UNGASS COUNTRY PROGRESS REPORT

Libya

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I. Status at a glance

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

The preparation of this report was limited by the post-conflict situation in Libya. Instability persists as the interim government works to re-establish essential services and improve security throughout the country. Competing priorities precluded the participation of a wide range of stakeholders in the reporting process.

Data collection and information gathering was limited to review of recent UNAIDS trip reports and planning documents prepared by development partners. The final report was reviewed and validated by the National AIDS Programme (NAP). Workshops or validation meetings were not possible due to lack of governmental processes for convening and funding meetings.

(b) The status of the epidemic

Limited information is available on the HIV situation in Libya. The most recent population prevalence survey, which was carried out in 2005, found a very low prevalence (0.13%) of HIV in the general population. Case reporting, primarily from mandatory screening, has identified 11,910 cases to date ,with 2000-2500 currently receiving ART. Estimates of the total number of PLHIV are not available.

The epidemic in Libya is primarily concentrated among high-risk groups. Injecting drug use is the dominant mode of transmission, which in the past has accounted for as many as 90% of infections.[1] Although case-reporting statistics are not available due to the post-conflict situation, government sources have indicated an increasing trend toward sexual transmission. Estimates of HIV prevalence among people who inject drugs vary widely and date from before the civil war. Published estimates range from 15% to 32%.[2] There are few studies among sex workers with questionable validity, and none among men who have sex with men.

Bio-behavioral surveys (BBSS) among key affected populations, including sex workers (SW), men who have sex with men (MSM) and people who inject drugs (IDU) were in progress and interrupted during the civil war. It is planned to resume the data collection in the near future. The results of the BBSS will provide much needed information on risk behaviors and HIV prevalence among key populations.

In the post-conflict situation, several factors have emerged with the potential to fuel the epidemic. A nationwide stock-out of ARV drugs has led to long treatment interruptions among PLHIV, which could increase transmission, drug resistance and mortality. Disruption of infection control and blood safety systems could lead to increased risk of nosocomial transmission, and a rise in sexual and gender-based

[1] UNGASS Country Progress Report, 2010.

[2] Laith J. Abu-Raddad F, Akala A, et al. (2008). Characterizing the HIV/AIDS epidemic in the Middle East and North Africa: Time for Action. World Bank.

violence could increase sexual transmission and create barriers to access to services.

(c) The policy and programmatic response

Although the Libyan civil war has ended, the political situation remains unstable in many areas of the country. The transitional government was installed in December 2011 and is reinstating disrupted health services with the support of the United Nations system. The HIV/AIDS response is being integrated into health systems wherever possible. The National Centre for Disease Control (NCDC), which includes the National AIDS Programme (NAP), has included HIV among its three highest priorities for the reconstruction.

During the conflict, health and social services were interrupted. An assessment by WHO of health systems in the eastern part of the country in 2011 already indicated a collapse of the primary health care system due to lack of staff and supplies, even where structural damage was not widespread. [Can we reference this – is there a report?] Hospitals were overloaded with war-wounded patients, foreign health staff departed resulting in serious human resource shortages, and infection control lapsed. The drug procurement and distribution stalled, leading to severe shortages of anti-retroviral (ARV) drugs. Many persons living with HIV (PLHIV) have been without drugs for several months, leading to demonstrations at government offices. ARV procurement is now among the short-term priorities of MOH.

The highest priority health issues of the transitional government include:

a) Strengthening peripheral health services. Human resource development is a primary concern.
b) Securing procurement and supply of drugs and medical supplies, including ARVs, and maintenance of medical equipment (which was also a challenge prior to the civil war).
c) Health information, disease control and surveillance. Blood safety is of particular concern, as well as control of nosocomial infections. Many war-wounded sent abroad were found to be infected with multi-resistant Staphylococcus aureus (MRSA) infections contracted in hospitals in Libya.
d) Involvement of civil society, particularly for strengthening of peripheral health services and for access and involvement of key populations, including in the area of HIV prevention and response.

Plans are underway to revive pre-conflict plans to strengthen the national HIV response, including improving surveillance and strategic information; strengthening policy, strategy and coordination of the response; and expanding interventions and access to services for key affected populations.

