National Centre for Disease Control

GARPR 2015
COUNTRY PROGRESS REPORT
LIBYA

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I. Status at a glance

The inclusiveness of the stakeholders in the report writing process

As with the previous Global AIDS Response Progress Reporting (GARPR) reports the preparation of this report was limited by the post-revolution situation in Libya which is now entering its fifth year. Instability persists as interim governments work to re-establish essential services and improve security throughout the country. This process has been further hampered by the political turmoil of 2014 which has reignited more conflict in numerous areas. This stagnation is reflected in the fact that the 2012 progress report has been used as the framework for this GARPR report, with adaptations and updates integrated where appropriate.

Competing priorities precluded the participation of a wide range of stakeholders in the reporting process. Data collection and information gathering was limited to the contribution of the National AIDS Program (NAP) staff members from its various divisions, cooperating bodies and to the review of recent UNAIDS trip reports and planning documents prepared by development partners. This limitation is partly due to the lack of integration between major relevant departments, an issue further explored in later sections. The final report was reviewed and validated by the National AIDS Programme (NAP). Workshops or validation meetings were not possible due to lack of governmental processes for convening and funding meetings.

The status of the epidemic

The political turmoil has hampered HIV response efforts just as it was beginning to build steam with many progressive projects, planned in cooperation with international partners prior to 2011, now postponed or failing to thrive in the current security situation. The ability to adapt to the present circumstances is improving; however, it nonetheless remains a hindrance to the continuation of these projects. Instability has affected the budget allocated to the HIV response and, in combination with long-existing challenges, this has meant some aspects of the HIV response have seen slow progress while others have either regressed or remained stagnant.

As a result, limitations were found in submitting indicator data and relevant information into this year's GARPR report. Data for the majority of the 10 targets' Universal Access (UA) and GARPR indicators are either unavailable or outdated except for those regarding HIV Testing & Counselling (HTC), diagnosis of HIV cases indicators (both of Target 1) and indicators regarding Anti Retroviral Therapy (ART) of Target 4. Where there appears to be voids in data submission as is the case for size estimations and PMTCT indicators, this is often representative of the situation on the ground.

Despite the current circumstances, an array of activities and programs have been conducted throughout the reporting period, although these efforts tend to be centralised to Libya's relatively more stable western region. These can be seen in the 'National response to the AIDS epidemic' section despite there being in some areas a general lack of data collection to fortify and validate this work; the lack of a comprehensive Monitoring and Evaluation system

means there is no strong integrated structure for data collection and dissemination which will be a common theme in this report.

GARPR does provide an important opportunity to clearly reflect upon the advances and major obstacles faced by the NAP. The availability of more accurate figures can be greatly attributed to the relatively recent instalment of a Health Information System (HIS), which was achieved in cooperation with European Union. Starting only in 2013 it is still in its initial stages.

As services and institutions adapt to the security situation, and with further progress in addressing the lack of integration, monitoring and evaluation of NAP, the new major challenge becomes the lack of funding. In addition, recent years have also seen the country suffer a severe deterioration in basic services, particularly for people who inject drugs (PWID) and in the Prevention-of-mother-to-child-transmission (PMTCT) project.

There has been a gradual stagnation in the production of new research and studies regarding HIV/AIDS. This is with the exception of the study titled 'Knowledge, behaviour and attitudes regarding reaching the adolescent category to voluntary testing and counselling services' planned to commence in 2015. Further recently conducted studies include the Seroprevalence study of HIV, HBV, HCV, and syphilis among blood donors in Tripoli, Gherian and Elbeda blood banks conducted by Dr.Laila B. Aghil, and another study on HIV, HBV, HCV prevalence among applicants for marriage certificates in Tripoli referral lab conducted by Dr. Abduladim habibi (Unpublished- presented in Final Symposium Libyan - European Partnership for Infectious Disease Control (LEPIDC).

The most relevant recent study was conducted in 2011 in cooperation with the Liverpool School for Tropical Medicine (LSTM) into Libya's vulnerable populations [1, 2]. It was long understood from data of out-dated surveys that the HIV epidemic in Libya is a concentrated epidemic, where injecting drug use is the dominant mode of transmission with relatively low HIV prevalence in the general population. However recent results from these Bio-behavioural surveys (BBSS) among key affected populations, including SWs, MSMs and PWIDs have provided us with a much deeper understanding and much needed information on risk behaviours and HIV prevalence among key populations. Preliminary findings are mentioned in the section below and have been used to inform the National HIV Strategy which is currently being redrafted and has yet to be implemented. Although case-reporting statistics are not widely available due to the post-conflict situation, government sources have indicated an increasing trend toward sexual transmission.

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[1] Berendes S., Danon L., Jeffery C., Mirzoyan L., Othman H., Saffialden R., Thomson J., Turki A., Valadez J. J. (2013). New Evidence on the HIV Epidemic in Libya: Why Countries Must Implement Prevention Programs Among People Who Inject Drugs. *Journal of Acquired Immune Deficiency Syndromes* 62-5: 566-583.

[2] Berendes S., Danon L., Jeffery C., Mirzoyan L., Othman H., Saffialden R., Thomson J., Turki A., Valadez J. J. (2013). Filling the Knowledge Gap: Measuring HIV Prevalence and Risk Factors among Men Who Have Sex with Men and Female Sex Workers in Tripoli, Libya. *PLoS ONE* 8(6).

