UNGASS COUNTRY PROGRESS REPORT 2010

STATE OF KUWAIT (KW)

Narrative Report (Draft)

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Submitted by

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Glossary of terms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral Therapy
CSO	Civil Society Organization
HIV	Human Immunodeficiency Virus
MARPs	Most at risk populations
MENA	Middle East and North Africa
MOH	Ministry of Health
MOHE	Ministry of Higher Education
MSM	Men Having Sex With Men
NAP	National AIDS Program
NGOs	Non governmental Organizations
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RST	Regional Support Team
STI	Sexually Transmitted Infection
UNAIDS	The United Nations Joint Programme on HIV/AIDS.
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
WHO	World Health Organization

I. Status at a glance

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

The 2010 UNGASS Report enclosed has been prepared with the direct involvement of many stakeholders in the HIV/AIDS response in Kuwait. This included most governmental stakeholders involved in the HIV/AIDS response. The direct support of the Assistant Undersecretary for Public Health and NAPs offices Within the Ministry of Health in providing coordination (content and logistics) for the report preparation was critical, so was the involvement of the Infectious Disease Hospital. Other governmental agencies involved included the Ministry of Planning, Ministry of Defense, Ministry of Education, as well as the Central Transfusion Services Administration. All of these government agencies showed commitment and provided information that were instrumental in completing the report.

International organizations, especially UNDP and UNESCO, showed great willingness to support HIV/AIDS response and were supportive of the efforts of UNGASSS reporting.
It is worth noting that in addition to the valuable and individual contribution of the organizations/enteritis mentioned above to the UNGASS report, they were generous with their time devoted to the meetings held to discuss and validate the different processes involved in the UNGASS reporting.

(b) the status of the epidemic

The State of Kuwait is one country in the Region where information on HIV/AIDS epidemic has been scarce, although it has been more than 25 years since the first case of Human Immunodeficiency Virus (HIV) in Kuwait was diagnosed (1984). In 2009, there were 160 PLHIV, 119 were males and 41 were females. Of those, 131 are currently receiving ART treatment (101 males and 30 females).

(c) the policy and programmatic response

Historically, the issue of HIV/AIDS has acquired political support. However, that support has not been translated into actionable state on a micro-level. Most of the political debate on the issue of HIV/AIDS has been on how to deal with the issue of testing and interpreting clinical findings (borderline results, dormant period, etc.) for incoming non-nationals. This is a hot issue for debate as all of the incoming non-nationals to Kuwait have to be tested for HIV (among other infectious diseases). Those who test positive are denied entry and are deported. Very recently, a ministerial decree was issued (February 2010) re-outlining the roles and responsibilities of the National AIDS Program. It is the hope that such a ministerial decree will have a positive effect on the HIV/AIDS response in the State of Kuwait.

The NAP program in Kuwait has an opportunity to be more proactive in its response to the disease, especially in the issue of prevention and raising awareness. Because very little is done at this point, it is expected that well-planned efforts will have a favorable impact. This should be done in the context of the Three Ones:

- **One** agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.
- **One** National AIDS Coordinating Authority, with a broad-based multisectoral mandate.
- **One** agreed country-level Monitoring and Evaluation System

As such, it is greatly advisable that efforts start towards that goal.

(d) UNGASS indicator data in an overview table

Serial	Indicator	Remarks
Reported Indicators		
1	Indicator 1: Domestic and International AIDS Spending	4.22 million USD in 2007 (1,198,712 KD) 4.70 million USD in 2008 (1,255,540 KD) 4.58 million USD in 2009 (1,315,533 KD)