A Libyan delegation headed by First Deputy Minister of Health Dr. Adel M. Abushoffa met with UNAIDS Executive Director Michael Sidibe in Geneva in early 2012 to establish short-term priorities for the national HIV response and request assistance to establish a national strategic plan. To support the national response, establishment of a UNAIDS secretariat presence is being considered in Libya.

(d) Overview of UNGASS indicator data

Table 1. UNGASS Indicators at a glance.

Indicator	Status 2010	Status 2012	Comments
Target 1. Reduce sexual transmission of HIV by 50 per cent 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	Not available.	Not available.	Most recent information is from KABP among high school students in 2005.
1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Not available.	Not available.	No population-based surveys undertaken.
1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	Not available.	Not available.	No population-based surveys undertaken.
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	Not available.	Not available.	No population-based surveys undertaken.
1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	Not available.	Not available.	No population-based surveys undertaken.
1.6 Percentage of young people aged 15-24 who are living with HIV	Not available.	Not relevant.	
Sex workers			
1.7 Percentage of sex workers reached with HIV prevention programmes	Not available.	Not available.	BBSS data collection partially completed but interrupted by civil war. Report on analysis of available data is pending.
1.8 Percentage of sex workers reporting the use of a condom with their most recent client	Not available.	Not available.	BBSS data collection partially completed but interrupted by civil war. Report on analysis of available data is pending.
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	Not available.	Not available.	BBSS data collection partially completed but interrupted by civil war. Report on analysis of available data is pending.
1.10 Percentage of sex workers who are living with HIV	Not available.	Not available.	BBSS data collection partially completed but interrupted by civil war. Report on analysis of available data is pending.

Indicator	Status 2010	Status 2012	Comments
Men who have sex with men			
1.11 Percentage of men who have sex with men reached with HIV prevention programmes	Not available.	Not available.	Report on analysis of BBSS data from Tripoli is pending.
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Not available.	Not available.	Report on analysis of BBSS data from Tripoli is pending.
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	Not available.	Not available.	Report on analysis of BBSS data from Tripoli is pending.
1.14 Percentage of men who have sex with men who are living with HIV	Not available.	Not available.	Report on analysis of BBSS data from Tripoli is pending.
Target 2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015			
2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes		Not available.	No needle and syringe exchange programs in place.
2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	Not available.	Not available.	Report on analysis of BBSS data from Tripoli is pending.
2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	Not available.	Not available.	Report on analysis of BBSS data from Tripoli is pending.
2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	Not available.	Not available.	Report on analysis of BBSS data from Tripoli is pending.
2.5 Percentage of people who inject drugs who are living with HIV	Not available.	Not available.	Report on analysis of BBSS data from Tripoli is pending.
Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths			
3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	Not available.	Not available.	
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth		Not available.	
3.3 Mother-to-child transmission of HIV (modeled)	Not available.	Not available.	
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	Not available.	Not available.	
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Not available.	Not available.	

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	Not available.	Not available.	
Target 6. Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries			
6.1 Domestic and international AIDS spending by categories and financing sources	Not available.	Not available.	
Target 7. Critical Enablers and Synergies with Development Sectors			
7.1 National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	9 NCPI questionnaires administered (6 Govt, 1 Civil society, 1 PLHIV, 1 UNDP)	Not available.	NCPI not done due to post-conflict situation.
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		Not available.	
7.3 Current school attendance among orphans and non-orphans aged 10–14	Not available.	Not relevant.	
7.4 Proportion of the poorest households who received external economic support in the last 3 months		Not available.	

II. Overview of the AIDS epidemic

Overall prevalence

Information on the HIV situation in Libya is very limited. To address the gap, bio-behavioral surveys (BBSS) among key affected populations, including sex workers (SW), men who have sex with men (MSM) and people who inject drugs (IDU) were planned in multiple sites. Data collection was completed in Tripoli, but was interrupted by the civil war before additional sites were surveyed. Preliminary findings are not available for inclusion in this report.

A limited number of surveys were conducted prior to the BBSS. However, they are all somewhat out of date since data collection was completed before 2005. In addition, the situation has changed in the post-conflict period, with anecdotal information pointing to the likelihood of an increasing epidemic.

