COUNTRY PROGRESS REPORT
LEBANON

Narrative Report

2012

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GLOSSARY OF TERMS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral Therapy
BSS	Bio-Behavioral Survey
CEDR	Center for Education Development and Research
DG	Director General
FSW	Female Sex Workers
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IDU	Intravenous Drug Users
IEC	Information, Education and Communication
MARP	Most at Risk Populations
MoPH	Ministry of Public Health
MSM	Men who have Sex with Men
NAP	National AIDS Control Program
NGO	Non-Governmental Organizations
NSP	National Strategic Plan
PLHIV	People Living with HIV
PMTCT	Prevent Mother to Child Transmission
STI	Sexually Transmitted Infections
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

I. STATUS AT A GLANCE

Lebanon is a small middle-income country of an estimated 4 million inhabitants. Located on the eastern shores of the Mediterranean Sea and to the western part of Asia, Lebanon is at a crossroads of the Mediterranean Basin and the Arabian vicinity. The unique location of Lebanon has dictated its rich cultural identity of religious and ethnic diversity. A lengthy civil war devastated the country for 15 years (1975 – 1990) and had a huge toll on the country, including a major negative impact on the health care sector. But Lebanon has since invested extensive efforts to rebuild its political institutions and revive the economy. Since the end of the war, the country has experienced a period of relative calmness and prosperity, driven by tourism, agriculture, and banking. The assassination of former Prime Minister Rafiq Hariri in February 2005 caused a major political deadlock in the country. And in July 2006, a 34-day armed conflict caused significant civilian death and heavy damage to Lebanon's civil infrastructure.

The total health care expenditure in Lebanon summed up to 2 billion US dollars in 2001 accounting to 12.3% of the national GDP (Kronfol, 2006). This high spending on the health sector is considered to be a significant source of economic waste in the nation. The Lebanese government, through the MoPH, initiated a series of reforms in the sector in an effort to combat the increasing health costs and to decrease the inefficiency in the health care system. Although the reform process succeeded in improving certain figures in the system, it was not able to address all the pressing problems.

According to the latest statistics from the World Fact Book, 68% of the Lebanese population is between the ages of 15 and 64, with the median age of 30 years. The population growth rate is estimated at 0.24% with 87% of total population living in an urban area. From a health perspective, the maternal mortality rate is around 26 deaths/100,000 live births and the infant mortality rate is estimated at 15.85 deaths/1,000 live births; with a live expectancy at birth of 75.01 years. Lebanon, uniquely, has a high physician density of 3.54 physicians/1,000 population. The HIV/AIDS - adult prevalence rate is estimated at a 0.1% as of 2009 with the country ranking as 137th compared to its international peers; with around 3600 individuals reported living with HIV/AIDS according to UNAIDS estimates.

(A) The Inclusion of Stakeholders in the Report Writing Process

The UNAIDS Country Progress Report for Lebanon 2012 has been developed collaboratively. A number of stakeholders and experts joined efforts in determining the actions set out in these pages. Under the leadership of the National AIDS Program (NAP) and with the support of the Ministry of Public Health (MoPH) in Lebanon, broad consultations were held to solicit feedback on the document. National HIV/AIDS organizations, health care professionals, and researchers at all levels participated in meetings to solicit input and/or feedback on the draft.

(B) The Status of the Epidemic

In 2011, the UNAIDS estimated that a rough 34 million people were living with HIV at the end of 2010 compared to 26.2 million in 1999 — a 30% increase (UNAIDS, 2011). In specific, the estimated number of children living with HIV is 2.5 million, and slightly more than 50% of the population living with HIV are women and girls (UNAIDS, 2010a).

The lack of timely and consistent epidemiological data in Lebanon and the region hinders the comprehensive understanding of HIV-related dynamics and trends. From that end, passive reporting is considered the only reporting mechanism for acquiring the latest epidemiological trends in Lebanon (NAP, 2010). Despite the fact that Lebanon is considered a low prevalence country for HIV/AIDS, still there are indications of clearly defined pockets of concentrated epidemic with MARPs (UNFPA, 2011).

For instance, the Lebanese National AIDS Control Program (NAP) reported the cumulative cases at 1455 cases by November 2011, with 109 newly reported cases, and mostly through sexual transmission. 33% of the cases are HIV, 34% are AIDS and the rest (33%) are unspecified. Only 28% had a history of recent travel. Over the past 5 years, data shows that the vast majority of the cases are males (93% in 2011) (Figure 1). Data analysis of the reported cases in the past year has revealed that 28% of the cases are below thirty years of age, 30% are between 31 and 50, 9% are above 51, while the rest are unspecified (Figure 2). Sexual transmission accounts for 51% of the cases and 47% being non-specified (Figure 3). Out of the specified sexually transmitted cases, 27.5% are among heterosexuals, 22% are among Males who have sex with Males (MSMs), 0.9% among bisexuals and 49.6% unspecified (Figure 4).

