



Lebanese Republic
Ministry of Public Health
National AIDS Control Program

NATIONAL HIV STRATEGIC PLAN

2023 - 2028

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FUTURE VISION

It is our vision that new HIV infections and sexually transmitted diseases will be reduced with the implementation of this plan and that persons living with HIV will continue to be cared for properly through the free supply of medications and patient care as well as free laboratory testing along with the elimination of stigma and discrimination, despite the current and expected economic hardship faced by the country.

ACKNOWLEDGEMENTS

- The National HIV Strategic Plan was produced by the National AIDS Program of the Ministry of Public Health of Lebanon.
- The National AIDS Program, under the governance of the Ministry of Public Health, showed invaluable leadership and expertise in developing the new National HIV Strategic Plan. Their commitment to fostering collaboration among diverse stakeholders has been instrumental in ensuring that the plan is inclusive, evidence-based, and responsive to the needs of key populations affected by HIV.

The National HIV Strategic was a result of contributions from multiple sources:

- Ministries of Social Affairs, Labor, Interior and Municipalities, Defense, Youth and Sports, Education and Higher Education, Finance, and Information
- WHO staff and advisors
- Community groups representing various vulnerable or key populations
- Civil society organizations
- Providers of various disciplines in health, mental health, and social affairs
- Researchers and academics
- Various government agencies
- UN joint team for HIV/AIDS agencies

The National AIDS Program hopes that dedication, inspiration, collaboration, and hard work are reflected in this guiding plan and acknowledges that this plan would not be possible without full stakeholders' participation and collaboration.

The National AIDS Program wishes also to thank all partners who contributed to the creation of this document and who spent years of their careers addressing the HIV epidemic in a concerted effort to serve all key populations.

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EXECUTIVE SUMMARY

The previous comprehensive national HIV/AIDS strategic plan for Lebanon was released in 2016. During the subsequent five years, people and organizations have joined around visions and goals set by the National AIDS Program to implement the plan. The plan had its successes and failures on which we built the new plan and gaps that we addressed and learned from in preparing the new 2023-2028 plan. In addition, its implementation was plagued by the COVID-19 epidemic and by continuous worsening of the economic situation in the country and progressive emigration of key workers in the field.

Over the last 5 years, the main research progress worldwide has focused on the successes of pre-exposure prophylaxis (PrEP) as well as the implementation of long-acting ARV combinations and injectable agents. Most research focused on COVID-19 and how it relates to HIV. The COVID-19 vaccine research had a positive impact on the HIV vaccine research, and this is being currently implemented.

Additionally, the NIH reported the Strategic Timing of Antiretroviral Therapy (START) Trial, which showed that patients with HIV who received immediate treatment significantly reduced their risk of serious, adverse health outcomes. Furthermore, the introduction of PREP (pre-exposure prophylaxis) in 2012, the adoption of new testing technologies enhancing the ability to diagnose HIV soon after infection, and the universal access and availability of ART recommendations are all significant advances that have positively affected our approach to HIV.

In light of such remarkable advances and 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 is presented in this document.

The development of the 2023-2028 NSP started in the fall of 2022 involving several meetings with key stakeholders followed by national review and consensus meetings, during which previous achievements were reviewed and new priority areas identified. An initial workshop was conducted on the 10th of August 2022 to draft the decisions retrieved from the meetings and discussions. A final national workshop was held on March 8th 2023 and the National Strategic Plan for the period 2023-2028 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, multi-sectoral response to HIV/AIDS.

This NSP 2023-2028 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 a template the WHO proposed scheme for strategic planning but included a specific topic pertaining to the recently overarching refugee 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 the prison population, as well as youth.

The NSP 2023-2028 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 frameworks.

It is expected that this new plan will become the roadmap for collective action and should bring new energy and commitment across the country. This plan was put in line with the National Health Strategy: Vision 2030 that hopefully shall bring Lebanon closer to eliminating new HIV infections, effectively supporting all people living with HIV in leading long and healthy lives and eliminating the disparities and stigma that persist among some populations. This plan retains the 2020 vision set by the WHO on which to build future efforts with its respective 5 strategic directions. However, eight directions were added regarding the refugees, which require special, focused attention. To each of the 8 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.

In conclusion, there is still an HIV epidemic, and it remains a major health issue for Lebanon. Most people can live long and healthy lives with HIV if they are diagnosed and receive timely treatment. People across Lebanon deserve access to tools and education to prevent HIV transmission, and every person diagnosed with HIV deserves immediate access to treatment care that is non-stigmatizing, competent, and responsive to the needs of the diverse populations impacted by HIV.

LIST OF ACRONYMS AND ABBREVIATIONS

AIDS: Acquired Immunodeficiency Syndrome

ART: Anti-Retroviral Therapy

ARV: Anti-Retroviral

ATS: Amphetamine type stimulants

ANC: Antenatal care

RC-UNDP: Resident coordinator

BBV: Blood Borne Virus

BMT: Buprenorphine

5 C's: Informed Consent, Confidentiality, Counseling, Correct Test Result, and connection to HIV prevention, treatment and care

CSO: Civil Society Organization

CSW: Commercial Sex Worker

DCR: Drug Consumption Rooms

DIC: Drop-In Center

DGUH: Daher El Bachek Governmental University Hospital

FHH: Female-Headed Household

FDC: Fixed Dose Drug Combination

FSW: Female Sex Workers

GARPR: Global AIDS Response Progress Reporting

GBV: Gender-Based Violence

GDP: Gross Domestic Product

GF: Global Fund

GP: General Practitioner

HBV: Hepatitis B Virus

HCV: Hepatitis C Virus

HCW: Health Care Worker

HIMU: Health Information Management Unit

HIV: Human Immunodeficiency Virus

HR: Harm Reduction

HTC: HIV Testing and Counseling

IBBS: Integrated Biological and Behavioral Surveillance

IC: Infection Control

ICT: Information and Communication Technology

IDU: Injecting Drug User

IEC: Information, Education, and Communication

IOM: International Organization for Migration

IT: Information Technology

KABP: Knowledge, Attitudes, Beliefs, and Practices

KP: Key Population

KVP: Key Vulnerable Population

LISF: Lebanese Internal Security Forces

LGBTQI+: Lesbian, gay, bisexual, transgender, queer and intersex

MARP: Most-at-Risk Population

MHH: Male-headed households

MHPSS: Mental Health and Psychosocial Support

M&E: Monitoring and Evaluation

MER: Middle East Response

MENA: Middle East and North Africa

MENAHRA: Middle East and North Africa Harm Reduction Association

MIS: Management Information System

MOPH: Ministry of Public Health

MOIM: Ministry of Interior and Municipalities

MOSA: Ministry of Social Affairs

MMT: Methadone Maintenance Treatment

MPox: Monkey Pox

MSM: Men who have Sex with Men

MTC: Mother to Child

MMU: Medical Mobile Unit

NAP: National AIDS Program

NEP: Needle Exchange Program

NHA: National Health account

NGO: Non-Governmental Organization

NIH: National Institutes of Health

NSP: National Strategic Plan

OAT: Opioid Agonist Therapy

OBGYN: Obstetrician-gynecologists

OST: Opioid Substitution Therapy

OOP: Out-of-Pocket

PAAR: Prioritized Above Allocation Request

PCR: Polymerase Chain Reaction

PHENICS: Primary Health Care Network of Information Communication System

PEP: Post-Exposure Prophylaxis

PHC: Primary Health Care

PITC: Provider-initiated HIV testing and counseling

PLWHIV (PLHIV): Person Living with HIV

PNC: Postnatal care

PMTCT: Prevention-of-Mother-to-Child Transmission

PPE: Personal protective equipment

PrEP: Pre-Exposure Prophylaxis

PSEA: Prevention of sexual exploitation and abuse

PWID: Persons Who Inject Drugs

RDT: Rapid diagnostic tests

SD: Strategic Direction

SRHR: Sexual and Reproductive Health and Rights

STI: Sexually Transmitted Infection

SOP: Standard Operating Procedure

TB: Tuberculosis

TTRC: Test-treat-retain cascade

TOT: Training of Trainers

UN: United Nations

UNHCR: United Nations High Commissioner for Refugees

UNICEF: United Nations International Children's Emergency Fund

UNFPA: United Nations Population Fund

UNRWA: United Nations Relief and Works Agency

UNOCHA: United Nations Office for the Coordination of Humanitarian Affairs

UNODC: United Nations Office on Drugs and Crime

VCT: Voluntary Counseling and Testing

VDRL: Venereal Disease Research Laboratory

WHO: World Health Organization

WIDU: Women Injecting Drug Users

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Table 5: Private vs Public Facilities

Table 6: Types of Facilities

1. BACKGROUND

1.1 PREAMBLE

This 2023-2028 National Strategic Plan for HIV/AIDS is meant to be a milestone in Lebanon's response to the HIV epidemic in this critical period of the Middle East, a turbulent region, a region at war. Lebanon in particular is suffering continuous political instability, financial and economic turmoil, and increasing rates of poverty with the resulting decline in health care.

The NSP demonstrates the progress made in achieving a clearer understanding of the challenges posed by the epidemic and the growing awareness and motivation of all the stakeholders towards the long-term vision of zero new HIV infections by 2030.

This NSP requires the reaffirmation of the fact that all stakeholders must collaborate to reduce new infections and foster an appropriate environment for work to collaborate with the National AIDS Program. The current NSP 2023-2028 builds on prior achievements to reach the key strategic objectives. All these efforts will contribute to the global vision of an AIDS-free world by 2030. The implementation of this NSP will be as strong and successful as the partnership that is built around it. Everyone has a role to play in its implementation in close collaboration with the NAP Lebanon.

1.2. GLOBAL SITUATION OF HIV

The world has committed to ending the AIDS epidemic as a public health threat by 2030, representing an ambitious target. To reach that end, the AIDS epidemic will require rapid acceleration of the response over the next five years and then sustained action through to 2030 and beyond. This can only be achieved through renewed political commitment, additional resources, and technical and programmatic innovations.

The global strategy positions the health sector response to HIV as essential for attaining universal health coverage. It is fully aligned with the post-2015 health and development agenda and targets. It is also aligned with other relevant global health strategies and plans, including those for sexually transmitted infections (STI's), tuberculosis (TB), viral hepatitis, sexual and reproductive health, maternal and child health, blood safety, non-communicable diseases, and integrated people-centered health services.

The global strategy outlines a vision, goals and actions for the global health sector response, including five strategic directions:

- Strengthening and focusing national HIV programs and plans through sound strategic information and good governance
- Defining a package of essential HIV services and high- impact interventions along the HIV services continuum
- Adapting and delivering the HIV services continuum for different populations and locations to maximize quality and achieve equitable coverage
- Implementing systems to fully fund the continuum of HIV services and to minimize the risk of financial hardship for those requiring the services; and
- (5) embracing innovation to drive rapid progress.

In brief, the enormous investments in the HIV response over the past 15 years are paying off. Large declines in new HIV infections and HIV-related deaths in the past decade attest to the commitment, resources and innovations that have been already directed at the global HIV epidemic.

New HIV infections in 2022 were estimated at 1.5 million [1.1 million–2.0 million] – 32% lower than in 2014. Fewer people are dying of HIV-related causes, with 650 000 [510 000–860 000] deaths in 2021, down 52% from the peak in 2014, largely the result of increased access to ART.

1.3. REGIONAL SITUATION OF HIV

The overall prevalence of HIV has remained low in the MENA Region. However, it is still growing among key populations at higher risk. Most countries in the region continue to increase access to life-saving antiretroviral therapy. Regionally, the number of people on antiretroviral therapy has increased from 48000 in 2016 to 88000 in 2022. Despite this progress, the regional coverage with antiretroviral therapy has not increased significantly and, at 50%, remains far below global targets.

The biggest gap lies in the fact that the majority of people living with HIV do not know their HIV status. In addition, the high levels of stigma and discrimination against people living with HIV, particularly in health care settings, remain an overarching concern. Moreover, ensuring the continued engagement of people living with HIV with health services along the continuum of care is challenging.

In the MENA region, there are 5100 [3900-6900] deaths from AIDS-related causes. However, only 50% [44–59%] of adults and 40% [34–46%] of children

aged 0-14 years living with HIV have access to antiretroviral therapy, which is the lowest of any region.

As the world looks to 2030, anyone infected with HIV should begin antiretroviral treatment as soon after diagnosis as possible. With its "treat-all" recommendation, WHO eliminates all limitations to antiretroviral therapy eligibility for HIV patients.

The major challenges for an effective response to the HIV epidemic in the MENA Region are:

- Insufficient or unreliable information.
- Increasing numbers of people acquiring HIV, mostly among key populations (MSM, PWID, FSW).
- Low testing and treatment coverage, including pregnant women.
- Low prevention coverage and deeply rooted stigma, punitive, and discriminatory laws against key populations and people living with HIV, including travel restrictions in many countries and mandatory HIV testing for residence or refugee permits.
- Political turmoil and conflict have led to significant mobility, refugee movements, and migration, disrupting social and health services and increasing vulnerability to sexual violence, food and housing insecurity, human trafficking, and other human rights violations - all with potential implications for the epidemic and related response.

2. 2.HIV IN LEBANON

2.1. NATIONAL SITUATION IN LEBANON: GEOGRAPHIC & DEMOGRAPHIC DATA

Lebanon is a 10452 Km² country with an estimated 6 million inhabitants (among which 1.8 are immigrants) located on the eastern shores of the Mediterranean Sea and to the western part of Asia. Lebanon has the highest population density per Km² (600 inhabitants/Km²). Lebanon sits at the crossroads between East and West, and its unique location has shaped its rich cultural identity of religious and ethnic diversity. A 15-year civil war devastated the country (1975-1990) taking a huge toll on the country, including a major negative impact on the health care sector. However, Lebanon has since made extensive efforts to restore its governmental institutions and revive the economy. Since the end of the war, the country has experienced a period of relative calmness and prosperity, driven by tourism, agriculture, and banking. After 2005, there was a major political deadlock in the country. And in July 2006, a 34-day armed conflict caused significant civilian deaths and heavy damage to Lebanon's civil infrastructure.

On the other hand, for the past 4 to 5 years, an influx of about 1.8 million refugees, mostly Syrians, flooded Lebanon, most of whom live in camps all over the country with more concentration in the North, the South, and the Beqaa. Such immigrants live under harsh health and social conditions, which lead to a risky lifestyle and unsafe sexual practices, conducive to HIV transmission.

Lebanon reported its first case of HIV in 1984 (Mokhbat et al. 1985)¹. The cumulative number of reported cases of HIV up to December 2015 is 1893, with

¹ *The Acquired Immunodeficiency syndrome: The first case in Lebanon and Review of the literature.* J.E.Mokhbat, N.Ibrahim, F.Abdelkarim, M.Kuleilat-Shatila and Z.Salem. 1985. *Lebanese Medical Journal*

113 new cases in 2015, among whom 91.7% are males and 8.3% are females. Cases are mostly reported between the ages of 15 to 49 (51.8% of new cases) and in homosexuals (36.7%). The mode of transmission is mostly sexual (68.3%) (Figs. 1-5). However, there was a plateauing of reported cases in the past 7 years to a yearly average of almost 100 cases (Fig. 1). It is a low prevalence country (less than 0.1%). In 1988, Lebanon recognized officially that HIV is a public health threat and established a National AIDS Program (NAP) in 1989, aiming to lead the concerted efforts of the public and private sectors in the fight against the disease. Lebanon developed a series of national action plans based on evidence gathered from a series of studies covering the general population as well as high-risk groups. The adopted strategies made the anti-retroviral drugs universally available and accessible for all individuals diagnosed with HIV. Would the influx of refugees change this trend?

Research on drug use and HIV risk in Lebanon is also scarce, and studies have produced contradictory findings. According to certain data, PWID have a high prevalence of HIV-risk behaviors such as sharing syringes. In a study conducted on PWID (n = 212) in the Beirut region in 2007, researchers discovered that 65% of participants knew something about HIV transmission and prevention, but only half were aware that sharing syringes could result in infection, and only 30% said they had used condoms consistently over the previous month. A systematic review of HIV knowledge in the Middle East and North Africa indicated that PWID in Lebanon had nearly universal awareness of the dynamics of HIV transmission. More recent research by UNAIDS estimated that 98.5% of PWID in Lebanon followed safe injection techniques. More recent research by UNAIDS

revealed that 98.5% of PWID in Lebanon followed safe injection techniques and HIV transmission ².

2.2. EPIDEMIOLOGICAL DATA

Recent data indicate that local transmission and spread of the disease are taking place, becoming a significant, if not the prevalent, mode of transmission in the country (82.3% in 2014 and 92.7% in 2015, 99.55% in 2022), mostly driven by sexual relations.

About 25.9% of the newly reported cases were in the advanced HIV infection stage, implying that diagnosis of HIV infection in Lebanon occurs in the HIV stage of infection and, hence, the need to strengthen early detection and to promote early testing (Fig. 2), and pointing to the need to organize a truly effective system/network for testing and early detection of the infection.

Sexual intercourse remains the main route of HIV transmission in Lebanon, accounting for 90% in 2013, 81.4% in 2015, and 99.55% in 2022 of total infections. Transmission in MSM is shown in Fig. 3. Testing of transfused blood for HIV has been mandatory since 1990, and during the last NSP exercise, there were no new cases of HIV infection reported as due to transfusion.

The data in figure 4 portray a steadily increasing trend of newly reported infections, particularly amongst the young population aged 15-29 (37.06%). Moreover, the data reveal that an average of 26.2% (2016), 39.7% (2019), and 53.44% (2022) of all documented HIV/AIDS cases in Lebanon fall within the 30-49 age group (Fig. 4). This finding suggests and clearly needs to be substantiated

² *Stress, Marginalization, and Disruption: A Qualitative Rapid Situational Assessment of Substance Users and HIV Risk in Lebanon.2022. MENAHRA <https://www.menahra.org/en/menahra-resources/external-publications>*

with prolonged prospective studies on HIV/AIDS transmission, a delay in detection that should be improved and scaled up. All of these data were generated before the introduction and availability of free testing of PCR, viral load and VCT expansion.

Analysis of the gender distribution of HIV/AIDS cases over 6 years (2016-2022) shows a trend of low rate in the female reported cases compared to males from 8.3% in 2014, 14.2% in 2015, and 5.7% in 2022 (Fig. 5). Such higher prevalence of infection amongst males prompted a nationwide study of MSM, and the results are reported in the appendix. This study estimated the prevalence of HIV among the MSM's to be 3.7% as compared to 0.1% in the general population.

ChemSex:

During the year 2022, SIDC was able to identify 567 Chemsex users through testing at the clinic and in field outreach.

In addition, among 1918 individuals tested for HIV at SIDC's clinic in 2022, 158 individuals (8%) were Chemsex users. It is important to note that some of them were tested as they were users and were aware that they performed a risky situation. Fifty percent of these 158 individuals were commercial sex workers.

Through outreach activities, tests were done for 4,330 individuals in field testing, 8% of them were Chemsex users. Out of the 60 individuals who tested positive and are living with HIV, 14 (around 23%) are Chem sex users.

One hundred twenty-eight LGBTQI+ individuals were enrolled in PrEP program at SIDC, 42% of them are Chemsex users.³

³ SIDC DATA.2022

2.3. CURRENT SITUATION OVERVIEW

According to the most recent IBBS (2018), Lebanon has a concentrated HIV epidemic among men who have sex with men (MSM) with a prevalence of 12%. The COVID-19 situation, the Beirut blast in August 2020, and the ongoing overlapping political, social, and economic crises are only a few of the difficult and dramatic events that have occurred in the country. Nevertheless, the NAP continues to focus its access efforts to vulnerable populations through collaboration with HIV-thematic NGOs. In recent years, the improvement of HIV prevention and testing services, as well as the identification of cases of HIV that had not yet been diagnosed, have all demonstrated the effectiveness of this strategy. Through civil society engagement, the NAP was able to expand the geographic reach of HIV prevention, testing, and treatment programs under the Middle East Response (MER) of the Global Fund (GF) and offer comprehensive treatment coverage at no cost to patients of all nationalities without discrimination. Lebanon continues to provide the same services and activities through MER-1, MER-2, and MER-3, which were put into effect in 2022, and commits to placing an even greater emphasis on the quality of life of PLHIV.