The most recent population based survey, which was carried out in 2004-2005 among 65,000 persons using random cluster sampling, indicated an HIV prevalence of 0.13% (90 cases). However, the higher prevalence in Al Kufrah in the south (0.67%) and in Tripoli (0.4%) indicated hotspots on migration and drug smuggling routes, and in urban areas.[3]

The cumulative number of people diagnosed with HIV in the country is now 11,910 with 2,ooo-2500 on ART according to NCDC data . Case reporting is primarily from mandatory screening statistics and therefore likely under-estimates the total number of PLHIV. In addition, the available information is incomplete, reported from only some hospitals and laboratories. Overwhelmingly low CD4 counts at the time of diagnosis indicate that most PLHIV are identified late in the course of their disease, further supporting the likelihood that the identified cases represent a relatively low proportion of the total number of PLHIV. Over 70% of newly diagnosed HIV cases are found to have a CD4 count less than 350 cells/mm^3 and half are below 200 cells/mm^3 (LEPIDC)[4]. It's likely that most PLHIV remain undetected due to lack of information and access to VCT also due to stigma and discrimination against PLHIV. Modelling estimates of the scope of the epidemic have not been carried out.

In the absence of surveillance data, blood bank data can provide a proxy for the general population. In Tripoli Central Blood Bank, 0.3% of blood donors tested HIV positive in 2011, but a much higher prevalence was noted at the Benghazi Blood Bank during the same period.[4]

Prior to the civil war, Libya was host to a large number of immigrants – 1.5 million irregular foreign immigrants, most from sub-Saharan Africa with no access to the health system – which created a large potential for epidemic growth.[5] Half of the HIV cases in neighbouring Tunisia prior to 2003 were people who had come from Libya

[3] El-Zouky A, et al. Libya national sero-prevalence study. 2004-2005.
[4] Libyan European Partnership on Infectious Diseases Control (LEPIDC). Critical analysis of the present situation and planning of activities. Presentation to Minister of Health.
[5] UNGASS Country Progress Report, 2010.

for ART or drug rehabilitation programmes.[6] The post-conflict situation has created several additional factors with the potential to fuel the epidemic. In addition to a nationwide stock-out of ARV drugs, infection control and blood safety systems have been disrupted and a rise in sexual and gender-based violence has been reported due to the breakdown in the social fabric.

The epidemic in Libya is primarily concentrated among high-risk groups. Injecting drug use is the dominant mode of transmission, which in the past has accounted for as many as 90% of infections.[7] Although case-reporting statistics are not available due to the post-conflict situation, there are some indications an increasing trend toward sexual transmission.

Estimates of HIV prevalence among people who inject drugs vary widely and date from before the civil war. Published estimates range from 15% up to 49%.[8] Prior to 2008, 60% of drug users admitted to drug treatment facilities tested HIV positive and the HIV prevalence in prisons was reported to be 18%.[9] Size estimates of the injecting drug user population in Libya range from a low of 4,663 to a high of 9,779.[10]

There is currently little or no information about HIV in other key population groups, such as sex workers (SW), men who have sex with men (MSM), migrants, refugees, and internally displaced people.

III. National response to the AIDS epidemic

The Libyan national response is coordinated by the National Centre for Disease control (NCDC) under the Ministry of Health (MOH). The National AIDS Programme (NAP) was launched in 2002, reporting to the Director General of NCDC. Other units of the NCDC with HIV-related responsibilities include PMTCT, TB, VCT, nosocomial infection control, and the referral laboratory. NCDC also coordinates mental health and psychosocial support, including a national coordination committee; surveillance and special surveys; epidemiology; and ARV procurement and supply. The Director General of NCDC is responsible for coordination of the national response between NAP and the other units involved in the national HIV response. However, the NCDC does not have authority over health service provision, limiting its influence in key components of the HIV/AIDS programme.

The NAP is comprised of 15 professional staff at headquarters level. There are four departments: monitoring and evaluation (M&E); education and awareness; treatment and care; and research. The NAP provides guidance and training to infectious

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[6] Laith J. Abu-Raddad F, Akala A, et al. (2008). Characterizing the HIV/AIDS epidemic in the Middle East and North Africa: Time for Action. World Bank.