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

There is a keen understanding of the value, importance and benefits of forming partnerships with relevant international organizations and institutions with high experience in HIV /AIDS research, surveillance and programs; these kinds of collaborations will ensure the provision of properly planned and conducted studies to inform the policy making bodies and will help create a reliable HIV database in Libya.

The policy and programmatic response

The Libyan civil war was thought to have ended, however the political situation remains unstable in many areas of the country. The recent turmoil of 2014, giving rise to two rival governments, has caused further outbreaks of violence across the country. The task of reinstating disrupted health services with the support of the United Nations system is still underway. The HIV/AIDS response is being integrated into health systems wherever possible. The National Centre for Disease Control (NCDC), which includes the National AIDS Programme (NAP), has included HIV among its three highest priorities for the reconstruction.

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

The highest priority health issues include:

a) Strengthening peripheral health services. Human resource development is a primary concern.

b) Securing procurement and supply of drugs and medical supplies, including ARVs, and maintenance of medical equipment (which was also a challenge prior to the civil war).

c) Health information, disease control and surveillance. Blood safety is of particular concern, as well as control of nosocomial infections. Many war-wounded sent abroad were found to be infected with multi-resistant Staphylococcus aureus (MRSA) infections contracted in hospitals in Libya.

d) Involvement of civil society, particularly for strengthening of peripheral health services and for access and involvement of key populations, including in the area of HIV prevention and response.

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

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

II. Overview of the AIDS epidemic

Overall prevalence

The apparent lack of national statistical data regarding HIV has drastically improved over the last decade, largely contributed by the most recent population based survey, which was carried out in 2004 through to 2005 among 65,000 persons using random cluster sampling. The results indicated a HIV prevalence of 0.13% (90 cases) in the general population. However, the higher prevalence in Al Kufrah in the south (0.67%) and in Tripoli (0.4%) indicated hotspots on migration and drug smuggling routes, and in urban areas [3].

As already mentioned, to address the gap BBSS among key affected populations, including SWs, MSMs and PWIDs were planned in multiple sites [4, 5]. Data collection was completed in Tripoli, but was interrupted by the civil war before additional sites were surveyed. The limited number of surveys conducted prior to the BBSS, are all relatively outdated since data collection was completed before 2005. In addition, the situation has changed in the post-conflict period, with anecdotal information pointing to the likelihood of an increasing epidemic. In the absence of surveillance data, blood bank data can provide a proxy for the general population. In Tripoli Central Blood Bank, 0.3% of blood donors tested HIV positive in 2011, but a much higher prevalence was noted at the Benghazi Blood Bank during the same period.

In addition to recent research and past surveys, current surveillance information on the HIV situation in Libya is limited to three main data sources which offer variable degrees of accuracy and geographical representation.

The first being epidemic forecasts provided by the Department for Surveillance, Investigation and Rapid Response, a unit within the NCDC giving a cumulative number of people diagnosed with HIV in the country as 10,557 beginning from year 2000. This figure relies upon a network of case reporters in cooperation with the department, primarily from mandatory screening statistics for blood donations and health certificate issuances. Figures are unlikely to be highly accurate as they are exposed to both under-estimations due to the high risk of duplications occurring and over-estimation since case reporting on PLHIV deaths is poor. In addition, the available information is incomprehensive, reported from only some hospitals and laboratories.

A second important data source on the HIV epidemic is the medicine data system which relies upon pharmacy records from the main infectious disease hospital units across the country including those which have not yet established a HIS; this is mostly due to both a lack of administerial commitment and the negative effects of the current conflict. There are approximately 6000 recorded cases of HIV of which approximately 4000 are under treatment.

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[3] El-Zouky A, et al. Libya national sero-prevalence study. 2004-2005.

[4] Berendes S, et al. (2013). New Evidence on the HIV Epidemic in Libya: Why Countries Must Implement Prevention Programs Among People Who Inject Drugs. *Journal of Acquired Immune Deficiency Syndromes* 62-5: 566-583.

[5] Berendes S, et al. (2013). Filling the Knowledge Gap: Measuring HIV Prevalence and Risk Factors among Men Who Have Sex with Men and Female Sex Workers in Tripoli, Libya. *PLoS ONE* 8(6).

These numbers include patients from Tripoli Medical Centre (TMC), Tripoli Central Hospital (CH), Al Joumhouria Benghazi and Sabha Medical Centre which are the main hospitals in the country that offer HIV treatment and care. These numbers, although more accurate than epidemic forecasts, are also subject to scrutiny since they do not take into account people living with HIV (PLHIV) who do not seek treatment.

The last and also most accurate and recent main information source is the Health Information System (HIS) which has so far only been established in the two main hospitals of Tripoli: CH and TMC, although there have been problems with the former, and with further plans to expand in the cities of both Benghazi and Sabha. Although challenges have been experienced this system has proven significantly effective in managing the fight against AIDS and STIs, particularly in the areas of patient monitoring, restoring data, planning and policy making as well in conducting research.

Overwhelmingly low CD4 counts at the time of diagnosis indicate that most PLHIV are identified late in the course of their disease, further supporting the likelihood that the identified cases represent a relatively low proportion of the total number of PLHIV. Over 70% of newly diagnosed HIV cases are found to have a CD4 count less than 350 cells/mm^3 and half are below 200 cells/mm^3 (LEPIDC)[6]. The HIS data for TMC shows that the number of monthly recorded HIV cases fluctuates between a low of 7 and a high of 45 within the first 10 months of 2014. An average of 12% of cases each month results in death while the remaining cases are recorded as at the end-of-life. It's likely that most PLHIV remain undetected due to lack of information and access to VCT and also due to stigma and discrimination barrier. Modelling estimates of the scope of the epidemic have not been carried out.