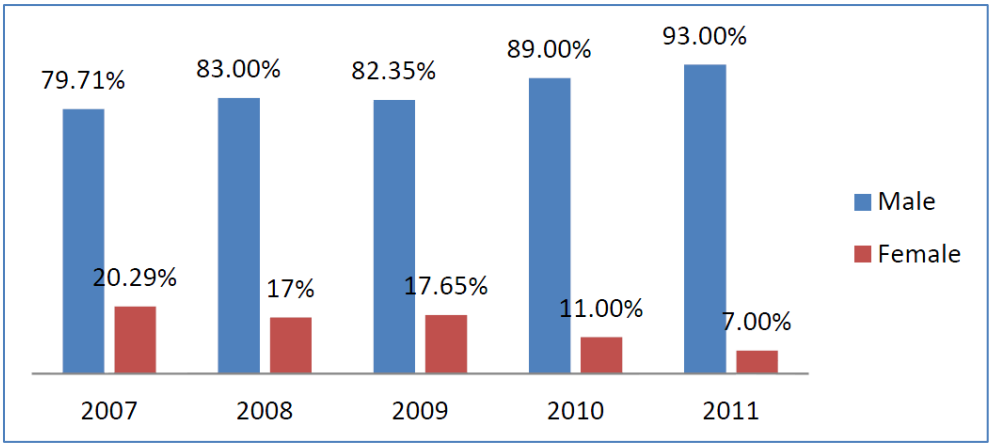

Figure 1. Gender distribution over the last 5 years

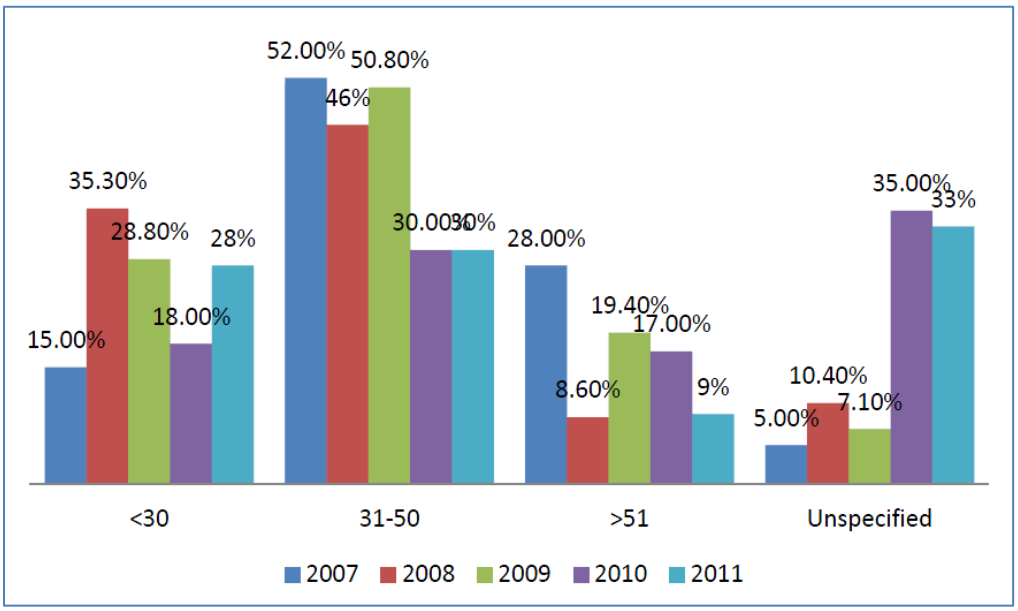

Figure 2. Distribution of HIV/AIDS Cases by Age Group

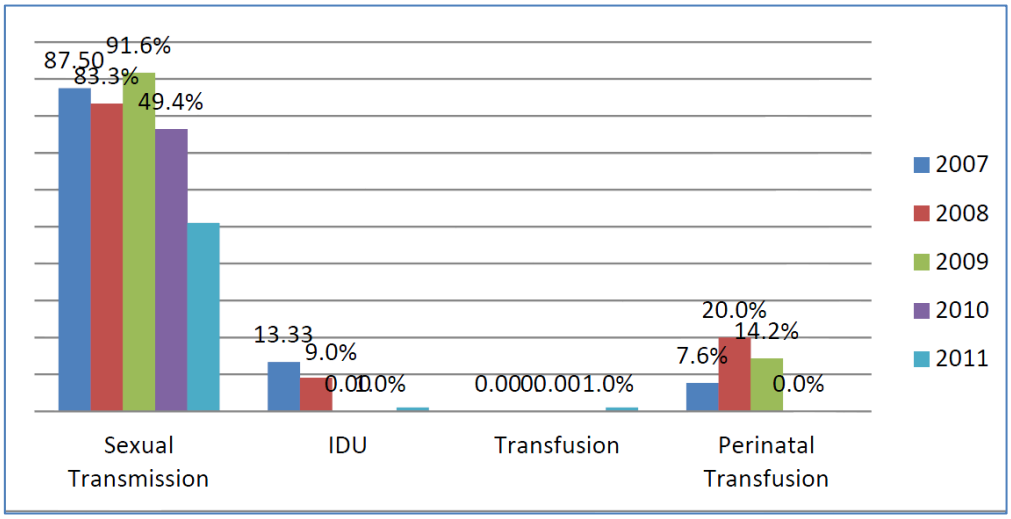

Figure 3. Distribution of HIV/AIDS Cases by Modes of Transmission

N.B. For 2010 we have 24% and for 2011 we have 47% of the reported cases did not specify their way of transmission.