[7] UNGASS Country Progress Report, 2010.

[8] From published reports dating from 2002 to 2008, cited in Laith J. Abu-Raddad F, Akala A, et al. (2008). Characterizing the HIV/AIDS epidemic in the Middle East and North Africa: Time for Action. World Bank.

[9] Based on literature reviews published in 2006 and 2008, cited in Laith J. Abu-Raddad F, Akala A, et al. (2008). Characterizing the HIV/AIDS epidemic in the Middle East and North Africa: Time for Action. World Bank.

[10] Laith J. Abu-Raddad F, Akala A, et al. (2008). Characterizing the HIV/AIDS epidemic in the Middle East and North Africa: Time for Action. World Bank.

disease hospitals and peripheral health centres whose staff are not under NAP supervision. It has also encouraged establishment of 19 voluntary AIDS Committees in the Regions to increase HIV awareness and knowledge and work to reduce stigma and discrimination. Its sub-committees include representatives from five sectors: Health, Education, Religious Affairs, General Security, and civil society.

A National HIV/AIDS Strategy is not yet in place. Efforts were initiated in 2010 by the National AIDS Programme with the support of the Liverpool School of Tropical Medicine (LSTM), funded by the European Commission. An early draft consisting of objectives and proposed supporting actions was developed before progress was interrupted due to the conflict in 2011. Planning is underway to resume the strategic planning process with inputs from additional planned surveys and multi-sectoral consultations.

At the national level, multi-sectoral involvement has been limited to programmes in schools (Ministry of Education) and prisons (Ministry of Justice). There are no multi-sectoral coordination mechanisms in place and the HIV/AIDS response continues to be viewed within a health and disease framework with a focus on treatment. The broader multi-sectoral and societal dimensions of the epidemic have received relatively less attention. It is hoped that development of a National HIV/AIDS Strategy will address these issues.

Civil Society

Civil society has been rapidly building strength and gaining recognition for their contribution to the national HIV response. In the 1990's, the Red Crescent and Scout movements started by initiating HIV awareness and education programmes. Then in 1998, the Benghazi nosocomial epidemic of children increased attention on HIV/AIDS and spurred the birth of additional NGOs working on HIV/AIDS.

In 2005, a network of 12 NGOs was formed with support from UNDP and UNAIDS. The network includes the Libyan Youth Association, which supports HOPE, a PLHIV group. The network has contacts with international NGOs such as HIV Alliance and the Regional Arab Network Against AIDS (RANAA), which have supported some training activities. The NGO network is planning to conduct an assessment of NGO capacities, with support from the Alliance.
There is also Y peer network whose activities include awareness and education among young people.
Capacity building of NGOs is urgently needed, particularly in resource mobilization and programme management, with a focus on prevention and response in key affected populations.

Prevention

As reported in the 2010 Country Progress Report, prevention efforts prior to the conflict were focused primarily on raising awareness of HIV among the general public through the media, training programs for selected professions (e.g. members of the judiciary, medical providers, teachers and religious leaders), World AIDS Day celebrations, and health education in schools.

The Drug and HIV Project was initiated in 2010 but suspended in 2011 when the conflict erupted. The project, which is financed by the Government of Libya and supported by UNODC, includes drug rehabilitation service development; support to

civil society organizations for HIV prevention outreach service development and establishment of VCT centres and a mobile VCT facility. The project has supported development of the national strategic plan on harm reduction, which has been approved by the NAP and the MoH.

HIV testing and counselling

Planned implementation of recommendations from a 2009 UNAIDS assessment of VCT were put on hold when the civil war broke out in 2011. Most HIV testing continues to be mandatory screening for various certificates (e.g. marriage, driving licenses, hospital admissions, ANC, prison admissions, etc.) Voluntary counseling and testing are available only at the NCDC reference laboratory in Tripoli, which is used primarily for referral services for people sent for confirmatory testing from other laboratories. Prior to the conflict, NCDC had planned to expand testing to all 25 NCDC regional branches, but the plans were put on hold.