Key Populations

Prior to the civil war, Libya was host to a large number of immigrants – 1.5 million irregular foreign immigrants, most from sub-Saharan Africa with no access to the health system – which created a large potential for epidemic growth [7]. Half of the HIV cases in neighbouring Tunisia prior to 2003 were people who had come from Libya for ART or drug rehabilitation programmes [8]. The post-conflict situation has resulted in the deterioration of essential services including drug rehabilitation centres, while creating several additional factors with the potential to fuel the epidemic. In addition to a nationwide stock-out of ARV drugs, infection control and blood safety systems have been disrupted.

The epidemic in Libya is primarily concentrated among high-risk groups signifying that Libya is experiencing a concentrated epidemic since the HIV prevalence in the general population remains to be relatively low.

[6] Libyan European Partnership on Infectious Diseases Control (LEPIDC). Critical analysis of the present situation and planning of activities. Presentation to Minister of Health.
[7] UNGASS Country Progress Report, 2010.
[8] Laith J. Abu-Raddad F, Akala A, et al. (2008). Characterizing the HIV/AIDS epidemic in the Middle East and North Africa: Time for Action. World Bank.

Injecting drug use is the dominant mode of transmission, which in the past has accounted for as many as 90% of infections[9]. Although case-reporting statistics are not widely available due to the post-conflict situation, there are strong indications of an increasing trend toward sexual transmission. Recent data from TMC reinforces that sexual transmission is becoming an increasingly important contributor to the national HIV incidence rate.

Estimates of HIV prevalence among PWID vary widely and date from before the civil war. Published estimates range from 15% up to 49%[10]. Prior to 2008, 60% of drug users admitted to drug treatment facilities tested HIV positive and the HIV prevalence in prisons was reported to be 18%[11]. Size estimates of the injecting drug user population in Libya range from a low of 4,663 to a high of 9,779 [12].

The number is likely to have only risen due to the rise in drug availability and a drop in prices which is likely caused by the heightened security situation and increasingly porous, unregulated borders. Furthermore, the current crisis is likely to contribute in creating an environment which may encourages drug use which is anecdotally evident by the sharp rise in cases of mental illness often associated with warfare. This is particularly troubling among the more vulnerable youth population whom are less capable of coping and in finding alternatives.

Considering that the national response regarding the PWID cohort has always been limited in addition to the counteractive policies implemented in the past, the severe consequences presented in the findings released from the 2011 BBSS are to be partly expected. The cross-sectional survey conducted among 328 PWID in Tripoli estimated an HIV prevalence of 87%, hepatitis C virus prevalence of 94%, and hepatitis B virus prevalence of 5%. These results, among the highest HIV incidence rates in the world, indicate the gravity of the issue and also suggest an urgent need to implement more vigorous harm reduction programs [13, 14].

However, considering the recent deterioration of drug treatment facilities and of health facilities in general (further discussed in the 'National Response to the AIDS epidemic' section), this leads to the conclusion that there is a growing and alarming crisis in the Libyan PWID population, whom have been neglected much too long and a phenomenon which will cause broad implications upon Libya's general population.

A pioneering assessment on the annexed BBSS among female sex workers (FSW) and men who have sex with men (MSM) populations in Tripoli was also conducted. The HIV, HBC and HCV prevalence rates among the 69 FSW respondents was 15.7%, 0%, and 5.2% and among the 227 MSM respondents 3.1%, 2.9%, and 7.3%, respectively [14].
There is currently little or no other information about HIV in other key population groups, such as migrants, refugees, and internally displaced people.

[9] UNGASS Country Progress Report, 2010.
[10] From published reports dating from 2002 to 2008, cited in Laith J. et al. (2008). Characterizing the HIV/AIDS epidemic in the Middle East and North Africa: Time for Action. World Bank.
[11] Based on literature reviews published in 2006 and 2008, cited in Laith J. et al. (2008). Characterizing the HIV/AIDS epidemic in the Middle East and North Africa: Time for Action. World Bank.
[12] Laith J. et al. (2008). Characterizing the HIV/AIDS epidemic in the MENA: Time for Action. World Bank.
[13] Berendes S, et al. (2013). New Evidence on the HIV Epidemic in Libya: Why Countries Must Implement Prevention Programs Among PWID. *Journal of Acquired Immune Deficiency Syndromes* 62-5: 566-583.
[14] Berendes S, et al. (2013). Filling the Knowledge Gap: Measuring HIV Prevalence and Risk Factors among Men Who Have Sex with Men and Female Sex Workers in Tripoli, Libya. *PLoS ONE* 8(6).

III. National response to the AIDS epidemic

The National AIDS Programme (NAP)

The Libyan national response is coordinated by the National Centre for Disease Control (NCDC) under the Ministry of Health (MOH). The NCDC now has 31 local offices in cities and towns across the country. The National AIDS Programme (NAP) was launched in 2002, reporting to the Director General of the NCDC. The NAP, which often also goes by the title 'Department for the control of AIDS and STIs', has its headquarters situated in the capital Tripoli. There were initially four divisions: monitoring and evaluation (M&E); education and awareness; therapy management; and studies and research with the further addition of two divisions by the end of 2013: STI control and Hepatitis control.