Plans and activities targeting MSM and other key population groups and their communities are being designed as Lebanon has an HIV-concentrated epidemic in MSM. In reality, a number of HIV-focused NGOs are collaborating closely with the NAP to reach these groups and provide them with a variety of prevention tools, including Needle Exchange Programs (NEPs) and Opioid Substitution Therapy (OST) as well as condoms, educational materials, PEP, PrEP (for MSM), and treatment as prevention (ART). In the country, male circumcision at birth is frequently used, and advocacy for those who are not circumcised at birth remains. A consultant (ID physician) visits jails frequently to provide NAP medication as

well as HIV, Hepatitis B and C, and TB testing. As a part of the tasks, the consultant is also providing a periodical follow-up for PLHIV with CD4 and viral load tests. The NAP ensured that all partners continued providing prevention and testing services despite the COVID-19 challenges in the country, the aftermath of the devastating Beirut bombing, and the converging political and economic crises. It did this by adapting with remote prevention sessions, on-site condom distribution, online education activities, as well as outreach (when feasible) among key and vulnerable populations.

Since 2017–2018, Lebanon has been implementing high-impact testing initiatives to scale up testing efforts through the HIV self-test wide advocacy and distribution, partner notification, and outreach efforts in rural areas and vulnerable communities. COVID-19 regulations and lockdowns had an impact on activities, although they quickly resumed once the shutdown was lifted. These actions facilitated the country's arrival, as estimated, at the first 90. Lebanon is treating more than 65% of PLHIV as part of the "treatment for all" strategy and over 70% of those who are aware of their status. While out of people who know their status, more than 90% are under treatment, and 96% of those are virally suppressed as well.

The MOPH provides treatment at no cost to all Lebanese nationals, Syrian and Palestinian refugees or other refugees who have made their way to the countries and those with temporary status as they wait to be resettled elsewhere, as well as other non-Lebanese living with HIV in Lebanon. Since its implementation in the late 1990s, this government policy has expanded to cover the greatest majority of PLHIV around the country.

The GF MER program helped the government to support its effort in providing treatment to everyone. While the MOPH continues to provide coverage for additional refugees who are seeking temporary asylum in Lebanon while they wait to travel to their destination of ultimate asylum, MER currently supports the treatment of Syrian and Palestinian refugees in Lebanon. Despite the difficulties associated with COVID-19 throughout the country and the Beirut bombing that destroyed the NAP facilities, a quick plan for maintaining ART distribution and preventing treatment interruption was instantly implemented in collaboration with NGOs and medical professionals.

Ending vertical transmission and pediatric AIDS: According to national figures, there was no HIV infection among infants in 2022. With close monitoring from the NAP and its partners, a strong PMTCT is evident, notably at the private prenatal clinics where the majority of deliveries take place. The NAP's main goal is to ensure that no new neonatal HIV infections occur. While the NAP advocates for strict adherence to WHO PMTCT standards, gaps in the lack of systematic implementation of prenatal HIV testing remain.

Despite the overlapping catastrophes plaguing Lebanon and deprioritizing HIV, conferences and seminars were regularly held in community centers, universities, and schools. These conferences aimed to target young and key populations who are at higher risk of contracting HIV. The messages delivered in the workshops and seminars were focusing on ending gender inequalities and rejecting all forms of discrimination, stigma, and violence against women, PLHIV, and LGBTIQ+ groups. The marginalized population in Lebanon, including youth, women, PLHIV, and other affected communities, constitutes an integral part in planning, delivering, and advocating for activities in the HIV response plan. They also

contribute to HIV technical working groups and stakeholders' meetings. More efforts are now concerted to refine the gender-discriminatory laws, including the one concerning naturalization.

Most HIV response activities in Lebanon are designed and supported by NAP. However, almost 90% of testing and prevention activities are decentralized and community-led by HIV thematic NGOs who have wide access to key and vulnerable populations. Although ART treatment is generally centralized at the NAP dispensing center, almost a quarter of ART beneficiaries are receiving their medication through thematic NGOs or community-based focal points. The latter act as facilitators for ART dispensing for logistic purposes, while they remain receiving the medications from the NAP dispensing center. Following the COVID-19 pandemic and Beirut blast, the number of PLHIV receiving their treatment through community or NGOs focal points further increased compared to the previous period.

Under MER 3, and during the reporting period, the NAP has been ensuring the scale-up of community testing campaigns and HIVST distribution based on the experience of the previous phase of HIVST implementation. The NAP is using the access to key populations granted through its thematic HIV NGOs to diversify its support. Moreover, NAP is continuously securing the availability and continuity of the essential diagnostic, treatment, and preventive materials. In addition, the NAP is working on strengthening the availability and use of the HIV programmatic data through updating its database and coordinating all HIV related data by developing and implementing common M&E tools. These efforts will strengthen information among KVPs (size, HIV incidence, testing and treatment coverage). This will be used to set national targets for scale-up of high impact

interventions (tailored to the specific Lebanese context), monitoring the implementation of the national HIV response, as well as supporting IBBS, TTRC, and sentinel surveillance, if not under regular allocation, then under PAAR.

Moreover, NAP is making use of the findings of the HIV program review to develop a national strategic plan for the next five years (2023-2028).

Below are some key achievements during 2022:

- Ensuring access to key and vulnerable populations, despite the dynamic situation in the country
- Continuation of ART services to PLHIV and to other key populations needing prophylaxis (pre/post exposure)
- Scaling-up the provision of longer ART refills to reduce beneficiaries' transportation
- Prioritization and active distribution of the HIVST
- Viral load testing for free for PLHIV at the PCR unit
- Procurement and distribution of PPEs to thematic partners
- Outreach activities when possible as part of the continuation of HIV services
- Creation and dissemination of electronic data reporting tools for NGOs and NAP
- Conducting continuous monitoring field visits to NGOs
- Preparation and submission of IOM reports
- Preparing an initial draft of the National Strategic Plan (2022-2023)
- Initiating a stakeholder steering committee for the 2023 upcoming IBBS

The NAP continues to represent the voice of the vulnerable population through advocacy with law enforcement agencies and decision makers to empower and

protect persons living with or affected by HIV. This was ensured through documenting and disseminating discrimination incidents and human rights violations to proper authorities through the complaint system that was created a few years ago. Presently, PLHIV and others affected by HIV are getting vociferous, and many rights are being reclaimed in every field, especially those concerning social protection and human rights. Besides, new laws and regulations are under revision/discussion at the judiciary level. Nowadays, key populations may still be indicted for their behaviors, however their rights to access preventive measures and treatment are respectable. What remains is to put an end to all punitive laws that discriminate against gender identity and social behavior.

Civil society and PLHIV are involved in the design, implementation, and monitoring of the HIV response. They have access to prevention, testing, viral suppression services, and treatment. Thus, a public health and people-centered approach remains the cornerstone for dissemination of HIV services. To minimize the financial burden and out-of-pocket expenditure on PLHIV, the NAP has implemented the new PCR unit, supported by GF, to offer free-of charge testing to all PLHIV, whether Lebanese or not. Treatment services are also provided for free. Besides, NAP has distributed VCT rapid testing for TB centers as well as for prisons. In addition, a more comprehensive testing approach is implemented through including Hepatitis B and C and other STIs in the screening process along with HIV.

As for treatment, all PLHIV are routinely tested and followed up regularly (including co-infections), and a comprehensive care plan is adopted as documented in the national HIV treatment guidelines (2019). In addition,

coordination with Primary Health Care (PHCs) centers is planned to integrate HIV prevention and treatment as part of their general plans and activities.

In an attempt to reduce stigma and oppression, a free-of-charge HIV self-tests have been introduced for people at risk of HIV, and public advocacy is warranted to ensure privacy of individuals. Alongside, self-test has been further endorsed by NGOs, and adequate quantities are distributed to these organizations by NAP. Moreover, an assisted partner notification has been implemented, creating a stigma-free environment for partners of key populations to get tested without breaching their confidentiality. Systematically, a strong partnership between HIV/TB programs has been established, and further cooperation with the Hepatitis and antenatal programs is warranted.

Currently, some testing is required mandatorily by law, such as premarital testing, testing prior to incarceration, and testing prior to delivery of a work permit for a non-Lebanese. In addition, some institutions, such as banks, insurance companies, some hospitals, and even universities, require testing for HIV prior to hiring or enrolling, despite the fact that the law clearly states that no discrimination among Lebanese nationals is to be exerted regardless of serologic status.

In summary, recent advances in HIV prevention and treatment have been introduced and implemented at the national level. These improvements are demonstrated by the introduction of innovative testing techniques, stigma-free preventive methods such as HIV self-tests, and the incorporation of new generations of ART medications. Nevertheless, suboptimal investments in the

field of HIV and the de-prioritization of HIV on the government agenda hinder further advancements in this critical field. These downplays are further aggravated by the ongoing economic crisis and the rising political and societal instability in Lebanon. These instabilities are shaped by the massive burden of armed conflicts in the neighboring countries, the refugee crisis, and other socioeconomic downstream. Nevertheless, Lebanon is maintaining a strong national HIV response and securing essential funds to provide optimal services through multi-sectorial collaboration and effective governance.

Monkey Pox:

In Lebanon, the first case of confirmed MPox was reported among a patient from the group MSM, and this patient had a recent travel history to a country with reported cases of Mpox among MSM. Up until December 2022, 26 cases were reported in the country, and most of those cases were MSM, and most of them have no recent travel history, which insinuates that Lebanon has now local transmission of the MPox infection.

It is well-known that the HIV situation in Lebanon is an MSM-concentrated epidemic, and the latest IBBS study in 2018 has shown that HIV prevalence among MSM is around 14% and the yearly incidence of HIV in the country is reaching almost 95% among MSM for the new HIV cases reported to the National HIV Program.

With the progress of the Monkey Pox public health threat in Lebanon and its increased prevalence among MSM in the world and taking into consideration the population size estimation of MSM in Lebanon and the prevalence of HIV among

this population, it is highly recommended to scale up joint activities against both infections, especially when targeting the MSM population. ⁴

Lebanon Geopolitical Situation:

Lebanon, due to its geographical proximity to the Syrian conflict, has experienced a significant influx of refugees in the past few years ⁵. Refugees now make up to 30% of Lebanon's population, the highest concentration per capita of refugees in the world. It is estimated that more than 1.5 million Syrian refugees are in Lebanon. The UNHCR also currently estimates there are over 504,000 registered Palestinian refugees, along with 75,000 non-registered/non-ID Palestinians in the country. Migration has created security and health system challenges ⁶. Lebanon has been affected by a financial crisis and countrywide anti-establishment protests, with refugees placing further severe pressure on its economy, infrastructure, and health and education services ⁷. Refugee numbers have stretched the country's capacity to respond to mental health, substance/drug use, and related infectious diseases⁸. Lebanon is a drug transit country, with its geographic location on the border with Syria, its domestic economic and political crisis, and significant cross border security and terrorist threats facing the Lebanese government, compounding difficulties in government prioritization in tackling the organization of cross-border criminal networks and trade in drugs (Global Initiative against Transnational Organized Crime, 2017) ⁹. Drugs available in Lebanon include marijuana, hashish, heroin, cocaine, ATS, synthetic drugs such as Captagon, and more recently, Salvia ¹⁰. Cannabis is the primary

⁴ World Health Organization.2022

⁵ Cathrine Thorleifsson .2016. *The limits of hospitality: coping strategies among displaced Syrians in Lebanon*, *Third World Quarterly*, 37:6, 1071-1082, DOI: 10.1080/01436597.2016.1138843

⁶ MOPH.2016

⁷ Shibli Rabih, 2014. *Reconfiguring relief mechanisms: The Syrian refugee crisis in Lebanon*. *Refugee Research and Policy in the Arab World*.

⁸ World Health Organization.2014

⁹ *Global Initiative against Transnational Organized Crime*. 2017

¹⁰ Kerbage, H., & Haddad, R. (2014). *Lebanon Drug Situation and Policy*. Last accessed on September 18, 2017: <https://www.coe.int/T/DG3/Pompidou/Source/Images/country%20pro-files%20flags/profiles/CP%20Lebanon%20English%20V2.pdf>

narcotic produced in the Beqaa Region, and increasing amounts of heroin are also being illegally cultivated there¹¹. Captagon is manufactured in Lebanon¹². Drug Use Substance abuse is becoming a major public health concern in Lebanon. Evidence on substance use shows a high prevalence, early age of initiation, high treatment gap, and increased burden of disease relating to substance use¹³.

In 2014, the primary diagnostic categories of admissions to mental hospitals in Lebanon were mental and behavioral disorders related to substance use (24% of admissions)¹⁴. The Lebanese Epidemiologic Survey on Alcohol study showed that alcohol use disorders are highly prevalent among the Lebanese general population¹⁵. Lebanon has the highest smoking prevalence of all MENA countries, including the highest prevalence of water pipe tobacco smoking¹⁶. In 2011, prescription opioids were reported by university students to be very accessible without a prescription¹⁷. A large survey on university students in 2012 indicated that cannabis, followed by ATS and opioids are the most common drugs of use among university students (Salameh, Rachidi et al. 2015)¹⁸. There is an observed increased misuse of licit substances, including anxiolytics and tranquilizers, among the Lebanese population in general and among adolescents in particular, especially among the 15-25 age group (IGSPS, 2012). El Halabi and

¹¹ Afsahi, K., & Darwich, S. (2016). Hashish in Morocco and Lebanon: A comparative study. *International Journal of Drug Policy*, 31, 190-198

¹² United Nations Office on Drugs and Crime (UNODC). (2020). *World Drug Report 2020*. Retrieved from: <https://wdr.unodc.org/wdr2020/> (United Nations publication, Sales No. E.20.XI.6)

¹³ Ministry of Public Health.2015

¹⁴ World Health Organization and MOPH.2015

¹⁵ Yazbek J.C. et al, 2014, *Prevalence and correlates of alcohol abuse and dependence in Lebanon: results from Lebanese epidemiologic survey on alcohol (LESA) J Addictive Dis* <https://doi.org/10.1080/10550887.2014.950026>

¹⁶ Maziak, W., Jawad, M., Jawad, S., Ward, K.D., Eissenberg, T. and Asfar, T. 2015. *Interventions for waterpipe smoking cessation. Cochrane Database of Systematic Reviews*.

¹⁷ Singh, G., and Ghandour, R. (2012). *Impact of neighborhood social conditions and household socioeconomic status on behavioral problems among US Children. Maternal and Child Health Journal*, 16, 158-169. <http://dx.doi.org/10.1007/s10995-012-1005-z>

¹⁸ Salameh P, Rachidi S, Al-Hajje A, Awada S, Chouaib K, Saleh N, Bawab W.2015. *Consommation de substances psychoactives des étudiants universitaires libanais : prevalence et facteurs associés [Substance use among Lebanese university students: prevalence and associated factors]. East Mediterr Health J.;21(5):332-41. French. PMID: 26343122.*

Salameh,2019¹⁹ have further highlighted concern for the rise in adolescent substance use in Lebanese schools. Lebanon and online services; ongoing year-round awareness campaign for vulnerable populations like senior high school students, residents at correctional facilities etc.; steps for implementation of NSP; extension of OAT using BMT (currently more than 130 patients benefit); continuing to provide ART, to improve adherence & continue having undetectable viral load in more than 90% of people who are on ART; and scale up of Pre Exposure & post exposure program; adding more categories for PrEP is being evaluated; and condom use is being promoted in all HIV awareness activities. Condom distribution is still a highly controversial issue. It is planned to conduct size monitoring studies by 2021 regarding key populations in Kuwait (MSM, transgender people, CSW and their customers) Harm Reduction. There is no UNAIDS 2019 or 2020 update on harm reduction. In 2010, it was estimated that patients suffering from substance use disorders in Lebanon ranged from 10,000 to 15,000, with heroin users accounting for 59%²⁰. Heroin use in 2010 accounted for almost 50% of treated patients, with a high rate of relapse²¹. Around half of the persons using substances, and of those institutionalized or who were seeking treatment also commonly injected drugs, with high rates of needle sharing observed²¹.

According to 2012 estimates, there were between 2,000 to 4,000 PWID in Lebanon²². Of the 1,373 admissions in 2012-2013 to eight Lebanese rehabilitation and detoxification centers, 70% of those in treatment were PWID²³. A PWID population size estimation conducted in 2015 confirmed the previous estimation

¹⁹ El Halabi, S. and Salameh, P. (2019) *Incorporating HPS Model into Lebanese Public Schools: Comparison of Adolescents' Smoking, Alcohol and Drug Use Behavior in HPS versus Other Public and Private Schools in Lebanon*. *Open Journal of Nursing*, 9, 418-448. doi: [10.4236/ojn.2019.94038](https://doi.org/10.4236/ojn.2019.94038).

²⁰ Lebanon Ministry of Public Health.2012

²¹ Karam, E., Ghandour, L., Maalouf, W., Yamout, K., Salamoun, M. (2010). *A rapid situation assessment study of alcohol and drug use in Lebanon*. *Lebanese Medical Journal*, 58(2), 77.

²² UNAIDS Country Progress Report, Lebanon, 2012

²³ Lebanon Ministry of Public Health, Lebanon Ministry of Education and Higher Education et al., 2016

of 2,000 to 4,000 (MENAHRRA 2015)²⁴. Most PWID are single, with low levels of education²⁴. Heroin (31%), followed by cocaine (20%) and cannabis (17%) were the most commonly used drugs among those seeking treatment for addiction in 2012. During 2015, in Greater Beirut, non-fatal opioid overdoses were reported by more than half of 390 PWID²⁴. Between December 2011 and December 2016, 1712 persons with drug use disorders were enrolled in the OAT program MoPH¹⁰. 2595 persons with drug use disorders were reported to be admitted in 10 treatment facilities (for rehabilitation, detoxification, or outpatient treatment). Most of the persons on treatment (82%) were between 18 and 38 years old²⁵. Of note is an observed rise in the prevalence of use of Salvia in those seeking treatment. Karam et al., (2019)²⁵ report on the prevalence of 66% of use of Salvia among heavy drug users admitted for detoxification in a psychiatric hospital in Lebanon. Another study also reports on the high risk of suicide among Lebanese heroin dependent inpatients who engage in multiple drug use and who have a family history of suicide²⁶. Women with substance use disorders and persons from the LGBT community using drugs are identified as key populations requiring additional supports (Lebanon MOPH et al., 2016; 2019). The underlying gender-specific determinants of women's drug use, stigma, sexual coercion, and risk behaviors such as needle sharing compound their risk of BBV acquisition in women receiving the syringe after their partners and using contaminated needles. In 2016, women in detention centers who were arrested for drug use constituted about 2% of the total number of persons arrested for drug use (Lebanon MOIM, 2016). For the same period, about 8% of the persons who received drug-related treatment were women⁶. The number of women in

²⁴ MENAHRRA (2015). *Annual Report: MENAHRRA progress and achievements. Middle East and North Africa Harm Reduction Association.*

²⁵ Karam, A., Said, A., Assaad, C., Hallit, S., Haddad, G., Hachem, D. and Kazour, F., (2019). *Abuse and effects of salvia divinorum in a sample of patients hospitalized for substance dependence. Community mental health journal, 55, pp.702-708.*

²⁶ Kazour, F., Soufia, M., Rohayem, J. and Richa, S., (2016). *Suicide risk of heroin dependent subjects in Lebanon. Community mental health journal, 52, pp.589-596.*

treatment from 2014 till 2016 increased by 38%¹⁰. 10% of the total number of reported beds for the treatment of substance use disorders are dedicated to women¹⁰. Lebanon is unique in having a special ruling stipulated in Article 151, which authorizes the court to combine sanction and compulsory treatment²⁷. The Lebanese Internal Security Forces (LISF) reported in the period 2014 and 2016, a yearly average mean of 3,053 individuals with a substance use disorder (cannabis, cocaine, and heroin) (LISF, 2014/2015/2016). According to Khalaf et al. 2019²⁸, there has been a reported significant decrease (around 49 %) of heroin users arrested compared to a previous study by El-Khoury et al., (2016). Khalaf et al., (2019)²⁸ speculate that this could be due to several factors, scaled up OAT implementation in the Lebanese community, including greater awareness about the importance of OAT as an evidence-based treatment; a possible decrease in use of opiates and related criminal activities; and the decision by the involved legal authorities to refer addicts to treatment rather than to prison²⁹. A variety of residential, inpatient, and outpatient detoxification and rehabilitation services are operating in the country and are mainly provided by non-governmental sectors. Detoxification services are provided in public and private hospitals, and in some facilities, services for mental health and other comorbidities are included in the treatment plan. One public hospital (Dahr El Bacheh Government University Hospital – (DGUH) offers detoxification for persons with substance use disorders with a 15-bed capacity. There are 5 other private residential facilities specifically for persons with substance (alcohol and drug) use disorders, totaling 90 beds. However, these facilities are mainly located at the central level (in the governorates of Beirut and Mount Lebanon), and the detoxification services they

²⁷ Al-Shazly, F. and Tinasti, K., (2016). *Incarceration or mandatory treatment: Drug use and the law in the Middle East and North Africa. International Journal of Drug Policy*, 31, pp.172-177.