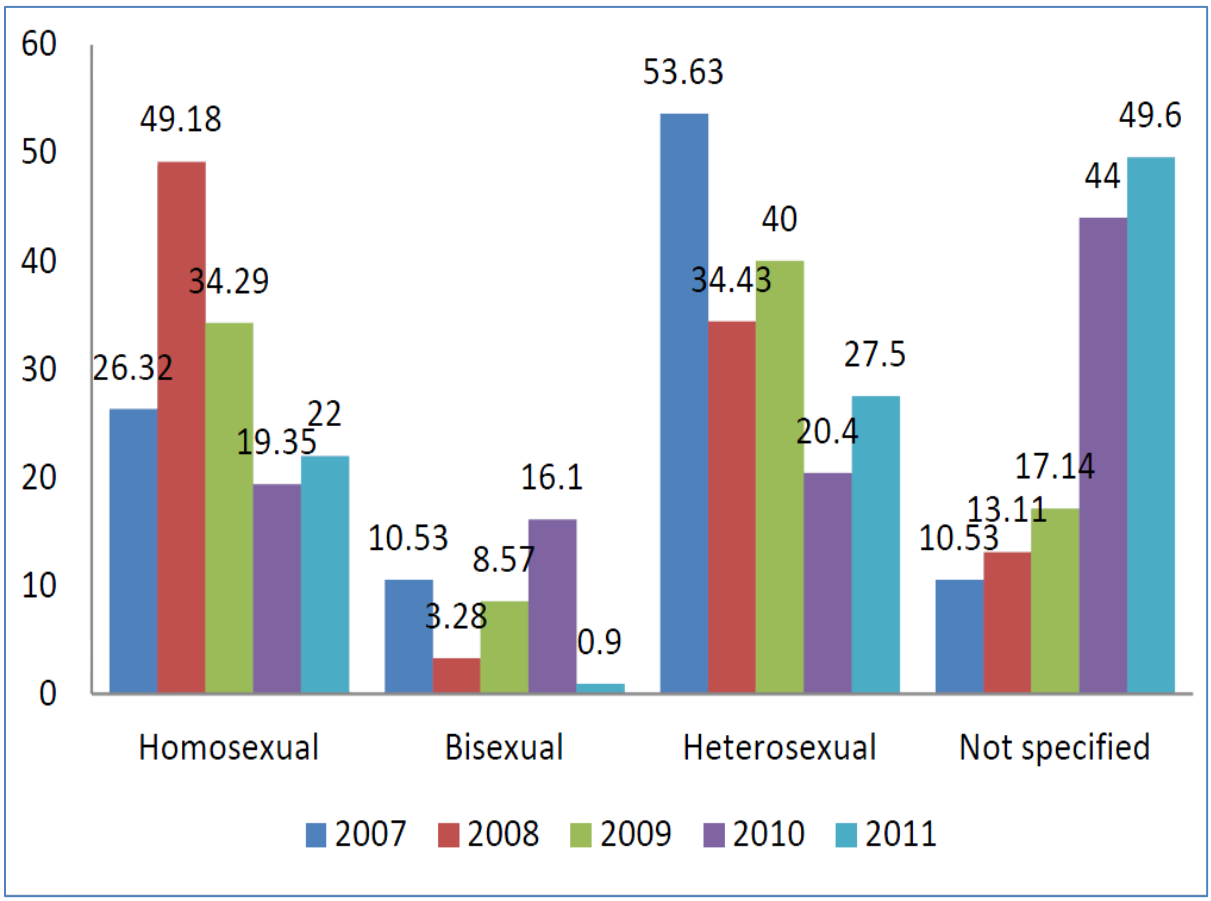

Figure 4. Distribution of HIV/AIDS Cases by Sexual Behavior

(C) The Policy and Programmatic Response

The situational assessment of HIV/AIDS in Lebanon established the need to strategically address four major priority areas and hence a strategic framework has been formulated. The framework guided the finalization and implementation of interventions listed under each of the four pillars identified for the National Strategic Plan aimed at sensitization, prevention, treatment and support for HIV patients and those at risk. The four pillars identified for the National Strategic Plan are as follows:

1. Advocacy, human rights and coordination
2. Prevention,
3. Treatment, care and support
4. Monitoring, surveillance, and evaluation

The National AIDS Program (NAP) established fundamental principles for guiding the national response to HIV/AIDS in the country. It identified clear priority areas where increased attention is anticipated to have the highest impact on preventive measures, and on reducing the impact for those already infected in Lebanon. It is understood that combating HIV/AIDS requires a broad and multisectoral response that addresses both its underlying causal factors as well as its complex consequences. As such, the National Strategic Plan was developed based on the following guiding principles:

i. Increased commitment by the government in terms of support in such areas as policies, visibility, and resource mobilization
ii. Increased commitment by employers' and workers' organizations
iii. Increased commitment by professional groups such as media, lawyers, and educators as facilitating agents of change
iv. Partnership between government and civil society in the fight against HIV/AIDS
v. Coordinating and harmonizing the national response through linking results and accountability to stakeholders (institutions and partners).

Strategic planning has stimulated central and local governments, NGOs, communities, and international partners to define strategies that are adapted to the different contexts in which the HIV/AIDS evolution took place. In specific, strategic planning has been able to identify different successful prevention activities and interventions that have targeted behavioral change and associated social norms in developing countries. Amongst the established activities are programs aiming at increasing condom use, follow-up visits of sex

workers, the delay of the first sexual relationships, and the decrease in needles sharing among IDUs.

Among the essential facts that make a program effective, one can observe: a strong political involvement to handle the disease, and a multi-sectoral approach for prevention and care. This is translated into the contribution of many ministries, responses at many levels, an effective monitoring of the epidemic and risk behaviors, and the implementation of a large-scale prevention and integrated care. The combined efforts of all the groups allow reinforcing the actions that help contain the disease and diminish the trauma of its impact on the nation and its development.

(D) Indicator Data in an overview table

Targets		Indicator	Measure
Target 1. Reduce sexual transmission of HIV by 50 % by 2015 *General Population*	1.1	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	A KAP study on the youth has just been finalized and we are awaiting the results
	1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	A KAP study on the youth has just been finalized and we are awaiting the results. The 2004 KABP study reported around 3.4% (35/1040)
	1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	No studies are currently available except for the 2004 KABP study 6.8% (217/3200)
	1.4	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	No recent data is available except for the 2004 the KABP Study that reported 78.8 % (171/217)
	1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	Data not available
	1.6	Percentage of young people aged 15-24 who are living with HIV*	Indicator relevant to our country but no data available NAP registry reports 9 cases (1 less than 19 and 8 are 20+)
Sex workers	1.7	Percentage of sex workers reached with HIV prevention programmes	Data is not available
	1.8	Percentage of sex workers reporting the use of a condom with their most recent client	No recent data is available except for the IBBS Study that reported 96.43%
	1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	No recent data is available except for the IBBS Study that reported 64.2%
	1.10	Percentage of sex workers who are living with HIV	No recent data is available (0%)

Men who have sex with men	1.11	Percentage of men who have sex with men reached with HIV prevention programmes	Data is not available
	1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No recent data is available. IBBS reported 44% (4/9)%
	1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	No data is available
	1.14	Percentage of men who have sex with men who are living with HIV	No recent data is available (IBBS reported 1.2%)
Target 2. Reduce transmission of HIV among people who inject drugs by 50 % by 2015	2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	No national data is available. One NGO reported 1.6 (464/291)
	2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	No recent data is available (IBBS reported 40%)
	2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	Data is not available 81 IDUs were surveyed and the results showed that 82% (71/81) reported injecting in the past month. Of those, 21% reported "always" using a new unused syringe while 30% reported using a new unused syringe "most of the times"
	2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	No national data is available. One NGO reported 100% (37/37), another NGO reported 55.5% (51/92)
	2.5	Percentage of people who inject drugs who are living with HIV	Data is not available. One NGO reports 0% (0/37), IBBS 0% (0/81)
Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths1	3.1	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	Indicator is not relevant
	3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Indicator is not relevant
	3.3	Mother-to-child transmission of HIV (modeled)	Indicator is not relevant
Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015	4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy	29.21% (425/1455)
	4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	86.8% according to the ART registry
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015	5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	Data is relevant but not available. Recent WHO estimates report 100% of HIV-positive TB patients started on CPT and ART https://extranet.who.int/sree
Target 6. Reach a significant level of annual global expenditure (US$22-24 billion) in LMIC	6.1	Domestic and international AIDS spending by categories and financing sources (2011)	Level: ($) Government: $1,570,000 NGOs/ Donors: $750,000 UN Agencies: $100,000