		Spending is almost entirely from domestic sources
2	Indicator 2: National Composite Policy Index	Completed
3	Indicator 3: Percentage of donated blood units screened for HIV in a quality assured manner	Online reported rate: 100% 100% of the donated blood units in Kuwait are screened for HIV/AIDS. National Blood Banks have an internal and an external quality assurance system. In 2008, of the 61,771 tests done on blood units and platelet donors, 84 screened positive for HIV1 Ag (P24)
4	Indicator 4: Percentage of Adults and Children with advanced HIV Infection receiving ART	**2008 Reporting Year:** Total:117 Males<15:2 Males=>15:90 Females<15=1 Females=>15=24 **2009 Reporting Year:** Total:131 Males<15:2 Males=>15:99 Females<15=1 Females=>15=29
5	Indicator 5: Percentage of HIV-positive pregnant women who receive ARV to reduce the risk of MTCT.	**2008 Reporting Year:** 5 **2009 Reporting Year**:4 Treatment Regimen: D (based on core indicator guide classification)
6	Indicator 6: Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	There were 0 confirmed cases in 2008 and 2009.
24	Indicator 24: Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of ART	**2008 Reporting Year:** Total:12 Males <15=0 Males =>15=9 Females<15=0 Females=>15=3 **2009 Reporting Year:** Total:14 Males <15=0 Males =>15=10 Females<15=0 Females=>15=4
Indicators with no information to report on/ Irrelevant to Kuwait		
7	Indicator 7: Percentage of women	HIV testing in Kuwait is mainly done at the 3

	and men aged 15-49 who received an HIV test in the last 12 months and who know their results	laboratories (Central Transfusion Administration Service, Virology Laboratory in Public Health Department and the WHO Collaborating Center in the Faculty of Medicine at the University of Kuwait). Most of the tests performed at the Central Transfusion Administration Service are for blood donors. The Virology Laboratory In the Public Health Department performs the testing for incoming non-nationals seeking residency as well as testing for referrals from hospitals and, kidney dialysis patients, transplant patients, health care workers, prisoners, students for police academy and military and national guards, IV drug users admitted to addiction center and HIV contacts among others. Self-referred individuals do not constitute the majority of those being tested. The number of tests done by the WHO Collaborating Center at the Medical School is significantly less than the other two laboratories. Confirmatory tests for HIV are conducted at the Virology Laboratory and the WHO Collaborating Center. It has to be noted that the system of reporting number of tests and test results is defragmented and because of the recent changes in roles and responsibilities for HIV/AIDS at the MOH, there is a discontinuation of reporting. Positive results are organizationally reported to the NAP for follow-up and documentation. The laboratories send the NAP forms on a monthly basis indicating the number of HIV tests and test results. No private laboratories test for HIV in the country. Testing for HIV/AIDS in Kuwait is mainly performed on non-nationals seeking residency, In all instances, there is little evidence/no documentation that individuals who tested negative know the result. The assumption is that since no notification of a positive result is given, then the test is negative. Nationals who test positive are notified based on procedures outlined in Figure 1 above. Non-nationals are offered counseling and deported. In addition, no population survey exists that provides

		information on the subject. A study conducted by Akhtar and Mohammad in 2008 [1] used information from January 1, 1997 to December 31, 2007, to determine the prevalence of HIV among the migrant workforce and how the number of infected workers is changing over the study period. The migrants predominantly came from India (31%), Bangladesh (14%), Sri-Lanka (14%), Egypt (12%), Indonesia (9%), Philippine (5%), Pakistan (5%) and 10% from other countries. HIV tests of 2,328,582 migrants were studied, and the results were as follow: • Overall HIV seroprevalence = 21 per 100,000 (0.021%) • The numbers ranged from 11 per 100,000 in 2003, to 31 per 100,000 in 1998 • Between 1997 and 2003, the trend in the prevalence of HIV among these workers was not discernable, but from 2003 to 2006 there was a consistent increase in the prevalence of HIV workers Another study was conducted to determine the impact of the policy to screen all the expatriates – upon entry into Kuwait – for HIV, HBV (Hepatitis B virus) and HCV (Hepatitis C virus) on the prevalence of these three diseases among expatriates seeking jobs in Kuwait.[2] During 1998 and 1999, 243,258 expatriates were included in the study, all of them were tested for HIV, but 129,973 were tested for HBV and HCV. The findings revealed the following: • 0.025% of the total workforce tested was infected with HIV, with the highest percentage among Indians (0.057%) • 0.635% was infected with HBV, and 0.336% was infected with HCV, and Egyptians (1.259%) and Bangladeshi (1.731%) represented the highest prevalence of these 2 diseases
8	Indicator 8: Percentage of most-at-risk populations who received	Prostitution and homosexuality are banned in Kuwait and are not looked at favorably in the religious, social