Other units of the NCDC with HIV-related responsibilities include PMTCT, Tuberculosis (TB) control, nosocomial infection control, and the referral laboratory. The NCDC also coordinates mental health and psychosocial support, including a national coordination committee; surveillance and special surveys; epidemiology; and ARV procurement and supply. The Director General of NCDC is responsible for the coordination of the national response between the NAP and other units involved in the national HIV response. However, the NCDC does not have authority over health service provision, limiting its influence in key components of the HIV/AIDS programme.

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

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

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

Civil Society

Civil society has been rapidly building strength and gaining recognition for their contribution to the national HIV response. However, much of civil society group's activity revolves around education and awareness, with key populations not being the key focus.

In the 1990's, the Red Crescent and Scout movements started by initiating HIV awareness and education programmes. Then in 1998, the Benghazi nosocomial epidemic of children increased attention on HIV/AIDS and spurred the birth of additional NGOs working on HIV/AIDS, namely the NGO At-Tahadi (Benghazi). Others include the Association to Care for Infected Children and the Libyan Association of NGO's (LANA).

In 2005, a network of 12 NGOs was formed with support from the UNDP and UNAIDS. The network has contacts with international NGOs such as HIV Alliance and the Regional Arab Network Against AIDS (RANAA), which have supported some training activities. The NGO network is planning to conduct an assessment of NGO capacities, with support from the Alliance.

The network includes the Libyan Youth Association (LYA), which supports "Amal" or "Hope", a PLHIV group; unfortunately Amal has become increasing inactive in recent years and it's disbandment has left Libya without an independent HIV/AIDS support group. The LYA also supports the Y peer network whose activities also include awareness and education among young people.

In 2014, the NAP trained 17 NGO representatives during a 3-day workshop. Yet, capacity building of NGOs is still urgently needed, particularly in resource mobilization and programme management, with a focus on prevention and response in key affected populations.

National HIV Response

In a country where there is evidently a concentrated epidemic, the lack of focus on key populations- namely, PWID- is still found in both civil society and governmental efforts. As reported in previous Country Progress Reports, the NAP prevention efforts prior to the conflict were focused primarily on raising awareness of HIV among the general public through the media, training programs for selected professions (e.g. members of the judiciary, medical providers, teachers and religious leaders), World AIDS Day celebrations, and health education in schools.

The current instability and political climate has caused a number of important projects to be placed on hold, chiefly the Drug and HIV Project which was initiated in 2010 but suspended in 2011 when the conflict erupted. The project, which is financed by the Government of Libya and supported by the UNODC, includes drug rehabilitation service development; support to civil society organizations for HIV prevention, outreach service development and the establishment of VCT centres and a mobile VCT facility. The project has supported development of the national strategic plan on harm reduction, which has been approved by the NAP and the MOH.

HIV testing and counselling (HTC)

Fixed VCT

Planned implementation of recommendations from a 2009 UNAIDS assessment of VCT (Voluntary Counselling and Testing) were put on hold when the civil war broke out in 2011, as is the case for the expansion and improvement VCT centres planned in the national HIV strategy draft.

Most HIV testing continues to be mandatory screening for various certificates (e.g. marriage, driving licenses, hospital admissions, ANC, prison admissions, etc.). Laboratory testing for HIV is widely available in both public and private laboratories throughout the country, however, lack the counselling aspect of HTC. Fixed voluntary HTC is available only at the NCDC reference laboratory in Tripoli, which is used primarily for referral services for people sent for confirmatory testing from other laboratories. Prior to the conflict, NCDC had planned to expand testing to all NCDC regional branches, which at the time numbered 25 but the plans were put on hold.

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

Other fixed services also offered at the NCDC in Tripoli include HIV counselling and psychological support. During the course of 2014, a total of 171 adults took counselling sessions; 18% of which regarded HIV, while the majority of the remaining sessions recorded were concerning Hepatitis C Virus (HCV) and Hepatitis B Virus (HBC). The majority, 92%, were of Libyan descent and 82% came from Tripoli, with the overall majority 64% being males.

Another 201 adults carried out psychological support sessions, with again the vast majority 98% being Libyan and 58% male. Of those who disclosed their cities (173) only 77% were from Tripoli. Of the 188 categorised sessions almost half concerned HCV and HBV, 37 regarded more general topics and another 53, a third of cases (28%), concerned HIV.

Mobile VCT

The Education and Awareness division is the largest and often considered the most active division within the NAP. In an effort to address the absence of widely available VTC (Voluntary Testing & Counselling), a mobile VCT clinic was first introduced in November 2013 at a preliminary trial run at Martyrs Square in Tripoli; No data was preserved from this trial. The mobile VCT service is carried out in large vehicle which consists of a reception room, a counselling room and a laboratory for rapid tests.

The mobile clinic, where people can receive a fully compressive HTC service, provides valid data for indicator 1.16 as opposed to the fixed HTC services at the NCDC which due to the nature of integration between the different health facilities and the flexibility on behalf of the participant in choosing to receive different aspects of a comprehensive HTC service, is not included in this indicator.

During the course of 2014, the mobile VCT clinic went on to provide the service to 626 volunteers in 7 separate visits in 5 different cities situated in the west of Libya: Tripoli, Gheryan. Khoms, Zawiya and Ajilat, with both Tripoli and Gheryan visited twice that year.