Target 7. Critical enablers and synergies with development sectors	7.1	National Commitments and Policy Instruments (NCPI)	Annex II
	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	Data not available.
	7.3	Current school attendance among orphans and non-orphans aged 10–14 Part A (attendance for orphans) Part B (attendance for non orphans)	Data not relevant
	7.4	Proportion of the poorest households who received external economic support in the last 3 months	Data not available

II. OVERVIEW OF THE EPIDEMIC

Knowledge & Practices

Two studies have been conducted on the knowledge, attitudes and beliefs of HIV/AIDS amongst the Lebanese population in the years 1996 and 2004. The studies showed that the HIV/AIDS knowledge improved as the awareness became universal. Surprisingly, however, the percentage of people endorsing appropriate and effective protection measures decreased from 93% to 87% (NAP, 2010). This result comes with reported variation in condom use amongst different MARPs groups despite the availability of and accessibility to condoms throughout the country. This is substantiated by evidence from literature showing that MARPS still engage in risky behaviors despite the high knowledge on HIV transmission, based on bio-behavioral surveys (BSS) conducted in Lebanon (USAID, 2010). Figures shows that 71.7% of men and women aged 15-49 years, 43% of FSWs, 47% of MSMs, and 43% of IDUs reported the use of condoms during their last sexual intercourse (NAP, 2010).

According to data from the field between the years 2008 and 2009, 2700 beneficiaries have visited the voluntary counseling and testing (VCT) centers across Lebanon. It is documented that 40% of the beneficiaries belong to the MARPs with the majority being young males (16 – 25 years) (Azzi, 2010). Of the said 2700 beneficiaries, 25 tested positive upon confirmatory test: 16 MSMs; 2 Bisexuals; 1 Ex- prisoner; 1 IDU; 1 Sex Worker (Azzi, 2010).

And most recently, a new project is currently underway to assess knowledge, attitude, beliefs and practices of youth (of the ages 13 – 29) and MARPs towards sexual and reproductive health including STI and HIV/AIDS. The project comes as a joint partnership between the WHO, NAP, UNFPA, and the UNICEF.

Vulnerability and MARPs

The trend in vulnerability has remained almost the same with the identified MARPs groups in Lebanon being: Men who have Sex with Men (MSMs), Female Sex workers (FSWs), Intravenous Drug Users (IDUs) and Prisoners. Nevertheless, other strata in the Lebanese population still present a liability due to their risky behavior coupled with limited knowledge and awareness. These include infected mothers and their children and the youth, mainly those between 15 and 24 years of whom a great proportion are out of reach hidden in the general population as laborers or homeless. Furthermore, special attention has to be given to migrant workers; including those who travel outside Lebanon and foreigners who come to work in Lebanon. Other groups including child laborers, tourists, refugees, and health workers may also be considered to be vulnerable but not as common.

The vulnerability of these groups may be attributed to varied causes and behaviors. For instance, the youths' irresponsible behaviors, curiosity to experience new things and their limited exposure to sexual education in schools may be amongst the most important contributing factors. In addition, the stigma and cultural taboo are seen as a major driving factor that force women living with AIDS not to report it especially if they contracted the disease from their spouse. In addition, illiteracy, discrimination and low status of women may be other contributing factors. Further, disadvantaged populations of lower socioeconomic status including those living in poverty, migrant labor, and commercial sex workers, are considered of higher vulnerability. This is because of their involvement in risky activities including sex work, drug abuse, sharing needles and having unprotected sex with multiple partners (Shawky et al., 2009).

From a judicial perspective, the Lebanese laws are generally non-discriminatory in nature and are clear on 'right for all' in terms of health. On the other hand, despite the absence of any contemporary law to reduce violence against women, a Lebanese NGO – KAFA, was founded in 2005 and is committed to the achievement of gender-equity, non-discrimination, and the advancement of human rights for women and children in line with the international human rights and standards. Most recently, KAFA introduced a bill to the parliament that is currently under revision by a parliamentary committee for possible enactment.

Men who have Sex with Men (MSM)

According to the reported numbers, over half (56%) of the estimated 3000 HIV cases in Lebanon have been due to heterosexual behavior, and 20% due to homosexual or bisexual behaviors. Although the most frequently reported mode of transmission of HIV/AIDS in Lebanon is heterosexual behavior, nevertheless, MSM are a significant vulnerable group in need of close attention as they have a higher risk of HIV infection compared with the general population in low- and middle-income countries worldwide. Indeed, a meta-analysis of published studies between the years 2000 and 2006 revealed that MSM have a 19.3-times larger chance of being infected with HIV than the general population (Baral et al., 2007). In the third outreach project conducted in Lebanon in 2005-2007, a sample of 166 MSM was targeted in the areas of Beirut, the South and the Bekaa regions. Findings from the project revealed that although MSM have a high level of HIV/AIDS awareness and knowledge on modes of transmission, and although they perceived certain sexual behaviors as high risk, this was not translated into safer sex practices. Only about 40% of the subjects always used condoms while 21% have never used one. Additionally, this outreach underscored the role of stigma and discrimination as well as peer and family pressure in keeping this population in hiding. It indicated that MSMs believe that society and families exert too much pressure on them to conform to heterosexual behavior.

Other studies also maintain that the services available for MSM vary greatly around the world. The UNAIDS estimates that only less than 5% of MSM globally have access to HIV prevention, treatment, and care services. Many factors contribute to this dire situation. Some of these reasons include denial by society of male-to-male sex, as well as the criminalization of, and resulting stigmatization and discrimination against MSM. Of the 192 nations that are member of the United Nations, 85 have laws which criminalize homosexual behaviors including MSMs (UNAIDS, 2010b). In Lebanon, the law does not explicitly condemn homosexuality; however it refers to sexual acts that are ‘against nature.’ This expression is subject to interpretation by the authorities. Article 534 of the Lebanon Penal Code stipulates that any sexual intercourse ‘against nature’ is punishable with up to one year of imprisonment. These laws, stigma and discrimination drive the MSM population underground, thus making it difficult to reach and raise their awareness on risk behaviors and HIV prevention. This also prevents MSM from seeking and receiving prevention and care services out of fear of reprisal. An assessment conducted by UNAIDS established that the laws against MSM and the stigma and discrimination they face constitute hinders access to

HIV prevention, treatment, care and support for more than 90% of the MSM population (UNAIDS, 2010b).