[1] Akhtar, S. and Mohammad, H.GHH. (2008). Spectral analysis of HIV seropositivity among migrant workers entering Kuwait. *BMC Infectious Diseases*, 8(37), doi:10.1186/1471-2334-8-37

[2] Al-Mufti, S.,Al-Owaish, R., Mendkar,Y.I. and Pacsa, A.(2002). Screening Expatriate Work Force for HIV, HBV, and HCV Infections in Kuwait. *Kuwait Medical Journal*, 34 (1), 24-27

	an HIV test in the last 12 months and who know their results	and cultural context of Kuwait. There is very limited data related to such groups. A worth noting fact is that The Central Transfusion Administration Services administer a survey to blood donors prior to blood donations. If the individual identifies himself/herself as have engaged in risky behavior, they are banned from donating blood from that point on. Most of the testing information available is based on studies and not on surveillance data. Testing was done among 1984 STD patients seeking a Family Planning Center (31% of attendees were nationals and 69% were non-nationals) to determine the prevalence of HIV/AIDS among these patients. None of these patients was HIV positive.[3] It has to be noted that results may not be totally representative of the situation since (1) attendees of the Center were mostly males since females are referred to the maternity hospital for STDs cases, (2) the majority of Kuwaiti males receive services in private clinics and (3) HIV positive non-nationals may be hesitant to visit the center for fear of deportation.
9	Indicator 9: Percentage of most-at-risk populations reached with HIV prevention programs	Implementing HIV prevention programs among MARPs in Kuwait is particularly challenging mainly because of legal and law enforcement barriers. Modest efforts are documented; For example, to manage STDs in Kuwait the Family Planning Center was established, it deals mainly with immigrants' male patients. Between June 1996 and June 1997, 1984 visits were made. However, most of these visits were for STD diseases other than HIV, mostly urethritis and gonorrhea. [4]
10	Indicator 10: Percentage of orphans and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	Indicator is irrelevant to the epidemiological context in Kuwait.
11	Indicator 11: Percentage of schools that provided life-skills based HIV education within the last academic year	The Ministry of Education introduced HIV/AIDS prevention messages in intermediate and secondary school curricula, as well as in health-related disciplines. However, in reviewing the curriculum, it was obvious that the approach used is based on

[3] Al-Owaish, R. A., Anwar S., Sharma P. and Shah S. F. (2000). HIV/AIDS prevalence among male patients in Kuwait. *Saudi Medical Journal*, 21 (9), 852-859.

[4] Al-Owaish, R. A., Anwar S., Sharma P. and Shah S. F. (2000). HIV/AIDS prevalence among male patients in Kuwait. *Saudi Medical Journal*, 21 (9), 852-859.

