HIV AIDS Response and Context in Lebanon in 2016

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1. Country Disease Context

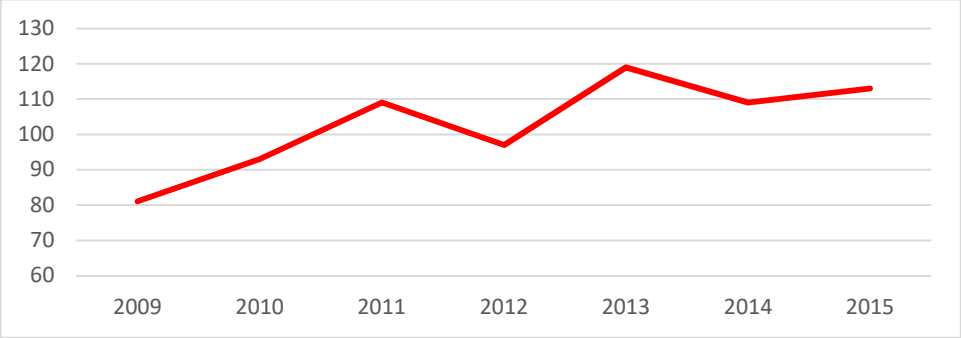
Current and Evolving Epidemiology of HIV in Lebanon

Lebanon is a small country of 10,452 km2; it extends 217 km from north to south and spans 80 km at its widest point. The country is bounded by the Syrian Arab Republic in both the north and east and by the occupied Palestinian territory in the south.

Similar to other countries in the Middle East and North Africa, existing data indicate that Lebanon has a low-prevalence of human immunodeficiency virus (HIV) in the general population (0.1%). However, due to various factors it is estimated that HIV is still underreported and sometimes due to issues related to stigma in local community[1].

By 2014, UNAIDS estimated that there were 1,800 (with a range of 200 to 3,500) People Living with HIV (PLHIV) in the country, roughly 15% of this figure are female. From the evidence we know that the majority of the new cases are between 15 to 49 years old (51.8% of new cases). Deaths due to HIV/AIDS remain low, estimated at less than 10 per 100 000 population per year[2].

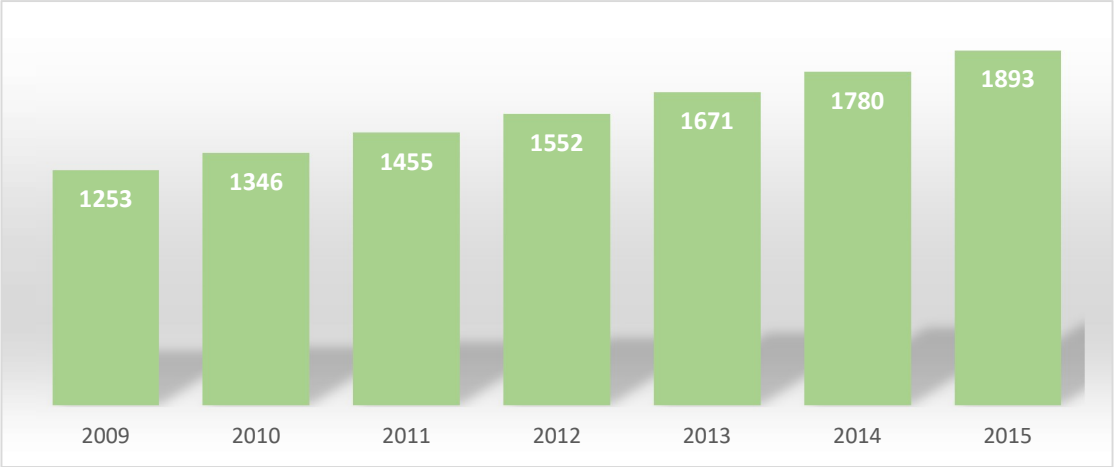
Figure 1: number of new reported cases each year.



[1] National AIDS Strategic Plan 2016 – 2020.
2 UNAIDS. http://www.unaids.org/en/regionscountries/countries

National AIDS Control Program (NAP) in Lebanon reported the cumulative cases at 1893 cases by end of 2015, with 109 and 113 newly reported cases in 2014 and 2015 respectively. 2015 accumulated patients figure is 50% above the figure reported in 2009, where the accumulative number at that time was 1253 cases[3].

Figure 2: Number of accumulated HIV/AIDS cases end of year (2009-2015)



HIV transmission in Lebanon is essentially a behavioral issue. The dominant mode of transmission is sexual (81.4%), with few reported cases attributed to injection drug use (2.7%) and since 1993, no cases due to blood transmission have been reported. Among the specified cases, the homosexual mode was dominant (34.5%), followed by the heterosexual mode (15.0%). The trend in vulnerability has remained almost the same during the last 8 years, where the Men who have Sex with Men (MSM), Female Sex Workers (FSWs), People Who Inject Drugs (PWIDs) and prisoners remain the key affected or at risk population groups. More specifically, the latest epidemiological data indicate a concentrated epidemic among the MSM population. Although local transmission of the infection is well documented, a clear correlation with travel and migration is currently accounting for 39.2% of the accumulated cases by 2012[4].

3 National AIDS Strategic Plan 2016 – 2020.
4 HIV Test-Treat-Retain Cascade Analysis for Lebanon 2015.

Key populations:

As mentioned before, MSM and PWIDs, and to lesser extent female sex worker (FSW) and prisoners are the main key affected population groups in Lebanon. With data reflecting that the prevalence of HIV among MSM is the major driver of the epidemic in the country. In addition to these groups, displaced people and refugees remain the most vulnerable population under the current social context in the country.

Men who have sex with men:

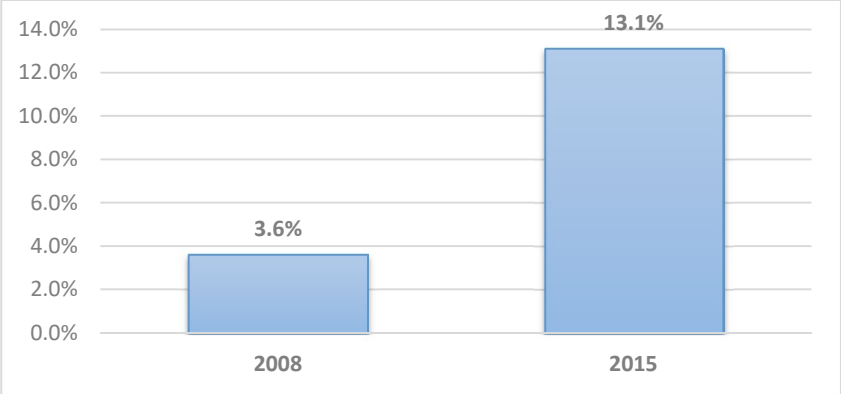
Men who have sex with men continued to be at high risk of HV. According to available evidence, over half (56%) of the estimated HIV cases in Lebanon have been due to heterosexual behavior, while 20% due to homosexual or bisexual behaviors[5]. Compared to other countries, Lebanon among the few countries in MENA region which has introduced comprehensive package of HIV prevention services for MSM. These programs have shown good practices where services demonstrate respect for beneficiaries' rights and dignity and when civil society and other partners are able to provide focus and saturation.

