KEY POPULATIONS IN LEBANON : REPORT ON AVAILABILITY AND ACCESSIBILITY OF HIV-RELATED SERVICES

THE ARAB FOUNDATION
FOR FREEDOMS AND EQUALITY
Written by Nour NASR, Consultant
JULY 2019

Table of Contents

Acronyms

AIDS	Acquired immune deficiency syndrome or acquired immunodeficiency syndrome
ART	Antiretroviral therapy
CD4	Cluster of differentiation 4; CD4 counts are used to assess the level of immune system functioning
CSO	Civil society organization
HIV	Human immunodeficiency virus
KP key population/ key affected populations:	
	People who inject drugs, men who have sex with men, transgender persons, sex workers, and prisoners and other incarcerated people
LGBTQI	Lesbian Gay Bisexual Transgender Queer Intersex
MENA	Middle East and North Africa
MOPH	Ministry of Public Health
MSM	Men who have sex with men
NAP	National AIDS control Program
NGO	Non-Governmental Organization
PeP	HIV Post-exposure Prophylaxis
PLHIV	People/Person living with HIV
PreP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
S.I.D.C.	Soins Infirmiers et Développement Communautaire
STI	Sexually Transmitted Infection
SW	Sex Worker(s)
Trans*	Transgender, non-binary, and gender nonconforming identities, including transmen and transwomen
UNHCR	United Nations High Commissioner for Refugees
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
VCT	Voluntary counseling and testing
WSW	Women who have sex with women

Introduction

CONTEXT

The MENA region has one of the lowest HIV rate of prevalence in the world, with estimates of 0,1% among ages 15 to 49[1]. However, the epidemiological dynamic makes it one of the most worrisome. According to the National AIDS Program (NAP), sexual transmission accounts for the totality of new cases[2]. While transmission and prevalence among MSM is well represented in current studies, data for other key populations such as sex workers and people who inject drugs remains scarce[3]. For instance, it has been found that transmission among MSM accounts for more than half of identified cases[4] while condom use of MSM is at 75%[5]. Nevertheless, most epidemiological information remains focused on the area of Greater Beirut, leaving the rest of Lebanon with significant data gaps[6]. More recently, commercial sex work and high-risk MSM behavior, attitudes, and population size estimate were explored using an Integrated Biological and Behavioral Survey (IBBS) in samples of Lebanese and non-Lebanese across the country[7]. Of the key recommendations of this study, the first was to optimize STIs and HIV knowledge and testing services among key populations, as the majority of participants did not have good knowledge about HIV/AIDS transmission. Another important finding was the sharp inconsistencies in condom use, thus clarifying the need to increase access to and use of condoms among key populations[8].

The National Aids Control Program (NAP) started providing full treatment coverage for HIV cases since 1997, through the Ministry of Public Health, including triple antiretroviral therapy. This access to treatment is ensured for Lebanese citizens, as well as Palestinian refugees registered with UNRWA and Syrian refugees registered with UNHCR. People living with HIV who will start ART (regardless of their CD4 count as per the WHO and national guidelines) need to consult their Infectious Disease physician and do the required blood tests, have a MOPH request form for ART filled by their physician and present it along with all required documents for approval at the MOPH. Upon approval, they can present their papers and obtain their medications at the National AIDS Program Dispensing Center. A recent protocol for treatment has been developed in 2016 in line with the new WHO protocol, so that treatment is initiated without reference to a specific CD4 number but given to each carrier of the virus. The NAP also conducts activities to strengthen HIV surveillance programs and raise awareness among the most vulnerable groups. One of the most important of these activities is the creation of a new workshop for the development of new services and tools, including voluntary rapid testing of the virus, as well as the establishment of personal screening and awareness raising on its use. The program encourages all health workers to put the issue of rapid screening in their centers, especially in people at high risk of HIV infection, as well as to sexual partners of HIV carriers. On the other hand, the NAP worked on the Guidelines of Opiates Substitution Therapy (OST) as part of the Harm reduction strategy, which have been agreed upon by the Ministry of Public Health. The OST services started in 2011 and the cumulative number of people under OST Treatment is 1470. In addition, the National Strategic Plan (NSP) is currently being developed with the support of the WHO and in coordination with civil society, including a five-year plan of activities from prevention, treatment, to care and support with a special focus on prevention of mother to child transmission and the most at risk population, as well as refugees and their host communities[9]. In addition, in 2019, Lebanon committed to an additional focus on psychosocial support and the quality of life of people living with HIV to be integrated within primary health care units[10].

LEGAL AND POLICY FRAMEWORK

Although the Lebanese Ministry of Public Health (MOPH) has adopted several circulars and decisions with regards to HIV/AIDS control, prevention, testing, and confidentiality, it has yet to declare policies for the protection of HIV-infected workers in the workplace[11]. The legal study by Martini and Aoun for the ILO (2013) does indicate that some decisions seems to indirectly refer to the right to non-discrimination of workers. For example, Circular 35/1 dated 1988: in Article 6 paragraph 1, the Lebanese State confirms that the AIDS prevention program protects the rights and dignity of the human and that all efforts will be made to prevent social discrimination between infected and non-infected citizens. Paragraph 2 of Article 6 provides furthermore that all efforts must be made and cooperation should occur in order to support and provide the best care for infected persons. On the other hand, the ILO (2013) study

1 UNAIDS. (2017). Country Factsheet – Lebanon 2017.

2 NAP. (2018). National AIDS Control Program in Lebanon. Ministry of Public Health: https://www.moph.gov.lb/en/Pages/2/4000/aids

3 NAP & Ministry of Public Health. (2008). "An integrated bio-behavioral surveillance study among most at risk populations in Lebanon: Female sex workers, injecting drug users, men who have sex with men, and prisoners."

4 ibid

5 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.

6 Crossroads. (2015). "Size estimation, risk behavior assessment, and disease prevalence in populations at high risk for HIV infection in Lebanon. Beirut."

7 Connecting Research to Development. (2019). "An Integrated Bio-Behavioral Surveillance Study among Two Vulnerable Groups in Lebanon: Men Who Have Sex with Men and Commercial Sex Workers."

8 Ibid

9 Ministry of Public Health: https://www.moph.gov.lb/en/Pages/2/4000/aids

10 WHO Annual report 2018: Bridging Humanitarian Support with Sustainable Development.

11 Martini, M., and Aoun, C. (2013). "Legal review, conformity assessment and priority-setting of HIV and AIDS and the World of Work in Lebanon." International Labour Organization, 2013.

highlights that the inclusion of HIV/AIDS in the list of communicable diseases in the decree of 1990 allows physicians to inform the concerned authorities about any communicable disease including the name of the infected patient. In contrast, in 1994, the Medical Professional Code of Ethics stated that the names of patients with STIs should not be disclosed unless they refuse treatment.