		stigmatizing those infected with HIV, and using that as a prevention message.
12	Indicator 12: Current school attendance among orphans and non-orphans aged 10–14	Indicator is irrelevant to the epidemiological context in Kuwait.
13	Indicator 13: Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	In 1994, a pilot study was conducted in Kuwait in order to understand how well nationals and non-nationals know about HIV/AIDS and its modes of transmission, what are their beliefs and attitudes towards AIDS control and AIDS patients, how do they behave regarding this disease, and what are their main sources of information on HIV.[5] The study was conducted between January and April 1994, and 116 individuals, both nationals and non-nationals, were interviewed. The respondents were chosen from 5 different categories (e.g. university students, school teachers, international travelers, primary health care patients and general public). The results of this study were as follow: • 41% have little knowledge about HIV • > 53% attribute AIDS transmission to mosquitoes, sharing of lavatory seats or breast feeding • 51% consider AIDS a contagious disease • 26% think that HIV is transmitted through blood donation • 97% are aware of the transmission of HIV through having "sex with prostitutes" • 96% know that "sex with multiple partners" can transmit HIV
14	Indicator 14: Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	No specific surveys among MARPs were conducted to test their knowledge.
15	Indicator 15: Percentage of young women and men who have had sexual intercourse before the age	Information is not available on that indicator.

[5] Al-Owaish, R. A., Moussa, M. A.A., Anwar, S., Al-Shoumer H. A. and Sharma, P. (1995). Knowledge, attitudes, beliefs and practices of the population in kuwait about AIDS – a pilot study. *Eastern Mediterranean Health Journal*, 1(2), 235-240.

	of 15	
16 17	Indicator 16: Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months Indicator 17: Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last sexual intercourse	Data is very limited on this indicator. Most sexual relations in Kuwait are unprotected; the use of condoms is recent and only 1.5% of STDs clinic attendees reported using condoms in their exposures.[6]
18	Indicator 18: Percentage of female and male sex workers reporting the use of a condom with their most recent client	The illegality of sex work and absence of mapping for this group limits the ability to collect data on this group. No specific data is available on the indicator.
19	Indicator 19: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Information is not available on that indicator.
20 21	Indicator 20: Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse Indicator 21: Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	IDUs has been reported as one of the leading modes of HIV transmission in Kuwait.[7] The number of drug users in Kuwait is estimated between 27,000 and 55,000.[8] There is no data on the prevalence of condom use among this MARP. However, most sexual relations in Kuwait are unprotected; the use of condoms is recent and only 1.5% of STDs clinic attendees reported using condoms in their exposures.[9]

[6] Al-Mutairi, N., Joshi, A., Nour-Eldin, O., Sharma, A., El-Adawy, I., & Rijhwani, M. (2007). Clinical patterns of sexually transmitted diseases, associated sociodemographic characteristics, and sexual practices in the Farwaniya region of Kuwait. *International Journal of Dermatology*, 46(6), 594-599. doi:10.1111/j.1365-4632.2007.02843.x.

[7] UNAIDS/WHO. (2005). AIDS epidemic update 2005. http://www.unaids.org/epi/2005/doc/EPIupdate2005_pdf_en/epi-update2005_en.pdf Retrieved: March 24, 2010.

[8] Jenkins, C., Robalino, D. A. (2003). HIV/AIDS in the Middle East and North Africa: The Costs of Inaction. World Bank, 2003. http://books.google.com/books?hl=en&lr=&id=IfLm_bY6YIoC&oi=fnd&pg=PR9&dq=HIV/AIDS+in+the+Middle+East+and+North+Africa:+The+Costs+of+Inaction&ots=9lyviuEcPR&sig=I4vVbJDKtNqqlI4ehlWZvOKJgUk#v=onepage&q=&f=false Retrieved: March 24, 2010

[9] Al-Mutairi, N., Joshi, A., Nour-Eldin, O., Sharma, A., El-Adawy, I., & Rijhwani, M. (2007). Clinical patterns of sexually transmitted diseases, associated sociodemographic characteristics, and sexual practices in the Farwaniya region of Kuwait. *International Journal of Dermatology*, 46(6), 594-599. doi:10.1111/j.1365-4632.2007.02843.x.