A study conducted in 2008, Mishwar, has provided some indicators about sexual and risk behaviors of MSM. The study indicated that more than half of the sample reported not using a condom during their last anal sex, with more than a third of the respondents (36%) had sold anal sex. Less than a quarter of the sample (24%) reported having had an HIV test, and of these 46% reported having the test in the last year and 55% in the last two years. All those who had a test reported receiving their results. Considering the nationality, more than one-quarter of the sample were non-Lebanon (27%). The study estimated the population prevalence rate to be 3.6%[6].

[5] National AIDS Strategic Plan 2016 – 2020.

[6] Integrated Bio-behavioral Surveillance Study among Most at Risk Population in Lebanon 2008 (Mishwar).

Figure 3: HIV prevalence among MSM 2008 and 2015



By 2015 the situation has changed relatively. A study conducted in 2015 among MSM and other populations to identify sexual behaviors and risks in addition to size estimates of these population groups. Regarding the MSM, 65% of the respondents reported using condoms during their last anal sex with sex partner. 34% of the respondents report have gave or received sex for money, goods, or services. The study has indicated higher rates for HIV testing as 67% of the respondents got tested recently. Compared to 2008 study, the 2015 study sample composed of 29% with non-Lebanese nationality, with 25% of the respondents reported Syrian nationality. Finally the study estimated the prevalence among MSM to be around 13.1%. The study estimated the size of the MSM population in the region of Greater Beirut to be 4220. Among the distinct findings of 2015 study is the provenance of Sexually Transmitted Infections (STIs) among the MSM. 18% of the respondents reported that they have been medically diagnosed with one STI in the last year, with 98% of them received the required treatment[7].

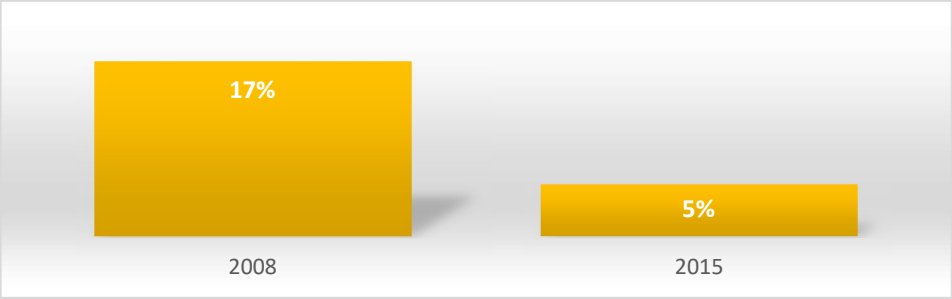
People who inject drugs:

People Who Inject Drugs is one of the population groups most severely affected by HIV infection in many countries. More than half of the new infections in key populations MENA

[7] Size Estimation, Risk Behavior Assessment, and Disease Prevalence in Populations at High Risk for HIV Infection in Lebanon 2015.

region of UNIAD are occurring among people who inject drugs, Lebanon however is an exception. Mishwar study of 2008 indicated that less than a fifth of PWIDs (17%) reported sharing needles during their last injection. In addition, less than half of the sample (43%) reported using a condom during the last sexual intercourse with a non-commercial regular sex partner. A very high percentage of the sample (97%) reported knowing that sharing needles while injecting drugs increases the risk of HIV transmission. The overwhelming majority of the sample consisted of Lebanese nationals (93%). Almost half of IDUs reported having bought sex and 17% reported having sold sex. The study estimated the prevalence among PWID to be around 0%[8].

Figure 4: Sharing needle behavior among PWIDs - Comparison 2008 and 2015



In comparison, 2015 study revealed that 5% of the respondents reported sharing needles during their last injection. 65% of the male respondents reported condom use with their female sex partners, while only 38% of female respondents report using condoms with their male sex partners. On average 12% of the male respondents engaged in giving or receiving sex for money, goods or services. Comparable to 2008 study, 95% of the study participants were Lebanese. 74% of the participants reported been tested for HIV prior to enrolling in the study and none reported having tested positive. Of the 339 who did seek testing, there was only one HIV-positive test result, with estimated prevalence of HIV in the sample of 0.26%. The study estimated the size of the PWIDs population in the region

[8] Integrated Bio-behavioral Surveillance Study among Most at Risk Population in Lebanon 2008 (Mishwar).

of Greater Beirut to be 3,114. In addition, 13% of the sample reported medically diagnosed STI during the last year, with only 37% reported receiving treatment[9].

Female sex workers:

There is very little visibility around sex work in middle east countries and there is a lack of data on the burden of HIV among FSWs. In Lebanon there has been only one study that has document the risks associated with FSWs which was 2008 Mishwar study. The 2008 study indicated that 98% of FSWs reported condom use in the last time you had sexual intercourse with non-regular client, but this figure drop to 43% when having sex with regular client. A clear majority (79%) of FSWs had been tested for HIV, and 88% of these had been tested within the last year and 99% of these had obtained their HIV results. Less than a fifth (18%) of the sample was found to be Lebanese citizens, although all reside in Lebanon. 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. Of the 150 FSWs recruited, 107 tested for HIV. Of those, no cases of HIV were identified among the FSW, for an overall sample prevalence rate of 0%[10]. On the STIs, other studies have shown that 28% of FSW have reported one or more of Sexually Transmitted Infection symptoms.

[9] Size Estimation, Risk Behavior Assessment, and Disease Prevalence in Populations at High Risk for HIV Infection in Lebanon 2015.

[10] Integrated Bio-behavioral Surveillance Study among Most at Risk Population in Lebanon 2008 (Mishwar).

2. Displaced and refugee populations in Lebanon:

Key statistics:

As of December 2015, a total of 1.85 million refugees from different nationalities were estimated in Lebanon, with 99% of them are Syrian and the rest from Iraq, Sudan and other nationalities. The Government of Lebanon estimates the total Syrian population in Lebanon to be 1.5 million, out of this number, according to March 2016 updates from UNHCR, only 1,051,325 Syrian refugees were registered in Lebanon, 52% of them are female. In addition, UNRWA reports indicated that 449,957 Palestinian refugee were registered in Lebanon[11].