The ILO has adopted guidelines for HIV/AIDS Recommendation No. 200. as it pertains to the world of work. This Recommendation states that the workplace should play a role in the response to HIV and calls for the adoption of national workplace policies and programs on HIV and AIDS to facilitate access to HIV prevention, treatment, care and support services (ILO, 2013). In the Lebanese context, however, it was found that laws with a non-discrimination principle do exist, but they had unclear definitions in the text which might lead to misinterpretation and consequently wrong application. For example, employers could use the mandatory medical tests indicating "fitness to work" prior to employment to illegally request HIV tests and make employment decisions accordingly.

A WHO awareness brochure[12] reveals telling details of some of the barriers and challenges facing PLHIV in Lebanon. It highlights the right to form a family, noting that compulsory pre-marital HIV testing results in denying people living with HIV the right to marriage. It also reports that women living with HIV are discouraged from getting pregnant, persuaded to terminate their pregnancy or even denied professional care by health care providers when presenting pregnant with HIV. In addition, the resource reports on the right to freedom of movement, principally for migrant workers, noting the existence of compulsory HIV testing which results in restrictions on entrance to the country or deportation for people that are HIV positive.

Lebanon's existing legislation essentially criminalizes populations at risk such as men who have sex with men, sex work and drug users, thereby limiting any legal reform to protect key populations. Any potential legal protection may also be opposed over religious and moral grounds that consider HIV to be taboo. It is posited that legal aid services and legal education services to PLHIV may be of high necessity to ensure protections given the current laws[13]. Indeed, in Lebanon, Article 523 of the penal code criminalizes people who engage in sex work, as per the following: "Anyone who encourages one or more persons, whether male or female, who have not reached twenty-one years of age to engage in debauchery or corruption, facilitates such for them, or assists in the performance of such acts shall be punishable with imprisonment from a month to a year and a fine ranging from one to three times the minimum wage. Anyone who deals in or facilitates secret prostitution shall be subject to the same penalty"[14]. Article 534 of the Lebanese penal code that stipulates that "any sexual intercourse contrary to nature leads to a sentence of prison up to one year"[15]. In addition, drug use is criminalized in Lebanon, with punishment ranging from three months to three years in prison in the case of personal consumption, along with a fine[16].

12 World Health Organization (2010). "I live my rights. I respect other people's rights. Access for all to HIV prevention, treatment and care is a critical part of human rights."

13 El-Jardali, F., El Bawab L. K2P Policy Brief: Addressing Limitations to Equitable Access to Healthcare Services for People Living with HIV in Lebanon. Knowledge to Policy (K2P) Center, Beirut, Lebanon, December 2015.

14 Lebanese Republic Chamber of Deputies: Law On the Protection of Women and Other Family Members from Domestic Violence: https://www.justice.gov.lb/public/uploads/Law%20On%20the%20Protection%20of%20Women_EN.PDF

15 https://www.daleel-madani.org/sites/default/files/Resources/HelemStudy.pdf

16 https://en.annahar.com/article/990084-support-dont-punish-skoun-calls-for-decriminalization-of-drug-use-in-lebanon

Aims and objectives of the study

In an effort to respond to the need for more data-informed service provision, Solidarité Sida and ITPC-MENA committed themselves in partnership with 5 organizations (AGD – Mauritania; Al Shehab - Egypt; ATP+ - Tunisia; M-Coalition – Lebanon and RDR Maroc - Morocco) to implement the "FORSS program – FORmer, Suivre, Soutenir: mobilisation communautaire pour lutter contre le VIH en région MENA" (Train, Monitor, Support: Community- based mobilization to fight against HIV in the MENA Region). The main purpose of this program is to improve prevention, medical care and access to treatments against HIV/AIDS, in particular for the key populations in the region, and especially in the targeted countries. The program hinges on three main axes:

- Improve community-based actors knowledges and practices in prevention, care and treatment for PLWHIV and key populations.
- Obtain national and regional data on access to prevention, treatment and care quality for PLWHIV and key populations
- Influence prevention and care strategies and their operating methods at the national, regional and international level. One of the first steps of the project is to conduct research to provide an overview of the available HIV/AIDS-related services, focusing on testing and treatment, and centering on the needs of men who have sex with men (MSM), sex workers (SW), people who inject drugs (PWID). The following report will provide a base for a comparative analysis during the project.

The aim of this study is manifold. First, before the start of the activities, the evidence gathered will guide the establishment of a baseline that will give a state of play of what services and needs currently exist, and give context to the project implementation. On the other hand, during implementation, insights from this research will help identify the levers and the paths to follow in order to anticipate and overcome potential obstacles. Finally, at the end of the program, it will enable the monitoring of changes induced by the project.

As such, the objectives of this study will be to first give a state of play of the prevention and care services available in the targeted country with the purpose of informing programs to improve community-based actors' knowledge and practices of prevention and care for PLWHIV and key populations in Lebanon.

In doing so, it will be a basis to train community-based actors on the quality of prevention and care services in the MENA region, but also serve as an asset for advocacy strategies to improve the services offered.

Methodology

The following study is based on a triangulation of evidence from multiple sources and stakeholders involved within the HIV prevention work in Lebanon. In a first instance, the study uses data from 42 service providers registered across Lebanese territories, providing a comprehensive mapping of the different services, locations, and target populations covered. Second, individuals from key populations participated in interviews and focus groups. One focus group was conducted with 8 MSM, and two focus groups were conducted with PWID, one in Skoun center (4 persons), and one in Hariri hospital (4 persons). In addition, one focus group was held with 8 sex workers working in Lebanon, of whom 3 persons were transwomen, 2 persons were MSM, and 3 cis-women. Three face-to-face interviews were also conducted with men living with HIV. In total, 27 individuals from key populations participated in this study and provided insights about their experience accessing HIV-related services and the main challenges and support mechanisms available.

Finally, interviews with service providers and national actors served to supplement the data available from service provision centers and the key populations accessing these centers. To this end, interviews were conducted with Ms. Nadia Badran from S.I.D.C., Dr. Jacques Mokhbat, President of the Lebanese AIDS Society (LAS) network, and Dr. Mostafa El Nakib, head of the NAP.

Quantitative data analysis was used to identify trends within the national mapping of service providers, while thematic analysis was employed to gather the main themes within the interviews and focus groups conducted.