The Tripoli fair of April 2014 was the first site to be visited and provided the largest number of volunteers out of all 7 visits, a total of 195 people, representing a third of those to have undertook the service. However, regrettably the questionnaire form only allowed for the input of age category rather than the actual age of the volunteer. Since the age categories used did not comply with those required in indicator 1.16 the Tripoli Fair group were not included in the final cohort used for this indicator.

A further 37 are also not included as they account for missing data entry, missing questionnaire sheets, invalid inputs and duplications. Only one person was found to be HIV positive, a male non-libyan, and this was during the Tripoli Fair where the only pregnant women was also found (HIV negative); and another 2 males were found to be HBV positive.

And in conclusion, 63% of the original 626 volunteers are included in the final cohort for this indicator; within this cohort, 3 other Libyan males were found to be HBV positive and one Libyan male HCV positive. Due to security reasons, the team are unable to carry out same services in the southern and eastern regions of the country.

HIV & Hepatitis Hotline

Another important development is the establishment of the HIV and Hepatitis Hotline, which provides a free, confidential, easily available and fast service for all. The main advantages of the hotline is that it has provided people from outside the capital Tripoli a faster, more accessible way to inquire and gain information about these relatively sensitive topics; the caller can choose to stay completely anonymous which helps tackle the barriers stigma and discrimination creates towards these infections, HIV in particular.

The service was widely advertised in the NCDC published materials and media outlets however experienced delays and was finally launched on the 9th of June 2014. However it was not long before it experienced another halt during the months of August and September due to the ongoing conflict in Tripoli and its surrounding areas.

The NAP members of staff accept call via rota during working hours and since its launch to the end of 2014 have answered 1014 callers. The service experienced a rush hour during June with the majority of calls, in fact, received during that month. The service then experienced a steadily decreasing number of calls throughout the rest of the year. 1498 callers were unsuccessful in reaching the service, 1402 of them unsuccessful during June. The NAP members provided 49 referrals and approximately a third (33%) of the callers were from out of Tripoli and also a third of the calls (28%) were HIV related.

Other significant developments

During the course of 2014, the NAP had conducted approximately 40 meeting between its divisions and with its cooperating partners. In terms of training courses, a large focus was placed throughout the year on the preparation of leaders from different fields in the prevention of drug abuse and AIDS, completing 13 separate 4-day courses in 8 cities, from here in the NCDC headquarters in Tripoli to as far as Al Jufra in the midwest of the country. Approximately 400 participants took part, including many civil society associations, police members, university students and staff and teachers, and health and social workers.

Three other training courses on the management of ARVs and HTC were directed at the NAP staff with the cooperation of development partners LEPIDC and UNODC respectively. Career training courses were conducted by the NAP Therapy Management division in the newly established Zawiya clinic during April that year. A further 9 workshops in cooperation with development partners and 24 separate field visits were carried out that year.

Awareness and education campaigns took place in higher education institutions and schools mostly in Tripoli targeting over 10,000 students, and also in Khoms and Sirt. There were 37 separate media contributions and interviews with video and audio channels with audiences across the country. A further 27 publications were released that year mostly targeting the general public providing correct information on hepatitis and HIV.

World AIDS day was observed on the 1st of December with a series of lectures open to the public at the NAP headquarters in Tripoli, as well as other global days observed. NAP members have attended the international conference in Stockholm, Sweden regarding the international training course for trainers regarding 'the stigma and discrimination on AIDS' programme [15].

Stigma & Discrimination

The legal and social environment in Libya has contributed in fostering a hotbed for stigma and discrimination which remains to be a major issue in affecting all aspects in the fight against the HIV epidemic, all the while there still remains to be a lack of data to help indicate any progress in this area. The infection is largely associated with vulnerable key populations PWID, SWs and MSM. During screening for the BBSS conducted in 2011, the results of which were released in 2012, it was found that there were overlaps in the networks between key populations in terms of acquaintance with one another [16]. Through a string of policies and laws these populations are often criminalised, often counteracting efforts to decrease the spread of the epidemic and to reduce the damage induced on these key populations and on society, a phenomenon further realised through their isolation from Libya's religious conservative society, which in turn affecting the general political will on issues regarding PLHIV. Since the establishment of the national AIDS program in 2002 a lot of focus has

[15] NAP year report 2014.
[16] Berendes S, et al. (2013). Filling the Knowledge Gap: Measuring HIV Prevalence and Risk Factors among Men Who Have Sex with Men and Female Sex Workers in Tripoli, Libya. *PLoS ONE* 8(6).

been directed at raising this issue, a process which may now be catalysed by the recent exponential increase in media outlets since the fall of the previous regime, as indicated by the rise in number of media contributions made by the NAP in recent years.

It is recognised that by considering local conservative societal values and the recommendations set by the WHO, the process of uprooting deep-seated stigma and discrimination towards HIV/AIDS is feasible through the inclusion of religious and civil society leaders and PLHIV; inclusion is crucial in combating the reluctance to address the problems at hand.

Knowledge and behaviour change

Young People

The most recently reported knowledge survey was conducted in 2014 among high school students in the south of Libya (496 students) and also in the capital Tripoli (440 students), resulting in a full cohort of 936 students. Results will shortly be available for comparison with a similar study conducted in 2005: Despite the existence of a school education programme misperceptions persist with 42% of students believing that HIV was transmitted through the use of public toilets, 31% believed it was transmitted through coughing or sneezing and 30% believed that it was transmitted through caring for an HIV-infected individual. Although high levels of stigma demonstrated in response to questions regarding PLHIV being dangerous to others, banishment from work and their entering the country, the majority (80%) of students either agreed or strongly agreed to providing free care for PLHIV [17].

