high-quality ART is free for all eligible, Kuwaiti citizens, with adequate patient follow-up in place. Clinical treatment is complemented by psychological and social care and support, although this aspect still needs to be more systematised. However, these achievements date back till the beginning of the century, and few new achievements were seen in the 2010-2012 period.

Another promising development is the adoption of a legal framework that will allow the establishment of confidential, voluntary counselling and testing services. While this new legal framework law still needs to be operationalised into the establishment of VCT services, this is a key step towards strengthening people's right to know their HIV status without fear of repercussions in the social sphere, employment, or legal measures.

V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

Overall challenge: "HIV is not a problem, HIV is not <u>our</u> problem"

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 UNGASS report in 2010, and few of them were adequately addressed in the 2010-2011 period.

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

From this perspective, the main response to HIV has always been to treat it as an *external* threat, which has to be kept *out*, and if it cannot be kept out, to deal with those infected on an individual basis: through deportation if possible, or treatment if necessary.

Thus, the two main approaches taken to *"keep HIV out"* are massive screening and antiretroviral treatment of HIV-infected Kuwaitis. Massive HIV screening applies to all expatriate workers – who constitute more than two-thirds of the Kuwaiti population – and of selected Kuwaiti nationals – mainly through testing of blood donors and pre-marital and pre-employment screening. Foreigners identified with HIV are not allowed into the country or are deported to their home countries.

This summarises in a nutshell the key challenge facing the national response to HIV in Kuwait to date, which is characterised by a firm belief that measures taken so far work, and that no additional measures are needed. Moreover, the approach is shared by most countries in the region, especially the GCC countries, which share common policies towards HIV.

Effective <u>and</u> convenient, or just convenient?

Apart from the fact that these two main strategies are considered *effective*, they are also *convenient*, as they don't require facing the many sensitive issues that HIV is surrounded with. HIV/AIDS has always been associated with politically, socially and religiously sensitive issues, that are hard to face head-on, and easy to ignore, especially in the absence of apparent consequences. In this regard, 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.

Rather than proactively addressing the potential underlying drivers of a future epidemic – such as large-scale mobility, exposure to different societies and cultures, changing socio-cultural and sexual behaviour patterns, particularly taboos on extramarital or homosexual sexual relations – it remains easier to continue doing "business as usual" through massive screening and deportation of foreigners, and ART for nationals.

To date, Kuwait has been able to afford its traditional approach to HIV: few cases were found in the last 25 years. However, rapidly increasing exposure to other countries and cultures, globalisation and changing cultural and sexual norms and practices make it clear that HIV can no longer be contained by labelling it as an *"external"* problem. Despite a serious lack of

research into the drivers of HIV/AIDS, there is clear, albeit anecdotal evidence that Kuwaiti nationals, especially young people, are increasingly exposed to HIV. In consequence, the dual approach of screening and ART that seemed to have worked so far, may no longer be an effective response for the future. Complacency and underestimating the risk of HIV, especially for young and future generations, may lead to an increasing number of cases in the near future: while only 206 Kuwaiti HIV cases were found in the last two decades, 25 new cases were found in 2011 alone: this is 12 percent of all cases of the last 25 years, found in one year. If this becomes a trend, it is clear that new approaches are needed.

Specific challenges, specific remedies

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

1. Lack of political support – HIV is still not considered a public health priority in Kuwait. The continuously low HIV-prevalence rates and sensitivities surrounding HIV make it convenient to downplay its potential to become a serious public health problem. Therefore, political support for a more comprehensive national response to HIV – with specific attention for targeted HIV-prevention programmes for MARP groups, and other vulnerable populations, including young Kuwaitis – continues to be weak. 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.

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

Remedial action: 1) Research into the social and behavioural dynamics of MARP groups, youth and other vulnerable groups, that increase HIV risks. 2) Strengthening of existing surveillance systems, especially bio-behavioural surveillance studies among MARPs; 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.

3. Inadequate institutional support systems an budgets – The absence of a functional *National AIDS Committee* or *Council* (NAC), comprising high-level leadership from different sectors, hampers the establishment of a strong, multisectoral response to HIV. In addition, the current MOH-based *National AIDS Programme* (NAP) remains severely 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 NAC.

Remedial action: 1) Establishment of a functional NAC, with effective membership from key sectors, clear mandates and TORs, and adequate administrative support; 2) Strengthening of NAP through: a) Strengthened institutional position as separate HIV/STI Department; Increased technical and administrative staff, with clearly described mandates and TORs that allow NAP to act accordingly; and adequate budgets.

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

Remedial action: Immediate development (2012) of an NSP and costed Operational Plan, with active involvement and participation of all key stakeholders – governmental, civil society including PLHIV, private sector and UN agencies.

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

Remedial action: HIV programmes and services need to be developed and implemented – in line with the NSP – 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 services; programmes to reduce stigma and discrimination; peer education and outreach for MARPs and young people; workplace programmes for Kuwaitis and expatriates; condom promotion for MARP groups; MARP-friendly STI treatment; PLHIV support groups; Legal support for expatriate PLHIV; harm reduction programmes for IDUs; advocacy for and involvement of social, political and religious leaders in HIV prevention; regional collaboration.

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

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

7. Lack of supportive legal, social and policy environments, including stigma and discrimination – In addition to all the challenges mentioned above, legal and policy frameworks and social norms and values may often not be supportive of specific HIV/AIDS programmes and services. Laws criminalising certain groups or behaviours may hamper effective outreach or may not allow certain interventions, such as opioid substitution therapy, safe injection programmes, condom promotion or explicit HIV education for young people.