CHALLENGES AND LIMITATIONS

This analysis is not taken to be a definitive account of the challenges, concerns and services in relation to the fight against HIV in Lebanon. Rather, the results provide an overall guide of the major tensions of the community in light of discussions with a restricted sample of informants. First, we note that the informants were not sampled using rigorously random and representative techniques, as they were mostly recruited by the service provider NGOs and partners. It is highly probable that the sample represents the most engaged beneficiaries, or those with most at stake within these particular NGOs. Due to the sensitive nature of the subject of the study, we expect that self-reports and individual accounts were subject to social desirability bias. This factor may incline participants to respond in line with the perceived social expectations, such as being overconfident about one's knowledge or overestimating the uniqueness of one's challenges. To this end, employing a triangulation technique is considered a good mitigation for such bias, yet as is the case with qualitative research, it is not possible to assess the exact degree of reliability. On the other hand, the geographical focus, while originally intended for all of Lebanon, eventually came to be centered mainly in Beirut, with few discussions with respondents from outside Beirut. Thus, the findings cannot be taken to represent the whole of Lebanon. Although we did supplement the analysis with the accounts of the main community-based and national actors, they are by no means comprehensive of the national and regional policy-making climate. Finally, it is important to note that the recommendations proposed focus on these initial and key findings, yet more research would need to be carried out before a full national perspective can be presented.

Results

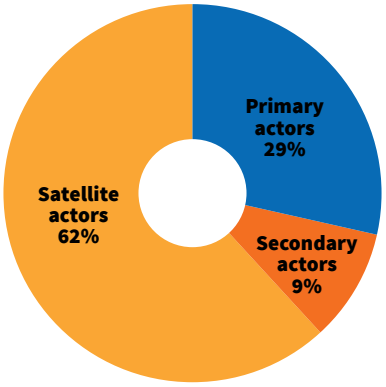
1- TESTING AND TREATMENT

TYPES OF SERVICE PROVISION

Service providers in Lebanon are divided between primary actors, secondary actors, and satellite actors. Primary actors typically provide essential services such as rapid HIV testing, referrals, and key awareness materials. Secondary actors are not typically based within specialized organizations for HIV prevention and treatment and usually provide a number of other services. Finally, satellite actors provide services sporadically across regions.

The majority of service providers are satellite providers (62%), followed by primary actors (29%). Secondary actors fare at 9% and are only present in the restricted Beirut area.

PROVIDERS IN LEBANON

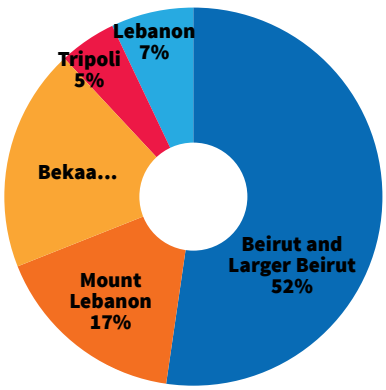


When asked about their preferred service providers, participants in this study commonly listed S.I.D.C., Marsa, Skoun, Proud Lebanon, Karantina Hospital of the Ministry of Health, and the NAP. Others listed different hospitals such as Hariri hospital and Rizk hospital, in addition to Anwar el Mahabe. Other organizations were mentioned, although not as frequently (Embrace, Helem, Tayf, M-Coalition, KAFA), and some were mentioned because they provided psychological support for Syrian refugees such as Makhzoumi, UNHCR and Restart. What is more interesting is that many participants only knew their own service provider but were not able to list some other service providers that may cater to key populations. Several said they were not aware of other providers, while the rest said that they were unable to remember their names. This is notable because one of the key recommendations outlined by participants revolved around the need for more awareness campaigns as well as more "marketing" of available services. If key populations are unable to name service providers other than their own, it will likely limit their ability to access other services that could be more adapted to their needs. Another implication is that service providers that are most commonly cited or remembered may be unduly burdened by an inordinate amount of service seekers, rather than having service seekers that are more evenly distributed across the available service providers. Such undue burden may affect the ability of these providers to keep a high level of quality of service, and would eventually mean greater wait times and a loss in key population retention.

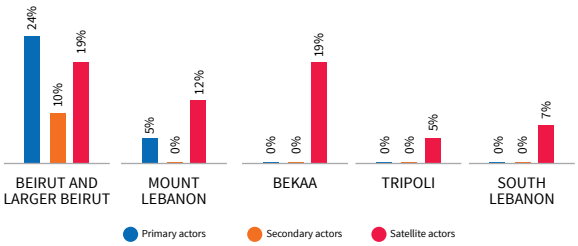
REGIONAL DISTRIBUTION OF SERVICE PROVIDERS

The largest concentration of service providers was in Beirut and Larger Beirut area (includes Sin el Fil, Dawra, Tayouneh, Badaro), making up for more than half of all service providers in Lebanon. Of these, 24% were primary actors, 10% were secondary actors and 19% were satellite actors. As such, there is a clear disproportion in the availability of services that favors Beirut and places other regions at a disadvantage. Other serviced regions are the Bekaa, with 19% of service providers that are all satellite actors. In addition, Mount Lebanon possesses 17% of service providers, with 5% as primary providers and 12% as satellite providers. What is notable, however, is that regions that are the farthest away from Beirut, namely Tripoli in North Lebanon as well as the South Lebanon region, were the least serviced of all regions. Both these regions were serviced by satellite providers, at a rate of 5% and 7% respectively.

DISTRIBUTION OF SERVICES PROVIDERS BY REGION



SERVICE PROVISION BY AREA AND TYPE



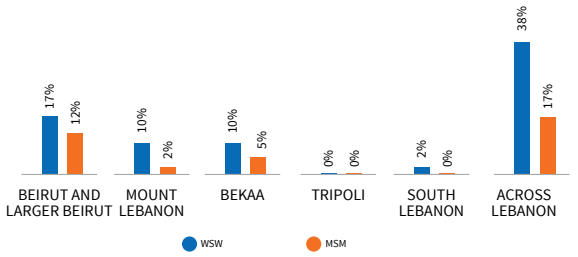
All participants were aware that most services could be accessed within Beirut but emphasized the dire need for services to be available outside Beirut as well. Within the MSM focus group, in addition to the focus group with PWID at Hariri hospital, but also one interviewee living with HIV all concurred that services outside Beirut were practically non-existent. This may have serious implications for key populations that do not dispose of the resources to commute to Beirut on a regular basis. Furthermore, and perhaps more worryingly, service providers outside Beirut were described as harboring misconceptions and a judgmental attitude that furthers the stigma associated with seeking HIV-related treatment. Taken together, these factors constitute a significant barrier to accessing the needed services.