Key populations

Completion of the recent BBSS has provided much needed information on knowledge and behaviour among key affected populations. It was found that risky behaviours among PWID, MSM and SWs were widespread and knowledge and attitudes to HIV were limited [18, 19]. A previous survey conducted in 2003-2004 among injecting drug users in a rehabilitation programme found that about 70% of drug users surveyed said they had engaged in behaviours that put them at great risk of contracting blood-borne diseases such as HIV and HCV, and nearly half (44%) of injecting drug users had shared needles and syringes[20]. However, it must be noted that the previous survey was not representative of the actively injecting population in the community. In comparison, 85% PWID respondents reported having shared needles in the more recent BBSS.

[17] El Gadi S., et al. (2008). HIV-related stigma among high school student in Libya. *International Journal of STD & AIDS* 19: 178–183.

[18] Berendes S, et al. (2013). New Evidence on the HIV Epidemic in Libya: Why Countries Must Implement Prevention Programs Among PWID. *Journal of Acquired Immune Deficiency Syndromes* 62-5: 566-583.

[19] Berendes S, et al. (2013). Filling the Knowledge Gap: Measuring HIV Prevalence and Risk Factors among Men Who Have Sex with Men and Female Sex Workers in Tripoli, Libya. *PLoS ONE* 8(6).

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

Care, treatment and support

Drug Treatment facilities

Libya had two drug treatment facilities specific for PWID both of which are now closed: the Tajoura Treatment and Rehabilitation Centre, east of Tripoli, and the Il Irada clinic in Benghazi. The latter, opening in 2009, is still considered the ideal model since service is based upon patient consent which isn't always the case for the centre in Tajoura. In addition, the drug treatment department at the Al Razi psychiatric hospital in Tripoli had also closed, and now offering mainly psychosocial support. The five-year agreement signed between the MOH and the UNODC in 2007 regarding a national prevention campaign against drug misuse and HIV/AIDS among IDUs has yet to be implemented, largely due to the current instability in the country. The project is ongoing despite the slow progress and as a result the deadline has been extended till the end of 2015 and is currently again undergoing procedures for another 2 years extension in order to address this serious situation.

ART Procurement

All procurement is under the Medical Supply Organisation (MSO), a unit within the MOH, which via the NCDC supplies eight 'branches' with ART as shown in Table 1: two in Tripoli which are Tripoli Central Hospital (TCH) and Tripoli Medical Centre (TMC), three in Benghazi which are Al Joumhouria Hospital, Benghazi Centre for Infectious Diseases and Immunology (BCIDI) and Benghazi Medical Centre (BMC), one in Sabha (Sabha Hospital), one in Zawiya (Communicable and Infectious Diseases Clinic) and lastly the prison clinics which are counted as one branch with many further sub-branches across the country.

National guidelines for treatment of adults and children were developed in 2009 in collaboration between NCDC and the European Union[21, 22]. HIV treatment is currently provided to an estimated 3700 PLHIV according to NCDC data and a further 5942 PLHIV are registered in pharmaceutical records. More accurate data is not available since there is no accurate nation-wide central reporting system in place. HIS is only available in TMC, which is the only health facility which offers paediatric care among children living with HIV; it is likely that basic paediatric services are also provided in Sabha and Benghazi hospitals although there is no reporting system to confirm this.

Excel spreadsheets are an alternative to HIS in Tripoli CH while the remaining hospitals still rely upon outdated data collection mechanisms. The absence of accurate patient data in turn affects the forecasts used for ART procurement. New cases are often missed making the average monthly consumption rate unstable. In addition, problems in management and financial matters also affect the quality of ART supplies.

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

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

Although ART is free for all Libyan citizens, shortages have recently led to treatment interruptions which are usually quickly resolved. Instability within the MOH causes problems with procurement with regards to contracts and financial matters.

In the past, due to the conflict there was a prolonged ARV supply disruption for over six months in 2011 leading to an emergency situation for PLHIV. Among those who are not able to buy drugs from neighbouring countries, sharing of ARVs and relying on partial treatment with one- or two-drug regimens are reportedly common. In this scenario, development of resistance to first-line ARV drugs is a serious concern, which is further complicated by the lack of capability for resistance monitoring in Libya. Doctors at the Infectious Diseases Department of the Tripoli Central Hospital report increasing numbers of PLHIV admitted in very advanced stages of disease with high mortality.

Table 1: Health facilities in Libya which offer Antiretroviral Therapy and their patient numbers.