Similarly, social and religious norms and values may stigmatise HIV-related sexual behaviours and hamper programmes for sex workers and their clients or MSM. In the absence of these supportive environments, none of the above challenges can be effectively addressed.

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

VI. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

Kuwait is high-income country with excellent medical and other infrastructure. In this regard it is not in need of external financial support. However, external partners, especially UN agencies, can play an important role in strengthening the national response to HIV/AIDS through technical assistance.

However, UN presence is very limited, and restricted to a UNDP office. However, the UNDP can mobilise technical assistance from UN agencies, such as for the development of a National Strategic Plan (ASAP, World Bank/ UNAIDS); National M&E Plans (UNAIDS); HIV prevention among MARPs (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).

VII. MONITORING AND EVALUATION ENVIRONMENT

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

To date, Kuwait has not had 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 specific settings (see details below), as well as data from clinical monitoring of HIV patients. However, there is no HIV-surveillance system that assesses HIV prevalence among the general population, nor among most-at-risk groups, such as sex workers, MSM and IDUs, although IDUs 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 MARP groups, programmatic M&E data is mainly restricted to clinical monitoring of HIV patients. All those enrolled in pre-ART care and ART are regularly tested for CD4 and viral load, although some 11 percent of ART patients are lost to follow-up each year.

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

Mass HIV-screening programmes

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

- Expatriates seeking employment of residency in Kuwait; this mainly includes foreign labour migrants;
- Blood donors;
- Pre-employment screening (nationals and expatriates)
- Pre-marital screening (Law No. 31 was established in 2008 and implemented in 2009)
- Food handlers (mainly expatriates)
- Patients admitted to Hospitals for invasive procedures and organ transplants
- Prisons and police
- STI
- IDUs admitted to Psychiatry hospital
- Others, including army recruits and staff, scholarships etc.

In the context of these screening programmes, in 2010, a total of **842,432** people were tested; 21% were Kuwaiti nationals, while 79% were non-Kuwaitis. In the first six months of

2011 a total of **292,479** people were screened for HIV, of whom 13% were Kuwaitis and 87% 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 72% in 2010 and 57% in the first half of 2011. Other large groups tested were food handlers (11% in 2010; 21% in first half 2011); blood transfusion services (8% in 2010; 11% in 2011); pre-employment testing (3% in 2010; 4% in first half 2011); and premarital testing (3% in 2010; 4% in first half 2011).

As mentioned, ***Kuwaiti nationals*** only represent less than one-fifth of all HIV tests. On a yearly basis, approximately 7-8 percent of the Kuwaiti nationals (approximately 77-85,000 per year) are tested for HIV. Among *Kuwaiti nationals,* the largest numbers of people screened for HIV were *blood donors* (accounting for 36% of all Kuwaitis tested in 2010; 42% in first half 2011); *pre-marital* (26% of total in 2010; 30% in first half 2011); and *pre-employment* (20% of total in 2010; 19% in first half 2011) testing.

Clinical monitoring of HIV patients

Clinical monitoring of HIV patients is done in accordance with international standards, i.e. WHO. Patients are regularly followed up through CD4 and viral load testing, as well as clinical check-ups There are some problems with loss to follow-up and retention rates for 2010 and 2011 were 88 and 89 percent respectively.

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

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

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

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

Therefore, a first key challenge for developing (and eventually implementing) a national M&E plan and system is related to the need to develop a National Strategic Plan with a costed Operational Plan that specifies the national priority interventions in the field of HIV/AIDS, which is foreseen for 2012. M&E and surveillance will be a priority component for this new NSP.

2) Inaccuracies and gaps in data collection: as mentioned, the current mass HIV screening system is skewed towards testing of *non*-Kuwaitis, while Kuwaiti nationals account for only 13 percent of those tested, with a mere 7 percent of Kuwaitis 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 and pre-marital testing, while there is no systematic data collection among MARP groups. 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.

	2010	**%**	**2011**	**%**
Total Kuwaiti population	1,133,214		1,164,449	
Men	556,220		571,079	
Women	576,994		593,370	
Total No. Screened (Kuwaiti)	85,448	7.54%	38,348 **x 2**	6.59%
Men				
Women				
Percentage screened of total population		7.54%		6.59%

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

All the same, most-at-risk groups are present in Kuwait – including sex workers, MSM and IDUs – 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. The absence of more systematic data collection regarding the locations, population sizes and dynamics of sexual networks and risk behaviours among all these groups leaves the national response to HIV without a compass.

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

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

Accessibility of data is further hampered by the absence of a ***central database***; e.g. data collection for this GARP report regarding the main HIV statistics and financial data was difficult and requests for information had to be made through different departments with different persons responsible for subsets of data. As said, much of the data was not readily available to the NAP. In addition to these problems with regard to availability and accessibility of available HIV-related data, HIV-related data is not systematically utilised for

policy and programme development. This is evidenced by the absence of a national strategic plan since the 1980s. In this context, a priority remedial action to be undertaken in this context is the establishment of a central data base on HIV.

4) The lack of a unified national HIV/AIDS surveillance and M&E system is further compounded by the ***absence of a special M&E unit or dedicated, trained data-management staff in the NAP***. There has been very limited training in M&E, with most capacity building being offered by multilateral partners such as UNAIDS and WHO. In addition, the electronic infrastructure of the NAP is virtually non-existent with no access to internet at the NAP, and no resource allocation for establishing adequate surveillance and M&E systems.

ANNEXES

ANNEX 1: National Commitments and Policy Instrument (NCPI)