Female Sex Workers (FSW)

While sex work is a universal phenomenon, it is frequently illegal and difficult to determine the true extent of this industry. It is believed that sex workers are substantially increasing in recent years due to different factors including changes in political, civil and socioeconomic conditions and increased population mobility (UNAIDS, 2002). Further, economic hardships have been documented as the major reason for going into the business of sex work. Even for migrant workers who end up on the streets after running away from their employer, they are often lured to pursue this career chasing the easy financial rewards in an illegal profession. Alcohol and substance abuse are related issues, as they both make it easier on the FSW to carry on their trade without moral remorse.

Studies have shown that 28% of FSW have reported one or more of Sexually Transmitted Infection (STI) symptoms. As with other vulnerable groups, there was a high tendency for not consistently using condoms with their clients (56%). Even more at risk are 52.5% who consented to intercourse even if the client refused to use a condom. So it does not come as a surprise that only 24% have been tested for HIV during the past year. Additionally, around a quarter of the women had experienced an STI in the past year, with most of these women receiving treatment for their symptoms. Results also revealed that over a quarter of the women (25.8%) interviewed had a bad relationship with their work lords and over 40% stated that they experienced personal, family and social problems.

Comparison data shows that there was a significant change in some behaviors among FSW in Lebanon in the time period of 2001 to 2007; in particular, regarding condom use and the percentage of women refusing sexual intercourse with partners who objected to condom use. Additionally, there was also a significant decrease in the prevalence of STI symptoms. However, there was a significant decrease in the amount of women identifying condom use as a mode of preventing HIV transmission, as well as in the number of FSW who were tested for HIV in the past year (NAP, 2008).

Prisoners

Not much research has been produced on a local level to produce evidence on HIV/AIDS among prisoners. Nevertheless, a recent study assessed 580 adult male prisoners

in Lebanon at Roumieh between August 2007 and February 2008. The results of the study showed that only one HIV positive case was detected, where the individual tested negative for HBV and HCV (Mahfoud et al., 2010). It was also shown that 30.2% of the prisoners in Lebanon were accused of drug related issues. In addition, 54% of the prisoners admitted to using drugs, while 47% admitted to using alcohol in the prisons. Over half of the sample admitted that drug trafficking occurs in the prisons and that inmates hide syringes in their cells. Results revealed as well that 71% of the sample injected drugs on the day they came into the prison and 7% reported sharing needles while in prison compared to 21% who have shared needles or syringes outside the prison.

Injecting Drug Users (IDU)

Due to the laws, regulations and taboos regarding drug use in Lebanon, drug users are not accepted by the society and are often stigmatized and discriminated against. This creates a situation where the population becomes hard-to-reach, especially concerning female drug users.

While there are no assessments of the total number of drug users in Lebanon, the estimated number of IDU is between 2000 and 4000 individuals. This is accentuated by 5.7% of the total numbers of PLHIV in Lebanon being injecting drug users. During the third and most recent outreach undertaken in 2005-2007, 212 IDU were contacted, in addition to 140 other drug users. More than 60% knew about HIV, its various routes of transmission, and the methods of prevention. The IDU admitted they have risky behaviors, such as sharing needles. Only 31.4% of the IDU used a condom every time they had sex in the past month.

One main issue that cuts across IDU and Prisoner as MARPs is drug trafficking that occurs in the prison, and that inmates hide syringes in their cells. As discussed earlier, over 70% of the IDU had injected drugs on the day they entered prison and 7% shared needles while in the prison. Another critical issue is advocating for the decriminalization of drug use. Admitting that drug users are patients who need treatment and not criminals to be thrown in jail is an essential necessity. Imprisoning drug users has only led to more environmental, behavioral, psychosocial and other health related problems.

Many problems face drug users in Lebanon, mainly with the family and society. The desolation and despondency of their lives have lead some of them to drug abuse, drug

trafficking and other crimes, and ultimately to prison. They are also putting their domicile partners under the risk of disease transmission.

III. NATIONAL RESPONSE TO AIDS EPIDEMIC

Considerable progress has been achieved in Lebanon's national response to the AIDS epidemic over the last few years. The sections below highlight the most important developments.

National AIDS Control Program (NAP)

In 1989, the Ministry of Public Health (MoPH) declared HIV as a national threat and established the National AIDS Control Program (NAP) entailing mandatory reporting of HIV/AIDS. A standardized HIV/Advanced HIV reporting form was developed, circulated and adopted by the physicians, hospitals and laboratories upon diagnosing and confirming new HIV infections. The national response to the challenge created by HIV/AIDS was principally allotted to the National AIDS Control Program.

The NAP structure, however, has hierarchical and functional positions that are not well defined. This is due in part to its status as a joint program between the MoPH and the WHO. In theory, the NAP administratively follows the Prevention Directorate, which is one of the four Directorates at the MoPH placed under the authority of the Director General (DG). However, NAP reports directly to the DG and do not appear in the organizational chart of the Ministry. On the other hand, the NAP administration is under the authority of the WHO. The WHO manages NAP's funds in consultation with the DG of the MOPH which might create some problems when defining priorities and setting targets.

The National response is also characterized by the support of technical committees. Three such committees have been created since 1990 to serve as consulting committees for the Government, particularly the MoPH and NAP, in the fight against HIV/AIDS; National Committee, Technical Committee and IEC Committee. The National Committee is the only multisectoral committee that could have a complete vision of the epidemiological situation of the country. Unfortunately, these multi-disciplinary committees are not active outside the setting of the MoPH; and though they have met sporadically since their inception, but not as frequently and periodically as per their national mandate.

The NAP has revised its NSP (2004- 2009) and herein developed a focused NSP (2012) that is evidenced based and grounded in human rights. After a comprehensive review that aimed at "knowing our epidemic" and the use of our "strategic information" NAP has identified the key populations, drivers of the epidemic and the key issues that are hindering universal access to prevention, treatment, care and support. With the collaboration and participation of the UN agencies, ministries, universities, target groups, PLHIV and the civil society, NAP developed and had a consensus on four costed operational plans targeting the MARPs. It is also offering preventive interventions including VCT, referral, hotline, outreach, and awareness-raising for targeted populations in addition to harm reduction including OST. The NAP developed the National Youth Operational Plan and the National Operational Plan for PLHIV, and is also in the process of devising a National Policy to Prevent Mother to Child Transmission (PMTCT).