Laboratory testing for HIV is also widely available in both public and private laboratories through the country. All confirmatory testing is carried out at the NCDC reference laboratory. The reference laboratory is a WHO collaborating centre and is seeking an accreditation at international level. Currently, reagents are imported by private providers and vary widely in quality. No external quality assurance (EQA) system is in place at the national level.

Prevention of mother to child transmission

National guidelines for PMTCT were developed in collaboration with the European Union in 2009.[11] The 2010 Country Progress Report described plans to expand availability of PMTCT beyond the two sites, which were operational at the time, namely Tripoli Medical Center and Benghazi Centre for Infectious Diseases and Immunology. The proposed expansion includes 5 site as pilot phase and in gradually expanded to 70 sites throughout the country. Although the expansion programme has not started, the Libyan European Partnership on Infectious Diseases Control (LEPIDC) project plan includes support for the initiative.

Care, treatment and support

HIV treatment is currently provided to an estimated 2000–2500PLHIV according to NCDC data More accurate data are not available since there is no central reporting system in place. Treatment services are available at two governmental infectious disease hospital departments in Tripoli, another two in Benghazi, and one in Sabha. ARVs are supplied by the NCDC. Although ART is free for all Libyan citizens, recent shortages have led to prolonged treatment interruptions over the past several months.

Due to the conflict, the ARV supply was disrupted for over six months in 2011, leading to an emergency situation for PLHIV. Among those who are not able to buy drugs from neighboring countries, sharing of ARVs and relying on partial treatment with one- or two-drug regimens are reportedly common. In this scenario, development of resistance to first-line ARV drugs is a serious concern, which is

[11] Libyan National Centre for Infectious Diseases Prevention and Control (2009). National guidelines for the use of antiretroviral agents in pediatric HIV infection and prevention of mother to child transmission.

further complicated by the lack of capability for resistance monitoring in Libya. Doctors at the Infectious Diseases Department of the Tripoli Central Hospital report increasing numbers of PLHIV admitted in very advanced stages of disease with high mortality.

National guidelines for treatment of adults and children were developed in 2009 in collaboration between NCDC and the European Union.[12,13]

TB/HIV co-infection

The TB department of the NCDC is the lead agency for TB control in the country. Overall, the number of new TB cases is reportedly declining. In 2010 (the most recent data available from the TB Control Programme), there were 792 new TB cases, 189 of which were TB-HIV co-infected. In 2011 there were 731 new TB cases,128 of which were TB-HIV co-infected. The national policy is to screen all TB cases for HIV, hepatitis B and hepatitis C. However, there are no monitoring data available for quality assessment. PLHIV are not routinely screened for TB.

Current practice does not allow for simultaneous treatment with ART and TB medications for patients with TB-HIV co-infection. If an HIV-positive person on ART is diagnosed with TB, the ART is discontinued and only re-started after the six-month TB treatment has been completed. It is unknown whether any preventive TB treatment is provided to PLHIV.

Knowledge and behavior change

The most recently reported knowledge survey was conducted in 2005 among high school students. Questions focused on misperceptions about HIV transmission and stigma. Despite the existence of a school education programme, misperceptions persist with 42% believing that HIV was transmitted through the use of public toilets, 31% believing it was transmitted through coughing or sneezing and 30% believing that it was transmitted through caring for an HIV-infected individual. High levels of stigma were also found among high school students.

Information on injecting drug user behaviors is similarly outdated. A survey conducted in 2003-2004 among drug users in a rehabilitation programme found that about 70% of drug users surveyed said they had engaged in behaviors that put them at great risk of contracting blood-borne diseases such as HIV and HCV, and nearly half (44%) of injecting drug users had shared needles and syringes.[14] However, it must be noted that the survey was not representative of the actively injecting population in the community.

Completion of the BBSS will provide much needed information on knowledge and behaviors among key affected populations.

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[12] Libyan National Centre for Infectious Diseases Prevention and Control (2009). National guidelines for the care of adult HIV positive patients.

[13] Libyan National Centre for Infectious Diseases Prevention and Control (2009). National guidelines for the use of antiretroviral agents in pediatric HIV infection and prevention of mother to child transmission.

[14] AIDS Project Management Group (2008). Rapid Assessments of HIV/AIDS and Injecting Drug Use in Algeria, Egypt, Iran, Libya, Morocco and Oman: Findings and Lessons Learned.

II. Major challenges and remedial actions

The major challenges listed in the 2010 Country Progress Report were 1) development of a national strategic plan for HIV and AIDS; 2) reaching key affected populations; 3) strengthening prevention programmes; and 4) strengthening monitoring and evaluation.

In addition to the above areas, the National AIDS Programme lists the following among it's priorities in the post-conflict period: strengthening and expanding PMTCT services; addressing stigma and discrimination, particularly among health professionals; and increasing civil society engagement and empowerment.

National strategic planning

A draft outline of a National Strategy for HIV and AIDS was developed in 2010 by the National AIDS Programme with the support of the Liverpool School of Tropical Medicine (LSTM), funded by the European Commission. The document includes objectives, outputs and outcomes and proposed supporting actions. Further progress was not made due to the conflict in 2011 and the draft objectives have not yet been adopted by the government.

Development of the national strategy is at the top of the NAP's priorities in the post-conflict period, along with increased inter-sectoral coordination. Planning is underway to resume the strategic planning process with further inputs from additional planned surveys (described in the M&E section) and additional multi-sectoral consultations.

Key affected populations

Challenges in reaching key affected populations include cultural barriers to working with vulnerable groups, as well as a general lack of information on risk behaviors and HIV prevalence among sex workers, men who have sex with men, and people who inject drugs.

To address the lack of information, a series of surveys was planned but interrupted due to the civil war. Data collection was completed for the BBSS among key populations in Tripoli but preliminary results have not yet been released. Plans are underway to complete the BBSS and undertake additional KABP surveys (see M&E section for details).

Progress was made toward developing interventions to reach people who inject drugs. A national strategic plan on harm reduction has been developed and approved. Re-vitalization of the Drug and HIV Project (NAP and UNODC) is planned to improve drug rehabilitation services, support civil society in outreach services and establish community-based VCT services.

Prevention programmes

The 2010 Country Progress Report indicated that prevention programmes were geared primarily toward increasing knowledge through school-based interventions. However, these have not been assessed and the 2005 KABP survey among high school students indicated that misperceptions persist and stigma is common. No updated information on prevention programmes was made available for the reporting period.

Monitoring and Evaluation

See Monitoring and Evaluation section.

III. Support from the country's development partners

As the country recovers from civil war, the transitional government is relying heavily upon assistance from development partners for resumption of the HIV and AIDS response.

United Nations System:

The UN system was evacuated from the country in February 2011 and has been re-entering gradually since August 2011. Prior to the conflict, the UN Country Team did not include HIV on its agenda. Among the agencies, only WHO and UNODC had HIV related activities on their agendas. A Theme Group or Joint Team for HIV has not been established. In the post-conflict period, HIV has emerged as a priority due to ARV supply disruption.

A Libya recovery Trust Fund has been established to finance the UN system-supported activities in Libya, administered by the UNDP in coordination with the government. UNAIDS RST has signed the Trust Fund agreement. Contributions to the Trust Fund by donors now amount to USD 2.5 million, out of which 1.5 million is earmarked for election support.

UNAIDS

In response to the alarming ARV situation which has resulted in demonstrations at government offices and its political implications, establishment of UNAIDS Secretariat presence is being considered.

UNAIDS priorities are development of national HIV strategies and plans for strengthening HIV capacities, as well as re-establishing the United Nations HIV coordination system. Establishment of a Joint UN Team, to function as a coordination mechanism between UN system agencies, was agreed at a recent UN Country Team meeting. The Joint UN Team also includes other development partners, as well as national programme and civil society representatives. At the time of writing this report, the decision had not yet been announced by the UN Resident Coordinator.

During 2009-2010 there had been UNAIDS RST-initiated missions for assessment of various aspects of HIV response, such as a mission on VCT assessment in 2009 and on M&E and UNGASS reporting in 2010, and a desk review of available information in 2010. All plans for establishing VCT services, M&E systems, PMTCT were put on hold when the civil war broke out in 2011, along with developing the National Strategic Plan and strengthening civil society. UNAIDS plans to revisit and initiate the findings and recommendations of these missions.