Hospitals	Total No. of HIV+ Patients	Total No. of HIV+ Patients on Treatment
1. Tripoli Central Hospital	2027	1413
2. Tripoli Medical Centre	1420	1200
3. Al Joumhouria Hospital Benghazi	1200	300
4. Sabha Hospital	482	100
5. Communicable and Infectious Diseases Clinic, Zawiya	8	8
6. Prison Clinics	135	59
7. Benghazi Medical Centre	220	220
8. Benghazi Centre for Infectious Diseases and Immunology	450	400
Total= 8	5942	3700

There is evidently large pressure placed on major regional hospitals, particularly TMC and CH in the capital Tripoli. Major regional hospitals represent the bulk of health facilities which offer treatment whilst also being situated in more highly populated areas. Another reason for this pressure is that they provide PLHIV with an environment of relatively less stigma and discrimination in comparison to if they had sought treatment in smaller towns and cities. Work pressure and consequently its time-constraints on hospital staff can often result in a lack of cooperation with regards to data collection and other recommendations made by the NCDC, which fails to exercise any authority. Among other challenges mentioned in the next section below is the lack of administerial support, a general mistrust and negligence in recording and sharing data, as well as problems in monitoring, evaluation and integration between different departments. One way to help relieve the workload on hospital staff in these major hospitals is by opening health facilities in medium sized cities. A new health facility offering ART has been newly established in the city of Misrata by the NCDC and its staff are currently undergoing career development training.

Prevention of mother to child transmission

PMTCT is recognised as playing an instrumental part in combating HIV/AIDS, since HIV transmission from mother to child is considered the dominant route of in young children and with the implementation of a PMTCT program the risk of transmission can be reduced down to 1%. A study was conducted in the year 2003 through to 2006 in three of the largest hospitals providing maternity care in Tripoli, where the study involved 70442 pregnant women; the HIV incidence rate was at 0.13%, 0.07% and 0.3% for Al Jalaa Hospital, Al Istiglal (previously Al Khathra) Hospital and Tripoli Medical Centre, respectively [23].

National guidelines for PMTCT were developed in collaboration with the European Union in 2009 [24]. The 2010 Country Progress Report described plans to expand availability of PMTCT beyond the two sites, which were operational at the time, namely Tripoli Medical Center and Benghazi Centre for Infectious Diseases and Immunology. The proposed expansion initially included 10 sites which were then narrowed down to 5 (not all of which were of the original 10) for the pilot phase in anticipation of the gradual expansion to 70 sites throughout the country. The 5 sites are Tripoli Medical Centre, Al Jalaa Hospital- Tripoli, Sabha Medical Centre, Al Joumhouria Hospital and Misrata Hospital.

The discussion on the application of the PMTCT programme involved work teams from those 10 hospitals and leaders from health institutions across the country. The basic work team for the programme would consist of 7 professionals: a doctor specialised in maternity care, a midwife, paediatrician, lab technician, pharmacist, social worker and a doctor specialised in infectious disease.

This pilot phase would be subject to monitoring, evaluation and adaptations where necessary. The necessary training for the work teams in those 5 hospitals, regarding the application of the PMTCT programme, started in March 2012 and was completed by December that year as were the provision of documents and the collection of information regarding the programme. Although the Libyan European Partnership on Infectious Diseases Control (LEPIDC) project plan has also included support for the initiative, the expansion programme has not started.

[23] Report on the PMTCT project situation (2015), PMTCT department.

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

The pilot phase of the PMTCT project has seen little development. All 5 hospitals have experienced shortages in at least one area including in the necessary requirements for the project, and all have also experienced the repercussions of the ongoing conflict, some regions more than others. Only the hospitals present in Tripoli (TMC only), Sabha and Benghazi are at least partly functional. In the case for TMC, where ART is on the whole available, shortages in basic necessary equipment remains a problem. The maternity division will also be subject to maintenance work in the near future which will further affect the quality of the services provided. TMC is considered to be the main facility which provides services to PLHIV in Tripoli and its surrounding area. However in the case of PMTCT services anecdotal evidence suggests that many opt out of the TMC in fear of stigma and discrimination and the breaching of privacy, using private clinics as an alternative despite the rising prices of the necessary requirements of a PMTCT program.

The work team in Sabha medical centre have even resorted to grinding medicine for newborns in order to reduce the gap in shortages. The service also suffers from a lack of patient monitoring due to the lack of counselling and medicine.

The Al Joumhouria Hospital has been negatively affected by the conflict which has been relentless in Benghazi. This has resulted in members of the work team moving out of the city and others out of the country. The hospital has been closed since November last year, and as a result the remainder of the work team have transferred to Benghazi Medical Centre (BMC) where the Maternity division, according to the latest field reports, has yet to officially open; the BMC is also subject to shortages and cases are dealt with in accordance to what is available while there is added pressure due to a number of private clinics closing due to the security situation.

The Al Jalaa Hospital in Tripoli has been closed a number of times for numerous reasons, and despite the provision of the necessary medicine and the establishment of a work team the PMTCT project has failed to thrive in this hospital to the point where even the medicine has passed its expiry date without usage as a result of faults in the delivery system between the hospital and the PMTCT and pharmacy departments partially due to the sporadic closure of the hospital. In addition, there are shortages in the basic requirements of a maternity ward. Similarly, there are no PMTCT services in Misrata Hospital or in Zawia Teaching hospital which has also undergone training workshops for its work team in order to provide the service however has failed in the aspect of providing the necessary expertise and necessary requirements for the program to work.
Despite the unfortunate circumstances and the slow progress, plans to proceed by holding meetings to restore the project is underway and by undertaking more vigorous evaluation and restarting training.

TB/HIV co-infection

The TB department of the NCDC is the lead agency for TB control in the country. The national policy is to screen all TB cases for HIV, hepatitis B and hepatitis C. However, there are no monitoring data available for quality assessment. PLHIV are not routinely screened for TB.