INCLUSION

Across Lebanon, 38% of centers (16 centers) were inclusive of WSW and 17% were inclusive of MSM (7 centers). In Beirut, 17% of providers (7 centers) stated being inclusive of WSW, of which 6 centers who were primary providers. MSM were included in only 12% of centers in Beirut, all of which were primary providers.

In Mount Le banon, 2 primary and 2 satellite providers included WSW, while only 1 satellite provider included MSM.

INCLUSIVE PROVIDERS BY AERA AND TARGET POPULATION



In Bekaa, 4 satellite providers were available for WSW and only 2 for MSM. In the couth, only 1 satellite provider was available for WSW and none for MSM. In Tripoli, no service providers were inclusive of either WSW nor MSM.

As was apparent with the participants of this study, key populations have their fair share of discrimination on the basis of HIV status, substance use, or sexual orientation/gender identity. Discrimination represents a central barrier to access services and could be tackled with more efforts for awareness programs and campaigns that target service providers as well as the general public.

Dr. Jacques Mokhbat, president of the Lebanese AIDS Society (LAS) network cites discrimination as one of the main challenges in accessing key populations especially when it comes to prevention services. According to him, due to stigma and discrimination, individuals seem to rely on the internet or on each other's conversations for information. Dr. Mokhbat believes that such practices are worrying because the information shared is often either badly interpreted or incorrect. In addition, individuals may not readily speak about sex or sexuality within their surroundings or with their families. Keeping to oneself about such issues stems from the fact that many are afraid from being rejected from work, family, or housing. Dr. Mokhbat sees that this discrimination feeds the fear in some people who are afraid to seek a doctor's consultation. In his experience, many patients ask to meet him in the street or in the car parking or they wait for the end of the day when there are no more patients, for fear of being seen with him or at his clinic. In addition to increasing the quality of services provided for HIV testing, Dr. Mostafa El Nakib, head of the NAP, recommends that outreach towards a change of mentality and greater access and awareness of services should be done through peer educators. As youth rely on their peers more than on professionals, this could be an important entry point that would guide target groups in the right direction. Representing S.I.D.C., Ms. Nadia Badran states that in addition to its medical and psychosocial services for PLHIV, S.I.D.C. places high priority for its prevention efforts with the aim of sensitizing KPs through peer educators and youth groups, in addition to extensive trainings and refreshers for service providers such as nurses and social workers. Other programs focus on outreach

for MSM, sex workers and PWID using dating apps and in universities and night venues. Other trainings seek to involve the Lebanese police and provide awareness about sexual and gender minorities and how to better cater to vulnerable groups. For Ms. Badran, the ultimate goal is to address and reduce stigma and discrimination against KPs.

Discrimination was highlighted by all participants, both in focus groups and in individual interviews. For instance, participants who were living with HIV stated having been discriminated against by hospitals, by health professionals, in employment, and in their community. One doctor was said to have rejected his patient, another dentist was recounted as having worn three layers of gloves and being anxious when dealing with a PLHIV, one hospital was mentioned as having threatened the PLHIV to report him to the police, while other service providers had a judgmental attitude. Gaining employment opportunities was also difficult, as some employers required and HIV test while others practiced plain discrimination by discharging the employee who disclosed his HIV status. Another interviewee stated having lost two jobs because of his HIV status.

Other cases of discrimination are as follows. In both focus groups with PWID, it was mentioned that some participants had been arrested, in addition to being physically assaulted. On the other hand, several participants were denied treatment because they were either Syrian or Palestinian, and were therefore deemed not eligible for the relevant services. One of the participants who was living with HIV and engaged in sex work was jailed and forcibly disclosed, and a reputation spread about him in the gay community. He was stigmatized and subjected to discrimination, stating that he was verbally abused by people he had never met, and that some people told his clients about his status. As a result, he lost a lot of friends, then he started losing his clients, which forced him to reduce his prices and hide his face from dating applications.

NOTABLE CHALLENGES

Financial constraints

One of the main challenges that the key stakeholders concur on is financial. According to Dr. El Nakib, the NAP is confined to budgetary restrictions and overstretched service provision. This is in part due to the growing epidemic among the MSM population, but also related to the fact that the Lebanese NAP has been supporting treatment provisions in neighboring countries such as Egypt, Syria, Jordan and Morocco for the past two years. This has imposed a burden on a national actor that has been supporting organizations internally, both financially and technically. Dr. Mokhbat expressed that the NAP is struggling with funding cuts that threaten the continuity of treatment distribution. The political situation renders the NAP susceptible to budgetary freezing with each change of minister. In addition, the Ministry of Health is unable to cover the healthcare costs of Lebanese citizens, instead providing drug treatments for free but not consultations, follow-up and general support.

Ms. Badran expressed concern over the sustainability of S.I.D.C.'s services, noting that significant support is required in multiple areas such as trainings and campaigns. At the same time, Ms. Badran explains, global funding for HIV prevention and services has been reduced and redirected towards other services. To this end, she asserts that in order not to refuse services to any beneficiary, the organization has been obliged to redirect funding from other programs to support HIV-related services and ensure continuity. In addition, she notes that a large portion of funding is going in the direction of more thematic organizations, which may not always cater to the KP who are most in need of services.

Legal constraints

On the other hand, Dr. Mokhbat believes the legal landscape in general to be unsupportive as the rights to privacy and no discrimination are often overlooked. He recounts that anyone can be dismissed from their work based on their HIV status, while other cases may go viral in the press, forcing the person to come out as gay and as HIV positive. In Dr. Mokhbat's words, doctors should respect the confidentiality of a person and never allow disclosure without the consent of the patient. In addition, institutions should not be allowed to ask for an HIV test

before giving someone a job, and insurance companies should be required to cover PLHIV, even if at an increased cost that is normally applicable to chronic diseases. In addition, legal work should aim to protect the rights of PLHIV by removing the HIV test requirement from visa procedures and protecting non-Lebanese PLHIV residing in Lebanon from deportation. As per Ms. Badran's statement, S.I.D.C. provides legal assistance in case of job loss or if a Trans* individual needs help in adjusting their paperwork. At the level of advocacy, sensitizing campaigns have been devised for the general public to encourage regular testing behavior. In 2016, a Lebanese coalition was formed until the Speak Up – Know Your Rights project, lead by S.I.D.C with 13 non governmental HIV organizations. The coalition conducted a legal review of laws which would affect HIV positive individuals in Lebanon, and discussed the possibility of a protection bill to be put together. The following year, Speak Up investigated the work policies and mandatory HIV testing still widely practiced among corporations in Lebanon and a social media campaign was promoted on national television to raise awareness. Speak Up also documented the violations related to work, health, family and social circles in regards to HIV. Unfortunately, the end of funding halted this documentation.