22	Indicator 22: Percentage of young people aged 15-24 who are HIV-infected	Data from NAP reveals that there are a total of 8 cases of HIV/AIDS cases in that age group.
23	Indicator 23: Percentage of most at risk populations who are HIV-infected	There is limited information on the prevalence of HIV/AIDS among MARPs in Kuwait because of the lack of accurate information on the total number of MARPs.
25	Indicator 25: Percentage of infants who are born to HIV-infected mothers who are infected	Modeling was not conducted due to missing information

Table 1. Number of HIV Tests Done among Different Groups in Kuwait by Laboratory, 2008

	Central Blood Bank			Virology Laboratory in Public Health Department			WHO Collaborating Center in the Faculty of Medicine at the University of Kuwait		
Group tested	**Nationals**	**Non-nationals**	**Total**	**Nationals**	**Non-nationals**	**Total**	**Nationals**	**Non-nationals**	**Total**
Public Hospitals				1,993	987	2,980			
Private Hospitals				1,015	2,541	3,556			
Other Hospitals				70	41	111			
Individuals Seeking Medical Clearance for a Job				15,036	10,364	25,400			
Scholarship requests				0	336				
Prisoners				952	2,137	3,089			
Police Academy				2,562	200	2,762			
Drug Users in Mental Facilities				335	49	384			
Armed Forces				4,146	1,245	5,391			
Voluntary Testing for Health Certificate				687	733	1,420			
Food workers				737	101,349	102,086			
Individuals in Contact with HIV/AIDS Patients				7	2	9			
Non-nationals Seeking Residency				0	279,190	279,190			
Occupational Health Testing				466	594	1,060			
Blood Donors	28,063	32,415	60,478	0	0	0			
Total	**28,063**	**32,415**	**60,478**	**28,006**	**399,768**	**427,774**			**63**

II. Overview of the AIDS epidemic

In 2009, there were a cumulative number of 160 HIV/AIDS cases. Of those, 41 were females and 119 were males. Of the females, there was 1 female who was under 15 years of age (2 years). For males, two were younger than 15 (9 and 11 years of age) and 117 were 15 and older. The main modes of known transmission are through heterosexual sex (84.4%) followed by homosexual (6.3%) and maternal-fetal It has to be noted that these figures are only for Kuwaitis.

Table 2. HIV/AIDS Case Distribution by Age Group and Sex, 2009

Age Group	Cumulative total HIV/AIDS		
	Male	Female	Total
<15	2	1	3
≥15	117	40	157
Total	119	41	160

Table 3. HIV/AIDS Case Distribution by Age Group and Sex, 2009

Age Group	Cumulative total HIV/AIDS		
	Male	Female	Total
0-9	0	1	1
10-19	3	0	3
20-29	14	9	23
30-39	44	17	61
40-49	43	8	51
50-59	9	5	14
60-69	4	1	5
70-79	2	0	2
Total	119	41	160

Table 4. HIV/AIDS Mode of Transmission, 2009

Mode	No.	%
Heterosexual	135	84.4%
Homosexual	10	6.3%
Bisexual	1	0.6%
IDU	3	1.9%
Blood Related	2	1.3%
Maternal-Fetal	4	2.5%
Unknown	5	3.1%
Total	160	100.0%

III. National response to the AIDS epidemic

Countries should specifically address the linkages between the existing policy environment, implementation of HIV programs, verifiable behavior change and HIV prevalence as supported by the UNGASS indicator data.

The national response to HIV/AIDS in Kuwait has shown some progress in recent years. However, many areas remain in need of further development. The sections below highlight specific areas within the policy environment, prevention and treatment where developments were made and their potential effect.

(a)Political leadership & supportive policy environment

Historically, the issue of HIV/AIDS has acquired political support. However, that support has not been translated into actionable state on a micro-level. Most of the political debate on the issue of HIV/AIDS has been on how to deal with the issue of testing and interpreting clinical findings (borderline results, dormant period, etc.) for incoming non-nationals. This is a hot issue for debate as all of the incoming non-nationals to Kuwait have to be tested for HIV (among other infectious diseases). Those who test positive are denied entry and are deported. Very recently, a ministerial decree was issued (February

2010) re-outlining the roles and responsibilities of the National AIDS Program. It is the hope that such a ministerial decree will have a positive effect on the HIV/AIDS response in the State of Kuwait.

(b) Prevention programs

Most prevention efforts in the State of Kuwait are targeted towards the general population. Very few prevention activities are targeted at MARPs. At the core of these efforts are communication and awareness campaigns conducted to promote being faithful to spouse, infection control activities (especially in health care facilities), male circumcision and PMTCT-related activities. HIV prevention messages are also included in intermediate and secondary school curricula, as well as in health-related disciplines. Beyond knowledge and behavioral campaigns, very few action-oriented activities, e.g. condom distribution, are conducted to date. The key activities related to prevention are the introduction of a pre-marital testing and testing of incoming non-nationals. It is very important to note that currently there are no VCT centers in the State of Kuwait.

The shortcomings in the HIV/AIDS prevention efforts are (1) the lack of a communication campaign strategy, (2) the focus of efforts on behavioral change campaigns and (3) the scarcity of prevention efforts directed towards MARPs, (4) very limited inclusion of civil society and (5) the absence of assessments of effectiveness of the conducted activities.

(c) Care, treatment and/or support programs

Treatment is currently available for all nationals. Current treatment protocols conform to WHO guidelines. Furthermore, Kuwait started conducting phenotyping and genotyping on all HIV/AIDS patients. The genotype , started in 2004, happens in baseline screening on first visit and as needed when treatment failure occurs. Phenotyping, started in 2007, is done as needed for patients who experience treatment failure and are known to have a multiple drug resistant (MDR) HIV. Genotyping is conducted in Kuwait and in Germany

(as an option) and phenotyping is conducted in Germany. Depending on profile of patient resistance, the next treatment regimen is defined.

In 2009, there were 131 individuals who were receiving ARV treatment. Of those, 2 were males younger than 15 and 99 were males 15 years of age and older. On the other hand, there were 30 females receiving ARV treatment, 1 younger than 15 and 29 who were 15 years and older.