Refugee population has add-up significant growth to current population density in Lebanon. While there are no recent official figures endorsed by the Government of Lebanon, the World Bank has estimated the total population of Lebanon in 2014 to be 4,547,774. With this estimates, that means the new demographics of the country has changed significantly during the last few years with a ratio of 1:2.5 (i.e. 1 refugee to 2.5 Lebanese). This figure might vary from one side of the country to another, depends on the density of the population, making it sometimes difficult to separate between the refugees and their hosting communities.

Table 1 below provide estimated figures that reflect the refugee to population ration in different country sides (Governorates).

[11] UNHCR Lebanon 2016. http://www.unhcr.org/pages/49e486676.html

Table 1: Comparison between refugee communities and hosting communities

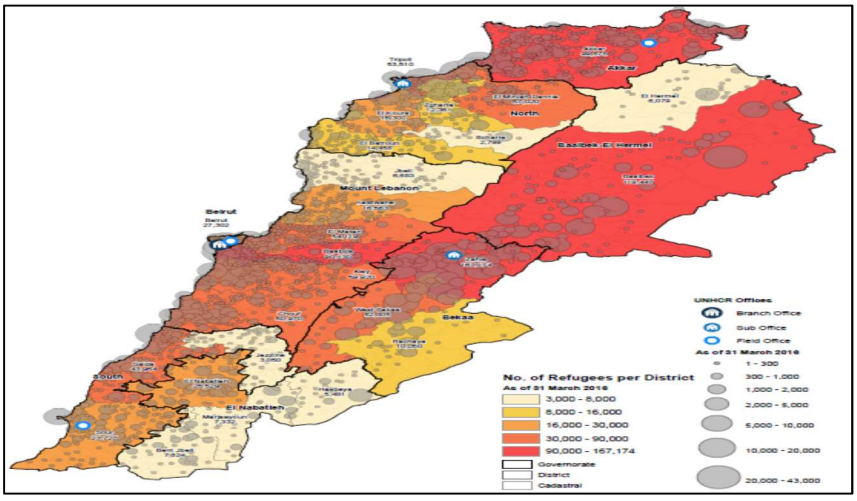
Governorates	Number of register Syrian refugees *[12]	Hosting community Population estimates **[13]	Refugees to population ratio
Bekaa	365,555 (35%)	67,1399	1:2
Mount Lebanon	278,385 (26%)	1,667,331	1:6
North	256,126 (24%)	941,309	1:3
South	74,741 (7%)	516,656	1:7
El Nabatieh	49,216 (5%)	323,961	1:7
Beirut	27,302 (3%)	427,118	1:15

* Source UNHCR 2016

** Ministry of Public Health – Statistical bulletin 2013. Adjusted to World Bank estimates for 2014.

The figure below provide visual explanation about the distribution of the refugees all over the country.

Figure 5: Distribution of refugee community over Lebanon in 2016[14]



[12] UNHCR Lebanon 2016. http://www.unhcr.org/pages/49e486676.html
[13] Ministry of Public Health – Statistical bulletin 2013
[14] UNHCR Lebanon 2016. http://www.unhcr.org/pages/49e486676.html

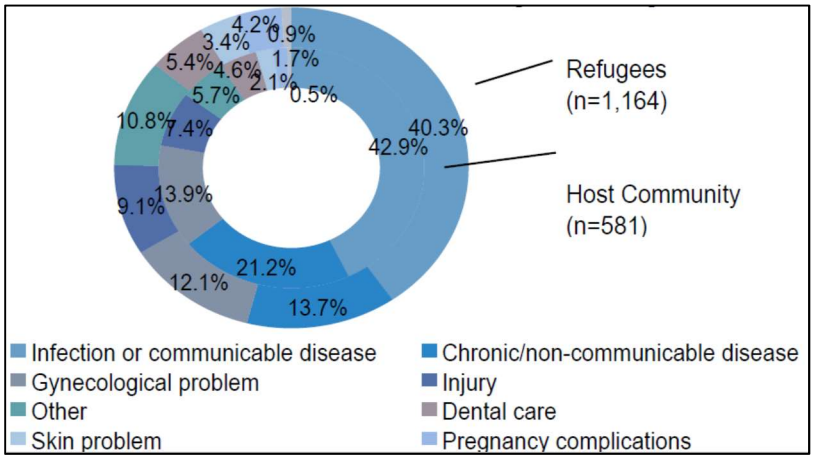
Health problems and burden[15]:

During 2015, UNHCR reported a total of 1,399,052 primary health care consultations provided to refugees in Lebanon through its network, out of this, 107,907 pregnant women attending ANC visit in the PHC centers and received the services. Part of the health programs, 11,270 persons assisted with their hospital bills to cover part of their medical care cost. With all of these numbers, the ability of partners to cover the huge gaps is limited. The services provided through the humanitarian response partners is only around 70% of the total needs. Given the number of refugees, resources are not able to meet all their health care needs. Funds are increasingly stretched among prioritized interventions and vulnerable cases, particularly at secondary and tertiary care levels. Lifesaving interventions in the area of maternal and infant health are extremely costly. Overall, UNHCR estimated the total budget for 2016 to cover the basic needs and essential services health to be USD 100,650,794, and for reproductive health and HIV related services to be USD 3,267,819[16].

The primary reasons for needing medical care in Lebanon for an adult household member among Syrian refugee households included infection or communicable disease (40.3%), chronic medical conditions and non-communicable diseases (13.7%), gynecological problems (12.1%), and injuries (9.1%). Health problems among the hosting communities are not different. The primary reasons for needing medical care in Lebanon for an adult household member among hosting communities households included infection or communicable disease (42.9%), chronic medical conditions and non-communicable diseases (21.2%), gynecological problems (13.9%), and injuries (7.4%).

[15] Syrian refugee and Affected Host Population Health Access Survey in Lebanon 2015.
[16] UNHCR. Health access and utilization survey among non-camp refugees in Lebanon 2015.

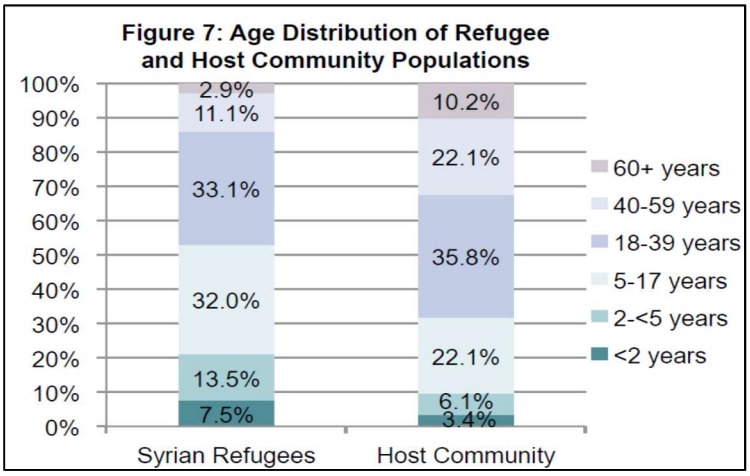
Figure 6: Reason care was last needed for an adult household member in Lebanon among Refugees and hosting communities[17]



These data indicates the importance of have a public health approach when managing any health programs or interventions targeting refugee communities and its hosting communities. This is especial concern when the health program is targeting communicable diseases and its control and prevention.