Cost to beneficiaries

Both focus groups with PWID were highly vocal about the unbearable costs of treatment. In one group, participants referred to the medical profession as "treatment mafias" that went unregulated by the government. The discussion went further, stating that "access to medicines should be easier, because right now access to the substance is easier than access to the medicines". In the other focus group with PWID, participants expressed that the Ministry of Health should have better policies as they felt like they were themselves used as commercial products, exploited by the providers who should not be solely focused on making a profit. This focus group referred to providers in the following words: "they are no different from drug dealers, we each should pay them a lot or we won't get what we need; but instead, it's legal." One of the participants who was a sex worker spoke about when he failed to access PreP through the Ministry of Health and bought it from his own money, stating it cost more than an entire month's income. He considered it insanely expensive and inaccessible. Other participants in the focus group found it hard to get PreP or PeP in Lebanon and when available, it was prohibitively expensive.

All participants, whether in focus group discussions or in individual interviews stressed the importance of providing treatments that are more accessible in terms of costs, either by being available for free or by being subsidized or reduced in price. The costs of healthcare are a major barrier to access health-related services, for MSM, SW, and PWID alike.

Mental health

A strong support system was what most participants in this study relied on for resilience and hope. Support systems consisted of family and friends that were present in participants' lives and that had helped them build perseverance and see the challenge in a positive light. It is also important to highlight that one recurrent recommendation that was apparent throughout focus groups and interviews is the need for services in the form of counseling, mental health interventions, and support groups. If one considers the psychological burden of living with stigma, discrimination, and high health costs, it becomes an utmost priority, then, to provide adequate mental health care to mitigate the effects of such stressors. The mental health component goes beyond support to day to day living conditions. Most PLHIV and especially those affected by stigma deal with constant anxiety of being outed as HIV positive, or losing family, friend, work or social status. The fear and stress affects individuals, as many report being depressed, and some studies even report thoughts of self-harm. This adds a new stress layer to individuals in addition to their identification within key populations. MSM, IDU and SW are all criminalized behaviors in Lebanon, making daily life, social functioning, and survival also a burden to anyone's mental wellbeing.

2- KEY POPULATIONS

MSM

According to Dr. Mokhbat, the main KP is MSM, representing about 80% of new infections, and around 60% of all current infections in Lebanon. As such, this is the group that is mostly targeted by interventions. Dr. El Nakib concurs, stating that HIV prevalence among MSM communities in Beirut is at 12%. According to Dr. El Nakib,

the national prevalence of HIV infections has been on the increase, as it was 14% 4 years ago and is likely as high as 18% or 20% at the time being. Ms. Badran states that the majority of beneficiaries at S.I.D.C. are relatively young, between 18 and 35 years old, 70% of whom are MSM, and others being heterosexual of from the rest of the LGBT community. A limited number of women access the center (between 10 and 20 women).

In the focus group with MSM individuals, services sought from providers centered on HIV and STI testing, PreP and vaccinations. In addition, the MSM community saw the centers that provided such services as a one-stop-shop that would also allow access to awareness and information materials pertaining to sexual health and general health, in addition to access to social services, counseling, and mental health support. Condoms were also cited as a need that was filled through centers, citing that the condoms provided by the Ministry of Health were of inferior quality and tended to break. In addition, lubricants were also sought because they were seen as being hard to find on the market.

When questioned about top needs, the MSM focus group primarily cited awareness materials and sessions, not only about sexual health but also about harassment and legal rights. In addition, PeP and CD4 and viral load tests were in need. One participant voiced the need for more availability of syphilis treatment, while another voiced that mental health services were primordial, especially as they relate to one's ability to accept their HIV status.

In addition, three individual interviews were conducted with men who were living with HIV. The primary services sought were testing services, treatment, and counseling/support groups. All interviewees mentioned having accessed treatment and services through the NAP and S.I.D.C., while two had received services from Anwar el Mahabe and one from M-Coalition. The principal barriers to access services were the long waiting times at hospitals and the unavailability of services outside Beirut. In addition, interviewees highlighted that insurance companies typically refused coverage of PLHIV and recounted that others they knew had lied in their insurance papers to be able to gain insurance coverage for other conditions that may arise. The three interviewees benefited strongly from family and friends' support and recommended for support services and counseling to be more available for those who may need it. Two of the three interviewees wished they could see more PLHIV speak up and be represented, both in programs and campaigns and in public life and media, in order to mitigate the stigma and common misconceptions.

PWID

When asked about the national strategy targeting PWID, Dr. Mokhbat stated that other KPs such as heterosexual youth, sex workers and PWID are also targeted as part of national actions, albeit to a lesser degree. In Lebanon, he argues, these groups do not represent a very high risk group and as the rate of incidence is still limited. When it comes to substance use, the view is that it is quite common within KPs but injecting drug use exists to a much lesser extent. In his words, this is reflected in national figures on Hepatitis C whose prevalence is also considered low in Lebanon. The HIV risk is very high for PWID but this does not translate to the context of Lebanon where, according to Dr. Mokhbat, the higher risks relate to transmission through sexual relations.

Two focus groups were conducted with PWID, one in Badaro and the other at Hariri hospital. The services sought primarily focused on prevention materials and information, in addition to testing, viral load testing, and treatment for Hepatitis C and vaccinations against Hepatitis B and HPV. Some individuals used the service providers to access medications such as Naloxone, Subuxone, Subutex, and Ribaviril. One notable observation is that in both focus groups, there seemed to be a great extent of uncertainty about the services offered, and in some cases, that the services or treatments existed. We note that one participant did not know what HIV was, many others did not know what PeP was, and others thought one had to live with HIV without any treatment available. None of the participants at Hariri hospital knew that the treatment was distributed for free by the Ministry of Health. Perhaps unsurprisingly, on the whole, participants in both focus groups could not name service providers except Skoun and the Karantina hospital, and several others said that they did not require counseling or other services because they could find the needed information over the internet. Given the stated expenses associated with the necessary medication, it is understandable that populations most at risk could resort to cheaper

options such as internet search rather than incur costs that are sometimes not affordable. This finding draws attention to a heightened and urgent need for awareness about HIV, as well as outcomes, prognosis, and available services for PWID.