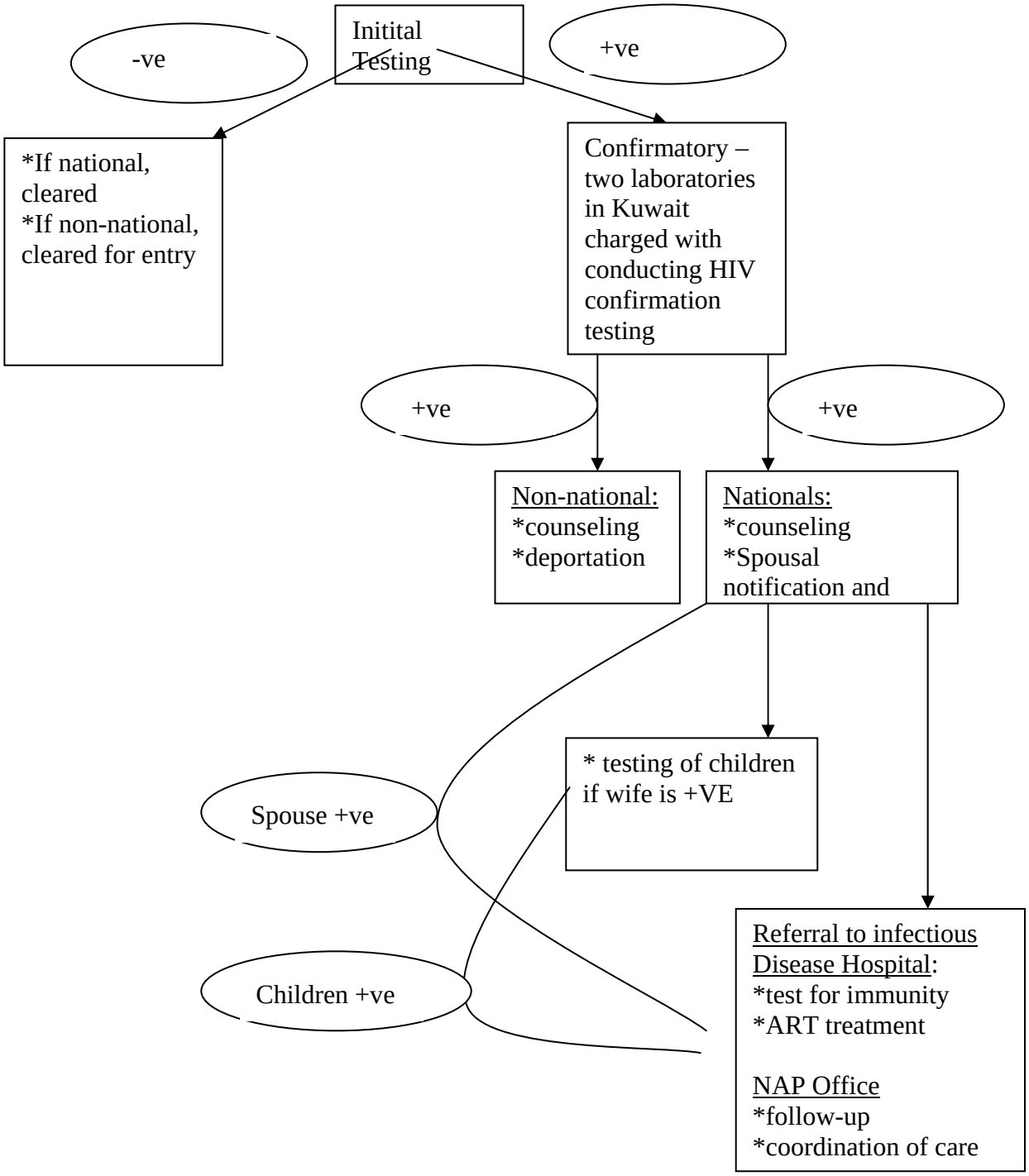
Table 5. HIV/AIDS Cases under Treatment

Age Group			
	Male	Female	Total
<15	2	1	3
≥15	99	29	128
Total	101	30	131

Table 6. HIV/AIDS Cases under Treatment by Age Group and Sex, 2009

Age Group			
	Male	Female	Total
0-9	0	1	1
10-19	3	0	3
20-29	9	2	11
30-39	33	13	46
40-49	41	8	49
50-59	9	5	14
60-69	4	1	5
70-79	2	0	2
Total	101	30	131

Figure 1. HIV/AIDS Care Diagram in Kuwait



IV. Best practices

A number of achievements/milestones that happened in Kuwait in the past few years are worth noting.

(1) There is comprehensive access to treatment that is according to WHO guidelines
(2) Premarital screening for couples has been implemented since 2008 (Emiri Decree No. 31)
(3) Genotyping and phenotyping has been initiated for all HIV/AIDS patients

V. Major challenges and remedial actions

The abovementioned milestones in Kuwait's HIV/AIDS response is matched with a number of major challenges that have to be addressed. Some of these can be addressed through short- and medium-term remedies, while others would need considerable investments with longer-term impacts.

(1) The State of Kuwait has not had a functional NAC for a number of years. There is a need to re-establish the committee with a clear reinforcement and commitment from National and MOH leadership to its strategic role in the HIV/AIDS response (*short-term*)
(2) The last National Strategic Plan (NSP) was developed in the 1980s. Since then, Kuwait did not develop a strategic plan. This is considered a major shortcoming of the HIV/AIDS response in the country. In the absence of an NSP and OP, the targeted and cohesive response will not exist and the response will continue to be sporadic and potentially inefficient and ineffective. The remedial action for such a shortcoming can be addressed relatively in a short-time frame, if there is a national commitment to participate in such a needed activity (*short-term*).