The Syrian refugee population in Lebanon is very young, with what would be expected in a refugee migration. The proportion of the population aged 17 and under in Lebanon is 52.9%. This usually add another level of challenges for health systems to respond to specific needs of these population groups.

[17] Syrian refugee and Affected Host Population Health Access Survey in Lebanon 2015.



With the increase number of refugees and the trend towards hosting them in camps the vulnerability towards communicable diseases, sexually transmitted diseases, in particular HIV/AIDS as well as sexual violence, will increase, the needs towards working in prevention and awareness raising among this continuously fragile environment. There are no accurate statistics as regarding the actual disease burden of HIV and AIDS among the displaced and refugee populations in Lebanon. However since 2011 there were 32 cases reported from different service providers among these populations, and currently 20 of them are actually receiving ARVs in Lebanon[18]. Sexually transmitted infections is among other communicable diseases that are reported from service providers to these communities. Recent study in 2015 aimed to assess whether there are pockets of infections in particular groups such as MSM, FSWs and PWIDs, or refugee women. The study has found many challenges regarding the availability of data and reporting from the key populations as well from refugees. There are some service providers reported cases among the refugees, but the data set was not suitable to generalize data about the whole population groups. The data sources from clinicians, but also programmatic data from NGOs working with these populations, pointed to more STIs among women than men[19]. In addition, in 2013 one of

[18] Administrative records of National AIDS Program of Lebanon 2016.
[19] Lebanon STI Assessment Report 2016.

NGOs working with UNHCR in Bekaa reported 4.6% of patients sough PHC services in their clinics were reported due to STIs conditions[20].

HIV burden in Syria and Palestine[21]:

Little is known about actual disease burden of HIV in Syria and Palestine, countries of origin of 99% of the refugees and displace people in Lebanon. However from the reports and statistics we know that both countries is characterized by a very low prevalence, i.e. less than 0.1% of HIV among the general population of both countries, with lack of evidence about the prevalence among specific key population that might disproportionally affected by the disease.

Syria has a low-prevalence HIV epidemic, with very low levels of HIV among the general population, as well as among key populations at risk. Between 1987 and December 2011, a total of 762 HIV and AIDS cases were reported. While the annual number of reported cases stayed below 25 till the year 2000, since 2006, the number of new cases increased to 50-70 per year. In 2010 and 2011, 66 and 69 new cases of HIV/AIDS were found respectively. The male-to-female sex ratio among reported Syrian HIV cases is 3:1. While current HIV rates remain low, various factors could drive a potential HIV epidemic in the future, if not attended. Poverty, massive labour migration and mobility, human trafficking, increased exposure to external cultural and economic systems, as well as changing sexual behaviors among young people may drive future HIV transmission.

The Ministry of Health in the Occupied Palestinian Territory reported a cumulative total of 79 cases of HIV through 2011. Of these 30 are currently living and on treatment. The majority of cases were among males and in over half of the cases, transmission of HIV occurred through heterosexual sex. According to the reported figures, the majority of cases are among males, and the majority of infections were transmitted through heterosexual sex

[20] UNHCR. Health access and utilization survey among non-camp refugees in Lebanon 2015.
[21] UNAIDS. http://www.unaids.org/en/regionscountries/countries

(56%), and blood transfusion (17%). Only 4% infections were attributed to injecting drug use and 1% to homosexual activity. While data is limited, OPT also considered a very low prevalence similar to rest of the countries in the region.

Vulnerability analysis of refugees to HIV infection in the current context:

Vulnerability and risk factors:

In the current context, we know that sexual transmission is the dominant mode of transmission, where many risk factors are associated with this mode in the current context based on available evidence. Below are some risk factors we should consider part of the vulnerability analysis of refugee population groups in our context:

- Engagement in risky sexual behaviors.
- Transactional sex and coerced or forced sex.
- None or limited use of condoms.
- Prevalence of sexually transmitted infections.
- Injecting drug use with sharing of non-save needles.

From the analysis of the epidemiological situation above, we would like to bring to attention these facts[22], [23]:

- Between 27-29% of men who have sex with men in the current community are non-Lebanese with 25% of the respondents in recent study reported Syrian nationality. With estimated HIV prevalence of 13.1% among these population group, many of them shared many of the above vulnerability and risk factor.

[22] Integrated Bio-behavioral Surveillance Study among Most at Risk Population in Lebanon 2008 (Mishwar).
[23] Size Estimation, Risk Behavior Assessment, and Disease Prevalence in Populations at High Risk for HIV Infection in Lebanon 2015.

- Around 7% of people who inject drugs are non-Lebanese. While they experience low risks due to injecting practice, still sexual behavior constitute significant risks, with 17% of them engaged in commercial sex.
- More than 80% of the sample among female sex workers was found to be non-Lebanese. 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. Some indicators revealed engagement in risky sexual behaviors.

Building on experiences from other situations, reported vulnerability factors may include the direct impact of the crisis on health, education, security and violence depending on the context – and the indirect impact such as displacement, migration, family separation and domestic violence. In the current context, here are some of the factors that make these populations more vulnerable to HIV infection are:

- Poverty and limited income.
- Disruption of families, which make women and young people more vulnerable.
- Violence and sexual abuse.
- Lack of access to basic health care.
- Lack of information about HIV, sexually transmitted infections or availability of services
- Lack of services (sexually transmitted infections, voluntary counseling and testing, care and treatment) for most at risk groups.

Legal status[24]:

Access to basic services for refugees in their country of asylum is usually tied to their registration status. Irregularity in legal status compounds the challenges of people with

[24] UNHCR, UNICEF & WFP. Vulnerability Assessment of Syrian Refugees in Lebanon 2015.

injuries and other life-threatening conditions. Being an unaccompanied patient increases the vulnerability of those who are not registered. While the status of registration in Lebanon might affect the ability of the refugees and displaced people to access some of basic services, this is not the situation regarding health services. This also apply to different health services, including prevention, diagnosis, care, support and treatment of HIV in Lebanon. These population groups can access these services regardless of their reiteration status.