Despite the limited financial and human resources, Lebanon has been responding effectively and efficiently on keeping HIV and AIDS at low prevalence. NAP under the governance of MoPH is fulfilling its obligation to the Declaration of Commitment on HIV and AIDS in 2001, the Millennium Developmental Goals and the 2006 Political Declaration that was signed by member states at the UN General Assembly High Level Meeting on HIV and AIDS. Nevertheless, NAP needs to address emerging challenges and barriers to an effective and efficient response especially in terms of its internal capacity and resources and in terms of the capacity of its partners in the public sector and the NGOs working on HIV/AIDS in Lebanon.

Civil Society Response

Lebanon has an effective network of civil society including NGOs that execute most of the interventions/programs such as VCT, outreach, referral, hotline, distribution of condoms and lubricants, raising awareness and reaching youth and MARPs. They work in collaboration with NAP, ministries, UN Agencies and they have a meaningful involvement for PLHIV and target groups in all their interventions and activities. It is noteworthy to mention that around 55% of the national HIV budget was spent activities implemented by civil society in the past year.

Many NGOs play an important role in the fight against HIV/AIDS. These NGOs have segmented actions, such as working with vulnerable groups and PLHIV through programs which support them as well as their families. The NGOs conduct sporadic national activities, sometimes in coordination with NAP, which aim at increasing awareness and encouraging prevention among the vulnerable groups, especially the youth.

This collaboration with NGOs in the fight against AIDS has proven to be productive. It allowed using resources in the field and in reaching a larger segment of the population, especially in peripheral regions, taking into account the particularities of the concerned communities.

These interventions fall within the following areas:

1. Preventing sexual transmission of HIV
2. Prevention of HIV among MARPs
    a. Prisoners
    b. MSMs
    c. IDUs
    d. SWs
3. Prevention among other vulnerable groups
4. Prevention of mother to child HIV transmission (PMTCT)
5. Voluntary Counseling and Testing Centers (VCT)
6. Ensuring safety of the blood supply
7. Confronting and mitigating HIV-related stigma and discrimination
8. Reproductive Health Programs
9. Informative research and studies
10. Intervention programs and studies targeting the youth
11. Interventions targeting people living with HIV (PLHIV)

Similarly, the private sector is involved at different levels in the fight against the epidemics through the private hospitals and clinics, private schools, media and pharmaceutical companies. However, religious groups are still not much involved.

Awareness, Risk Reduction, and Prevention

Production and Dissemination of Media Material

A large quantity of educational and informational material was produced for HIV/AIDS sensitization. Around 9000 IEC material was disseminated in various forms: 2000 copies of booklet advocacy, 40000 flyers, 30000 calendars, 200posters, and 15000

newsletters. This material was distributed to diverse groups of the population. The NAP-distributed (in collaboration with NGOs) brochures and leaflets contained directives and studies on HIV related issues during its activities in the country. These documents targeted travelers, students, women, laboratory technicians, blood banks, and health care personnel. Furthermore, posters were distributed and posted in blood banks, medical health care centers, hospitals, universities, buses, schools, supermarkets, pharmacies, and restaurants, as elements of awareness on questions related to HIV/AIDS to the general population and to some target populations.

At the level of audio-visual support, TV spots, public announcements, and slides were produced either by NAP or by NGOs or TV and radio stations. These spots, which presented information and attitudes towards AIDS, were broadcasted on different TVs nationwide. A set of slides on HIV was developed by NAP for health educators. The presentation was reproduced and distributed to Qadaa physicians and health educators. In addition, a song was composed and produced in collaboration with the private sector and broadcasted on all radio stations. To help in the combat against AIDS, newsletters were used as another mean of communication to sensitize people on the question of AIDS. .

The relative openness on sexual issues, as well as the various media actions and liberty of speech, have all contributed to and eased the awareness campaigns organized to reach a larger number of persons in the general population. The impact of these mass media productions on behavioral change have to be evaluated. The production and dissemination of informational material must be continued in conjunction with a regular evaluation of changes in knowledge, attitudes and behaviors to assess the material's effectiveness.

Training

Training is an important element in the strategy against AIDS. Activities were conducted for capacity building of health care workers to help develop their skills in promoting HIV/AIDS prevention. The targets for these training sessions have been Qadaa physicians, nurses, and laboratory technicians.

The available capacity which has been trained is essential in further building the capacity of health workers to play an essential role as part of a comprehensive scheme. Nevertheless, further training needs have to be identified and, accordingly, a training and development plan should be established along a monitoring and evaluation system to help

assess the value added by the training as well as its impact on the epidemic and its traumatic effect on the nation.

Blood Transmission Prevention

Thanks to the introduction of the mandatory HIV test for blood donors and thanks to the reinforcement of protective measures in blood supply, there was no new case of HIV infection due to transfusion since 3 years. This success should not lead to lowering vigilance on this mode of transmission in years to come.

Outreach Activities

A number of NGOs are primarily founded by and for PLHIV with the aim to enhance the lives of those who are affected directly and indirectly by the HIV/AIDS epidemic. They also provide social support, peer to peer education for PLHIV, and a friendly atmosphere devoid of stigma and discrimination. The major premise is to encourage PLHIV to express their feelings, frustrations and demands and to let them know their rights and obligations towards themselves and their community.

Outreach programs usually performed by NGO trained personnel target the MARPs including IDUs, FSW, and MSMs, their aim is to reach these marginalized populations and help raise awareness on the risks of HIV transmission and encourage HIV testing.

Work with Youth

Working with the youth was an important area of intervention in the fight against AIDS. This was first motivated by the fact that the youth constitute a particularly vulnerable population, and, also, by the fact that the youth are a key sounding board to their families. As such, most of the HIV/AIDS intervention programs targeting the youth were based on the life of these youth in school and out-of-school.

At the school level, the intervention was focused on the curriculum. NAP collaborated with the Center for Education Development and Research (CEDR) to integrate the topic of AIDS in the public schools programs. A number of educational elements were developed and tested in the 3 languages. Along these lines, a topic on HIV and some aspects of reproductive health were added to secondary schools curricula.

At the extracurricular level, community-based actions and projects conducted by NGOs were encouraged and supported, such as the education of peers during summer camps. Such activities provided information and sensitized youth on their attitudes and their role in

HIV prevention. Prevention and promotion of safe behavior activities among the youth took place in 60 public school clubs. These clubs were used to disseminate information on HIV/AIDS. An evaluation was performed showing that there was a high number of students in these clubs and that the proposed activities were successful. This activity has to be encouraged and replicated in other schools and it has to be evaluated in terms of the messages transmitted during these activities and its impact. Though this experience was conducted in the public schools, this should be tested and evaluated in private schools.