SW

Although Ms. Badran did note the presence of sex workers among the beneficiaries at S.I.D.C., Dr. Mokhbat stated that female sex workers do not appear in national statistics. One possible reason for this observation is illuminated in the focus group with sex workers, where all participants stated that they had never disclosed this fact to a service provider. When seeking services, participants felt that it would be unnecessary to say they were sex workers, mainly to avoid potential issues or complications due to the reaction of service providers. According to respondents, sex work in Lebanon is not considered as an official job, and all said they had to work in secret. There is no fixed mechanism for accessing clients, as some used phone applications, others used LGBT cafés in Beirut or relied on their networks. Caution against police and other people who can do harm was essential and caused significant anxiety and fear. Due to extreme caution and secrecy, participants said that there was no community life for sex workers, and each was on their own.

The exception were cis-women in the focus group, who did present themselves as sex workers when working with KAFA. KAFA runs protection programs against SGBV, prostitution and trafficking.

However, when accessing HIV-related services without much disclosure, the participants did not feel they were subject to discrimination or to stigma with any provider. Nevertheless, the group as a whole had some notable remarks about the existing services. The most cited issue was the lack of lubricant provision and the poor quality of condoms available with service providers, which increased the risk of rupture, and hence the risk of STIs. Once more, long waiting times to schedule appointments were also considered as a principal complaint. When discussing STI and HIV treatments, all participants were aware that the Ministry of Health provided HIV treatment for free. Most participants ask their friends first or trusted ones for health-related information, and some took their questions to the concerned organizations. All received counseling about HIV transmission methods and prevention during at least one visit to a service provider. In terms of rights, three participants mentioned that Helem advocated towards LGBT rights and other sexual liberties, one participant said that he would call Mosaic if he ever got arrested. Cis-women said that KAFA had legal services they could benefit from.

Conclusions

AVAILABLE SERVICES

While the National Strategy to combat HIV and reach 90-90-90 goals are in place, there seems to be many gaps to be addressed for a full and comprehensive coverage.

For one, services are available for people living with HIV, but these services are not well promoted as many do not know what services are available, where to access them or who provides them. Access to services is also an issue especially that most services are centralized in Greater Beirut. Integral services such as treatment disbursement among others, are centralized and therefore create an additional transportation time and cost obstacle to accessing them. Yet, many PLHIV prefer leaving their cities to seek services, in an effort to remove the risk of being identified, stigmatized or discriminated against in their own hometowns.

Essential targeted services still do not seem to be as available. Targeted prevention, lube distribution, mental health, needle exchange program, opioid substitution therapy among others are still not available which affects the effectiveness of other programs like prevention, HIV testing and condom distribution. Lack of data and research extensively in Arabic is problematic because individuals seek internet information rather than service provider information. Many individuals do not seek care, doctor visits or even their medication for fear of stigma, of being outed or being identified with a key population. Often the information given out is generic and not targeted to populations, prevention is available but not comprehensive.

PrEP is not available in Lebanon and the cost of buying it and shipping it is very high. While PrEP is recommended to be used in a comprehensive package of HIV and STI testing along with health monitoring tests, those who purchase it online do not go through the comprehensive package of services, which adds to their risks of misuse and STI infections. Moreover, in many national recommendations, condoms and lube are often recommended but only condoms are given out for free. Lube is not available for free, some organizations have had issues with the ministry of health for trying to get large quantities of lube and pharmaceutical lube is expensive and most of it is for vaginal use, leaving MSM without proper access. PEP is available in Lebanon but is not given without a bureaucratic screening and situation analysis which makes it harder for people to access especially with the 72-hour margin. Opioid Substitution Treatment is still not legal to access in Lebanon and lack of evidence-based drug dependency issues and needle syringe exchange program have become an issue. People who use drugs are unable to access the prevention services they need, and those wanting to quit drugs are not given the services they need to do so. Although HIV prevalence among PWUD is smaller than other KPs, the Hep C prevalence is still high. Some organizations provide clean syringes but not as accessible or allowed to be accessible to respond to the national needs.

The issue increases when drugs and sex intersect, such as the growing phenomenon of chemsex in Lebanon; the practice of sex under the influence of drugs which usually involves many partners, longer periods of sexual contact and mixing of drugs. For people engaged in chemsex, the risks are higher but the response is lower as few of the harm reduction organizations have developed adequate services for chemsex.

Finally, mental health services remain expensive and an out of pocket cost. While PLHIV require mental health attention, those who are MSM or IDU or SWs have added layers of issues relating to their identities, practices, added stigma. Still, in Lebanon, with the variety of services, there still is no support group system that provides support for PLHIV. Although many organizations in Lebanon have been trained by M-Coalition on creating support groups, the costs associated with the process are still not available, and it has become common for people to need support but not find it.

DOUBLE DISCRIMINATIONS

Trans* populations in Lebanon are generally denied work and struggle to find food and shelter, thereby limiting the community's access to treatment. Barely able to meet ends meet, many often go to sex work, increasing the risks of HIV transmission and decreasing the chances of getting any treatment or services. For survival sex workers, prevention is not always an option. Power dynamics in the situation sometimes dominate who gets to decide on condom use or lack of it, not to mention the widespread abuse and rape.

Refugees and migrants in Lebanon are a key population because of the status and living conditions for any post war country. Lebanon hosts refugees from Syria, Palestine and Iraq, a number of whom are MSM or have contracted HIV and had to flee difficult situations. But while the UNCHR provides treatment for HIV, not all refugees are registered and therefore do not have access to treatment. Universal coverage is ever-more important to leave no one behind, regardless of their documented status.

While no laws criminalize HIV, those who are detained and discovered to be HIV+ are put in solitary confinement. The police fear for the person's life and other inmates' lives, and place people in solitary, pending investigation.

FUNDING AND SUSTAINABILITY OF SERVICES

Budget cuts to the National AIDS programs have affected the availability and quality of services. The NAP has on many occasions trained civil society actors on service delivery and nondiscrimination, yet reports still exist of maltreatment in service delivery stations. As the political situation in Lebanon and the new ministry is not very clear in terms of their commitment to HIV/AIDS planning, it is uncertain how the interventions will proceed. On the other hand, the quality of services is not consistent as delivery is dependent on external donor funding. This compromises the sustainability of these services which can cease at any time, making the response insufficient and jeopardizing the progress achieved by other services.

The National AIDS Program provides free HIV screening in around 25 civil society organizations and provides treatment for Lebanese PLHIV and refugees registered by the UNHCR and UNRWA. Since cost was an important concern discussed by beneficiaries, it is important to note that HIV-related screenings are not covered, and the cost of other important services such as STI testing, mental health, co-infection and regular screenings is out of pocket. Any additional medication required, surgeries, treatments, or vaccinations are expensive but not obtained because of financial restrictions.