Income and work[25]:

While the registration status is not considered a barrier for these population to access services, it indeed affect their ability to afford these services especially in the current context in Lebanon. Recent UNHCR statistics show that "almost half of the refugee population lives below the Lebanese poverty line of US $ 4 per day, with a third at or under US $ 2 – 3 per day and unable to meet basic needs, including basic and other health services. Given that most refugees in Lebanon do not have a right to work in their country of asylum, they have no means of responding to stressors or emergency costs themselves, apart from seeking humanitarian assistance, personal donations or loans. When informal work is available, whether legally or not, it is usually manual work for which older people and those with physical impairments cannot compete for. These restrictions furthermore negatively influence their resilience and ability to cope with unforeseen stresses such as illness, or other causes of medical expenditures including medical investigations and medications. It is know that however, through informal, some of the refugee groups tends to seek working illegally in some work places that expose them to some of the risk factors mentioned before.

[25] UNHCR, UNICEF & WFP. Vulnerability Assessment of Syrian Refugees in Lebanon 2015.

Gender and age[26]:

Being the head of a household as well as coping with injury, disability or other chronic health condition is a significant challenge in its own right. However, being a single woman heading a household as a refugee in a patriarchal cultural context exacerbates the challenge. From the statistics we know that 19% of the Syrian refugee households in Lebanon are led by women. In addition to physical health concerns, most of these women were also coping with mental health issues that arose due to the trauma induced by being separated from their husbands, witnessing the death of close family members, and struggling to survive and ensure the wellbeing of their children. As evidence suggest, some of these women may engaged in high risk factors associated with HIV transmission; for example engagement in commercial sex services in their local communities, or being a victim of human trafficking which entails in majority of cases violence, sexual abuse and coerced or forced sex, which is most of the cases is unprotected.

In addition, in these situations, existing gender inequalities and norms may be further exacerbated, making women and children disproportionately more vulnerable to HIV. For example, as a consequence of loss of livelihoods and a lack of employment opportunities, sex work and sexual exploitation may increase. Mass displacement may lead to the separation of family members and the breakdown of community structures and of the social cohesion and sexual norms that regulate behavior.

Some of the refugee groups are at higher risk of Sexual and Gender-Based Violence (SGBV) than the rest of the population, including children, refugees with disabilities, older people, and lesbian, gay, bisexual, transgender and intersex (LGBTI) among the community. Rape may be reported more frequently than at normal situations in local communities. People living with HIV (PLHIV) and other key populations at higher risk of

[26] Equal access monitor. Intersecting Vulnerabilities among Syrian refugees 2015.

exposure to HIV may require specific measures to protect themselves against neglect, discrimination and violence.

Stretched capacity of the hosting community and basic services:

The Syrian refugees in Lebanon are scattered all over the country with over 60% being in the North and Bekaa governorates. The two governorates, together with the South governorate, are known to have the highest poverty rates in the country. The refugees and displaced people influx to Lebanon has strained Lebanon's public finances, service delivery and the environment. The crisis is also expected to worsen poverty incidence among Lebanese as well as widen income inequality. In particular, it is estimated that as a result of the Syrian crisis, some 200,000 additional Lebanese have been pushed into poverty, adding to the erstwhile 1 million poor. An additional 220,000 to 320,000 Lebanese citizens are estimated to have become unemployed, most of them unskilled youth.

According to recent health assessment study (Syrian refugee and Affected Host Population - Health Access Survey in Lebanon 2015); Syrian refugees reported needing medical care more often than Lebanese host community members; one possible reason for this difference is that poor living conditions among refugees are associated with increased morbidity. Refugees are charged similar medical fees as Lebanese nationals. Despite subsidized healthcare in primary health care centers supported by the humanitarian community, many refugees still find it difficult to cover the remaining costs of medical. In addition, medications and diagnostic tests are frequently overprescribed; increasing costs for refugees and thereby heath agencies. In the month preceding mentioned study i.e. July 2015, mean Syrian refugee household spending on health was US$105, equating to 33% of monthly income. Lowering user fees and increasing access to free or subsidized medication are two possible approaches to improving access to care for both refugees and the Lebanese host community. Within the context of current funding shortfalls neither may be feasible at the levels required to substantially improve access and care seeking

behaviors. The results revealed than the Lebanese host community is more likely to seek and receive health care than Syrian refugees. Cost is the primary barrier to accessing health services and medications in both the Syrian refugee. Refugees have full access to health services, but due to the costs associated with seeking care, a sizeable percentage of the refugee population do not seek care. Given the number of refugees, resources are not able to meet all their health care needs[27].

The people that are subject to forced migration are known to be the weakest and most vulnerable. Their health needs, among others, continues to rise with the protraction of their displacement. Furthermore, media reports and anecdotal information indicate the rise of HIV risk determinants and risk behavior. This includes male and female sex work and gender-based violence (GBV). Those media reports also testify to Syrian men who have sex with men seeking refuge in Lebanon.

3. Health System in Lebanon and HIV Services in Lebanon

The health system in Lebanon has witnessed several changes that aimed to include some initiatives toward achieving the objectives of health sector reform initiated in 2003. The period following the civil war was characterized by rapid growth in an unregulated manner of the private for-profit sector and a weakened public sector. Although the health sector reform was halted by the volatile political and security situation, progress was made towards improving the health system performance in general, and regaining the stewardship function of the Ministry of Public Health. Lebanon remains in a state of epidemiological transition in which infectious and communicable diseases are still endemic with an increase in the prevalence of non-communicable and degenerative diseases. There

[27] Syrian refugee and Affected Host Population Health Access Survey in Lebanon 2015.

are remarkable improvement in major health outcomes in the country. The infant mortality rate, estimated to be 9 per 1000 live births in 2009 which has been remarkably improved compared to 19 per 1000 live births in 2004. Under five mortality rate in 2009 was 10 per 1000 live births, compared to 33 per 1000 live births in 2000. The maternal mortality ratio (per 100 000 live births) has changed from 86 in 2004 to 18 in 2013. However, these indicators come at the high price of US$ 751 annual expenditure on health per citizen in 2012[28].

As discussed before, the increased population largely due to the influx of refugees has had significant impact on the health system such as (1) an increased utilization of the health services at PHC level by 50%, especially mother and child health related conditions; (2) an increased secondary and tertiary health services utilization by around 35%; and (3) an overstretched capacity of the MOPH in terms of HIS for monitoring health trends and risks[29].

Health financing[30]:

While the overall health expenditure out of the public expenditure remains low at 2.6% in 2012, still the overall expenditure on health is adequate in Lebanon, but the balance of spending across segments of the health system may be ameliorated to deliver the expected outcomes. That was evident also with a relatively reasonable total health expenditure that represent 7.2% of the total GDP in 2012. Out of this, 68.4% was contributed through private resources. The Ministry of Public Health remains the insurer of last resort for around 50% of the population, which reflects the government efforts to address the inequities in access to health care. The out-of-pocket contribution is estimated at 37% in 2012, which is still considered high. On average, households spent a little over 9% of their household expenditures on health services in 2004. With a relatively high total Health Expenditure per

[28] Country Cooperation Strategy for WHO and Lebanon 2010–2015.
[29] Interagency Coordination in Lebanon. Support to Public Institutions under the LCRP 2015.
[30] Country Cooperation Strategy for WHO and Lebanon 2010–2015.

capita, it is noticeable that the health outcomes do not compare favorably to other countries with similar health spending. The current public financing for health services tends to focus more on curative care and gives relatively less focus to areas such as disease prevention and public health management in primary care.