UNODC

UNODC has established a Drugs and HIV Project with financing from the Libyan government in the amount of USD 6 million over four years. The project was

suspended in 2011 due to the civil war, but is being restarted. The project components include: a) rehabilitation of drug addicts; building or reconstruction of a centre in Tripoli and a centre in Benghazi; establishment of guidelines and training for drug rehabilitation; life skills education in schools; b) capacity building of NGOs for outreach among key populations, training and awareness raising, establishment of drop in centres; c) HIV assessment in prisons, training and awareness raising among prison staff and inmates; and d) study tours in other countries of the region (Egypt, Morocco). A full time national project officer is based in the National AIDS Programme.

WHO

The World Health Organization is the main supporter of the MOH and health sector development. WHO is supporting surveillance and health system assessments. All these are in the initial stages or still to be activated.

Plans for WHO support to HIV and AIDS in the post-conflict period include integration of HIV and AIDS in health systems strengthening, HIV and AIDS-related information and surveillance development, and emergency ARV procurement.

Other UN agencies

UNHCR and IOM have supported services for internally displaced, migrant and refugee populations with and through NGOs. These services, although not HIV specific, provide information about risk behaviours and potential spread of HIV.

UNFPA have expressed an interest to incorporate HIV in the Sexual and Reproductive Health and Maternal and Child Health programmes development, as well as support VCT expansion, and the engagement of the regional Y-PEER (youth) network which UNFPA is supporting.

<u>European Commission</u>

The European Commission financed project was originally designed to address the Benghazi children's hospital nosocomial epidemic. In response, it established a model centre with an advanced hospital information management system. The project was suspended in 2011, but is now being reactivated to expand the lessons and model programmes of the Benghazi experience for the benefit of other regions, and to support the development of PMTCT, blood safety, PEP and hospital infection control programmes and clinical research training, as well as to contribute to the National AIDS Strategic Plan development.

A bio-behavioural study on HIV has been partially implemented by the Liverpool School for Tropical Medicine (LSTM) under another EC funded project but the results are not yet available. LSTM has also worked on the national HIV strategy development providing preliminary inputs to a process that was suspended during the conflict.

<u>International NGOs</u>

International NGOs have provided health services during the conflict but are gradually withdrawing. Some will continue to provide services for migrant and other key populations.

IV. Monitoring and evaluation environment

The national HIV/AIDS monitoring and evaluation system has not changed since the last Country Progress Report in 2010. A National M&E Plan with indicators to monitor the National Strategy for AIDS Prevention is not in place and M&E capacity remains a critical challenge for the national HIV and AIDS response. The lack of data available for UNGASS reporting is due to the general lack of a national M&E framework and centralized M&E reporting system. The use of existing information for policy and priority setting is hampered by lack of data analysis capacity and regular monitoring and evaluation of service delivery.

However, some progress has begun with the establishment of a Monitoring and Evaluation Department in the National AIDS Programme in December 2011 and the appointment of a national M&E officer.

Data management is a general challenge throughout the country. An evaluation of the national disease surveillance system carried out by WHO in July 2011 revealed several weaknesses, ranging from lack of proper registration, incomplete reporting, lack of trained surveillance experts and lack of outbreak response teams. The surveillance system fails to function in some areas. Moreover, it is mainly based on hospital and laboratory records and reporting. Data are not reported routinely from all hospitals, PHC centres or polyclinics.

Information on disease-specific morbidity and mortality in key populations, such as injection drug users, sex workers and men having sex with men, migrants and internally displaced populations in IDP settlements or in rural areas, is limited or absent.

To address the challenges, several remedial actions are planned:

- Develop an M&E framework in conjunction with the national strategic plan that defines the elements of the M&E system, indicators to monitor the progress of the HIV and AIDS response, and capacity building plans.
- Expand the established Benghazi children's hospital information and management systems.
- Establish a sentinel surveillance system for TB patients, pregnant women and blood donors.
- Complete the planned BBSS among key population groups.
- Conduct three KABP studies among students, religious leaders, and young people.

Technical assistance needs for M&E will be identified during the development of the National Strategic Plan for HIV and AIDS in Libya. However, it is likely that assistance will be required for development of the National M&E Plan, as well as for development of reporting systems in the country.