²⁸ Khalaf, D., Hayek, M., Bakhos, J.J. and Abou-Mrad, F., (2019). *Comparative study between prison-and community-based treatment satisfaction for opioid use disorder in Lebanon. International Journal of Prisoner Health*, 15(2), pp.138-152.

²⁹ Khalaf, D., Hayek, M., Bakhos, J.J. and Abou-Mrad, F., (2019). *Comparative study between prison-and community-based treatment satisfaction for opioid use disorder in Lebanon. International Journal of Prisoner Health*, 15(2), pp.138-152.

provide are reported to be fairly expensive. Only a few NGOs offer rehabilitation services for minors. In May 2015, the Ministry of Public Health launched the “Mental Health and Substance Use Prevention, Promotion, and Treatment Strategy for Lebanon 2015-2020” and is currently moving forward in successfully implementing it through the National Mental Health Program and all its partners ³⁰. Several groups are identified as vulnerable by the Inter-Ministerial Substance Use Response Strategy for Lebanon 2016-2021 (Ministry of Public Health, Ministry of Education and Higher Education, Ministry of Interior and Municipalities, Ministry of Justice, and Ministry of Social Affairs, 2016). These are PWID living with a 68-communicable disease, women with substance use disorders, and persons from the LGBT community using drugs (Group 1) and persons living in a context that further limits the accessibility to substance use response services. This category includes children living in adverse circumstances, youth and adolescents, Palestinian refugees, displaced populations, and persons in prison (Group 2). The 2016-2021 Inter-ministerial Substance Use Response Strategy for Lebanon (MoPH, 2015; Ministry of Public Health, Ministry of Education and Higher Education, Ministry of Interior and Municipalities, Ministry of Justice, and Ministry of Social Affairs, 2016) and the UNODC Program on Drug Control, Crime Prevention, and Criminal Justice Reform in the Arab States particularly recognize refugees as an at-risk population due to their marginalization, significant traumas of conflict and displacement, and adverse socio economic situation. BBV Lebanon has a low endemicity profile for HIV and HCV ³¹. The NAP and UNAIDS (2012) reported 1,455 cumulative cases of HIV through 2011, with 109 cases reported in the previous year mostly through sexual transmission. Later, the NAP of the Lebanese MOPH reported a cumulative of 2366 PLHIV¹⁰. In 2014, for the first time, the NAP and UNAIDS

³⁰ Hajal, S., Kik, N., El Chammay, R. and Ammar, W., (2017). *Developing an interministerial substance use response strategy for Lebanon: process, content and lessons learned. EMHJ*, 23(3).

³¹ Retrieved from old NSP

reports indicated an increasing national prevalence and the presence of clearly defined pockets of concentrated epidemic within key populations, which include MSM, PWID, and CSW (UNAIDS, 2014). Less than 3% of the HIV epidemic is attributed to IDU⁶.

In Lebanon, there is no accurate detail on the prevalence of IDU, HIV prevalence among PWID, or number of current PWID living with HIV³². Closed small networks among Lebanese PWID appear to reduce transmission risks (Mahmud et al., 2020). In Lebanon, an estimated 51.9% (40.5–63.1) of PWID inject daily or more (estimated number 2500; 1500–4000) and 48.2% (36.9–59.5) inject less than daily (estimated number 2500; 1000–3500)³³ (Colledge et al., 2020). Young PWID under the age of 25 years constitutes 17.3% (9.8–27.3) of the total population with an average age of 29.5 years (29–30) (Hines et al., 2020). In Lebanon, Mahmud et al., (2020) reported on pooled mean HCV prevalence among PWID of 25.0 years (4.4–54.5); with an estimated population size of 3,207 (1,506–4,908) estimated number of HCV antibody-positives among current PWID of 802 (66–2,675) and estimated number of HCV chronically infected current PWID of 565 (47–1,884). Lebanon has a concentrated HIV epidemic among MSMs. Kassak et al., (2011) previously reported an HIV prevalence of 3.7% in Lebanese MSM. A later 2012 study by Wagner and colleagues (2014) estimated HIV prevalence at 1.5% in a sample of MSM (3 of 198). More recent national-level surveillance has suggested an increase in HIV prevalence

³² Larney S, Leung J, Grebely J, Hickman M, Vickerman P, Peacock A, Stone J, Trickey A, Dumchev KV, Colledge S, Cunningham EB, Lynskey M, Mattick RP, Degenhardt L. 2020. Global systematic review and ecological analysis of HIV in people who inject drugs: National population sizes and factors associated with HIV prevalence. *The International Journal on Drug Policy*.77:102656. doi: 10.1016/j.drugpo.2019.102656

³³ Colledge, S., Leung, J., Larney, S., Peacock, A., Grebely, J., Hickman, M., Cunningham, E., Trickey, A., Stone, J., Vickerman, P. and Degenhardt, L., 2020. Frequency of injecting among people who inject drugs: A systematic review and meta-analysis. *International Journal of Drug Policy*, 76, p.102619.

concentrated among MSM in Lebanon³⁴. The IBBS (2014-2015) conducted by Heimer and colleagues on 292 MSM identified 36 cases of HIV (12.3%)³⁴. This study revealed that a quarter of the MSM were born in Syria and had recently arrived in Lebanon. Condom-less sex was common, and group sex was reported by 22% of participants. Heimer et al., (2017) reported on the higher HIV-1 prevalence than in any previous study, the existence of a large number of Syrian-born recently arrived MSM, and HIV risk behaviors concentrated among HIV-negative MSM that are centered around the use of social media for partner acquisition and participation in group sexual encounters. Sexualized drug use was also reported. This study highlighted the need to control future increases by reducing specific risk behaviors and experiences of stigma and abuse, especially among Syrian refugees. The most recent IBBS in 2018 showed a rate of 12% HIV among Lebanese MSMs.³⁵ Assi et al., (2019)³⁶ in their study of 2238 MSM attending a sexual health clinic in Lebanon between 2015 and 2018 reported an HIV prevalence rate of 5.6%. Risk behaviors included high rates of inconsistent condom use and multiple partners. Assi et al., (2019)³⁶ underscore the urgent need for accurate and comprehensive sexual health and harm reduction education and promotion in Lebanon and making PrEP available for free to key populations to contain the epidemics at an early stage. Systematic reviews have reported on a 2.5–5% HBV prevalence and more than 50% for HCV in PWID in Lebanon (Nelson et al., 2011). HBV prevalence in Lebanon has been reported among other high-risk groups to show a prevalence of 1.6% in hemodialysis patients (Abou Rached et al., 2016), 0.99% in MSM (Kassak et al., 2011), 0.28% in Thalassemic patients (Othman et al., 2014), 2.4% among prisoners secondary to unprotected

³⁴ Heimer, R., Barbour, R., Khouri, D., Crawford, F. W., Shebl, F., Aaraj, E., & Khoshnood, K. (2017). HIV risk, prevalence, and access to care among men who have sex with men in Lebanon. *AIDS Research and Human Retroviruses*, 33(11), 1149-1154.

³⁵ *Lebanon Global AIDS Monitoring report, 2019.*

³⁶ Assi, A., Abu Zaki, S., Ghosn, J., Kinge, N., Naous, J., Ghanem, A., Abou Abbas, D., Bakouny, Z., Azzi, G. and Tomb, R., 2019. Prevalence of HIV and other sexually transmitted infections and their association with sexual practices and substance use among 2238 MSM in Lebanon. *Scientific reports*, 9(1), pp.1-10.

sexual intercourse and tattooing as well as PWIDs³⁷, and 6.9% in HIV patients³⁸. The Lebanese Ministry of Public Health has reported that HCV prevalence reduced from 27% to 16% in 2014 (El-Khoury et al., 2016). The IBBS study conducted in 2014-2015 in the Greater Beirut area among current PWID reported an HIV prevalence of 0.26% and an HCV prevalence of 27.6%³⁹. Nakhoul et al. 2018⁴⁰ in their prospective cross-sectional study between June 2015 and June 2016 on PWIDs (n=250) reported a prevalence of HBV and HCV among PWIDs of 1.2% and 15.6%, respectively. Older age, longer duration of drug use, and the lack of awareness were found to be significantly correlated with a higher rate of HCV infection. They identified a relatively high rate of sharing needles among PWIDs without significantly affecting the prevalence of both viruses. Mahfoud et al. (2010) have previously reported an HCV prevalence of 52.8% in 106 Lebanese PWID. HCV genotype 3 is the most prevalent genotype in the Lebanese PWID population, followed by genotype 1⁴¹. In 2020, Abou Rached et al., (2020)⁴² also indicated higher rates of HCV among Lebanese PWIDs than the general Lebanese population, hemodialysis patients and prisoners, making PWID the population group most affected. They reported a prevalence of HBV and HCV among PWIDs of 1.2% and 15.6%, respectively, in their study on 250 (98% male) PWID. Older age, longer duration of drug use, and lack of awareness were

³⁷ Mahfoud, Ziyada; Afifi, Remaa; Ramia, Samia; Khoury, Danielle Elb; Kassak, Kassem; Barbir, Farah Ela; Ghanem, Maguya; El-Nakib, Mostafab; DeJong, Jocelyna. 2010. HIV/AIDS among female sex workers, injecting drug users and men who have sex with men in Lebanon: results of the first biobehavioral surveys. *AIDS* 24():p S45-S54, | DOI: 10.1097/01.aids.0000386733.02425.98

³⁸ Ramia, S., Mokhbat, J., Ramlawi, F. and El-Zaatari, M., 2008. Occult hepatitis B virus infection in HIV-infected Lebanese patients with isolated antibodies to hepatitis B core antigen. *International journal of STD & AIDS*, 19(3), pp.197-199.

³⁹ MENAHRA.2015

⁴⁰ Mary Nakhoul, Carine Richa, Afif Jreij, Antoine Abou Rached. 2018. *J Infect Dev Ctries* 2018; 12(2S):28S. doi:10.3855/jidc.10076

⁴¹ Abou Rached, A., Yaghi, C., Khalil, L., Saba, J. and Ammar, W., 2017. Prevalence of hepatitis C virus genotypes and subtypes in Lebanese population and major high risk groups. *Arab journal of gastroenterology*, 18(2), pp.114-117.

⁴² Abou Rached, A., Nakhoul, M., Richa, C., Jreij, A., Abi Hanna, P. and Ammar, W., 2020. Prevalence of hepatitis B and anti-hepatitis C virus antibody among people who inject drugs in the Lebanese population. *Eastern Mediterranean Health Journal*, 26(4), pp.461-467.

significantly correlated with a higher rate of HCV infection. The high rate of needle sharing significantly affected HCV prevalence. Of note was that the association between MSM, sex working, living with someone infected with HBV/HCV, sex with a person infected with HBV/HCV, history of blood transfusion, history of tattoos or piercings, and the frequency of HBV and HCV in their sample was not significantly related to the prevalence of either infection⁴⁰. Pooled estimates in % for risk of exposure to HCV in the general population in Lebanon were 0.15% (0.06-0.25); in PWID were 25.03% (r4.40-54.51); and in populations of intermediate risk (includes prisoners) were 2.16% (0.26-5.36)⁴³. Nakhoul et al. (2018) underscores the need for appropriate screening strategies and targeted educational programs and that adequate HBV vaccination is of extreme importance for further viral prevention among high-risk PWID in Lebanon. The country has launched the 2023-2028 NSP. HIV prevention for PWID is included in the program. NGOs are active members of the national multi-sectoral coordination body (Lebanon MoPH, 2014). Lebanon is one of five MENA countries providing a NSP program (along with Egypt, Morocco, Palestine, and Tunisia). Currently, only SIDC provides NSP in Lebanon. Skoun stopped the service due to funding issues. There is one DIC in which NSP is provided at SIDC in Mount Lebanon. All other sites are reached throughout SIDC's outreach program (mobile unit), and sites are mainly limited currently to 2 governorates: Beirut and Mount Lebanon. In the recent years, about 200 PWIDs were reached and about 50,000 syringes were distributed annually by support received from MENAHRA. Syringes are provided in pharmacies, but with Ghaddar et al. (2017)⁴⁴ reporting on the frequent denial of access to clean syringes by pharmacists and contributing to increased stigma and intimidation of PWIDs. A national HBV

⁴³ Chemaitelly, H., Mahmud, S., Kouyoumjian, S. P., Al-Kanaani, Z., Hermez, J. G., & Abu-Raddad, L. J. (2019). Who to test for hepatitis C virus in the Middle East and North Africa?: pooled analyses of 2,500 prevalence measures, including 49 million tests. *Hepatology communications*, 3(3), 325-339.

⁴⁴ Ghaddar, A., Nassar, K. and Elsoury, G., 2017. Barriers to access to sterile syringes as perceived by pharmacists and injecting drug users: implications for harm reduction in Lebanon. *Substance use & misuse*, 52(11), pp.1420-1428.

vaccination campaign was initiated in 2015 and continues to run to ensure provision of HBV as well as HBV/HCV testing for PWID. One hundred HTS centers are operating throughout the country (Lebanon MoPH, 2016). More than 50% of HIV programs for PWID are estimated to be provided by NGOs (Lebanon MoPH, 2013). 87% of facilities provide on-site testing for viral hepatitis. The National Aids Program at the MOPH provides ART free of charge. The MOPH is providing high-quality, 100% free of charge treatment to all the Lebanese PLHIV, but it is also providing the same quality of treatment and free of charge to all HIV patients residing in Lebanon, whether Syrian, Palestinian, or other settled refugees in the countries, and for those on temporary status awaiting their resettlement in other countries. Under the treatment for all strategy, Lebanon is providing treatment to 64% of people who know their status (Lebanon Global AIDS Monitoring Report, 2019). On-site ART for HIV/AIDS is provided by 29% of substance use treatment services (Lebanon MoPH, 2017). Data on prisons in Lebanon are scant. Heijnen et al., (2016) have reported on the HIV prevalence rate of 0.7% and 28.1% of HCV in Lebanese incarcerated populations, with high rates of drug related offenses (30.2%) among PWID (UNAIDS, 2012). Repeated incarceration was significantly associated with HCV infection among Lebanese prisoners³⁷. 2.6% reported anal sex with another prisoner in Lebanon⁴⁵. Prison-based testing for HIV, HCV and TB, and the provision of ART are reported to be available in Lebanon⁴⁵. OAT is available in prisons in Lebanon but only available to people who were enrolled before entering prison⁴⁶. This remains a major gap in the OAT program. Khalaf et al., (2019) have reported on significantly lower satisfaction in those accessing in prison OAT compared to the community in Lebanon. Harm Reduction According to UNAIDS (2019), use of sterile injecting equipment at last injection (2014) in Lebanon was 98.5%; there was no detail on the number of needles and syringes distributed per person who injects; coverage

⁴⁵ UNAIDS, 2014; Ataya, 2016; Stone, 2016

⁴⁶ Brandt, 2018; EMCDDA, 2018; UNAIDS, 2018

of OAT (2015) was 49.7%; and naloxone and DCR are not available. The 2020 UNAIDS report did not report any change. There is a harm reduction policy on OAT in Lebanon, with actions mainly conducted by CSO (Aaraj and Abou-Chrouh 2016). In 2011, Lebanon adopted an OAT take-home buprenorphine (BMT) pilot program only provided by authorized psychiatrists working within pre-registered treatment settings. A small-scale take-home pilot has been in implementation ever since, with around 1800 enrolled patients (800 of which are currently active)⁴⁷. OAT is provided by facilities in two governorates: Beirut and Mount Lebanon; however, dispensing of the medication is available in Mount Lebanon governorate only (MoPH, 2017). BMT was initiated in January 2012. The country reports that by the end of 2016, the number of people who had received BMT was over 1,700; of which 6% were female. An evaluation showed that 71% of those enrolled were still in treatment at six-month follow-up. Nevertheless, access to BMT is centralized and expensive; it is provided under the strict supervision of a psychiatrist (El-Khoury, Abbas et al. 2016, Lebanon Ministry of Public Health, Lebanon Ministry of Education and Higher Education, 2016, Abbas 2017). The country had planned on initiating a pilot project on MMT for 2019 (Lebanon Ministry of Public Health, Lebanon Ministry of Education and Higher Education, 2016). Recent 2020 updates include the scale up of existing services: a new delivery OAT service was opened in Beqaa and in Safra (Byblos) areas, and two new dispensing centers were opened in the Beqaa area (Zahleh) and in Mount Lebanon (Tannourine). Three new psychiatrists joined the OAT program and started providing OAT services to patients in need. The provision of psychosocial support is a basic component of the treatment. Ghaddar et al. (2017)⁴⁴ conducted a study to evaluate OAT in improving the health of patients at SKOUN Lebanese Addiction Centre between January 2013 and December

⁴⁷ Ghaddar, A., Khandaqji, S. and Abbass, Z., 2018. *Challenges in implementing opioid agonist therapy in Lebanon: a qualitative study from a user's perspective. Substance Abuse Treatment, Prevention, and Policy*, 13(1), pp.1-9.

2014. This study revealed significant improvements were observed three months after treatment in quality of life, anxiety, substance dependence, overdose, employment, and injecting behavior. A qualitative study by Ghaddar in 2018 reported on inequalities in access to OAT as one important gap to be tackled in the management of OAT in Lebanon. Overdose prevention efforts included advocacy for policy change that required hospitals receiving overdose cases to report to the police; this policy was removed in order to encourage PWUD to seek help in cases of overdose (MENAHRRA 2015, 2016). On March 22nd, 2016, in view of protecting persons who struggle with drug use disorders from arrests while seeking medical assistance, the Lebanese MoPH issued Circular 461 requesting that hospital administrations and medical personnel refrain from reporting cases of overdose to police officers. Skoun (2018), however, reported that 101 hospitals denied ever receiving the Ministry's circular, in some cases, the administration had received the circular but had not communicated it to the ER staff, and that Lebanese hospitals are hesitant to perform their duty without reporting the "crime" of drug use to the authorities, fearing legal repercussions on the hospital and on the staff. There was also a very recent update during COVID-19 regarding OAT in which the MOH (through an official circular) has allowed the dispensing of buprenorphine for two-week intervals for people on OAT as one of the measures for COVID-19. This was not possible previously (there was only dispensing at one-week intervals). The launch of the national observatory for drug abuse and addiction is currently on hold for financial and logistic reasons.