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

IV. Best practices

Blood safety

In Libya, HIV testing is mandatory in blood banks and in hospitals for pregnant women during pregnancy and before labour. It is also used in the issuance of health certificates used in affairs regarding employment and marriage. There are 3 main central blood banks and 87 hospital blood banks. Blood donors tend to be male relatives which reflect the dependency of blood banks on family/replacement donations in Libya [25]. The involvement of other family members increases the pressures of donating the blood, whilst also increasing the affect stigma and discrimination can cause upon any donor diagnosed with HIV. This can incur an adverse reaction where fear may lead to a lack of responsiveness on the behalf of the donor towards necessary treatment.

Counselling and treatment are important factors in protecting both those diagnosed with HIV and the community at large. At the centre of all of this is the need for accessible and effective screening and confirmatory test procedures. It is necessary to integrate counselling sessions within both screening and confirmatory tests during the process of blood donation in a way as to minimize unnecessary donor deferrals, and to provide maximum care and support for donors regardless of their HIV status.

A workshop held on the 20th of November 2014 was designed to initiate a new collaboration between the NCDC's NAP (Department for the Control of AIDS and STIs), and the Central Blood Bank (CBB) in Tripoli. Thirty speakers, delegates and decision makers participated in the workshop regarding the handling of HIV diagnosis results from blood donor screening tests at the CBB, and in a broader sense, the nation at large.

The CBB highlighted during the workshop the absence or lack of post-donation counselling within the CBB, and hence the need to overcome this deficiency by setting the frameworks of a new collaborative effort with the NCDC in order to provide this important service. This reflects upon both organizations' mutuality in their duty of care towards donors and the population as a whole. What was also most apparent was the lack of national statistical data regarding STIs, and the lack of a national blood regulatory database and guidelines. Cooperation and joint activities between various national organizations are necessary for the interest of the population and this workshop is a good example of this. Blood donors are important in the community with those infected in need of care for both their own benefit and for the interest of the whole population.

National blood regulatory guidelines are a mandatory step toward achieving the safe blood target. Implementing post donation counselling in collaboration with the Libyan NCDC will involve confirming repeatedly reactive screening results, notifying donors, follow up & referral for treatment. The confirmed results will be then forwarded to the CBB. All personal and medical data of donors including tests results should be shared under confidentiality. Screening of donors for other infections such as those causing malaria should be based on local epidemiological evidence.

This meeting was just a starting step toward further collaborative goals and activities between the CBB and NCDC. Colleagues in other central blood banks as well hospital blood banks were also advised to follow a similar model.

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[25] Aghil L. (2014). *Seroprevalence and Trends in Transfusion Transmitted Infections Frequency in Blood Donors; a retrospective Analysis in Tripoli, Gherian & Elbeda Blood Banks.* Lecture given at the Central Blood Bank in Tripoli on 20th November 2014.

V. Major challenges and remedial actions

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

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

National strategic planning

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

Development of the national strategy is at the top of the NAP's priorities along with increased inter-sectoral coordination. Planning is underway to resume the strategic planning process with further inputs from additional planned surveys (described in the M&E section) and additional multi-sectoral consultations. Using the original draft as the framework, the strategy is currently being revised and redrafted according to the current situation.

Key affected populations

Challenges in reaching key affected populations include cultural barriers, and fear of stigma and discrimination. A series of surveys were planned to address the general lack of information on risk behaviours and HIV prevalence among key populations. Although the BBSS was interrupted, the results will be instrumental in creating more informed future outreach programs. Plans are underway to undertake additional KABP surveys (see M&E section for details).

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

Prevention programmes

Prevention programmes continue to be geared primarily toward increasing knowledge through school-based interventions. However, these have not been formally assessed and the 2005 KABP survey among high school students indicated that misperceptions persist and stigma is common.

Monitoring and Evaluation

See Monitoring and Evaluation section.

VI. Support from the country's development partners

As the country continues to plunge into sporadic warfare even after the civil war of 2011, there is an increasing reliance upon assistance from development partners for resumption of the HIV and AIDS response.

United Nations System:

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

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

UNAIDS

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

UNAIDS priorities are development of national HIV strategies and plans for strengthening HIV capacities, as well as re-establishing the United Nations HIV coordination system. Establishment of a Joint UN Team, to function as a coordination mechanism between UN system agencies, was agreed at an UN Country Team meeting. The Joint UN Team also includes other development partners, as well as national programme and civil society representatives.

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

UNODC

UNODC has established a Drugs and HIV Project with financing from the Libyan government in the amount of USD 6 million over four years. The project was suspended in 2011 due to the civil war, but is being restarted with the deadline extended. The project components include: a) rehabilitation of drug addicts; building or reconstruction of a centre in Tripoli and a centre in Benghazi; establishment of guidelines and training for drug rehabilitation; life skills education

in schools; b) capacity building of NGOs for outreach among key populations, training and awareness raising, establishment of drop in centres; c) HIV assessment in prisons, training and awareness raising among prison staff and inmates; and d) study tours in other countries of the region (Egypt, Morocco). A full time national project officer is based in the National AIDS Programme.

WHO

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

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

Other UN agencies

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

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

<u>European Commission</u>

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

A bio-behavioural study on HIV had been partially implemented by the Liverpool School for Tropical Medicine (LSTM) under another EC funded project. LSTM had also worked on the national HIV strategy development providing preliminary inputs to a process that was suspended during the conflict.

<u>International NGOs</u>

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

VII. Monitoring and evaluation environment

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

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

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

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

To address the challenges, several remedial actions are planned:

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

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