Upon discussions with schools, NAP in coordination with thematic NGOS conducts sensitization activities in these schools. The participative approach used in the intervention has encouraged some youth organizations, such as WAC, to take an active role in the planning, implementation and evaluation of such youth activities.

Work with Vulnerable Groups

Migrants:

Community-based sensitization actions were developed in zones of high migration (North, Mount Lebanon, and South) to increase awareness of the migrants and their families. The airport's managers were also sensitized. They have helped distribute the IEC material produced by NAP to all travelers coming into or going out of the country. Meetings were organized with travel agencies for the distribution of leaflets and brochures to travelers. In addition, NGOs have worked with communities of foreign workers to increase their awareness on STIs, HIV and AIDS. Material was developed in different languages and distributed to foreign workers. In 1996, an official visit was undertaken to establish contact with the Lebanese Diaspora in Africa. The mission was composed of the NAP, MoPH, and the Ministry of Migrants. It was an original and important initiative, given the role of migrants in the dynamics of the epidemic. Unfortunately, there was no follow-up on that action.

Prisoners:

All prisoners are tested for HIV upon their entry to the prison. Those infected are placed in a special section in the prison. Advocacy and sensitization actions were undertaken with the leaders to facilitate IEC activities in prisons and to improve the care given to HIV/AIDS patients. NGOs have been active in caring for this category of vulnerable population.

Two important problems persist. First, an important issue is the follow-up of HIV-infected prisoners after their release. In addition to their personal health situation, they represent a transmission vehicle of the disease. It is thus crucial to positively encourage them to continue follow-up after their release. The second problem concerns the training of personnel in contact with prisoners. These include guards, officers and judiciary police who currently lack the necessary training on the ways to handle HIV-infected persons.

Uniform Services:

Workshops were held for educators at the military schools and the interior security forces, on universal precautions to be adopted to prevent HIV/AIDS. In addition, an intervention was undertaken to integrate HIV/AIDS in the military schools curricula. Unfortunately, there was no monitoring on this issue due to the difficulties of collaboration between NAP and the armed forces. Aside from the distribution of informational material produced by NAP to the armed forces, interventions with armed forces are limited, although they might constitute a vulnerable population.

Access to Care

The decision to treat HIV/AIDS patients with ARV was taken in 1998. The standard treatment is composed of a tri-therapy. The decision to give treatment is based on national guidelines that were established in 1998 and updated in 2002. These guidelines take into account the existing data on the advantages and disadvantages of an early treatment, the quality of life and the economic burden.

Antiretroviral Treatment is currently provided by the Ministry of Public Health free of charge (to Lebanese citizens and Palestinian refugees). Patients who are deemed eligible for treatment by their physician (i.e. if their CD4 T-cell count drops below 350cells/mm3 as per WHO guidelines) can obtain a medication card and thus pick up their anti-retroviral treatment from the National AIDS program at the Ministry of Public Health.

STI Surveillance and Control

Before the HIV epidemic, STIs were not recognized as a particular group. It was an orphan entity that could be managed by the dermatologist, the urologist, or any other specialist based on the symptoms presented.

The emergence of the AIDS epidemics led to consider STIs as a particular entity. Given the role of STIs in the transmission of AIDS, many actions were undertaken to aid in the control of STIs. A guide for the syndromic approach was developed. The physicians and

pharmacists of the public and private sectors were trained on its application and on the syndromic management of STIs. On the other hand, the syndromic approach for STIs treatment should soon be added to the medical curriculum. The STIs diagnostic protocol was improved in laboratories by training the personnel and by installing appropriate equipment.

Surveillance and Monitoring

An effective monitoring and evaluation is essential to ensure the success of the implementation of the NSP. It is imperative to have a global vision of the epidemic and the appropriate response associated with a second-generation surveillance system. There should be a synthesis of this information in matrices updated on a periodic basis.

The NAP and some NGOs conducted a project on HIV/AIDS among high-risk groups living in Beirut. This project aimed at modifying the risky behavior of these groups and creating a favorable environment for maintaining preventive practices. A 3-phase situation analysis (exploratory, qualitative, and quantitative) was performed between these groups to devise the best-adapted actions to be undertaken. A communication strategy was then established where peer educators were contacted in each of the target communities, condoms were distributed, personalized discussions were held, and informational material was disseminated. The information was related to basic data on HIV/AIDS and STIs, the possibilities of undertaking an HIV test, and the promotion for a hotline number. Evaluating the work done has presented strengths and weaknesses that would be worth taking into consideration in the formulation and implementation of the National Strategic Plan.

IV. BEST PRACTICES

A number of practice models have been developed through the initiatives and efforts of the Lebanese MoPH in collaboration with NAP and other international and local partners. These include Lebanon's experience with the Opioid Substitution Therapy (OST) program, the improvement of the medications prescription system and Voluntary Counseling and Testing (VCT) services administered by the NAP, and prisoners support program.

The *Opioid Substitution Therapy* (OST) Program is the second of its kind in the Middle East and North Africa region. This service complements the outreach intervention program where needles and syringes being provided by NGOs. This project is the outcome of cooperation and collaboration efforts between a wide range of national partners, including the

Ministry of Public Health, Ministry of Interior, NAP, psychiatrists association and civil society organizations. Specifically, UNODC in cooperation with the Pompidou Group of the Council of Europe and WHO supported this national initiative through capacity building workshops, guidelines development and training cascades funded by the European Union (EU). This participatory approach between national, international partners and civil society organizations strengthened the efforts to develop and implement the OST program in Lebanon.

The decree related to the OST implementation criteria was signed by the Ministry of Public Health on September 2010. A National OST taskforce provided the technical support to develop the clinical guidelines and operating modalities necessary for launching the OST program. Furthermore, a software system for monitoring the dispensation of Buprenorphin was developed and implemented. This software represents a tracking system, permitting the MoPH to closely monitor the distribution mechanism and avoid any potential misuse of the OST. Reliable data and reports were generated for statistical purposes and further follow-up. As of March 2012, 120 clients were enlisted on the Buprenorphin program, being dispensed from two hospitals in Beirut.

Capacity building was also provided through the development of a cascade of training on evidence-informed drug treatment and rehabilitation using UNODC's TreatNet training package. A cadre of trainers trained a number of healthcare service providers in Lebanon on the management of Opioid Substitution Therapy. Trainings on the utilization of the software system and dispensing of Buprenorphin were also organized for psychiatrists and MoPH staff.