3. RESPONSE ANALYSIS

3.1 RESPONSE TO HIV

The National AIDS Program, which operates through a MOPH-WHO agreement, oversees all facets of the HIV response in Lebanon. The NAP's initiatives include promoting HIV testing, educating people about the disease and how to manage it, and combating stigma and discrimination. The NAP's range of work includes programmatic monitoring and evaluation, epidemiological surveillance, and research, preventing and reducing the spread of HIV, HIV treatment, and care, including the distribution of free ART. Along with raising awareness of the illness and its treatment, the NAP works to remove stigma and discrimination.

The NAP also works closely and in collaboration with the private sector, non-governmental organizations (NGO), ministries, media, religious authorities, United Nations (UN) agencies, and other significant stakeholders to improve the lives of HIV-positive individuals and to stop the epidemic from spreading. The mobilization of 12 non-governmental organizations behind prevention programs has greatly aided the fight against HIV in Lebanon. Partnerships and cooperative initiatives with the NAP have grown to be increasingly common, and they have successfully produced a number of programs on prevention, testing, and stigma reduction. The scaling up required additional partners and distant locations. At the moment, the country has more than 80 fixed and mobile VCT centers, which are spread out over the entire country and open to the general public.

This has led NGOs to increase their scope of work in several areas. NGOs providing HIV and Sexual Health services are distributed around Lebanon: Beirut, Beqaa, Baalback-Hermel, North, Beirut, Baalbeck, Tripoli. Damour, women's prisons in Baabda, Tripoli, and Zahle, in eight Palestinian refugee camps (Burj al-Shamali camp, Rashidieh, Ain al-Hilweh, Burj al-Barajneh,

Marlias, Nahr al-Bared, Beddawi, and the Galilee camp, Baalbek), in Sidon (South of Lebanon), and Roumieh Central Prison.

NGOs collaborating with NAP are funded by several entities, such: the WHO-NAP, the Lebanese-European Initiative for Human Rights, along with support from expatriates outside Lebanon, the Norwegian Embassy, AFD, the Global Fund, private donors especially from Italy, IPPF, UNFPA, AMAZE, Expertise France-SIDC, UNRWA, the European Endowment for Democracy, UNOCHA, UNICEF, Expertise France, MENAHRA, GIZ, and through fundraising activities.

The majority of NGOs in Lebanon that provide VCT services do so for free. This targets all population groups from the general public, including youth, STI patients, as well as MARPs, including sex workers, MSM, LGBTQ+, PWIDs, prisoners, and sexual partners of PLHIV. These NGOs offer counseling and rapid testing services either in their centers, outreach, or through mobile clinics. Activities are varied between voluntary HIV and sexually transmitted diseases (Syphilis, Hepatitis B, Hepatitis C) testing and pre/post counseling. These services are provided anonymously in an environment free of stigma and discrimination. Moreover, some NGOs distribute HIV self-tests and condoms.

In addition to that, NGOs also provide Medical related services such as: Family Planning & Contraceptive methods (pills, condoms, IUD, emergency contraceptives and general counselling), Abortion related services (pre & post abortion counselling and treatment of incomplete abortion), Gynecological services (manual breast exam, manual pelvic exam, screening for cervical cancer), Urology services, Endocrinology, Dermatology services, and infectious diseases specialists consultations for LGBTIQ+ individuals and other vulnerable groups (People living with HIV, detainees and refugees), Hepatitis B vaccination,

Antenatal and post-natal care ,pregnancy tests , and sexuality & relationship counselling. Additionally, some NGOs provide psychosocial support for LGBTIQ+ individuals and other vulnerable groups (people living with HIV, detainees, and refugees). Moreover, most NGOs also refer PLHIV cases to specialists for treatment. Besides that, a few NGOs provide services that facilitate access to OAT for regular patients, and for others who are not adherent, we support them. In collaboration with NAP, a few NGOs also distribute PEP, Prep, and ART to members of the LGBTQ+ communities.

NGOs also conduct awareness and outreach activities aiming to promote safe sex practices. During these activities, the outreach teams distribute condoms in places that are LGBTQI+ friendly and frequented by youth. Awareness sessions for educational purposes are also conducted in NGO centers and several Palestinian and Syrian refugee camps. During these sessions, topics tackled are related to sexual and reproductive health rights, such as sexually transmitted infections, preventive methods, consent, and communication among partners. These sessions are usually tailored according to the needs of the participants and usually held in schools, universities and sometimes in organizations. Several NGOs also promote their activities and raise awareness through social media and TVs such as that in the Rabieh Shelter. Adding to that online outreach through mobile dating apps is also common among a few NGOs.

Few NGOs also provide Legal support through advocacy and lobbying toward more rights for LGBTIQ+, sex workers and other vulnerable groups and documenting the violations against marginalized groups by producing documented stories that show the violations they have been subjected to by their parents, families, media, service providers and law enforcement agents. Furthermore, some NGOs developed new policies and internal protocols to leverage their work: PSEA, safe and security policy, through revising the human

resource policy, procurement policy and financial policy as well. Some NGOs also developed internal protocols for standard operational procedures for case management of key populations and to deliver online mental health support services for KPs among others.

With all the efforts done, NGOs have therefore been able to expand the types of services they provide and enhance capacity of more staff to target more key populations and displaced people; thus, achieving a greater number of testing. Few NGOs initiatives were able to target other types of stakeholders such as Health care providers through such as MARSAs's yearly regional workshop on "Enhancing sexual health and harm reduction services for a better patient care". This workshop is catered to health care providers to help them in identifying deeper needs and in providing comprehensive and inclusive services that are free of stigma and discrimination. Moreover, Marsa takes part in developing a curriculum on SRHR for universities, and it is being taught in specific universities. Also, for the first time, AJEM was able to distribute HIV self-tests in Blue House Roumieh prison (in October 2022) since VCT are forbidden, noting that the awareness sessions are still carried out. Moreover, all beneficiaries of the OAT in AJEM, especially patients who have a history of injection, do the HIV test according to the procedures. Dar Al Amal was able to carry a qualitative study about female sex workers situations in Lebanon and expand Outreach activities for this KP. Additionally, SIDC has documented around 106 cases of GBV in 2022 amongst key populations and helped them to receive Emergency cash assistance either directly from our projects or through another NGO. Testing services has thus seen a rise as more NGO work is being done. In 2022, 15838 HIV tests were done, 1215 self-tests, more than 39708 condoms and more than 370 harm reduction kits were distributed. Moreover, more than 680 outreach activities including online sessions were conducted reaching more than 8028 beneficiaries all over Lebanon.

Total Testing:

MSM	3971
PWIDs	2378
CSWs	293
Prisoners	196

(Source: NAP)

3.2 RESPONSE TO MPOX

The response to the Monkey Pox outbreak entails a comprehensive approach that engages and protects affected communities, intensifies surveillance and public health measures, strengthens clinical management and infection prevention and control in hospitals and clinics, and accelerates research into the effectiveness of vaccines, therapeutics, and other tools. NAP will thus coordinate with NGOs on the prevention, detection, and response to Monkey Pox. NGOs will play a key role in raising awareness and empowering at-risk populations, stopping the spread of Monkey Pox in vulnerable populations, and providing care for affected individuals.

NGOs who are working across Lebanon on HIV testing, outreach, and facility-based activities to key populations among Lebanese and non-Lebanese, namely MSM, female and male sex workers, PLHIV and people who use drugs, are contracted to be part of the Monkey Pox response through scaling up prevention, diagnosis, and treatment services.

After attending a mandatory training by NAP, NGOs are conducting outreach and facility-based activities for awareness-raising on MPox to key populations in

addition to delivering MPox testing services. Furthermore, NGOs are responsible for ensuring that all those suspected MPox positives receive a confirmatory test result through transport of samples/clients to the designated referral laboratory and return of the test results.

NGOs are working towards ensuring that all clients with a confirmed-positive MPox test result are linked to treatment. On the other hand, NGOs liaise with the diagnostic reference laboratories as advised by the NAP for MPox confirmatory testing. It will also play a major role in referral to specialists for treatment of positive cases as well as follow-up of treatment with their physicians.

3.3 GUIDELINES AND CURRENT STATUS FOR HIV TESTING, COUNSELING, AND CLINICAL MANAGEMENT

National Voluntary Counseling and Testing Protocol

In 2006, the national Voluntary Counseling and Testing (VCT) protocol was established. The protocol entailed practical guidelines and thorough explanations on how to conduct each of the components of the voluntary counseling and testing, namely: 1) awareness on sexually transmitted infections (STIs) (including HIV/AIDS) and on how to decrease infection risk; 2) pre-testing counseling; 3) voluntary testing; and 4) post-testing counseling, follow-up, support, and referral. Specific and detailed algorithms were integrated within the national protocol for each of the four above-mentioned components. The protocol also details the characteristics of the VCT centers, lists the logistic and human requirements needed at the center and specifies algorithms and checklists to guide the counselor throughout each process. A series of training workshops were performed to explain and promote the VCT guidelines, thus enhancing smooth implementation of the VCT series. Actually, more than 550 healthcare workers in primary health care centers and sociocultural and NGO's health facilities received the training.

3.4 NATIONAL GUIDELINES FOR ANTI-RETROVIRAL TREATMENT

National guidelines for ART were set in Lebanon to provide guidance on the medical management of all age groups and sub-populations among PLHIV. These guidelines focus on ART for treatment and prevention of HIV infection, ranging from testing and counseling to pre- and post-exposure prophylaxis (PrEP and PEP), pretreatment evaluation, treatment initiation, management of co-infections, and drug resistance testing. These guidelines target all parties involved in the management of HIV/AIDS in Lebanon, primarily the physicians, pharmacists, and laboratory directors, in addition to the national HIV treatment and advisory board, program managers (tuberculosis programs, maternal and child health programs), PLHIV and community-based organizations and service providers. ART guidelines are adapted to the Lebanese context in terms of current epidemiological traits, availability of drugs and laboratory testing capacities. They are tailored to provide a timely response to the current situation in Lebanon and are destined to be periodically updated to match state-of-the-art international protocols.

The newest ART national guidelines issued in 2018 were adopted from the most recent international recommendations, especially the 2018 WHO consolidated guidelines, indicating a treat-all policy, in addition to new recommendations for PrEP, PEP, and PMTCT. These changes imply that all PLHIV will be eligible for treatment, leading to additional burden on the HIV drug budget that needs to be addressed. The standardized first-line treatment regimen consists of a Fixed Dose Drug Combination (FDC) of Dolutegravir/Lamivudine/Tenofovir disoproxil or Dolutegravir/Lamivudine/Abacavir. Alternatively, other choices consist of Emtricitabine/Tenofovir/Efavirenz, or Lamivudine/Tenofovir/Boosted Lopinavir. All these regimens are provided for free by the MOPH and dispensed through the NAP. Currently, all treatment applications are reviewed by the NAP

and re-evaluated in light of the national guidelines. Alternative protocols are tailored according to previous drug usage, resistance assays and drug tolerance. In addition, an update of the ART guidelines is being done in light of the new international and regional recommendations to cover all patients with HIV regardless of CD4 count, a universal coverage.

3.5 THE SERVICES CONTINUUM

The national guidelines recommend that all forms of HIV testing and counseling should be voluntary and adhere to the five C's: consent, confidentiality, counseling, correct test results, and connection to HIV prevention, treatment, and care services.

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).

The VCT services in Lebanon are free of charge and delivered primarily by NGOs. These centers provide counseling and rapid testing services to the general population, including youth, premarital couples, blood donors, tuberculosis (TB) and STI patients, as well as MARPs, including sex workers, MSMs, PWIDs, prisoners, and sexual partners of PLHIV. During the year 2015, 970 tests were conducted by VCT centers, of whom 18 were positive. The centers are intended to provide targeted services with extreme privacy and confidentiality. The VCT services are also destined to be easy to access, with reliance on measures of quality-assurance. Finally, the VCT services include focusing on life skills, problem-solving and decision making with the target population. Use of peer education is also an integral component of the provision of these services. In the past couple of years, scale-up of the VCT activities through a higher level of training and implementation was achieved. The scale-up involved new partners

and remote geographical areas. Currently, more than 100 fixed and mobile VCT centers are available and dispersed all over the country, making them accessible to the entire population living in Lebanon, including Iraqi and Syrian refugees. Most of the VCT centers are currently active in terms of service provision. Additional efforts are being deployed to advertise for the centers among the different target groups, and plans are being put in place to further expand the VCT coverage.

The linkage between testing and treatment depends on where and how the initial HIV test is done. If done through a rapid test, such as in the case of VCT centers, the individual is referred to a laboratory to perform an enzyme immunoassay confirmation. If confirmed, the individual is referred to an infectious disease clinician. If the test is performed in a laboratory, through self-requested or provider-initiated testing or during blood donation, the individual is directly referred to an infectious disease physician for treatment and follow up.

Regarding treatment, since 1997, ARVs are fully covered by the MOPH. 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. The vast majority of PLHIV in Lebanon have access to the ARVs through the NAP. Some individuals prefer not to be listed through the MOPH; they seek treatment on their own and acquire the ART through out-of-pocket money. Occasionally, because of resistance problems, some individuals get some medications that are not available at the NAP, through some civil society organizations.

Finally, clinical service providers are relatively few in the country, and most patients are concentrated with approximately 10 to 12 infectious disease physicians.

3.6 ACCESS TO HIV TESTING AND CARE

Recent data provide evidence of high levels of HIV testing and awareness of infection and treatment among the MSM population in Lebanon. Only 3.1% of the MSM recruited within the latest bio-behavioral survey (IBBS, 2015) in Lebanon were never tested for HIV infection. The prevalence of HIV-testing in this population has greatly increased since the first IBBS conducted between 2007 and 2008, where only 22% of recruited MSM reported ever being tested for HIV.

MSM in this country exhibits, nowadays, much higher rates of HIV testing compared with MSM in other countries of the region. This may reflect the success of promotional campaigns for HIV testing and outreach programs led by the NAP and NGOs. Nevertheless, it is worthy to note that MSM who had ever tested were more educated, have a relatively high monthly income, self-identify as gay, are in a committed relationship and are less likely to report transactional sex. On the other hand, men who are at highest risk for HIV infection (engaging in unprotected anal sex with partners of unknown or positive HIV status, and transactional sex, and those with a history of having STIs) were least likely to have been tested. The evident mismatch between perception of risk of HIV infection and actual experience of testing among MSM is consistent over the years, suggesting the need for more targeted prevention campaigns promoting HIV testing. Data from the Crossroads IBBS (2015) indicate a 74% HIV testing rate among surveyed PWID. This figure is also greater than the one reported in 2008, where 61% of sampled PWID were ever-tested.

The Crossroads IBBS among infected MSM who were aware of their status revealed complete access to treatment (100%). In details, the average time since last visit to the medical care provider was 3 months (median time: 1.7 months).

Moreover, all (100%) of the MSM who were aware of their infection received CD4 and VL counts, and 93% of them were on ART at the time of the assessment. Data regarding HIV care in PWID are currently unavailable. Moreover, data on the HIV testing and treatment in other MARPs are also unavailable.

Finally, data from the GARPR in 2014 indicate that no facility experienced stock-outs of rapid HIV test kits, nor one or more required ARV drug, in the past 12 months.

3.7 MONITORING AND EVALUATION ENVIRONMENT

In Lebanon, the NAP is responsible for monitoring and collecting data reported by physicians, laboratories, and VCT centers. The NAP performs and periodically reports data analyses and projections based on the models developed by the Joint United Nations Program on HIV/AIDS (UNAIDS) and the WHO. Furthermore, a National Monitoring and Evaluation framework with 11 indicators was also recently developed. Thus, the physicians have to report diagnosed cases to the NAP for epidemiological purposes. They also have to fill out an application form to request ARVs. This application is reviewed by the medication distribution committee at the MOPH.

Despite this, some problems persist at the levels of data nature, collection, reliability, quality and estimation; the currently employed monitoring system solely relies on passive reporting and consists of observing on a regular basis the priority information and the results related to the programs fighting HIV/AIDS. Within this scope and in an attempt to facilitate the surveillance and monitoring activities in key populations, population size estimation for the MSM and PWIDs was recently conducted in coordination between the NAP and Middle East & North Africa Harm Reduction Association (MENHARA).

In regard to 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. The only drawback at this level is the excess bureaucracy and paperwork. There are now efforts to implement a network between the physicians, the MOPH medications committee and the central pharmacy at the NAP to facilitate the dispensing of medications.

As for updates in prevalence among key populations, especially MSM, a new integrated bio-behavioral study (IBBS) is being planned by NAP for the coming few weeks.

3.8 MAJOR CHALLENGES TO THE NATIONAL RESPONSE TO HIV/AIDS

Despite the achieved progress, major challenges are still slowing the progress of the national response to HIV/AIDS. One of the key challenges is the absence of legal protection for PLHIV. The unstable political situation and internal security of the country, the shortage of continuous and stable funding, the difficulties encountered in recruiting skilled human resources and the low academic interest in HIV-related research remain major obstacles towards the sustainability and advancement of research, advocacy, policy changes, access to treatment, and training. In addition, taboos and religious sensitivities still surround subjects such as HIV, MARPs, as well as sexual freedom, condom use, drugs or alcohol use, thus delaying the achievement of preset targets of the fight against HIV/AIDS.

Several additional obstacles are currently causing further resistance to change, reinforcing stigma and discrimination, and impeding access to care, treatment and support for PLHIV in the country. Among them is the shortfall in the general awareness of HIV, even among key parties, namely the health care providers, MARPs, decision-makers and religious leaders, among others. Punitive laws in the country also create a major challenge in improving HIV-related issues. For

instance, criminalizing homosexuality, in addition to many policies and regulations related to drug users, sex workers, prisoners, and other high-risk populations. Despite significant improvements over the years, the lack of effective collaboration, coordination and transparency between the key stakeholders remains an important shortcoming in the country's effort to fight against HIV/AIDS. On the other hand, the Syrian and Iraqi crises have shed new burdens on the fight against HIV/AIDS in Lebanon.

The Syrian refugees in Lebanon are scattered all over the country, with over 60% being in the North and Beqaa governorates. The two governorates, together with the South governorate, are known to have the highest poverty rates in the country. For the residents of those governorates, the influx of refugees poses competition for economic, health and infrastructure resources in addition to opening ways to exchange communicable diseases. The people that are subject to forced migration are known to be the weakest and most vulnerable. Their health needs, among others, continue to rise with the protraction of their displacement. Furthermore, media reports and anecdotal information

indicate the rise of HIV risk determinants and risk behaviours. This includes male and female sex work and gender-based violence (GBV). Those media report also testify to Syrian men who have sex with men seeking refuge in Lebanon.

The national response to HIV comprises HIV prevention and diagnosis services among key populations delivered by NGOs, in addition to government-free antiretroviral medicines (ARV). Medical care for people living with HIV is mainly delivered through the private sector. The government of Lebanon is also providing free ARV to Syrian refugees living with HIV. Due to the re-

prioritization of resources towards other health concerns among refugees, the financial resources for HIV-related programs have become scarcer. Finally, the impact of the presence of high-risk Syrian refugees in Lebanon needs to be addressed.

In brief, the national response to the epidemic in the past 5 years was multi-sectoral and addressed efficiently various aspects of the NSP 2023-2028 hoping to halt the spread of the epidemic.

The NAP is leading such efforts as part of a collaborative multi-sectoral national response to HIV/AIDS and managing ably such an approach by working in the direction of shared national goals and aligning efforts across sectors. Such a response was very well illustrated in good part in the 2014 GARPR report to UNAIDS. It covered efficiently most indicators requested in addition to policy issues related to HIV.