The difficult economic situation in Lebanon is compounded to a high cost of the treatment (Viraday Indian generic is sold at 250$ in Pharmacies, and Genvoya can go up to 1800$ per month). Insurance companies in Lebanon do not cover HIV related services and insurance plans are suspended in case a person is identified as HIV positive. This is unlawful and is left to the discretion of insurance policy makers. This reason has been used by employers when requesting an HIV test to make the recruitment decision. When confronted, employers use the lack of insurance coverage as a reason for discriminatory practices.

Recommendations

- Wider and far-reaching promotion of the currently available resources and prevention services is needed, in addition to improved outreach to be implemented collectively by the National AIDS program, civil society and primary healthcare units.
- Access to quality service should be an integral part of the HIV response and not considered a luxury. HIV testing services should be accompanied with prevention set up.
- Decentralization of services specific to or affecting HIV testing, treatment and adherence.
- Targeted services for populations should be addressed to be adequately responding to the rising new infections. Men who have sex with men have different prevention needs than those of people who use drugs and people who engage in paid sex.
- Discrimination needs to be addressed at different levels of service provision. Service providers should be sensitized to provide stigma-free services, but they should also be trained on compassion and proper interviewing skills.
- Ensure health insurance plans include clauses to protect marginalized and vulnerable populations from discriminatory practices in health care delivery.
- Public institutions need to be responsive to the needs of communities through training and sensitization of government officials, law enforcement, and health professionals.
- Health programs need to be tailored to the specific needs of key populations by ensuring access to affordable: HIV and TB treatments; comprehensive sexual and reproductive health services; mental health services; opioid substitution therapy and evidence-based drug dependence treatment; and hormone therapy.
- HIV incidence for those at highest risk should be addressed, with prevention programming inclusive of: condoms, lubricants, and pre and post exposure prophylaxis; STI testing and treatment; and harm reduction.
- Confidentiality and privacy of client data should be protected, including information about sexual practices and sexual orientation, sex work, gender identity and expression, and drug use.
- Local communities should be engaged and consulted as key partners in the development, implementation and monitoring of national strategies plans.

Bibliography

i UNAIDS. (2017). Country Factsheet – Lebanon 2017.

ii NAP. (2018). National AIDS Control Program in Lebanon. Ministry of Public Health: https://www.moph.gov.lb/en/Pages/2/4000/aids

iii NAP & Ministry of Public Health. (2008). "An integrated bio-behavioral surveillance study among most at risk populations in Lebanon: Female sex workers, injecting drug users, men who have sex with men, and prisoners."

iv ibid

v 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.

vi Crossroads. (2015). "Size estimation, risk behavior assessment, and disease prevalence in populations at high risk for HIV infection in Lebanon. Beirut."

vii Connecting Research to Development. (2019). "An Integrated Bio-Behavioral Surveillance Study among Two Vulnerable Groups in Lebanon: Men Who Have Sex with Men and Commercial Sex Workers."

viii Ibid

ix Ministry of Public Health: https://www.moph.gov.lb/en/Pages/2/4000/aids

x WHO Annual report 2018: Bridging Humanitarian Support with Sustainable Development.

xi Martini, M., and Aoun, C. (2013). "Legal review, conformity assessment and priority-setting of HIV and AIDS and the World of Work in Lebanon." International Labour Organization, 2013.

xii World Health Organization (2010). "I live my rights. I respect other people's rights. Access for all to HIV prevention, treatment and care is a critical part of human rights."

xiii El-Jardali, F., El Bawab L. K2P Policy Brief: Addressing Limitations to Equitable Access to Healthcare Services for People Living with HIV in Lebanon. Knowledge to Policy (K2P) Center, Beirut, Lebanon, December 2015.

xiv Lebanese Republic Chamber of Deputies: Law On the Protection of Women and Other Family Members from Domestic Violence: https://www.justice.gov.lb/public/uploads/Law%20On%20the%20Protection%20of%20Women_EN.PDF

xv https://www.daleel-madani.org/sites/default/files/Resources/HelemStudy.pdf

xvi https://en.annahar.com/article/990084-support-dont-punish-skoun-calls-for-decriminalization-of-drug-use-in-lebanon

Further Readings

1. https://www.moph.gov.lb/userfiles/files/Prevention/NationalAIDSControlProgram/FSW.pdf

A case study on behavior change among female sex workers. This study is based on interventions with female sex workers, MSM and IDU and youth. This study is based on three interventions along 6 years. It's about the development of the interventions on three phases for prevention and inciting these population to adopt safer behaviors. Outreach peer education; enhance referral system; development of support materials; assessment of behavior change.

2. http://www.menahra.org/images/pdf/PSE.pdf

Project crossroad: a study on population size estimation; HIV prevalence and risk taking behaviors among MSM and IDU. Harm reduction; risky behavior; drug use.

3. http://www.menahra.org/images/OPERATIONAL_RESEARCH_ON_DRUG_USE__HARM_REDUCTION_AMONG_PEOPLE_LIVING_WITH_HIVAIDS_IN_MENA_-_web.pdf

Multicenter operational research on drug use and harm reduction among people living with HIV in the MENA. Drug use context; knowledge about HIV/ Harm reduction; healthcare services.

4. http://www.menahra.org/images/pdf/Situation-Assessment_-_web.pdf

Assessment of situation and response of drug use and its harm in MENA; HIV infection; drug use situation including injecting drug use, HIV and hepatitis C and B infection among People Who Inject Drugs (PWIDs), risk behaviors, policies that support evidence based HIV prevention programming among PWIDs, services available for harm reduction, and priority areas for future planning.

5. http://moph.gov.lb/userfiles/files/Programs%26Projects/MentalHealthProgram/MentalHealthStrategy-Eng%20-2015.pdf

Mental health and substance use, prevention promotion and treatment; national health strategy; stigma; discrimination; service development delivery and utilization; Syrian crisis and refugees.

6. http://sidc-lebanon.org/wp-content/uploads/2018/04/Final-ENG-Speak-UP-Final-report-EN.pdf

Monitor on violation of basic rights for PLHIV.

7. http://sidc-lebanon.org/wp-content/uploads/2018/04/SIDC.pdf

Aging with HIV, needs and challenges of PLHIV.

8. https://webcache.googleusercontent.com/search?q=cache:diMHdbEjaVoJ:https://www.moph.gov.lb/userfiles/files/Prevention/NationalAIDSControlProgram/MishwarIBBS.doc+&cd=1&hl=en&ct=clnk&gl=lb

Mishwar, an integrated bio-behavioral surveillance study among most at risk populations in Lebanon; female sex workers, injecting drug users, men who have sex with men and prisoners.