On a parallel scale, several other success stories and projects were implemented in Lebanon to enhance the living of PLHIV and raise awareness on the issue. The UNDP office ran several media awareness campaigns including radio and TV spots by university students in collaboration with religious leaders. On the other hand, the NAP office enhanced the national AIDS Medications system. It was able to improve the system of gathering patients files/information and follow up. The program, also, was able to augment adherence to treatment regimen and sustain triple/quadruple therapy for patients. The appropriate support and follow-up with patients increased the confidence in the services provided by the Ministry. In addition, the UNODC and NAP established a technical taskforce to cater for the special

needs of the incarcerated patients in direct coordination with the Internal Security Forces – Prisons Department.

V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

There are several challenges to effective intervention in the current scheme of service delivery and cultural context in Lebanon in terms of national commitments, surveillance, coordination of response efforts and care and support. Under-reporting is a critical issue in the fight against HIV/AIDS in Lebanon. The current system of reporting is a mandate by law but is characterized by incomplete statistical data and an underreporting of cases. Nevertheless, efforts at all levels (political and professional) are geared towards improving the reporting system. More discussion groups can be targeted to promote compliance and efficient reporting. The weakness of the current surveillance system may also be linked to the lack of a fully computerized program that links the MoPH-NAP to physicians, laboratories and other referring centers. Such a system will serve as a tracking tool that allows the Ministry to generate precise yearly reports on the current HIV/AIDS situation in the country.

Furthermore, the national response has to take into consideration the shortages in human and financial resources, ineligibility to the global fund and limited budgeting. This can be resolved with proper coordination and collaboration among all sectors, UN agencies and civil society organizations to ensure an effective and efficient response to HIV/AIDS.

Several other challenges hinder or limit the access for prevention, treatment and care for HIV positive persons including marginalization of and stigmatization against MARPs and PLHIV. This issue is further exacerbated by certain Lebanese laws that still criminalize drug addicts or MSM. In addition, the lack of space in prisons, the inadequate provision of health services and the poor environments in the prisons may hinder the interventions at the prisons. As well, despite the involvement of religious leaders in the design and provision of many of the activities being carried, the role of these figures has been focused on involvement in training and education; and sometimes personal views may contribute to prejudice towards PLHIV. However, as pivotal community leaders, the role of religious figures should be expanded to community mobilization, PLHIV psycho-social support and care, stigma reduction and community education.

Lebanon must expand its response to HIV/AIDS by taking into consideration the key determinants that affect the spread of the disease and the socio-cultural and political environments. The response must be associated with a reliable second-generation surveillance system that monitors not only the symptomatic and asymptomatic cases, but also the risky behaviors. Furthermore, the expanded response to HIV/AIDS must focus on a multisectoral response at different levels, ranging from advocacy to surveillance and from prevention to treatment and care. For that, continuous advocacy and dialogue with decision makers to ensure strong national commitments that would secure the prioritization of HIV/AIDs as part of the national health strategy.

VI. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

Several donors, bilateral organizations and private foundations support NAP or specific interventions in Lebanon. The principal support comes from the United Nations agencies including: United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Educational Scientific and Cultural Organization (UNESCO), United Nations Office on Drugs and Crime (UNHCR), United Nations Office on Drugs and Crime (UNODC). Smaller bilateral agencies support NAP through UNAIDS, international and national NGO and private sector players. With the support of UN agencies NAP has been able to significantly mobilize an effective health response towards AIDS and strengthen the existing HIV related systems in the country.

Following are some of the activities undertaken by Lebanon's development partners:

- **UNDP:** In collaboration with the National AIDS program and with the support of the UNDP/RBAS OFID funded HIV AIDS project carried out a series of trainings:
    - *Capacity building training* for focal points that work in thematic NGOs on topics such as project design, proposal writing, strategic planning and other relevant topics.
    - *Training of media personnel* owing the distinct power of media in reaching the various segments of society and influencing public opinion in Lebanon.
- **UNFPA:** In partnership with the MoPH, NAP, (Y-PEER) network, and Masar Association, UNFPA organized a number of activities under 'Let's Talk' Campaign based on 2 main pillars:

- *capacity development* of young people through workshops in the areas of social media and advocacy
- *rising awareness* among young people about HIV/AIDS routes of transmission and prevention, stigma and discrimination, Voluntary Counseling and Testing, among others.

- **UNESCO**: *Building capacity* of school health educators in Lebanon to deliver life skills based reproductive health and HIV/AIDS education.
- **UNHCR**: Enhancing the reproductive health situation of non-Palestinian refugees in Lebanon by:
  - *building the capacity* of youth and supporting refugee access to relevant national institutions, providing awareness sessions
  - providing free *voluntary counseling and testing* (VCT) services to non-Palestinian refugees in Lebanon similar to nationals
- **UNODC:** Provided technical support to combat HIV/AIDS through different activities:
  - empowering national capacities aimed at reducing demand for as well as harm from drugs by adapting successful international best practices to national level
  - introducing initiatives for HIV prevention and care activities in prison settings
  - providing information on access to, availability and use of HIV voluntary testing and counseling services in prisons
  - piloting of the first Opioid Substitution Treatment program

VII. MONITORING AND EVALUATION ENVIRONMENT

Monitoring and evaluation remains a major challenge in Lebanon as indicated earlier. Efforts are being concerted to collect needed data under dire conditions characterized by the lack of financial resources and specialized human resources. All concerned stakeholders expressed the need to scale up the current limited monitoring and evaluation plan in the country. Nevertheless, sporadic efforts among NGOs can be witnessed in collecting needed data though at the operational level or at a much limited capacity of project/study based.

Complete and integrated monitoring and surveillance systems of the AIDS epidemic in Lebanon should be developed along the following: i) monitoring the process and the

outputs of the programs in the fight against HIV/AIDS, ii) monitoring of the knowledge and the attitudes facing sexuality and sexual behaviors, iii) monitoring and evaluation of the availability and quality of services, and iv) surveillance of HIV, AIDS, and STIs. For that, major interventions have to be executed over the coming few years including the development of key M&E personnel at the national level s well as the capacity of NGOs in M&E. Furthermore, studies and surveys will have to be undertaken that will inform the revision and operationalization of the National Strategic plan. In addition, M&E tools currently used have to be examined and further developed under this comprehensive M&E plan. These will be used to collect data from service delivery points, CSOs and NGOs but also to collate the data for informed decision. This development will benefit all partners to evaluate their performance and take corrective measures when needed.

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