CHALLENGES ENCOUNTERED AND ACTIONS TAKEN

Challenges	Actions Taken
Increasing security risk in reaching remote places.	Use of WHO car and assistance in most travel missions.
Decreased tolerance to key population groups with developed negative propaganda.	Lobbying with stake-holders to minimize stigma.
Convincing NGOs to advocate for PrEP among MSM.	Intensify advocacy for PrEP during all key population awareness workshops and on social media platforms.
Unstable contractual staff situation.	Mobilization of resources from other donors.

4. DISPLACED AND REFUGEE POPULATIONS IN LEBANON

4.1 BACKGROUND

Equitable access to quality and affordable primary healthcare and hospital care services continues to be challenging for all population cohorts. According to the Vulnerability Assessment of Syrian Refugees in Lebanon⁴⁸, those who didn't access the healthcare they needed couldn't afford it, with the cost of treatment (73%), doctor's fees (67%), and transportation (40%) cited as the top reasons for not having access overall. Female-headed households (FHH) (82%) more commonly reported not accessing healthcare because of the cost of drugs or treatment than male-headed households (MHH) (71%). MHH (41%) reported lack of access due to cost of transportation more commonly than FHH (34%); Additional barriers that continue to hinder accessibility and timely use of services in Lebanon at the supply and demand levels are related to availability, geographical accessibility, and acceptability⁴⁹:

- Unable or unwilling to seek healthcare services while supply-side determinants.
- Maternal depression among both Syrian and Lebanese women.
- Lack of access to menstrual hygiene products is another factor negatively affecting girls' and women's wellbeing and mental health.
- According to the Child-Focused Rapid Assessment conducted in April 2021, 75% of children aged 6-14 in Lebanon had difficulty concentrating

⁴⁸ VASyR 2021: *Vulnerability Assessment of Syrian Refugees in Lebanon. 2021. UNHCR-UNICEF-WFP VASyR 2021: Vulnerability Assessment of Syrian Refugees in Lebanon - Lebanon | ReliefWeb*

⁴⁹ *Lebanon Response Crisis plan 2022-2023. Government of Lebanon and UNITED Nations. <https://reliefweb.int/report/lebanon/lebanon-crisis-response-plan-lcrp-2022-2023>*

or were unable to concentrate on their studies at home and 80 % of children in Lebanon are worse off in April 2021 than they were at the beginning of 2020.

- Mood swings, aggressively and feeling depressed.
- Girls (62%) were more likely to report symptoms of stress and anxiety compared to boys (45%).⁵⁰ Lebanon remains the country hosting the largest number of refugees per capita with the Government estimation of 1.5 M Syrian refugees and some 12,159 of other nationalities⁵¹ in addition to more than 479000 Palestinian refugees⁵².

The socio-economic downturn coupled with the COVID-19 pandemic and Beirut blast have all contributed to nine out of ten Syrian refugees living in extreme poverty.

The health services are largely privatized in Lebanon, and under further pressure due to the pandemic, accessing basic and lifesaving care has become more challenging for refugees. (UNHCR,2021)

4.2 HEALTH SITUATION

The proportion of respondents that reported having access to primary health care was the same in 2021 compared to 2020, despite a slight increase of in those who reported needing primary health care. Access to hospital care decreased, despite the need reported being like 2020, with more than 80% reporting to access the

⁵⁰ *Lebanon Response Crisis plan 2022-2023. Government of Lebanon and UNITED Nations.* <https://reliefweb.int/report/lebanon/lebanon-crisis-response-plan-lcrp-2022-2023>

⁵¹ *Lebanon Factsheet December 2022. UNHCR [Lebanon factsheet / Global Focus \(unhcr.org\)](#)*

⁵² *Where we work. 2022. UNRWA. [Where We Work / UNRWA](#)*

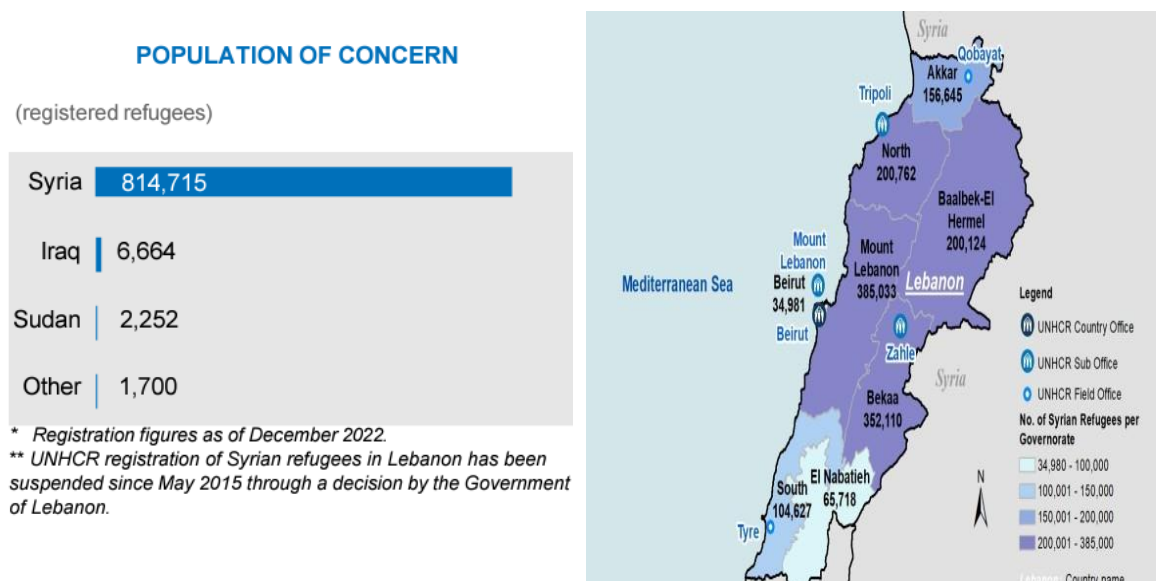
hospital care they needed. For both primary health care and hospital care, the greatest obstacle to accessing care remained financial, and households in the lowest expenditure quintile reported having the least access to care. There were also significant differences in reported access between governorates, and particularly residents in Mount Lebanon and Beirut reported having less access to care. A quarter of children under the age of 2 suffered from at least one disease, with the majority (60%) suffering from diarrhea, and an increase from 2020 of 23 percentage points in children who suffered from a cough (56%). Access to medication was a challenge, with less than half of the respondents reporting to be able to access all their needed medication. There was a marked increase in knowledge of how to access health care for COVID-19 compared to the previous year. There was no increase in the proportion of women reporting having delivered at home.⁷

Syrian refugees holding legal residency have further decreased, hampering their access to basic services and civil documentation and increasing the risk of deportation.

The degradation of the economic situation in Lebanon has negatively impacted refugees' access to healthcare and medicine. UNHCR's health care interventions aim to ensure access for refugees in Lebanon to primary and secondary health care.

UNHCR operates a large referral care program to subsidize hospitalization fees. The assistance includes covering a major part of the cost for refugees in need of obstetric care and urgent lifesaving interventions at hospitals through a network of 30 contracted hospitals.

In addition, UNHCR and partners support 210 primary health care centers across the country to provide general health care services such as vaccinations, maternal care, and care for chronic non-communicable diseases. In addition, UNHCR supports the delivery of mental health services that are scarce and limited in Lebanon. By December 2022, a total of 102,153 consultations were provided to refugees and vulnerable Lebanese through facilities receiving support from UNHCR and its implementing partners.¹⁰



(UNHCR,2022)

4.3. VULNERABILITY ANALYSIS OF REFUGEES TO HIV INFECTION IN THE CURRENT CONTEXT

4.3.1 VULNERABILITY AND RISK FACTORS

Refugees know one condition better than most populations - instability. War destroys hospitals, schools, farms, and houses, tears up communities and rips

apart families. The breakdown of the social fabric usually quickens the spread of disease. In many countries, HIV infection rates are particularly high along truck routes or at border crossings, where the population is mobile and drug use is more widespread. Female refugees often find themselves at risk from sexual violence or are forced to trade sex simply to survive. Child refugees might be orphaned and uneducated, leaving them vulnerable to sexual predators.

Although conflict, displacement, food insecurity, and poverty might leave them more susceptible to HIV, refugees do not always display higher rates of the infection. According to the UNHCR, a variety of complicated factors determine how seriously HIV affects refugees: Pre-conflict HIV rates among refugees, rates of surrounding communities in refugee camps, the level of interaction between refugees and host populations and exposure to violence will all determine the overall HIV rate in a given refugee population (UNHCR).

In several areas, access to health care seems to have reduced compared to 2020:

- Fewer pregnant women went for ANC (49% had 4 visits before delivery compared to 61% in 2020)
- There was also a general shift towards seeking health care in public facilities rather than private
- The median cost for an ANC visit in a private clinic went to over 2000000.
- Of pregnant women going for ANC, 68% went to public PHC facilities compared to 59% in 2020.

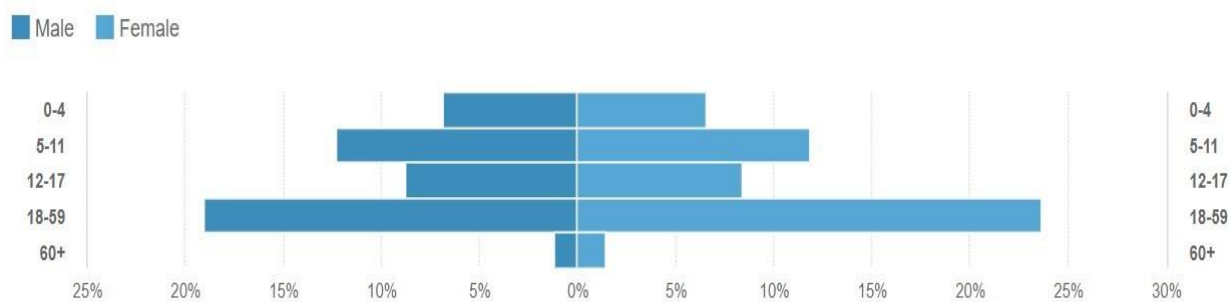
The above is probably a result of private care becoming more expensive. On the other hand, the cost of care in public facilities and UNHCR supported care remained stable in general.

A contributing factor to the above changes is believed to be the deteriorating financial situation for the refugee population resulting from the compound crises. The average household has during 2021 seen its purchasing power reduce significantly since prices of non-subsidized products are increasing a lot faster than salaries, and according to the 2021 vulnerability assessment for Syrian refugees⁷, 9 households out of 10 are now living in extreme poverty. This is, however, not always clearly reflected in the survey responses. For example, the most reported reason for not attending ANC was “not thinking it was necessary” rather than not affording the fees. It should be considered that there can be an overlap between “not affording” and “not needing” since in the face of scarcity, certain needs are not prioritized.

Another worrying observation is the reduction in children reporting having received oral vaccination (72% compared with 83% in 2020). Cost of care should not be a factor contributing to decline, but disruptions in access due to COVID-19 restrictions and increased cost of transport could have played a role.

- There was no difference in the proportion of women delivering at home.
- Knowledge about available services remained more or less the same.
- No important difference in usage of contraceptive methods.
- No change in proportion of women going for PNC (still low).
- No changes in proportion of children having received injectable vaccines⁵³.

⁵³ *Health access and utilization survey among Syrian refugees in Lebanon. 2022. UNHCR,:* <https://reliefweb.int/report/lebanon/health-access-and-utilization-survey-among-syrian-refugees-lebanon-march-2022>



Source - UNHCR

Demography of Registered Syrian Refugees (Source: UNHCR,2022)

Substance Use and HIV Risk in Lebanon: There are few and mostly outdated statistics on the frequency of substance usage among Lebanese nationals and chemsex among PWUD and other KPs

5. HEALTH SYSTEM IN LEBANON

More than ten years since the start of the crisis in Syria, the impact of the situation continues to rebound in Lebanon, including on its economy, institutions, and people across the country. Lebanon continues to host the highest number of refugees per capita and per square kilometer in the world. Since 2019, Lebanon has further faced an unprecedented and multifaceted economic, financial, social, and health crisis.

Lebanon’s health system is under extreme strain as a result of the multifaceted crisis. Demand for public health services has increased as people are less able to pay for private healthcare. The lack of electricity and fuel shortages in 2021 have heavily impacted the operational capacities of all healthcare facilities, especially hospitals, with some forced to operate at 50% capacity or less or resort to complete closure. The urgency is further compounded by the decreased access to prevention-focused primary healthcare, including routine immunization, and by shortages of essential medicines and medical supplies, resulting from gaps in

critical supply chains. The dire health situation extends to all vulnerable populations. The main barriers to accessing primary healthcare services reported in 2021 were financial, relating to the direct and indirect costs of the service, such as consultations, drugs, doctors' fees, and transportation. 82 % of female-headed households who were unable to access the healthcare they required reported that this was due to the cost of drugs or treatment, compared to 71 % of male-headed households. 18 Female-headed households were also more likely to report not being able to get surgery compared to male-headed households (68% and 47% respectively).⁸

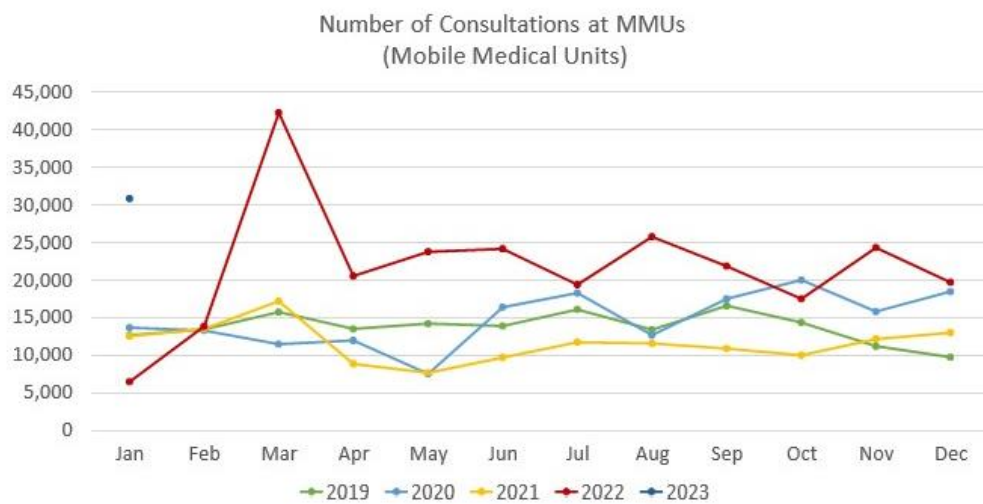
The economic crisis has also led to a lack of human resources in the medical field. Levels of dissatisfaction with health services rose to exceed those observed in any of the previous RC-UNDP Regular Perceptions Surveys, including at the height of the pandemic, with 63 % of Lebanese and Syrian respondents assessing the current quality of health services as poor or worse and 59 % expressing fears about being able to access medical care or medication. 19 Mental health issues are increasingly affecting all groups, with particular concerns related to maternal mental health, children, and adolescents, in particular girls, with concerns regarding a lack of quality services with the ability to absorb the growing caseload⁸.

5.1. HEALTH

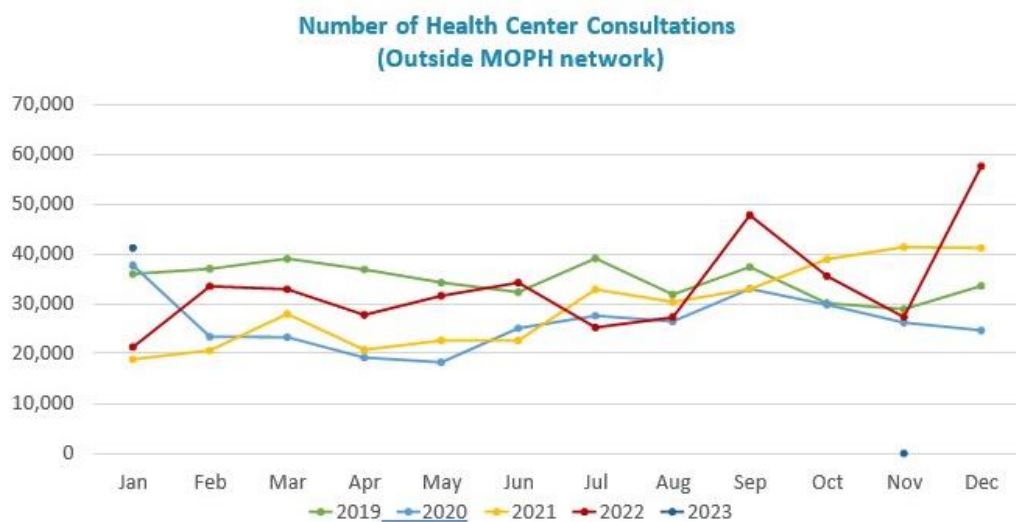
The current COVID-19 pandemic has placed additional stress on public hospitals, which have been experiencing financial hardships due to the decreasing purchasing power of Lebanon. A stable, reliable and affordable electricity supply is vital for public hospitals to continue providing the first line of defense against the pandemic as well as other health services. Without adequate electricity supply, health facilities cannot run equipment, such as vaccine refrigerators, or use many of the most basic, life-saving medical devices in an optimal fashion. As

such, Lebanese health facilities have been forced to run diesel generators to preserve uninterrupted cold chains for 24 hours, further constraining their already scarce financial resources and threatening their sustainable service provision.

This challenging situation hindered the ability of the health sector to respond to the increased needs of a growing vulnerable population while impeding their access to primary healthcare⁵ and hospital care services from both the supply and demand sides.⁸

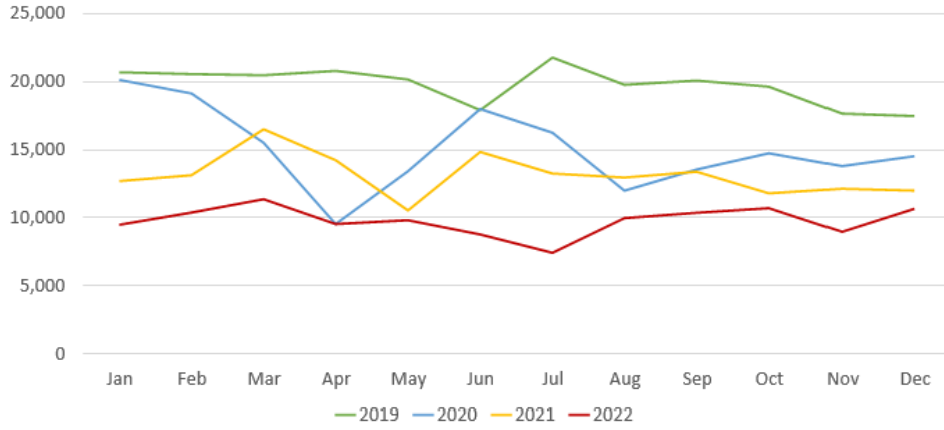


Number of consultations seen by the mobile medical units (Period: 2019–2022) (Source: UNHCR retrieved on 22 FEB 23)



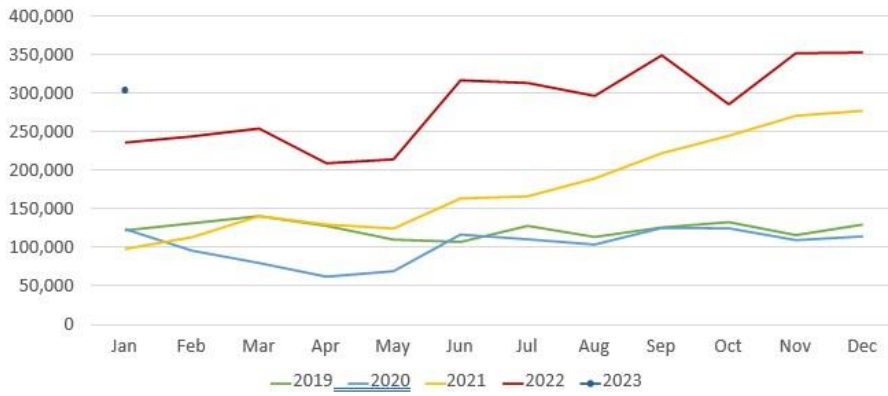
Number of health center consultations not in the MOPH network (Period: 2019–2022) (Source: UNHCR retrieved on 22 FEB 23)

Number of Hospital Admissions of MOPH Patients



Number of hospital admissions for Lebanese patients supported by MOPH (Period: 2019-2022) (Source MOPH retrieved on 4 Jan 2023)

Number of Primary Health Care Beneficiaries for Basic Services (MOPH Network)



Number of primary healthcare center beneficiaries for basic services (consultations provided by general practitioner, family physician, pediatrician, gynecologist / midwife, endocrinologist, cardiologist, mental health and dentist) within the MOPH network (Period: 2019-2022) (Source: MOPH retrieved on 23 FEB 2023)

Primary Health Care:

- The number of consultations increased by 29% when comparing January 2022 to 2023.
- The number of consultations outside MOPH doubled (93% increase) when comparing January 2022 to 2023.
- The number of consultations via MMU saw a 5-fold increase when comparing January 2022 to 2023.
- The number of children receiving vaccinations fluctuated during the past 3 years (597,103 in 2020, 486,466 in 2021, and 526,912 in 2022) (WHO,2023).