(3) The surveillance system in the State of Kuwait can be significantly improved. This issue is beyond HIV/AIDS to include the overall health surveillance system (*medium-term*)

(4) The NAP in any country plays a critical role in the HIV/AIDS response. In the State of Kuwait and due to mostly lack of clarity in roles and responsibilities, the NAP involvement has been sub-optimal. As such, a revision of the TOR for the NAP and a clear organizational outlay of its position within the MOH would help address this issue (*short- to medium-term*).

(5) There is no monitoring and evaluation system for HIV/AIDS in Kuwait. Most M&E activities are being conducted on a per-needed basis with much time and energy invested to obtain indicators with questionable reliability. This problem is further complicated by the recent transition of HIV/AIDS records between Departments within MOH which resulted in confusion and displacement of patient records (*short- to medium-term*).

(6) There is a scarcity of CSOs that are directly involved in the HIV/AIDS response. The main CSOs that are currently supporting activities are mainly two human resources (Kuwaiti Union for Women's Organizations and Lothan Center for Youth Achievements) agencies who cater for a wide range of social services. Their involvement in HIV/AIDS has been primarily to address a gap in the response and, to a lesser degree, to capitalize on resources that may be available for HIV/AIDS. Although the efforts of these CSOs are noteworthy, there is a great need for CSOs to develop whose primary role is to address gaps in the social commitment to the disease. However, for this to happen, a welcoming political and social environment should exist, as well as resource support (*medium to long-term*).

(7) There are no VCT clinics in Kuwait. The presence of such clinics in other countries has proved to serve a facilitating role in the HIV/AIDS response. The establishment of VCTs in Kuwait can greatly help the response on multiple fronts including outreach, preliminary testing and support services (*medium to long-term*).

(8) There is an extremely limited contribution of PLHIV in the HIV/AIDS response in Kuwait. This is mainly due to the groups' reluctance and fear of being identified (there were no PLHIV willing to write a newspaper article on HIV/AIDS even when anonymity is preserved). Reversing such a fact requires concerted and long-term efforts. However, it is believed that involvement of PLHIV would be a valuable tool in the HIV/AIDS prevention efforts (*medium to long-term*).

VI. Support from the country's development partners

The State of Kuwait, similar to a number of other GCC countries, is a financial supporter vs. receiver of international aid. As such, the presence – and influence – of international organizations is limited to providing technical assistance in areas identified jointly with the Government of Kuwait and based on the countries set priorities. To date, HIV/AIDS response has not been an area jointly identified by both parties as a priority in the country. As such, the technical support (since financial is not needed) has been limited in the building capacity. It is the hope that with the commitment of the leadership in the Ministry to the issue of HIV/AIDS, such efforts will be expanded in the next period.

VII. Monitoring and evaluation environment

There is no formal – or informal – M&E system in the State of Kuwait. The information present is mostly based on individual investigations. Surveillance for HIV also includes regular screening for pregnant women and blood donors, pre-marriage screening, as well as testing hairdressers, cleaners and food-handlers.[10]

[10] AL-Fouzan, A. and AL-Mutairi, N. (2004). Overview of Incidence of Sexually Transmitted Diseases in Kuwai. *Clinics in Dermatology*, 22, 509–512, doi:10.1016/j.clindermatol.2004.07.002

The following action can serve as a preliminary roadmap for addressing the gaps in the M&E system:

1- The establishment of a national M&E committee or working group with a clear mandate and terms of reference to coordinate M&E activities
2- The approval of a designated budget for the implementation of M&E plans and activities
3- Building M&E capacity at the NAP level, Infectious Disease Hospital and Laboratories
4- Formalizing the design of an M&E system with associated data collection tools, points, indicators, communication routes, responsibility centers and dissemination approaches, as well as clear timeframes