In Lebanon there 6 different public agencies contributing to achieve the universal access to health services; which include mandatory social insurance for employees in the formal sector, medical services of the Army and the other uniform staff (total of 4), the cooperative of civil servants, a few social mutual funds and a private voluntary insurance provider.

Service delivery[31], [32], [33]:

Primary health care facilities:

The country counts around 950 primary health centers that range from simple dispensing centers that operate sometimes only once every month, to well-developed comprehensive primary health care centers. Around 70 primary health centers are operated by the Ministry of Social Affairs, 130 centers are operated by the Ministry of Public Health, a few are operated by municipalities, and the rest are operated by nongovernmental organizations that are often religiously or politically affiliated. The Ministry of Public Health has strengthened access to primary care through a large network of primary care centers (currently around 120) established in collaboration with nongovernmental organizations and with the municipalities, providing since 1996 a package of health services by contractual agreement.

Hospitals:

According to 2013 statistics, there are 168 hospitals in Lebanon, 28 are public, that have close to 13,000 beds with a rate of 34.5 bed per 10,000 population. The majority of private hospitals are owned and managed by charitable organizations, with other 3

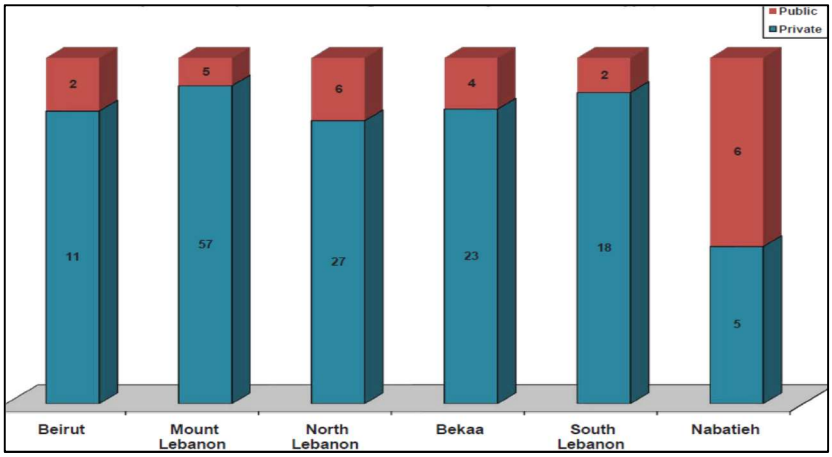
[31] Lebanese health care system: Challenge and solutions 2013.
[32] Country Cooperation Strategy for WHO and Lebanon 2010–2015.
[33] National Health Statistics Report in Lebanon 2013.

private/charitable university teaching hospitals. The Rafic Hariri University Hospital in Beirut is the only government university hospital and is intended to serve as the lead referral hospital for the public hospital sector. The utilization of the public hospital sector has increased tremendously in recent years, and the sector has attracted more than 40% of the hospitalized patients covered by the Ministry of Public Health.

Private ambulatory services/clinics:

Private practice is dominant in the health service delivery system. Almost all physicians have private consultation cabinets, most of them outside a health centre (hospital or other health facility). It is estimated that there are around 8000 private medical consultation cabinets all over the country, with a concentration favouring large cities.

Figure 8: Hospitals contracting with MOPH by Governorate and type, 2014



Health services for the refugees[34]:

As could be expected in such kind of settings, the dominant health services targeting refugees were delivered through, and built on, primary health care through public and private service providers as 40% of the PHC were Syrians. Still the needs for secondary and tertiary health care is not small. Public secondary and tertiary service provider work in semi-autonomous management system and usually the referral care to these institutions is very expensive. Secondary and tertiary health care institutions in Lebanon are mostly private and cost is a significant barrier to access.

Given the number of refugees, resources are not able to meet all their health care needs. Funds are increasingly stretched among prioritized interventions and vulnerable cases, particularly at secondary and tertiary care levels. Refugees are charged similar medical fees as Lebanese nationals. Despite subsidized healthcare in primary health care centers supported by the humanitarian community, many refugees still find it difficult to cover the remaining costs of medical. To harmonize access to secondary healthcare and manage costs, UNHCR has put in place referral guidelines in Lebanon. The costs covered by UNHCR vary by estimated cost of care, vulnerability status, and type of care (e.g. emergency life-saving, obstetric, medical and surgical). Since 2014, 15,200 refugees from Iraq, Sudan and Somalia were also covered under the UNHCR referral health care programme. The majority of accepted referrals are covered in the 20 receiving hospitals. UNHCR paid 76% of the 35.9 million USD spent on referral care in 2014, with 38% of total expenditure was spent on obstetric care. The annual cost of referral care per capita among the refugees was 33.4 USD. Still the out-of-pocket expenditure for the refugees is considered high. Studies indicates that the average cost of health care paid per household in the preceding month increased to 136 USD compared to 90 USD in 2014. Many other reports highlighted this high financial burden as major barrier to access health services.

[34] Syrian refugee and Affected Host Population Health Access Survey in Lebanon 2015.

Refugees are spread over 1,700 locations, making access challenging even though the geographic spread of public health facilities is relatively good. Refugees who live further away from facilities bear the extra cost of transportation. Humanitarian agencies operate mobile health clinics to reach as many vulnerable individuals as possible living in remote areas. Medical Mobile Units (MMUs) provide uniformed basic minimum primary health care services through targeting to most vulnerable persons of concern residing in remote locations with difficult or no access to Primary Healthcare Centres and dispensaries. By 2015 there are 23 MMUs operating throughout Lebanon through 12 agencies in 250 locations. An MMU team includes at least one medical doctor, one nurse, and/or one health educator or counselor.

Human resources[35]:

Lebanon has a high number of specialist physicians per capita, a high number of pharmacists and a low number of nurses. There are around 12,000 registered physicians (a rate of 31.9 per 10,000 population in 2013) with more than 8000 being specialists. In 2013, there were around 7000 pharmacists (with a rate of 16.8 per 10,000 population in 2013). The issue of balanced skills mix is high on the agenda, especially with only below 4000 nursing and midwifery personnel registered in the country (i.e. 9.1 per 10,000 population in 2013).

Information system[36]:

Significant efforts were made to improve on the health information system over the past few years, such as issuing a periodical births bulletin, introduction of geographic information systems technology in health. However, information about morbidity and

[35] National Health Statistics Report in Lebanon 2013.
[36] Country Cooperation Strategy for WHO and Lebanon 2010–2015.

mortality at national level remain suboptimal, and most of the data in Lebanon are usually obtained from studies done through certain projects. Small-scale studies, usually limited to certain population groups and most of the time to certain geographic areas. It is frequently difficult to use these studies and generalize the results to the population at large because of its limitations. There are efforts towards developing a national health information system at the Ministry of Public Health. In that respect, the Ministry of Public Health has computerized its archived data regarding the licenses given by the Ministry to health professionals, as well as its pharmaceuticals distribution systems. A collaborative effort led to a unified database between the Ministry of Social Security and the Ministry of Public Health as public funders. The epidemiological surveillance hospital-based network generates substantial information regarding communicable diseases.

Main issues challenging the further development of the health information system include the following:
(1) Computer literacy of concerned MOPH staff, both centrally and peripherally need to be strengthen (2) Equipment across the MOPH offices need to be increased; (3) Cooperation of stakeholders in sharing their data, (4) Collaboration with the private sector; and (5) Strengthening the feedback of information.

Health system strengthening[37]:

Many donors and partners, under the UN Inter-Agency Coordination, has expressed interest to support the Lebanese public institutions, which has been channeled through Lebanon Crisis Response Plan (LCRP). Out of 171.5 million USD that was channeled to public institutions in 2015, a large share of the 290m USD requested to support Health Systems has being dedicated to strengthening public health institutions. The technical and financial assistance provided to the healthcare system has been channeled focusing on: (1) Strengthening healthcare institutions and enabling them to face the increased demand

[37] Interagency Coordination in Lebanon. Support to Public Institutions under the LCRP 2015.

on services and the scarcity of resources; (2) Ensuring wider access to a primary health care package of basic services through the support of 250 PHCs; and (3) Improving access to hospitals and specialized referral care by targeting 27 public hospitals. While this investment was essential to address the current gaps in the health system, the remaining gaps and required funding is still huge. It is worth mentioning that HIV and AIDS has not benefited from any of the interventions covered under this initiative. For example, HIV service availability and readiness was not assessed neither included in these plans and interventions.

HIV and AIDS Services:

National AIDS Program, which is operating through a joint agreement between the MOPH and WHO, is in charge of every aspect of the HIV response in Lebanon. The activities of the NAP also include awareness about the disease and its management, fighting stigma and discrimination. Another major activity of the NAP is collaboration and coordination with the private sector, with non-governmental organizations (NGO's), ministries, media, religious leaders, United Nations (UN), agencies and other key stockholders to improve the situation of people living with HIV (PLHIV) and to halt the spread of the epidemic. In Lebanon, the mobilization of non-governmental organizations around preventive programs has had a significant impact on the fight against HIV. Partnerships and collaborative project with the NAP have become very frequent and have led to successful results and establishment of different projects on prevention, testing and stigma reduction.

Testing and counselling services[38]:

In 2006, the national Voluntary Counseling and Testing (VCT) protocol was established. The protocol entailed practical guidelines and thorough explanation on how to conduct each of the components of the voluntary counseling and testing. In the last period, more

[38] National AIDS Strategic Plan 2016 – 2020.

than 550 healthcare workers in primary health care centers, sociocultural and NGO's health facilities received the training.

Testing services are also provided by laboratories (private and public hospital-based and stand-alone laboratories) and VCT centers (stand-alone centers or mobile units). Recent statistics indicate that more than 100 fixed VCT centers are operating all over the country. The VCT services in Lebanon are free of charge and are delivered primarily by NGOs. The VCT services include focusing on life skills, problem-solving and decision making with the target population. Use of the peer education is also an integral component of the provision of these services. However, it is not feasible with current capacity of NAP to do proper monitoring of services provided by these centers, especially that the majority of them are operating through private and NGO sectors, and adherence to reporting remains a major challenge.

These centers provide counseling and rapid testing services to the general population including youth, premarital couples, blood donors, tuberculosis (TB) and STIs patients, as well as MARPs, including sex workers, MSM, PWIDs, prisoners and sexual partners of PLHIV. All refugees can access these services where they located. It is estimated that 40% of the beneficiaries belong to the MARPs and most are young males between the ages of 16 to 25 years of age. Recent data provide evidence of high levels of HIV testing, awareness of infection and treatment among the MSM population in Lebanon. Only 3.1% of the MSM recruited within the latest bio-behavioral survey (BBS, 2015) in Lebanon were never tested for HIV infection. Data from the Crossroads BBS (2015) indicate a 74% HIV testing rate among surveyed PWID.

The recent Test-Treat-Retain study found that the biggest gap in the general cascade is achieving better outcomes of diagnosis services. This has been evident as there are still 31% of HIV-infected individuals in Lebanon are not aware of their status. Provider initiated HIV testing is still need to be strengthened part of the current culture. The TTR study highlight that; identifying PLHIV represents the largest breakpoint for Syrian and

Palestinian refugees. The study consider that, identifying HIV-positive patients among the Syrian refugees seems to be extremely challenging due to many social and structural factors. This is consistent with published reports where refugees from Syria and Iraq were found to be less likely to test for HIV[39].

Care, Support and Treatment Services[40]:

The National guidelines for ART issued in 2013 were adopted from the most recent international recommendations, especially the 2013 WHO consolidated guidelines. The guidelines has provided guidance for all services providers from different sectors on the medical management of all age groups and sub-populations among PLHIV. Part of the wider health services, HIV care services are provided by infectious diseases specialists, which are dealing with all communicable diseases and not only HIV/AIDS. Currently there are around 100 specialist, high physicians to patients ratio, however, the majority of the cases were followed by around 10 specialist located in Beirut.

ARVs are fully covered by the MOPH, and they are provided through 4 hospitals in Beirut, with no stock-out reported during the last couple of years. The medications are provided free of charge for eligible Lebanese and refugee (registered Palestinian and Syrian refugees) patients, upon approval of the file by a central committee at the MOPH. However, the supporting laboratory tests, such as viral load (VL) and CD4 count need to be paid out of pocket.

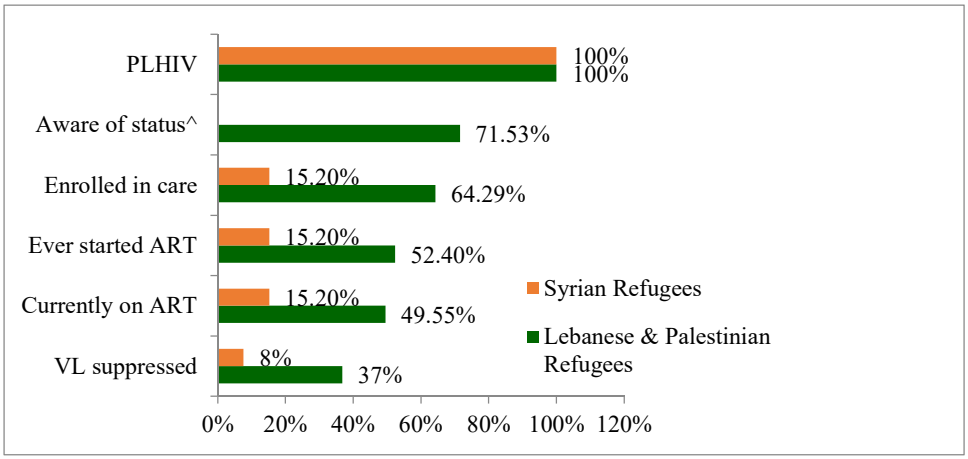
There is active involvement of people living with HIV in national responses in the country, with string presentation from people living with HIV and their associations. Many NGOs are engaged in outreach, interventions and support groups for people living with HIV (PLHIV). These programs have not only enhanced the lives of people affected directly but also

[39] Size Estimation, Risk Behavior Assessment, and Disease Prevalence in Populations at High Risk for HIV Infection in Lebanon 2015.
[40] National AIDS Strategic Plan 2016 – 2020.

indirectly by the HIV epidemic, by providing social support, focus group sessions, peer to peer education for PLHIV, and environments devoid of stigma and discrimination.

The recent TTR study highlighted that the current continuum of care is doing better on the care, support and treatment side, as 90% of all the patients who are aware of their infection, are adequately engaged in HIV care and the rest are not eligible for treatment. In addition, retention in care is remarkably high in both populations (Lebanese: 94.55%; n=938, Syrian refugees: 100%; n=16). The following figures are a summary of main indicators of the cascade analysis[41].

Figure 9: The HIV TTR cascade in Lebanon, disaggregated by nationality.



HIV and STIs Information System and Surveillance[42]:

In Lebanon, NAP is responsible for monitoring and collecting data reported by physicians, laboratories and VCT centers. The physicians have to report diagnosed cases to the NAP for epidemiological purposes. They also have to fill an application form to request for ARVs. This application is reviewed by the medication distribution committee at the MOPH. However, and as highlighted before, health information system in general, and not only the HIV, is suffering from fragmentation and under-reporting from different sectors.

[41] HIV Test-Treat-Retain Cascade Analysis for Lebanon.
[42] National AIDS Strategic Plan 2016 – 2020.

The TTR study pointed that “there is a weak information system for tracking the testing and treatment of HIV patients. Many key informants expressed that the existing information system is not unified, meaning that there is no sharing of information between the NAP, hospitals, labs and NGOs” ….. “The need for an automated system as well as a secure database that can be shared between the public and private health sectors was greatly expressed”.

Regarding the medication dispensing flow, the monitoring system is running well. All patients are to submit yearly applications with requested VL, and the medications are dispensed accordingly.

In Lebanon most of the behavioural surveys (knowledge, attitudes and practices studies) on HIV are funded by UNAIDS or WHO under specific projects. Some cross-sectional studies on outcomes of deliveries conducted during the last 10 years.

Summary of major health system challenges related to AIDS Program:

1. Lack of supporting policies or laws that protect the rights of MSM, drug users and sex workers to access services without discrimination.
2. Financial protection for HIV is still a challenges as insurance companies do not cover HIV patients, with some of the patients acquiring high costs related to laboratory tests before and after initiation of their treatment.
3. The current funding is poorly allocated for HIV programs, with a majority going towards medication. There was an identified need of financial support for trainings and awareness sessions.
4. With the growing refugee population in Lebanon, funds are being directed towards humanitarian aid. As a result, HIV has become less of a priority.
5. NAP, as key player in health system, is understaffed and could not effectively and efficiently function with only three people.

6. There is no funding for long-term recruitment of HIV healthcare providers, with clear challenge regarding the sustainability of human resource is a major issue that is negatively impacting the quality of service
7. Shortage in adequate human resources involved in HIV care, especially in the peripheral areas of Lebanon, is a key aspect to be addressed for better outcomes among PLHIV.
8. The capacity of people working with PLHIV is inadequate. Some healthcare providers and volunteers were not well trained on HIV, especially outside of Beirut.
9. Low level of provider-initiated HIV testing.
10. There is a weak information system for tracking the testing and treatment of HIV patients.
11. The existing information system is not unified, meaning that there is no sharing of information between the NAP, hospitals, labs and NGOs.

4. Lebanon National HIV Strategic Plan 2016 – 2020

Executive Summary of the NSP[43]:

The last comprehensive national HIV/AIDS strategic plan for Lebanon was released in 2011 to cover the period up to 2015. In the subsequent five years, people and organizations have joined together around visions and goals set by the National Aids Program to implement the plan. The plan had its success on which we built the new plan and gaps which we addressed and learned from in preparing the new 2016-2020 plan. In light of the demographic changes in Lebanon caused mostly by the influx of refugees from Syria forming about 1/3 of the Lebanese inhabitants, and based on new data emerging about HIV in Lebanon, a new National Strategic plan has been developed. The development of the 2016-2020 NSP was initiated by several meetings with key stakeholders followed by national review and consensus meetings, during which previous achievements were reviewed and new priority areas identified. A final national workshop was held on December 29, 2015 and the National Strategic Plan for the period 2016-2020 was drafted. The development of the National HIV Strategic Plan was coordinated by the National AIDS Program. However, the entire process was participatory and inclusive, aiming to actively involve all key sectors – government and non-government, national and international – in developing a reinforced, multisectoral response to HIV/AIDS.

The NSP 2016-2020 is supported by the available evidence from epidemiological surveillance and social research, as well as the experiences with the national response to date. Several reports are included to further support the needed actions. The NSP used as template the WHO proposed scheme for strategic planning but included a specific topic pertaining to the recently overarching refugees crisis in Lebanon and the whole region, impacting behavioral changes and placing further stress on hosting communities. More emphasis has also been placed on key and vulnerable populations particularly MSM and

[43] National AIDS Strategic Plan 2016 – 2020.

the prison population as well as youth. The NSP 2016-2020 reviews background data and available studies with analysis of available epidemiological data as well as the current drivers of the epidemic. Priority areas are identified and then addressed in specific six strategic directions listing objectives and a general scope of activities. Finally, modalities of implementation are reviewed through discussion of institutional arrangements and monitoring and evaluation framework.

The plan retains the 2020 vision set by the WHO on which to build future efforts with its respective 5 strategic directions. Additional direction was added regarding the refugees which require a special focused attention. To each of the 6 strategic directions a set of objectives and related activities were devised along with targets and indicators for each strategic direction to be able to monitor implementation and evaluate success.