Secondary Health Care:

- The number of persons covered by MOPH decreased by 16% when comparing Q4 2022 to Q4 2021.
- The number of persons covered by UNHCR is stable.
- Situation for medical supplies is critical, with an emphasis on anesthesia shortage.
- Due to the fuel crisis, most hospitals cut down on 50% bed capacity and sometimes even more.
- It is estimated that 17% of nurses and 20% of doctors have emigrated, leading to an increasingly human resources shortage (WHO,2023).

5.2 SERVICE DELIVERY

There are at the moment 173 operational hospitals in Lebanon (35 in the public sector and 138 in the private and university sectors).

5.3 HEALTH SERVICE UTILIZATION

The multifaceted crisis has also severely impacted access to and utilization of health care services, the main barriers being financial costs, issues of transport, and lack of awareness. Increasing impoverishment and inability to pay constitute real barriers to accessing care, which many households find insurmountable. Currently, many Lebanese no longer have the resources to pay for health care. The speed of this deterioration is accelerating; in just six months, the share of households having difficulty accessing health care rose from 25% (July – August 2020) to 36% (November – December 2020). Hospitalizations, particularly for surgeries, diminished by 30% in 2021 and the average hospitalization days per month decreased by 25% according to the Syndicate of Hospitals. This fall in utilization of hospital care, in addition to a 90% drop (in real, or fresh, dollars) of third-party reimbursement rates, threatens the continuity of the hospital sector, where most private hospitals have downsized their bed capacity since the beginning of the crisis. Referral to advanced diagnostics is also decreasing as hospitals are operating with around 50% capacity. Excessive 16 Lebanon National Health Strategy: Vision 2030 advance payments requested by hospitals from patients seeking emergency services or admissions, represent a big barrier to hospital care and to achieving universal health coverage within the current context. On the other hand, primary health care centers have seen higher demand for non-communicable disease and acute care services, with more than 220,000 beneficiaries for non-communicable disease medications in 2021 in comparison with 78,000 in 2016 and around 350,000 beneficiaries for acute care, along with

an increase in utilization of at least 25% compared with the pre-crisis situation. Additionally, the 2021 multisector needs assessment survey shows that 45% of Lebanese and 50% of non-Lebanese (Palestinians and migrant workers) who suffer from mental distress do not seek help. This phenomenon is usually explained by the fact that people did not seek care as they did not consider mental health as a health problem. However, other reasons related to aggravated poverty, high cost of services and shortages in medications should not be underestimated. According to the multisector needs assessment, the three main barriers reported by households in the three months prior to data collection that prevented them from accessing health care when needed were not being able to afford the cost of treatment, the cost of the medical consultation, or the transportation to the health facility.

Households' coping mechanisms to adjust to the barriers and access health care included going to pharmacies instead of doctors (18%), delaying or canceling doctors' visits and other diagnostic procedures (27%), switching to public health facilities (12%) or using no coping mechanism at all (40%). If no official measures are taken, timely access to health care will continue to be jeopardized, and high percentages of the population will continue experiencing catastrophic health expenses and relying on burdensome coping mechanisms to access health care. As for medications, the three main barriers experienced by households that prevented them from accessing needed medications included medications being too expensive (75%), medications not being available in private pharmacies (57%), or medications not being available in such health facilities as hospitals or primary health care centers (36%)⁵⁴.

⁵⁴ *Lebanon National Health Strategy: Vision 2030 Out of the crisis and towards better health for all Health workforces.2022. Ministry of Public Health.*

According to the Syndicate of Hospitals, 90 % of the functional adult intensive care unit beds are occupied, and there is an increase in emergency department visits. This is due, among other factors, to acute decompensated heart failure because patients were off diuretics, seizures because patients stopped anti-epileptics, strokes because blood thinners were not available and septic shocks since antibiotics are nowhere to be found. Even before the crisis, medicines made up 54 % of out-of-pocket expenditures of the total health expenditures. In 2020, the government's policy of relying on external sources for medications and medical supplies, coupled with the economic crisis, led to drops in imports, resulting in severe market shortages. This has paved the way to hoarding, smuggling, black market practices, and the entry of illegal, low-quality drugs and supplies into the country. This has also led to the closure of more than 600 of the 4,000 private pharmacies in Lebanon.¹³

The inability to pay made people look for more affordable sources of care, including traditional medicine and unsafe practices. The Ministry of Public Health has used donor funds to safeguard access to critical non-communicable disease medications and vaccines through the primary health care network and to medications for cancer and catastrophic illness through the central drug warehouse. However, this represents less than 10% of the total pharmaceutical market in the country. The Ministry encouraged the local pharmaceutical industry to increase its production, which responded successfully, delivering in a sustainable way 37% of the total market volume (in units), with about 72% of the acute over-the-counter and chronic medications¹³.

https://www.moph.gov.lb/userfiles/files/About%20MOPH/StrategicPlans/National-Health-Strategy%E2%80%933Vision2030/LHS_220124.pdf

5.4 HEALTH INFORMATION SYSTEM

The national health accounts (NHAs), which are an internationally recognized tool that measures and tracks health care expenditures in a country and explains where the money comes from, and where it goes. The Ministry is in charge of collecting health expenditures from different public funds, mutual funds and private insurance funds. Thus, the NHA is of great significance to policy development and adjustment in health expenditures and for improving the performance of health systems while enhancing transparency and accountability. The information provided by the 2017 NHA can hardly serve as a detailed guide for decision-making in the current context. The same goes for a whole range of other issues, including the distribution of human resources, the trends in out-of-pocket expenditure, the performance of health care providers, funding flows, the epidemiological situations, the unmet needs, among others. Importantly, brain drain (in the Ministry and in academia) risks curtailing the capacity to prioritize, design, and launch the surveys and studies necessary to guide recovery.¹³

The hospital-based mortality system has been facing sustainability challenges due to the emerging economic crisis, where the loss of hospital staff to emigration affects the timeliness of reporting and completeness of data, and the high turnover requires frequent training to ensure quality. Moreover, the emergence of the crisis at the end of 2019 halted the efforts to establish the Health Information Management Unit (HIMU) and exposed areas of priority, such as the importance of a unified patient identification number and harmonization of the fragmented systems. For example, during the COVID-19 pandemic, it was difficult to track cases from diagnosis to treatment and potential deaths due to the fragmentation of the available systems at that time. This is caused by the absence of a national e-health strategy and the inefficient coordination between the departments of the Ministry, resulting in fragmentation and duplication of data. The hospital-based

vital data observatory, which collects data on deliveries and maternal and neonatal mortalities, needs to be strengthened and expanded to collect accurate and timely information. The primary health care network of information communication systems (PHENICS) and MERA platforms, which provide data generated by the primary health care network, including data on vaccination, need to be expanded to include the private sector, while ensuring completeness of reporting. While COVID-19 was an opportunity for the e-health program to show its true potential, it also highlighted the pre-existing challenges the program had faced since its formation, and which hampered its efforts in implementing its action plan. These challenges have been exacerbated following the multiple crises since the end of 2019; they include shortages in financial resources, burdensome bureaucratic administrative procedures and, since mid-2020, the absence of proper leadership at the Ministry capable of managing this context of multiple crises, in addition to an insufficient number of motivated and competent staff, particularly in the domain of information and communications technology (ICT)¹³.

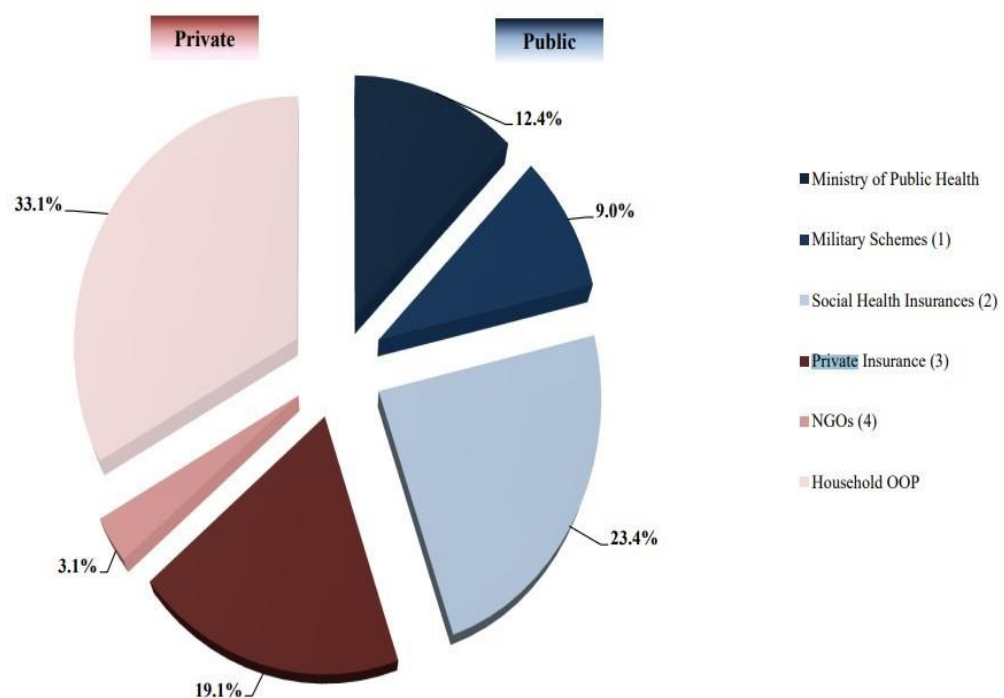
5.5 HEALTH FINANCING

Lebanon spent 10.7% of its GDP on health in 2000. This was reduced to a more sustainable 7.3% in 2015. In GDP terms, government, social security, and voluntary health insurance expenditures increased from 7.6 to 8.6%. Total health expenditure was also reduced by 22%. The most important feature of this reduction was that OOP payments dropped from 627,000 LBP per capita (US\$ 416) down to 273,000 LBP (US\$ 181); government spending and voluntary health insurance remained virtually the same, while social health insurance contributions doubled.

MoPH has updated the national guidelines on good manufacturing practices and reinforced its inspection capacity. Also, a review of pricing has been implemented, along with updating the list of essential and chronic medicines. A

standardized system for eligibility criteria for support in terms of catastrophic illness medications (cancer, hemophilia, renal failure, rare diseases) has also been established. In addition, the MoPH has developed a national strategy for medical devices, with a short-term plan of action whereby regulations and standards are elaborated. Vaccines are provided free of charge in more than 500 primary health care centers and dispensaries. Reinforcing the regulatory role of the MoPH and ensuring financial sustainability for chronic disease medications, especially in light of the influx of Syrian refugees, are some of the challenges faced by the country.⁵⁵

Graph I.4: Distribution of healthcare expenditure by financing agent in 2017



(1) Includes Army, Internal Security Forces, General Security, State Security, and Customs
 (2) Includes National Social Security Fund and Mutuelle des Fonctionnaires de l'Etat (previously known as Civil Servant Cooperati ve)
 (3) Includes private insurances, mutual funds, and corporations
 (4) Includes local and international NGOs
 Source: NHA-2017-MoPH

⁵⁵ Country cooperation strategy for WHO and Lebanon: 2010–2015. 2010. World Health Organization. Regional Office for the Eastern Mediterranean. <https://apps.who.int/iris/handle/10665/113219>

6. THE NSP PROCESS: GUIDING PRINCIPLES AND EXPECTATIONS

This HIV/NSP 2023-2028 is the culmination of extensive consultation and deliberation that already started in the past three months and continued for several weeks with a wide range of stakeholders. This process involved a review of achievements against the goals and objectives of the previous NSP 2016-2020 using reports and other documentation as well as interviews and discussions with key informants. The results of such a process constitute the key to determining the strategic priorities and the appropriate way forward in dealing with the HIV epidemic in Lebanon for the coming five years, 2023-2028.

The NSP 2023-2028 provides strategic guidance for HIV activities for the next 5 years in line with the set vision, goals and objectives. It focuses on the drivers of the HIV and builds on the achievements of the previous NSP. It is meant to scale up what has been done well, and improve the quality of services, while at the same time integrating new and proven strategies.

This NSP is intended to respond to the rapid changes in the epidemic and will, therefore, be reviewed regularly for relevance and effectiveness. It is meant to be in line with the broader development plan of the government. It is a multisectoral plan that will inform stakeholders, at various levels, on the strategic directions to be considered when developing implementation plans. It will also be used as the guiding framework for coordinating and monitoring implementation. A few guiding principles underpin this NSP and its national multisectoral implementation plans.

This NSP is:

- Long term focused and vision-led whereby all initiatives are clearly linked to the vision with high impact, high value, and scalable objectives. All activities are evidence-based and focused on the achievement of well-formulated objectives and targets.
- Flexible enough to ensure relevant changes, adjustments and multi-sectoral to combine resources of all sectors of society, thus promoting true partnerships at all levels and avoiding duplication of activities and information. It should be firmly rooted in the protection and promotion of human rights.

6.1. Past successes and challenges that guide this new NSP include

This plan will build on successes. It will stress the renewed engagement and high-level political leadership spearheading the HIV response, as well as the growing cooperation between government and its partners. In addition, this NSP will scale up and strengthen the program to maintain complete prevention of mother-to-child transmission of HIV, the increase in the number of people testing for HIV, and to initiate to all HIV positive people antiretroviral treatment (ART). Moreover, the NSP will enhance the introduction and scale up of medical male circumcision services as part of male sexual and reproductive health and commit to focus on the drivers of the HIV epidemic and to address the social determinants of health. Furthermore, this NSP will scale up prevention interventions to key and vulnerable groups including children, among others, who have access to social security services and increase the number of learners who have access to education, particularly girls. The 2023-2028 plan will strive to provide HIV life-skills education in all schools and grades, as a compulsory part of the education curricula. Finally, the new plan will maintain universal access to key commodities, including antiretroviral drugs (ARVs), and will try to mainstream HIV care and treatment in the overall health care delivery system. Last, but not least, the new NSP 2023-2028 should strengthen the involvement of the NGO

and private sector in service delivery, including the involvement of the MSM community in delivering services for HIV prevention, diagnosis, linkage to care, treatment, and further support to their community members.

6.2. NSP VISION FOR 2028

The strategic plan outlines a national vision aligned with the global vision.

The NSP 2023-2028 is driven by a long-term vision for the country with respect to the HIV epidemic. It has adapted the Three Zeros advocated by UNAIDS to suit the local context. The Lebanese vision is:

- Zero new HIV infections
- Zero new infections due to vertical transmission
- Zero preventable deaths associated with HIV
- Zero discrimination associated with HIV, where people living with HIV are able to live long and healthy lives

6.3. NSP goals for 2028

The goals are set taking into consideration to “End the AIDS” epidemic as a public health threat by 2030 within the context of ensuring healthy lives and promoting well-being for all at all ages. Consequently, in line with this five-year vision, the NSP 2023-2028 has the following broad goals in:

Prevention

- Achieve reduction in new HIV infections, including among key populations.
- Maintain zero new mother to child transmission of HIV.

HIV-related deaths

- Reduce national HIV-related deaths.

- Reduce TB deaths among people living with HIV.
- Reduce Hepatitis B and C deaths among people co-infected with HIV.

Testing and Treatment

- Ensure that people living with HIV know their virus status.
- Ensure that people diagnosed with HIV are receiving ART.
- Ensure that people diagnosed with HIV on treatment achieve viral load suppression.
- Ensure that people with HIV and achieving viral suppression on treatment are retained in care.

Stigma and Discrimination

- Ensure an enabling and accessible legal framework that protects and promotes human rights in order to support the implementation of the NSP.
- Have no HIV-related discriminatory laws, regulations, and policies, and no HIV-related discrimination in all settings, especially in health settings.
- Reduce self-reported stigma and discrimination related to HIV.

7. NSP STRATEGIC DIRECTIONS AND PRIORITY ACTION

This NSP draws on 3 organizing frameworks: universal health coverage; the continuum of HIV services; and the public health approach. Consequently, it was decided to have eight strategic directions (SD's) that would cover the whole spectrum of the projected Lebanese national NSP for 2023-2028. Each SD has a series of objectives to aim for, in addition to a list of actions or activities that need to be implemented targeting measurable outcomes and interventions that are evidence based with high impact.

Strategic Direction 1: Strengthening data collection, analysis, & use of HIV/STIs

Strategic Direction 2: HIV prevention packages among key populations in the healthcare sector and general population

Strategic Direction 3: Supportive social, legal, and policy environment

Strategic Direction 4: Strengthening technical, organizational, and institutional capacity of governmental institutions

Strategic Direction 5: Care and Support for People with HIV

Strategic Direction 6: Elimination of MTC Transmission

Strategic Direction 7: Strengthening access to key HIV services for migrant workers

Strategic Direction 8: Monitor and Evaluate

7.1 Priority ACTIONS UNDER DIFFERENT SDs

7.1.1 OBJECTIVES FOR STRATEGIC DIRECTION 1: STRENGTHENING DATA COLLECTION, ANALYSIS, & USE OF HIV/STI

7.1.1.1: OBJECTIVE 1: IDENTIFY THE POPULATION

- Activity 1: Perform IBBS.
- Activity 2: Use epidemiological data available from NGOs (NAP) through collaboration with local NGOs to unify questionnaires and data relating to risk factors and reach more key populations (people with disabilities, refugees, drug users, and sex workers) in awareness campaigns and activities/programs that carry a destigmatizing tone. In addition, revise the indicators to be aligned with the global reporting requests.
- Activity 3: Identify and optimize opportunities to use differentiated service delivery models for HIV, viral hepatitis, and sexually transmitted infection services, guided by strategic information to understand the diverse needs and preferences of beneficiary populations in various settings, as a means to expand access to comprehensive people-centered services.

7.1.1.2.: OBJECTIVE 2: OPTIMIZE HIV TESTING

- Activity 1: Scale up testing among NGOs (testing campaigns, outreach testing).
- Activity 2: Acquire more kits and make available the needed quantity of HIV self-tests (RDTs).
- Activity 3: Expand people-centred HIV, hepatitis, and STI testing through decentralized and differentiated service delivery and a combination of

testing approaches, including through clinical settings, community-based approaches, or self-testing with timely linkage to treatment and care.

- Activity 4: Integrate testing and treatment for HIV, hepatitis B, hepatitis C, and sexually transmitted infections as part of comprehensive sexual and reproductive health services. Where appropriate, integrate with other communicable and non-communicable diseases and establish the necessary linkage to care.
- Activity 5: Seek additional funding to partner with more NGOs and increase availability of human and material resources.
- Activity 6: Disseminate and revise SOPs for diagnosis of HIV/other STI cases.

7.1.1.3. OBJECTIVE 3: ENHANCE REPORTING (ACTIVE AND PASSIVE REPORTING)

- Activity 1: Passive and Active Reporting

Active Reporting:

- Active reporting from blood banks and big labs
- Computerize and establish a more extensive platform for data collection for all certified laboratories in Lebanon (in a means to decentralize data collection) + establishing proper follow up with positive patients (keeping in mind privacy and confidentiality) through networking to link to NAP.

Passive Reporting:

- Establish connections with IC to acquire HIV/VDRL Syphilis form.
- Activity 2: Identify Sentinel Sites (Large Hospitals) based on specifications/location/identifying location of targeted populations.
- Activity 3: Retrieve epidemiological reports from Concerned Parties.
- Activity 4: Implement and Facilitate Research Activities.

- Activity 5: Identify selected pharmacies through the order to get data on ART, PEP and PrEP that is purchased (always preserving the confidentiality of the person who is purchasing).

7.1.1.4: OBJECTIVE 4: RESEARCH AND INFORMATION

- Activity 1: Contribute to the global research agenda that addresses earlier diagnosis and more effective and equitable prevention and treatment through sharing data and participating in local and international clinical trials, market research, and another relevant research.
- Activity 2: Generate information and evidence, as well as expand the global, regional, and local knowledge base through publishing data, best practices, and implementation results.

7.1.1.5 DETECTION OF MPOX IN LEBANON

- Activity 1: Develop information, awareness, and education campaigns to inform key populations about features and epidemiology of Monkey Pox.
- Activity 2: Train physicians and technicians to diagnose MPox.
- Activity 3: Provide technical and financial support to the national reference laboratory with essential human resources, laboratory reagents, and testing kits (targeted and commercial) for the Mpox response.
- Activity 4: Develop epidemiological reporting methods.

7.1.2. OBJECTIVES FOR STRATEGIC DIRECTION 2: HIV PREVENTION PACKAGES AMONG KEY POPULATIONS IN THE HEALTHCARE SECTOR AND GENERAL POPULATION

7.1.2.1: OBJECTIVE 1: INCREASE AWARENESS ON HIV/STIS PREVENTION IN THE HEALTH SECTOR

- Activity 1: Organize awareness campaigns/lectures.
- Activity 2: Strengthen injection safety, blood safety, and infection control to prevent disease transmission in formal and informal health care settings and other service settings.
- Activity 3: Reemphasize the SOPs for international standard precautions for bloodborne infections.
- Activity 4: Distribute/ Use already-made advocacy materials or produce new ones as needed.

7.1.2.2: OBJECTIVE 2: IMPROVE APPROACH OF HCW TOWARDS KEY POPULATION

- Activity 1: Organize seminars/lectures to train HCWs, including mental health professionals and social workers, on communication skills with key population.
- Activity 2: Develop a social media tool for maintaining information for HCWs.
- Activity 3: Organize a seminar/social media campaign for Chemsex.

7.1.2.3: OBJECTIVE 3: IMPLEMENTATION OF PEP/PREP GUIDELINES

Sub-Objective 1: Develop/Update guidelines and protocols

- Activity 1: Recruit consultant for guidelines preparation/updates.

- Activity 2: Organize a workshop with stakeholders to disseminate protocols with physicians and NGO.
- Activity 3: Print and disseminate.

Sub-Objective 2: PEP/PREP distribution

- Activity 1: Make available PEP stock at NAP.
- Activity 2: Reassess already existing PEP centers and assign new ones.
- Activity 3: Training of identified sites for PEP.
- Activity 4: Distribute ARVs dedicated for PREP to specific targeted NGOs.
- Activity 5: Distribute ARVs dedicated for PEP to specific targeted hospitals/healthcare centers for occupational exposures.
- Activity 6: For non-occupational exposure in key populations, PEP may be offered and followed by implementation of Prep.
- Activity 7: Develop software to track distribution of PEP/PREP.
- Activity 8: Monitor and evaluate efficacy and appropriate use of PEP/PREP.
- Activity 9: Train the medical personnel (physicians, etc.) to raise awareness on the availability of PEP and PrEP in addition to reducing risky behaviours.
- Activity 10: Empower NGOs to implement PEP and PrEP with medical guidance and secure an emergency stock for drugs to them (PEP) at NAP.
- PrEP and PEP guidelines are in Appendix -----

7.1.2.4: OBJECTIVE 4: INCREASE AWARENESS AMONG THE GENERAL POPULATION

- Activity 1: Organize awareness campaigns with partner NGOs.
- Activity 2: Develop a social media platform for NAP.
- Activity 3: Target universities/schools through seminars/lectures.
- Activity. 4: Encourage partner NGOs to update/develop their own social media platform.
- Activity 5: Distribute/ Promote condoms to the general population.

7.1.2.5: OBJECTIVE 5: PREVENTION AMONG KEY POPULATION (MSM, DU, PRISONERS, REFUGEES, SW, OTHERS)

Sub-objective: Increase awareness among key populations

- Activity 1: Organize new platforms for dissemination of information.
- Activity 2: Organize seminars/workshops via social media.
- Activity 3: Conduct awareness sessions for the prisoners in the prison.
- Activity 4: Complete outreach initiatives.
- Activity 5: Conduct awareness sessions for ISF. And other police officers' general security as well and municipalities.
- Activity 6: Promote Hepatitis B&C testing (PCR and Fibro scan) and antibiotic resistance easting.
- Activity 7: Scale up delivery of primary prevention interventions tailored to the needs of affected populations in various contexts to reduce the number of people newly infected in accordance with global targets.

7.1.2.6: OBJECTIVE 6: CONDOM DISTRIBUTION AND VOLUNTARY MEDICAL MALE CIRCUMCISION

- Activity 1: Make available an adequate stock of condoms.
- Activity 2: Distribute condoms to NGOs and PHCs.
- Activity 3: Encourage and develop programs for voluntary medical male circumcision, and raise awareness about it

7.1.2.7: OBJECTIVE 7: PROMOTE HARM REDUCTION PROGRAM

- Activity 1: Train/Refresh thematic NGOs and physicians on harm reduction methods.
- Activity 2: Promote OAT on harm reduction tools.
- Activity 3: Make available OAT medications.
- Activity 4: Train/Refresh physicians/NGOs on OST guidelines and harm reduction strategies.
- Activity 5: Promote/Reinforce Needle Syringe Programs.
- Activity 6: Ensure availability of needles for the needle exchange program.
- Activity 7: Partner with the mental health program at MOPH to coordinate harm reduction strategies and activities.
- Activity 8: Coordinate activities of harm reduction with law enforcing agencies.
- Activity 9: Organize awareness meetings about Chemsex prevention for key populations.
- Activity 10: Implement a comprehensive package of harm reduction services for people who inject drugs where appropriate, along with targeted information, communication, testing, diagnosis, and management of HIV, hepatitis B and C virus, sexually transmitted infections.

7.1.2.8: OBJECTIVE 8: PREVENTION AND MANAGEMENT OF STIS

- Activity 1: Adapt guidelines for diagnosis and treatment of STIs based on WHO new recommendations (etiological versus syndromic).
- Activity 2: Disseminate and train on the guidelines for diagnosis and treatment of STIs.
- Activity 3: Integrate effective and comprehensive case management for people with sexually transmitted infections within primary health care.
- Activity 4: Ensure availability of diagnostic tools for STIs.
- Activity 5: Mobilize resources to strengthen diagnosis and treatment.

7.1.2.9: OBJECTIVE 9: PREVENTION OF HIV-TB TRANSMISSION

- Activity 1: Integrate and test for HIV in person with TB.
- Activity 2: Adapt Guidelines for management of TB in PLHIV.
- Activity 3: Mobilize resources for testing for TB resistance and acquisition of new anti-TB drugs compatible with ARVs.

7.1.3. OBJECTIVES FOR STRATEGIC DIRECTION 3: SUPPORTIVE SOCIAL, LEGAL, AND POLICY ENVIRONMENT

7.1.3.1: OBJECTIVE 1: ENSURE SOCIAL SUPPORT

- Activity 1: Enhance Education through developing supportive curricula in schools/ universities through comprehensive information and education in and out of schools in curricular and extracurricular activities. Additionally, integrate within university curricula from within the SRH approach.
- Activity 2: Provide the necessary HIV, hepatitis, and STI prevention, diagnosis, and management interventions for the victims of gender-based violence, including sexual violence.
- Activity 3: Develop and implement training sessions in PHCs.

- Activity 4: Prepare/distribute educational material pamphlets to PHCs.
- Activity 5: Organize meetings with religious leaders and media
- Activity 6; Establish collaboration between the public, private and academic sectors to expand coverage, enhance accountability, and concert efforts in service delivery and research.
- Activity 7: Efforts to decrease stigma and discrimination among key populations and most vulnerable groups through raising awareness and education.
- Activity 8: Support community engagement and leadership through engagement of communities in tailored specific interventions.
- Activity 9: Partner with media to ensure awareness and support on the subject matter through public awareness campaigns, development of IEC materials while addressing cultural issues, and tapping in on social media.

7.1.3.2: OBJECTIVE 2: ENSURE LEGAL AND POLICY SUPPORT

- Activity 1: Work with decision makers to modify discriminatory and primitive laws against key populations.
- Activity 2: Discuss the possibility of revising and reactivating laws that govern sex work in Lebanon.
- Activity 3: Organize meetings with syndicates of private employers'/decision makers to preserve the rights of people with HIV/STIs.
- Activity 4: Prevention of sexual and gender-based violence.
- Activity 5: Advocacy to ensure government commitments related to SRHR i.e. national commitments.
- Activity 6: Provide technical support for resource mobilization.

7.1.3.3: OBJECTIVE 3: STIGMA AND DISCRIMINATION

- Activity 1: Develop and implement human rights-based and gender-sensitive strategies for voluntary partner notification and other services for sexual and injecting partners of people diagnosed with HIV, hepatitis B, hepatitis C, and sexually transmitted infections.
- Activity 2: Eliminate stigma and discrimination in health care settings and strengthen accountability for discrimination-free health care.
- Activity 3: Provide the necessary HIV, hepatitis, and STI prevention, diagnosis and management interventions for the victims of gender-based violence, including sexual violence.

7.1.4 OBJECTIVES FOR STRATEGIC DIRECTION 4: STRENGTHENING TECHNICAL, ORGANIZATIONAL, AND INSTITUTIONAL CAPACITY OF GOVERNMENTAL INSTITUTIONS

7.1.4.1: OBJECTIVE 1: STRENGTHEN TECHNICAL CAPACITY BUILDING

- Activity 1: Training of trainers of NGO staff on HIV awareness, testing services and stigma and discrimination.
- Activity 2: Training governmental focal points on HIV/STIs awareness and testing in PHC testing (focal points).
- Activity 3: Training for testing and awareness in prisons.
- Activity 4: Expand person-centered monitoring to support people-centered services by ensuring data availability across the continuum of prevention, diagnosis, treatment, and care. This type of monitoring also requires

increasing the granularity of data and appropriate disaggregation, including information from community-led monitoring.

- Activity 5: Train and develop technical skills and capacity of care providers to ensure continuance of care for vulnerable/key population.

7.1.4.2: OBJECTIVE 2: STRENGTHEN ORGANIZATIONAL AND INSTITUTIONAL CAPACITY

- Activity 1: Recruit additional staff (epidemiology, IEC officer) for optimal program operations.
- Activity 2: Ensure technical support for IT management.
- Activity 3: Ensure technical assistance to update the electronic platform for ARV.
- Activity 4: Update the electronic information platform for reporting of treatment.
- Activity 5: Align information systems related to specific diseases or infections with broader health information systems and integrated disease surveillance; and support the transition to digital information systems with appropriate attention to data governance, security, and interoperability.
- Activity 6: Develop a contingency plan to ensure continuum of care in emergency situations.

7.1.5 OBJECTIVES FOR STRATEGIC DIRECTION 5: CARE AND SUPPORT FOR PEOPLE WITH HIV

7.1.5. 1: OBJECTIVE 1: ENSURE PROPER HANDLING OF POSITIVE CASES OF HIV

- Activity 1: Implement the specific indicated pathway for initiating treatment according to guidelines.

- Confirming positive cases
- Referral to physician
- Reporting to ministry/NAP
- Rapidly initiate HIV treatment with WHO recommended treatment regimens for all people living with HIV through differentiated service delivery models that provide people-centered care, monitoring, and support for adherence, retention, and re-engagement in care
- Dispensing of medication.
- Monitor and evaluate ART treatment in relation to suppression and resistance (through checking the viral load until undetectable at 3 to 6 months).

7.1.5. 2: OBJECTIVE 2: UPDATE GUIDELINES AND PROTOCOLS FOR MANAGEMENT OF HIV CASES

- Activity 1: Accelerate adoption of innovations, including new diagnostics, treatments, regimens, and new prevention approaches.
- Activity 2: Recruit consultant for the development, update, and dissemination of ART guidelines.
- Activity 3: Print and disseminate the updated guidelines.
- Activity 4: Integrate chronic care of HIV within primary health care clinics.
- Activity 5: Multi-month dispensing of ARVs and other HIV commodities such as condoms.
- Activity 6: Monitor and evaluate the proper implementation of the guidelines.

7.1.5.3: OBJECTIVE 3: IMPLEMENT INNOVATIONS IN PREVENTION, DIAGNOSIS, AND TREATMENT OF MAJOR CAUSES OF MORBIDITY/MORTALITY IN PLHIV

- Activity 1: Develop guidelines for prevention, diagnosis, and management of opportunistic infections with specific emphasis on comorbidities such as TB, hepatitis, cervical and rectal cancer screening, and hormone therapy enabling better integration with services.
- Activity 2: Integrate management of non-communicable diseases within the care system for HIV to avoid multiple visits to health care and to different sites. This will improve retention of people across the treatment cascade, including retention in care.
- Activity 3: Develop guidelines for management of the aging population of persons living with HIV as well as management and prevention of frailty.
- Activity 4: Develop a vaccination program for PLWH including influenza, COVID, hepatitis A and B, pneumococcal, and papilloma virus as well as an update on adult vaccination. Eventually consider zoster vaccination for the elderly.
- Activity 5: Develop and implement isoniazid preventive therapy guidelines.
- Activity 6: Develop virtual platforms (mobile phones and internet based) to improve outreach beyond health care settings and avoid stigma.
- Activity 7: Train and disseminate the updated guidelines.
- Activity 8: Monitor and evaluate the proper implementation of these guidelines.

7.1.5.4: OBJECTIVE 4: DEVELOP AND REINFORCE PROTOCOLS FOR PSYCHOLOGICAL SUPPORT

- Activity 1: Make linkage with the mental health program with MOPH.
- Activity 2: Recruit consultant to develop guidelines for psychological support in line with WHO guidelines.
- Activity 3: Develop innovative approaches to linking patients to mental health service providers at local NGOs.
- Activity 4: Organize workshops with stakeholders to disseminate/train protocols for psychological support.
- Activity 5: Monitor and evaluate that protocol is being followed.

7.1.5.5: OBJECTIVE 5: ENSURE APPROPRIATE ART STOCK AND UPGRADE STOCK FOR TREATMENT

- Activity 1: Make necessary calculations for inventory, including consumption needs and forecasts.
- Activity 2: Make necessary linkage with donors and/or MOPH for purchasing ART.
- Activity 3: Organize meetings with medical scientific officers of different pharmaceuticals.
- Activity 4: Monitor and evaluate ART treatment in relation to suppression and resistance.

7.1.5.6: OBJECTIVE 6: INTRODUCE FREE CD4 TESTING AND MAINTAIN PCR TESTING

- Activity 1: Purchase a new CD4 testing instrument.
- Activity 2: Training of personnel.
- Activity 3: Ensure sustainability of viral load testing through the acquisition of new machines, instruments, and kits.

- Activity 4: Reinforce screening, diagnostic workup, treatment and/or prophylaxis to address major causes of morbidity and mortality among people with advanced HIV disease.

7.1.5.7: OBJECTIVE 7: MANAGEMENT OF MPOX IN LEBANON

- Activity 1: Develop guidelines for treatment and vaccination for MPox.
- Activity 2: Ensure linkage of positive cases to retain in treatment.
- Activity 3: Organize vaccination campaigns for high-risk populations.

7.1.6. OBJECTIVES FOR STRATEGIC DIRECTION 6: ELIMINATION OF MTC TRANSMISSION

7.1.6.1: OBJECTIVE 1: DEVELOP AND UPDATE GUIDELINES FOR PMTCT

- Activity 1: Recruit consultant to update protocol.
- Activity 2: Train and disseminate the guidelines with concerned physicians (OBGYN, Family Medicine, GP and midwives).
- Activity 3: Develop an M+E system for follow up with physicians.
- Activity 4: Organize training workshops for PHC staff on raising awareness for PMTCT and implementing PMTCT.
- Activity 5: Organize awareness campaigns among pregnant women in Antenatal centers/services on the importance of MTC.
- Activity 6: Encourage provider-initiated counselling and testing.
- Activity 7: Validate MTC elimination when documented.
- Activity 8: Reinforce HIV testing and other STIs in ANC in the 1st prenatal visit and second test at the early 3rd trimester visit.

7.1.6.2: OBJECTIVE 2: PREVENTION OF HIV TRANSMISSION IN DISCORDANT COUPLES

- Activity 1: Organize an awareness workshop with OBGYN and other concerned physicians on the importance of HIV testing and using PREP on discordant couples.
- Activity 2: Counsel pregnant women in discordant couples on PREP indication and usage.
- Activity 3: Advance the triple elimination of vertical (mother-to-child) transmission of HIV, syphilis, and hepatitis B virus by delivering comprehensive and accessible prevention, testing, treatment, and follow-up services for women, children, and their families and focus on universal hepatitis B birth-dose and completion of a 3-dose infant vaccination program.

7.1.7. OBJECTIVES FOR STRATEGIC DIRECTION 7: STRENGTHENING ACCESS TO KEY HIV SERVICES FOR MIGRANT WORKERS

7.1.7.1: OBJECTIVE 1: MAKE LINKAGE WITH CONCERNED UN AGENCIES AND INTERNATIONAL NGOS TO STRENGTHEN ACCESS TO KEY HIV SERVICES WITH MIGRANT WORKERS

- Activity 1: Organize meetings with the concerned stakeholders (UNHCR, IOM, UNRWA) to develop a plan/roadmap for raising awareness among refugees and migrants.
- Activity 2: Develop awareness/prevention campaigns and workshops with partners and refugee representatives targeting refugees and migrants and hosting communities.

7.1.7.2: OBJECTIVE 2: SUPPORT SERVICES OF LOCAL NGOS WORKING WITH MIGRANTS AND REFUGEES

- Activity 1: Develop IEC materials for awareness about HIV to be distributed to local NGOs.
- Activity 2: Train NGO staff on specific HIV awareness among migrants and refugees.
- Activity 3: Provide testing material and other PPEs to migrants and refugees.
- Activity 4: Establish a referral pathway for refugees for testing and treatment of HIV cases.
- Activity 5: Develop care support and treatment with partners targeting refugees, IDPs, and migrants and host communities at an optimal level.
*Care support and treatment, including mental health support for adherence as a key component of MHPSS (Mental Health and Psychosocial Support) for most vulnerable populations.
- Activity 6: Provider-initiated testing and counselling.

7.1.8. OBJECTIVES FOR STRATEGIC DIRECTION 8: MONITOR AND EVALUATE

Monitoring and evaluation (M&E) is a key, integrated element of the National Strategic Plan (NSP) at all levels: impact, outcomes, outputs, and activities (inputs/process). For each level, annual targets will be set in accordance with international M&E standards and local priorities.

7.1.8.1 DEVELOPING A NATIONAL SURVEILLANCE AND M&E SYSTEM

An important component of the NSP is the strengthening of the National Surveillance and M&E System, based on an overall national surveillance and M&E framework and plan that will provide a detailed description of:

- 1) the types and frequency of M&E, surveillance and research data to be collected.
- 2) the data-reporting and sharing mechanisms and flows.
- 3) the specific responsibilities of key partner institutions for data collection, collation, analysis, dissemination, and use for policy and programming.

7.1.8.2 M&E AS A CROSS-CUTTING PRIORITY OF ALL SERVICE DELIVERY, PROGRAM IMPLEMENTATION AND CAPACITY-BUILDING ACTIVITIES

In addition to this national system, monitoring and evaluation (M&E) is an integral part of all service-delivery and capacity-building strategies of the NSP> The Work Plan includes several specific strategies for the development and implementation of M&E systems and tools to effectively monitor and evaluate HIV-prevention programs, treatment, and care services, as well as the impact of capacity building strategies.

7.1.8.3 HARMONIZATION OF M&E APPROACHES WITH INTERNATIONAL REPORTING REQUIREMENTS

To facilitate comparison of Lebanon's M&E data with other countries, and to allow adequate reporting on Lebanon's progress towards the commitments made in the context of the 2011 UN Political Declaration on HIV/AIDS, the NSP indicators for monitoring HIV trends, key behaviors and utilization of key services (impact and outcomes) are based on the latest international guidelines.

7.1.8.4 DATA COLLECTION AND REPORTING RESPONSIBILITIES

Monitoring and evaluation of the NSP is a shared responsibility of all stakeholders involved in the national response to HIV/AIDS. The final responsibility for monitoring and evaluating the implementation of the NSP 2023-2028 lies with the National AIDS Program (NAP). Data should flow from

the different sectors. Coordination and management of data from different stakeholders – service providers, researchers and donors should go into the National surveillance and M&E system.

8. BROAD TARGETS

1. In **Prevention**, the NSP targets are to:
 - Achieve a 90% reduction in incidence of HIV in the general population, key populations and refugees.
 - Achieve zero infections among infants.
 - Maintain zero incidence of HIV transmission via blood transfusion.
2. In **testing, counseling, and treatment**, the NSP targets are to:
 - Ensure that 90% of people living with HIV are tested and know their status.
 - Ensure that 90% of persons diagnosed with HIV receive ART.
 - Ensure that 90% of persons diagnosed with HIV and on ART achieve viral load suppression.
 - Do cost studies for all HIV services and programs.
3. Concerning **HIV-related deaths**, the NSP targets are to:
 - Reduce national HIV-related death by 90%.
 - Reduce TB deaths among persons living with HIV by 90%.
 - Reduce mortality in persons co-infected with HIV and hepatitis B or C by 90%.
4. Concerning **discrimination and stigma**, the NSP targets are to:
 - Ensure an accessible legal framework that protects and promotes human rights to support the implementation of the new NSP.
 - Achieve zero HIV related discriminating laws, regulations, decrees, and policies.
 - Achieve zero HIV related discrimination in all settings, especially the workplace and health sector.

- Reduce self-reported stigma and discrimination related to HIV by 90%.
- Reduce self-reported stigma and discrimination related to key populations by 90%.
- Emphasize the importance of empowering PLWHIV by involving them in policy-making, advocacy, and community outreach. Support initiatives that train and employ PLWHIV as peer educators and counselors.

9. INDICATORS:

9.1 INDICATORS FOR SD1: STRENGTHENING DATA COLLECTION, ANALYSIS, & USE OF HIV/STIS

Ind 9.1.1. HIV incidence: Number of new HIV infections in the reporting period

Ind 9.1.2. HIV prevalence in men who have sex with men: Percentage of men who have sex with men who are living with HIV

Ind 9.1.3. HIV prevalence in people who inject drugs: Percentage of people who inject drugs who are living with HIV

Ind 9.1.4. HIV prevalence in female sex workers: percentage of FSW who are living with HIV

Ind 9.1.5. Mother-to-child transmission of HIV: Estimated percentage of child HIV infections from HIV positive women delivering in the past 12 months

9.2 INDICATORS FOR SD2: HIV PREVENTION AMONG KEY POPULATIONS, IN THE HEALTH SECTOR AND AMONG GENERAL POPULATION

Ind 9.2.1. Young people: knowledge about HIV prevention: Percentage of young women and men aged 15-24 who correctly identify both ways of preventing

sexual transmission of HIV and who recognize major misconceptions regarding HIV transmission

Ind 9.2.2. Men who have sex with men using condoms: Percentage of men reporting use of condom the last time they had anal sex with a male partner.

Ind 9.2.3. People who inject drugs needle exchange programs: Number of needles and syringes distributed per person who injects drugs per year

Ind 9.2.4. People on opioid substitution therapy: Number of people on opioid substitution therapy

Ind 9.2.5. Female sex worker: Percentage of FSW reporting the use of a condom the last time they had sex

Ind 9.2.6. Prisoners: Percentage of prisoners who had at least one awareness session about HIV/STI prevention in the last 12 months

9.3 INDICATORS FOR SD3: SUPPORTIVE SOCIAL, LEGAL AND POLICY ENVIRONMENTS

Ind 9.3.1. Discriminatory laws: Number of laws discriminating against persons living with HIV

9.4 INDICATORS FOR SD4: STRENGTHENING TECHNICAL, ORGANIZATIONAL, AND INSTITUTIONAL CAPACITY OF GOVERNMENTAL INSTITUTIONS AND CIVIL SOCIETY ORGANIZATIONS

Ind 9.4.1. Antiretroviral medicines stock outs: Periods of time with stock outs of at least one ARV drug

9.5 INDICATORS FOR SD5: CARE AND SUPPORT FOR PERSONS LIVING WITH HIV

Ind 9.5.1. HIV treatment: ARV therapy: Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV

Ind 9.5.2. Twelve-month retention on ARV therapy: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

Ind 9.5.3. Viral load suppression: Percentage of adults and children on ART who were virally suppressed in the reporting period

Ind 9.5.4. Co-management of tuberculosis and HIV treatment: Percentage of estimated HIV positive incident tuberculosis cases that received treatment for both TB and HIV

Ind 9.5.5. Co-management of Hepatitis and HIV treatment: Percentage of estimated HIV positive incident Hepatitis cases who received treatment for both Hepatitis and HIV

9.6 INDICATORS FOR SD 6: ELIMINATION OF MTC TRANSMISSION

Ind 9.6.1. Prevention of mother-to-child transmission: Percentage of HIV positive pregnant women receiving effective antiretroviral regimens

Ind 9.6.2. Early infant diagnosis: Percentage of infants born to HIV positive women receiving a virological test for HIV within 2 months of birth

Ind 9.6.3. Coverage of infant ARV prophylaxis: Percentage of HIV exposed infants who initiated ARV prophylaxis

9.7 INDICATORS FOR SD7: STRENGTHENING ACCESS TO KEY HIV SERVICES CASE AND SUPPORT FOR INTERNALLY DISPLACED, MIGRANTS, REFUGEES AND HOSTING COMMUNITIES

Ind 9.7.1. Access to HIV testing among refugees, migrants, and hosting communities: Percentage of refugees, displaced, and hosting communities tested for HIV and aware of their status

Ind 9.7.2. HIV treatment: ARV therapy: Percentage of refugees and migrants currently receiving antiretroviral therapy among all persons living with HIV

10. IMPLEMENTATION OF THE NATIONAL STRATEGIC PLAN 2022-2027

Institutional Framework

- 10.1. Financial resources and funding: sustainability
- 10.2. Overall coordination, supervision, and policy guidance
- 10.3. Appendices

10.1. FINANCIAL SUSTAINABILITY

- 10.1.1 Making available domestic investments as part of the governmental budget as allocated by ministries in accordance with national priorities.
- 10.1.2 Mobilization of external resources to support funding: International donor organizations esp. the Global Fund, and including various UN agencies such as UNDP, IOM, WHO, UNAIDS, UNFPA, UNICEF, UNHCR, UNODC, and ILO.
- 10.1.3 Partnering with local NGOs and civil society organizations and charities to share implementation of planned activities
- 10.1.4 Integration of the private sector, especially private health care providers, local companies and other local donors, universities, and religious institutions.
- 10.1.5 Integrated essential HIV services into the national health financing arrangements.
- 10.1.6 Ensure financial risk protection for 90% of all people living with HIV.
- 10.1.7 Secure governmental and private insurance coverage for PLHIVs and at least non-rejection and non-exclusion of a person because of serostatus.

10.2. OVERALL COORDINATION, SUPERVISION AND POLICY GUIDANCE

The National AIDS Program with its supporting structures and collaborators will oversee the implementation of the NSP 2022-2027 and provide policy guidance to all its partners. The NAP will serve as the secretariat of the implementation, taking responsibility for effective coordination and implementation in close collaboration with all its partners.

The NAP also has the mandate to provide technical assistance and seek support whenever needed:

- Practical policy guidance and technical support
- Supervision of implementation of programs and services
- Monitoring and evaluation of programs and services
- Surveillance for monitoring HIV trends and behavioral trends among key populations
- Resource mobilization and funding allocation
- Program implementation and service delivery

In accordance with the Strategic Directions outlined above, the program will ensure delivery of services.

The implementation of HIV prevention programs among key populations is a joint responsibility of governmental institutions, ministries, and civil society. This should involve the police as well, military institutions and the prison system. Nongovernmental organizations will play a major role in service delivery to key populations in the fields of peer education, outreach, HIV testing and counseling, condom distribution, STI diagnosis and treatment, basic health services and referral programs. Drug treatment centers and NGOs dealing with refugees and displaced populations will also play an important role. These might seek technical support from international organizations such as WHO, IOM, UNFPA, UNICEF, and UNODC.

Service delivery to PLHIV especially ARV treatment care and support, viral load monitoring, CD4 testing, laboratory financial support as well as mental health support, will be the main responsibility of NAP-MOPH. Other ministries will also provide support such as the Ministry of Labor, Ministry of Social Affairs, Ministry of Justice, Ministry of Youth and Sports, Ministry of Education and Higher Education.

Strengthening supportive environments will involve the Ministry of Labor, Ministry of Interior and Municipalities, Ministry of Public Health, Ministry of Information, Ministry of Social Affairs, Ministry of Youth and Sports as well as other ministries as needed to ensure the proper conducive environment for effective implementation of programs and services.

Organizational and institutional capacity building centrally and peripherally will involve NGOs, universities, as well as the Ministry of Public Health and Ministry of Education and Higher Education, with the provision of technical support from UNAIDS, WHO, IOM, UNRWA, UNDP, ILO, and other agencies.

Managing HIV/STI prevention and care for the refugees will be the responsibility of various NGOs as well as the Ministry of Public Health and Ministry of Interior and Municipalities with technical support from UNRWA, UNHCR, and WHO.

10.3 APPENDICES

10.3.1 FIGURES

FIGURE 1. CUMULATIVE NUMBER OF CASES OF HIV FROM 2017 TO 2022

Cumulative cases	New infection per year	Year
2206	205	2017
2366	160	2018
2570	204	2019
2718	148	2020
2885	167	2021
2600	232	2022

FIGURE 2. HIV INFECTION ACCORDING TO SEXUAL BEHAVIOR 2016-2022

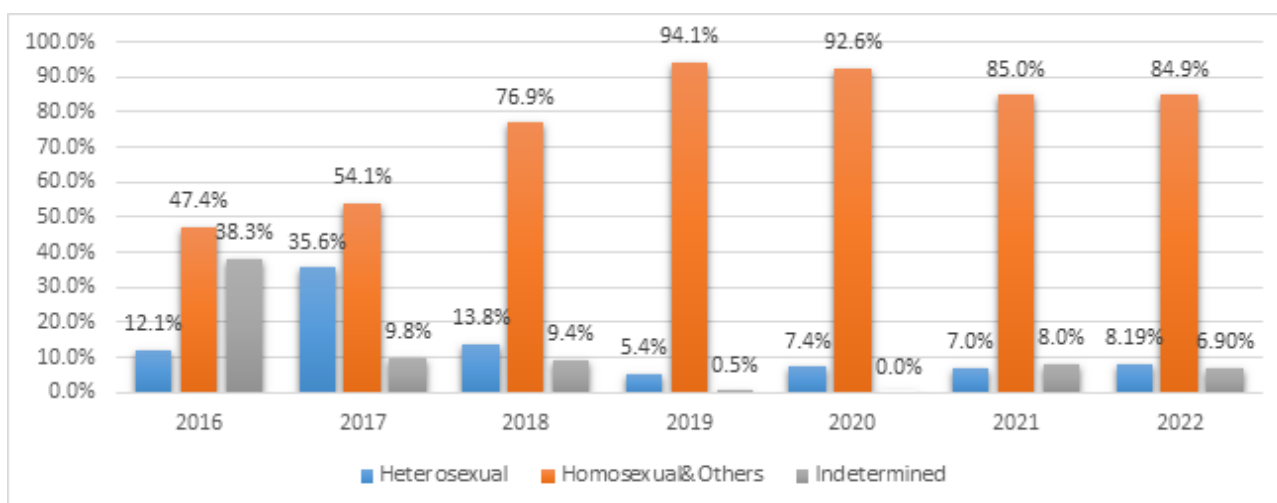


FIGURE 3: HIV INFECTION ACCORDING TO AGE GROUPS 2016-2022

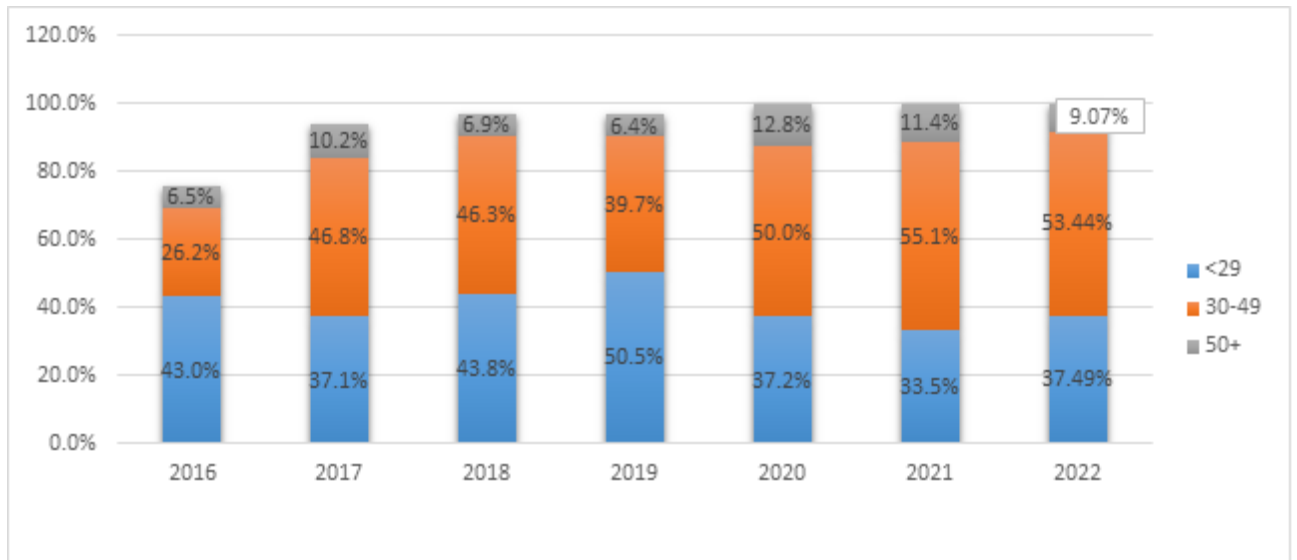
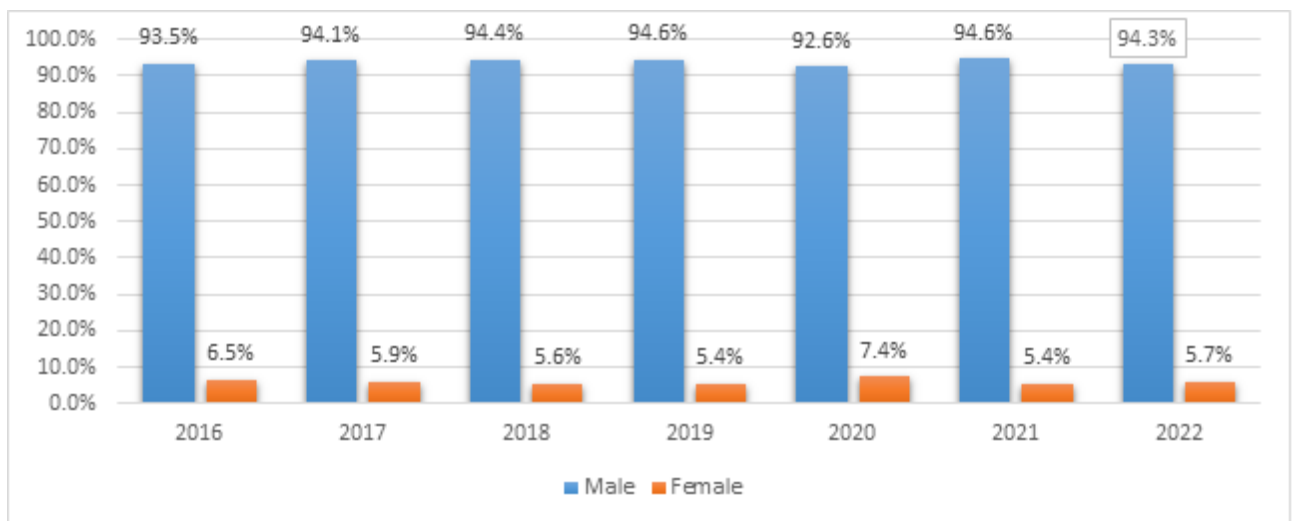


FIGURE 4. HIV INFECTION ACCORDING TO THE GENDER FROM 2016 TO 2022



10.3.2. TABLES

TABLE 1: DIAGNOSIS OF HIV CASES OVER 7 YEARS

	2016	2017	2018	2019	2020	2021	2022
Male	100	193	151	193	137	158	219
Female	8	12	9	11	11	9	13
Totals	108	205	160	204	148	167	232

TABLE 2: IDU'S TESTED IN 2022

	All	Males	Females	Trans
Percentage (%) Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results	100	100	100	
Numerator: Number of people who inject drugs respondents who have been tested for HIV during the last 12 months and who know their results	2396	1930	405	61
Denominator: Number of people who inject drugs included in the sample	2396	1930	405	61

TABLE 3: ALL PATIENTS ON ART IN 2022

	(Children, ages 0–14)	(Adults, ages 15+)	(Women, ages 15+)	(Men, ages 15+)
Number of people living with HIV who know their status	4	2,273	207	2,067
Total number of people who are receiving ART	4	2,105	181	1,924
Number of people living with HIV with suppressed viral load on ART	4	2,003	176	1,827
PEOPLE LIVING WITH HIV	24	2644	271	2349

TABLE 4: FACILITIES FOR HIV SERVICES

	Total
Total number of health facilities that offer antiretroviral therapy (ART) (i.e. prescribe and/or provide clinical follow-up)	5

TABLE 5: PRIVATE VS PUBLIC FACILITIES

	Data Values
Public	35
Private	138

TABLE 6: TYPES OF FACILITIES

	Data Values
Hospital	173
Health Facility	866
ANC	314
TB service	10

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