Appendix 1: Consent form

CONSENT TO SERVE AS A PARTICIPANT IN A RESEARCH PROJECT

Project Title: Investigating HIV-related services and experiences in the MENA region

Principal investigator and affiliation:

Contact Information:

Nature and Purpose of the Project:

This research study is being undertaken by M-Coalition, with the support of … It seeks to document the different HIV-related services that are available across the Middle East and North Africa region, by involving multiple stakeholders such as service providers, beneficiaries, and national programs. Through this research, we hope to obtain a comprehensive mapping of the services, recommendations, challenges, and potential areas for improvement that are adapted to different contexts of the MENA. The value of this research is that it will help identify key priority areas for work on HIV-related services and potentially inform national strategies by engaging with international bodies and linking them to local needs.

Explanation of Procedures:

If you agree to participate in this study, you will be asked a series of questions centering around ***(choose one according to target)***

1- Your experience accessing HIV-related treatment and services

or 2- The different services that your establishment provides for PLHIV

We expect that this discussion will take will take around 30-45 minutes of your time.

Potential Discomfort and Risks:

If you experience any discomfort disclosing personal information or discussing sensitive issues, you may discontinue your participation at any time.

Your participation in this research project is completely voluntary. You may withdraw your consent to participate in this research at any point without any explanation and without any penalty. You are free to leave this research at any time. Refusal to participate will involve no penalty or loss of benefits which you are otherwise entitled to. Please read carefully this informed consent, take your time, and decide.

Confidentiality:

The following discussion is completely anonymous. We will not ask for your name.

If you are in a focus group discussion, we would appreciate maintaining full confidentiality between attendees. Please do not divulge who was there and what was said in this discussion.

If you represent an establishment/institution/facility, we will use the name of this establishment only. The reason why we require the name of the institution is to inform us of the available services and procedures.

Who to Call if You Have Any Questions:

If you have any questions about your rights as a research participant, or to report a research related discomfort, you may get in touch with the principal investigator using their contact details above.

What Signing this Form Means:

By signing this consent form, you agree to participate in this research project. The purpose, procedures to be used, as well as, the potential risks of your participation have been explained to you in detail. You can refuse to participate or withdraw your participation in this study at anytime without penalty.

You will be given a copy of this consent form.

_____ _____

Your Signature Today's Date

Appendix 2: Study Protocols

FIELD VISIT/ SERVICE PROVIDERS INTERVIEW PROTOCOL

1. What are the HIV-related services that you offer at this facility?
2. Do you offer any refreshers/trainings for your staff? What are they about?
3. Do you offer any awareness materials or consultations for your beneficiaries? What are they about? Do they target safer sexual practices?
4. What are some other services that you offer at this establishment? Why would beneficiaries come to you and not to other establishments?
5. Do you accept referrals? Would you send clients on referrals to other centers? Why and what are they?
6. What is your largest client base?

(Who are most of your clients? Can you give us approximate or available proportions?)

7. Do you think there are any target groups that would avoid this facility altogether? Why would you say that they would? (Would they go elsewhere? Where?)
8. How accessible would you rate this facility to be for:
   a. People who are physically disabled
   b. Different genders
   c. Different sexual orientations (mention MSM if not mentioned)
   d. PWID
9. Are the services offered with anonymity? (i.e. do you request an ID?)
10. What steps are taken to ensure confidentiality? Do you share your results with any third party? Who is it and for what purposes?
11. To what extent are your services and procedures in line with the NAP's recommendations? Are there any areas for improvement? What are they and how would you tackle them?
12. What are your recommendations and top priority areas to improve this facility?
13. Would you be open for collaborations on trainings, workshops, or research? (Take contact details and focal point)

NAP INTERVIEW PROTOCOL

1. How does the work that you do reflect the WHO recommendations for your country? Can you give me some examples of recommendations that you have implemented in full?
2. What are the key populations that are targeted by the NAP in this country? What would you say are their proportions? (i.e. how many from each target group, in percentage)
3. What is the HIV-related treatment that you provide? What generation?
4. What are some of the challenges for the NAP's work in your country that you could identify? (Funding, access to key populations, inclusion, expertise, staffing, country-level socio-political challenges…)
5. What are some of the accomplishments of the NAP that you would like to share with us?
6. To what extent is the NAP catering to MSM? Would this be a target group that you would foresee engaging more and more with? (i.e. is there more willingness on the part of the NAP?) What could be some of the challenges?
7. To your knowledge, who are the main HIV service providers who work with inclusion of MSM in your country? How would you evaluate their services and approach?
8. What are your top priority needs as NAP to carry out your mission successfully? How would you recommend that those be addressed and by whom?

INTERVIEW PROTOCOL FOR MSM PLHIV

1. How would you describe your overall experience as an MSM PLHIV in your country of residence?
2. What are some of your support systems that you rely on? What are some other forms of support that you feel you would need further?
3. Are you aware of the different services that are available to MSM PLHIV in your country of residence?
4. Have you sought any HIV-related services? What are they and where would you receive them?
5. What do you feel are your top priority needs (in terms of services) that you would like to have access to/ that you would like to exist?
6. According to your experience, who are the main service providers that you would be comfortable approaching? Why would you choose those service providers and not others?
7. What would make you avoid a certain service provider?
8. Can you share with us a typical encounter with your chosen service provider? What are some of the positive aspects of this encounter? What are the potential areas for improvement for this service provider?
9. What are some steps you would recommend for others to take in order to gain better access to these services?
10. If you had to design a set of recommendations for better services that suit your community's needs, what would those be?
11. Would you like to add anything?

FDG PROTOCOL FOR MSM

1. What are some of the services that you seek as an MSM community?
2. What do you feel are your top priority needs (in terms of services) that you would like to have access to/ that you would like to exist?
3. Do you have any need for HIV-related services? (if not previously mentioned before)
4. What are the HIV-related services that you benefit from?
5. Who provides these HIV-related services? What is your preferred service provider and why?
6. Can you tell us more about the procedure you follow to reach these services?
7. Have you or anyone you know had any challenges/barriers in reaching these services? What are those challenges?

(Difficult access, stigma, lack of inclusion, discrimination, misunderstandings, anonymity and confidentiality, security issues, remote location, pricing if any…)

8. How do you overcome these challenges? What are some steps you would recommend for others to take in order to get better access to these services?
9. If you had to design a set of recommendations for better services that suit the community's needs, what would those be?

FORSS

Conception graphique **Anthony Bornachot**

Coalition afe mena

Solidarité SIDA
Des Jeunes contre le Sida

ITPC
International Treatment Preparedness Coalition
MENA

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME