

# **UNGASS COUNTRY PROGRESS REPORT**

Libyan Arab Jamahiriya

*Reporting period: January 2008–December 2009*

***Submission date: March 31st 2010***

**Acknowledgements**

The National AIDS Program would like to express its thanks and appreciation to Dr. Abdulhafid A. Abudher, Director of the National Center for Infectious Diseases Prevention and Control (NIDCC), under whose guidance and leadership, the National AIDS Program operates. Special thanks are also extended to all stakeholders from the different Ministries in the Libyan Arab Jamahiriya who cooperate to implement the national response to HIV and AIDS and who provided valuable input into this report.

The Libyan Arab Jamahiriya's 2010 UNGASS Progress Report was written with support from UNAIDS MENA.

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## **II. Status at a Glance**

### **a. The Inclusiveness of the Stakeholders in the Report Writing Process**

The process to develop the Libyan Arab Jamahiriya's 2010 UNGASS Progress Report was led and facilitated by the National AIDS Program (NAP) Team within the National Center for Infectious Diseases Prevention and Control (NIDCC). Prior to launching the process to develop the UNGASS Progress report, bi-lateral meetings with held with key stakeholders within NIDCC, namely the National AIDS Program Manager and his team, the Head of the Program for the Prevention of Mother to Child Transmission, the Head of the Voluntary Testing and Counseling Program that is soon to be initiated, the Director of the Central Lab for Blood Safety, the Head of the TB Control Program, the Head of the School Health Department within the Ministry of Health, Legal Counsel for NIDCC, representatives from the Liverpool School of Tropical Medicine (LSTM), and the President of the National AIDS Network, a network of non-governmental organizations, working on issues of HIV and AIDS throughout the nation.

Under the auspices of the Director of the National Center for Infectious Diseases Prevention and Control, Dr. Abdulhafid A. Abudher, an open consultative meeting was held with the above mentioned stakeholders, in order to provide an introduction to UNGASS reporting requirements and indicators as well as to highlight the importance of reporting within the overarching, long-term goal of strengthening monitoring and evaluation systems for HIV and AIDS programming. It has therefore been critical to highlight how current UNGASS reporting processes are an entry point for highlighting information availability and gaps. As a result of weeklong bilateral meeting and a one-day consultative meeting, a two-month data collection plan was developed for the compilation of information required for UNGASS 2010 reporting. The Plan provides an overview of the information that was to be collected, its data source, responsibilities of the different stakeholders in collecting this information and ways by which the information could be validated for accuracy.

Due to the absence of UN agencies and civil society organizations in this broad consultative meeting, their input was solicited largely during bi-lateral meetings as well as through the administration of the National Policy Composite Index (NCPI) questionnaires. Validation of the data took place through bi-lateral meetings.

### **b. The Status of the Epidemic**

UNAIDS estimates in 2005 regarding the AIDS Epidemic in the Middle East point to approximately 720,000 people living with HIV in the region with up to 210, 000 newly infected adults and children in 2006 alone. While there is little in terms of accurate data on the extent of HIV and AIDS in the Libyan Arab Jamahiriya, adult HIV prevalence is reported to be low, at less than 0.2%. According to a national sero-prevalence study in 2004-2005 conducted by the National Center for Infectious Diseases Prevention and Control among 65,000 persons, using random cluster sampling, HIV prevalence in Libya was 0.13% overall (90 cases)<sup>1</sup>. In 2008, the National Infectious Diseases Control Center reported that the cumulative number of HIV cases in the Libyan Arab Jamahiriya was 11, 152, out of which 8, 654 were Libyan nationals<sup>2</sup>.

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<sup>1</sup> Abdel El Nasser Youseff El Zouky et.al., Libya national sero-prevalence study, 2004-2005

<sup>2</sup> Powerpoint from the National Center for Infectious Diseases Prevention and Control on the HIV Epidemic in Libya, 2008.

The HIV epidemic in Libya is concentrated among at-risk groups, namely injecting drug users (IDUs) with ID use as the dominant mode of transmission, and reaching as high as 90%<sup>3</sup>. Of the 570 new infections reported in 2000 in Libya, almost all were among IDUs. Since many injecting drugs users go to prison for possession of drugs, dealing of drugs, and theft due to their addiction, prisons are a potential feeding ground for the spread of the HIV epidemic. Like many countries of the MENA region, Libyan Arab Jamahiriya does not have the adequate monitoring systems required to monitor and report on HIV cases, particularly among high risks groups such as commercial sex workers, MSM and injecting drug users, so the actual extent of the epidemic in Libya remains unknown.

The relative youth of the Libyan population, and the fact that Libya is host to some 1.5 million irregular foreign immigrants, most of whom from sub-Saharan Africa and have no access to the public health system, highlights that the epidemic has great potential to persist and grow.

### **c. Overview of the policy and programmatic response**

#### **The Libyan Arab Jamahiriya's National Strategy for HIV and AIDS**

In late 2002, the Libyan government was able to launch the National AIDS Program for combating HIV and AIDS. The National AIDS Program began its activities with a launch of National AIDS week and in 2002, UN agencies working in Libya established a thematic group with the assignment of lending technical assistance to the National Aids Program. Subsequently, regular meetings were held by the National Center for Infectious Diseases Prevention and Control (NIDCC) to develop a national strategy and work-plan for the year 2003. To date, this National Strategy has not been developed but plans are underway, with support from the Government and with European Union (EU) funding and technical assistance to develop the National Strategy by 2011.

In 2009, and as part of its national commitment to issues of HIV and AIDS, the Libyan government and the EU launched a project for the development of an HIV strategy and support program. In a collaborative effort with the Liverpool School of Tropical Medicine (LSTM), the National AIDS Program is leading the effort to finalize the National HIV Strategy. In order to inform strategy development, a team of researchers from the LSTM, Libyan institutions and Harvard University's Biostatistics Department (HUBD) in the are currently compiling comprehensive information on the current epidemiology of HIV infection in Libya. The main goals of this partnership include the development of a National HIV Strategy, based on sound surveys and studies.

#### ***Policies***

Several policies and regulations exist in Libya that relate to issues of HIV and AIDS in country, and are having a direct effect on Libya's response to the epidemic.

- Libya's Law #20 stipulates free health care to all Libyan nationals to be provided by the government in any and all public health facilities;
- The policy to ensure that no individual is deported from the country due to HIV status, while in turn all entrants into the country for residency purposes are required to provide a health certificate, including information on HIV status;
- All employees are required to provide a health certificate and by Law, with the law stipulating that no individual should be discriminated against based on health status;

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<sup>3</sup> UNAIDS/WHO (2001) AIDS epidemic update 2001.

- As of 2009, a policy has been put in place to ensure that students applying for secondary or higher education no longer have to provide a medical certificate, with no student being rejected from university for HIV positive status.

Additionally, all individuals have to undergo pre-marital health screening, all entrants into prisons are required to undergo HIV and other testing, as well as all hospital admissions. However, according to both government and civil society representatives that responded to the NCPI, many of these policies require more stringent enforcement mechanisms, especially those policies to afford treatment, care in health facilities and that reduce discrimination in the workplace.

There is a strong civil society presence in Libya and the involvement of these critical players is critical to the fight against HIV and AIDS. There is an AIDS NGO Network in Libya, in addition to several active NGOs working on HIV/AIDS issues such as the Red Crescent, the Scouts Movement, the Libyan Youth Organization *A-Chabab Al Lybi, At-tahadi* and *Weetasemu* NGOs. These NGOs are engaged in a range of HIV related activities such as prevention activities, information provision, supporting PLHIV, and education programming. The Association to Care for Infected Children, which deals with issues such as stigma and discrimination faced by children infected with HIV. This new NGO, established since 2002, is working with the Libyan Red Crescent, which has been in the forefront to support the children and their families. Despite a relatively active civil society in Libya, the engagement of NGOs in prevention, treatment, and care remains limited and their potential is not yet fully utilized.

## **Prevention**

The Libyan Arab Jamahiriya's HIV prevention efforts in 2009 have primarily been led by the NIDCC and the National AIDS Program (NAP) and have focused to a large degree on raising awareness of the general public through media coverage, information, education and training for members of specialized field such as the legal, health and education, through mass media celebration of World AIDS Day, through greater civil society engagement as well as through maintaining of a nationwide commitment of general health education in schools.

According to the NIDCC 2009 report on activities undertaken by the NAP, major activities included conducting 12 training courses and 16 workshops on HIV and AIDS, many of which were conducted for members of the judicial authorities, to raise awareness and discuss the legal aspects associated with people living with HIV (PLHIV) and to formulate sound policies based on medical and legal knowledge. Several of these meetings were also held for the religious leaders as well as people living with HIV as well as their family members. Additionally, approximately 59 lectures were conducted on HIV, targeting a total of 7, 047 individuals from the education and other service sectors.

Specialized training and capacity building has been provided to specialists in the field of drug addiction, for nurses on universal precautions in the health setting, and other members of the medical profession. Additional activities focused on the inclusion of civil society organizations in prevention efforts. In an effort to promote testing and counseling, a pre and post counseling guide was developed and workshops implemented for social workers and members of the Center providing testing and counseling for people living with HIV. Outreach efforts supported by the Center have also focused working with the 17 existing AIDS committees in the different districts to support education and health activities related to HIV in the different districts.

HIV testing is carried out and widely available in Libya, relying on mandatory screening in instances such as admission to health facilities, referral of IDUs to rehabilitation centers, pregnant women prior to admission, pre-marital screening, and screening for work permits. A pilot program is being launched, with an intended 5 VCT sites with intentions to scale up VCT services in Libya. Currently, the NIDCC houses the HIV Education and Counseling Unit, which provides counseling for PLHIV and referral to care.

Screening of pregnant women is mandatory in Libya and most often takes place prior to delivery. A national program PMTCT has recently been launched to ensure that women are screened well in advance, and for the protection of their lives and the lives of their infants, through a more comprehensive package of antenatal care services. Currently only two health facilities admit pregnant women with HIV, namely the Tripoli Medical Center and the Infectious Diseases Department in Benghazi. The PMTCT program is therefore looking to achieve national coverage. It is currently carrying out basic health worker training on HIV/AIDS for the approximately 75% health care providers and will provide in 2010 a training on package of care/counseling.

According to responses received through the NCPIs, from both government and civil society organizations, prevention programs in Libya should focus in the next phase on aspects of blood safety, treatment for TB/HIV co-infection, promoting universal precautions in health settings, and addressing stigma and discrimination amongst the general public but also in health care settings. Another important factor of prevention that remains unaddressed is the limited prevention programming associated with most-at-risk and vulnerable populations, whether in IEC provision, risk reduction for sex workers and MSM or harm reduction for IDUs. There are currently no outreach programs for most at risk populations.

### **Treatment, Care and Support**

ART is provided free of charge to all Libyan nationals seeking treatment. There is currently no nationwide information on the number of adults and children who are HIV infected who are receiving ART. There are no national level program monitoring tools in place yet to accurately monitor and report on number of adults and children receiving therapy, although an effort is currently underway to develop a system that provide estimates on the number of adults and children with advanced HIV infection, and can determine the numbers that are receiving treatment. This system is being developed in 2010.

Anti-retroviral treatment is being offered and distributed from the Central Pharmacy in NIDCC center to the different infectious departments in hospitals in the country and is offered free. HIV testing and counseling but the quality of post test counseling requires enhancement, particularly the psychosocial and physical aspects related to care and support of PLHIV and their families. To date, the guidance and counseling unit within the NIDCC has provided psychosocial, nutritional support to 67 male and females living with HIV. According to NCPI responses from government, VCT services remain under-used, and that there lack of coverage and quality of HIV testing and counseling services being provided to higher-risk populations. Stigma and discrimination, especially within the health care setting still need to be adequately addressed.

#### **d. UNGASS indicator data in an overview table**

The following Table summarizes the update on UNGASS and other national indicators. More details on each indicator value are to be found in the on-line report as well as in the body of this report.

**Table 1: UNGASS and National Indicators Overview table**

<b>NATIONAL COMMITMENT AND ACTION INDICATORS</b>	
1. National Spending	No NASA was conducted to generate this information.
2. National Composite Policy Index	A total of 9 NCPI questionnaires administered (6 to Government, 1 from CS and 1 PLHIV and UNDP). Comments are included throughout this report.
<b>INDICATORS OF NATIONAL PROGRAMS</b>	
3. Percentage of donated blood units screened for HIV in a quality assured manner	To date, no standard protocols, and no quality assurance or quality control assurance at national level.
4. Percentage of Adults and Children with advanced HIV Infection receiving ART	There is currently no nationally representative data for this indicator. A database is being developed for this purpose.
5. Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission	There is currently no nationally representative data for this indicator. A database is being developed for this purpose. Draft National Guidelines exist for the care of adult HIV positive patients, as well as for the use of ART agents in pediatric HIV infection and the Prevention for mother to child transmission. No Spectrum Projections for Libya available
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Libya is currently strengthening the system in 2010 to monitor and follow up numbers and treatment for HIV positive incident TB cases. Data available for number of cases and treatment for TB only for 2007, 2008 and partially for 2009. National Guidelines for treatment of co-infections are under development by scientific committees at NIDCC.
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	No population based surveys undertaken. Screening done for Premarital, pre-employment, hospital admission etc.
8. Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results	No data is available because of lack of Behavioral surveillance or other special surveys. Most recent data includes the 2004 sex workers KABP (convenience sampling), Assessment of mode of transmission study—2005 (in two districts of Tripoli).
9. Percentage of most-at-risk populations who reached with HIV prevention programs	No data is available because of lack of Behavioral surveillance or other special surveys. To be available with 2011 BBSS.
10. Percentage of orphans and vulnerable children aged 0-17 whose households received free external support in caring for the child	Topic is not relevant to country epidemic status. Mainly for generalized epidemics.
11. Percentage of schools that provided life-skills based HIV education within the last academic year	Life skills based HIV education, not incorporated in schools. A School Based Survey on knowledge re: HIV conducted in 2008 (administered to 26,000 students).
<b>INDICATORS FOR KNOWLEDGE AND BEHAVIOURS</b>	
12. Current school attendance among orphans and non-orphans aged 10-14	Topic is not relevant to country epidemic status. Mainly for generalized epidemics.



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13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	No population based surveys undertaken.
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Topic is relevant, indicator appropriate but no special behavioral survey undertaken. To be available with 2011 BBSS
15. Percentage of young women and men who have had sexual intercourse before the age of 15	No population based surveys undertaken. Mainly for generalized epidemics.
16. Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	No population based surveys undertaken. Mainly for generalized epidemics
17. Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last sexual intercourse	No population based surveys undertaken. Mainly for generalized epidemics
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	No behavior survey conducted, To be available with 2011 BBSS
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No behavior survey conducted, To be available with 2011 BBSS
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	No behavior survey conducted, To be available with 2011 BBSS
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	No behavior survey conducted. To be available with 2011 BBSS
<b>IMPACT INDICATORS</b>	
22. Percentage of young people aged 15-24 who are HIV-infected	No biological survey conducted.
23. Percentage of most at risk populations who are HIV-infected	To be available with 2011 BBSS.
24. Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of ART	No cohort analysis conducted
25. Percentage of infants who are born to HIV-infected mothers who are infected	No Spectrum Projections available for Libya

### III. National response to the AIDS epidemic

#### 1. National Commitment/National Expenditure on HIV

The government of the Libyan Arab Jamahiriya is the primary provider of resources to HIV/AIDS programming. However, there is also no data on actual financial expenditures that have been or are being made up to the present time or the categories of spending associated with HIV/AIDS programming. The government of the Libyan Arab Jamahiriya has made some significant financial commitments in the recent past to tackle issues of HIV and AIDS. While no National AIDS Spending Assessment (NASA) was conducted to determine how much was spent on HIV and AIDS-related activities over the course of the reporting period, recently it has been reported that Libya is to allocate \$2 million to the national HIV/AIDS response in the country, including prevention and care in prisons and treatment centers for IDUs.

Additionally, the European Union has made financial commitments in support of the HIV/AIDS programming in Libya since 2004. The preparatory phase for work between the EU and the government of Libya was carried out from November 2004 to August 2005 in support of structural changes at the Benghazi Centre and at national level, were financed by the European Commission for a total amount of € 162,500. This first phase of cooperation with the EU was supported in 2005 with a grant of € 1,000,000 to support the HIV Action Plan for Benghazi until 2006. The second phase of cooperation was launched and financed with an additional € 1 million in March 2006 and will further contribute to the development of a national strategy for treatment of HIV/AIDS.

#### Indicator # 2: National Policy Composite Index

Responses to the NCPI questionnaires were received from 6 governmental representatives, one civil society organization, one person with living with HIV and the UNDP and are analyzed below:

The Libyan Arab Jamahiriya currently does not have a National Strategy to guide the national response to HIV and AIDS. Despite this, there is some political support for HIV and AIDS in Libya, as evidenced through the establishment of the National AIDS Program and 17 sub-committees in the different districts to support activities on HIV and AIDS. The important achievement that has been cited is that Libya has launched the process to develop its National Strategy, largely built on nationally led studies as well as the Bio-behavioral surveillance survey that is planned for 2010.

There is a wide recognition of the current efforts by the NIDCC and NAP to ensure that prevention programs as well as treatment and care is provided to Libyan nationals. Prevention activities have mostly focused on raising public awareness through IEC campaigns, collaboration with NGOs such as *Weetasemu* and others on awareness raising for the general public, maintaining appropriate and culturally appropriate messages in schools, and training of judicial authorities and religious leaders to spread awareness on HIV and AIDS. Additional activities are underway to implement quality PMTCT and VCT programs, but these are not yet applied nation-wide.

Challenges however remain in that activities to date require more organized planning and a clearer indication of available budget, in addition to greater policy and resource availability from policy makers. Respondents to the NCPI from government stated that more can be done to ensure that HIV and AIDS is integrated into National Development Strategies and that existing general policies which are protective of rights are enforced. While there are general non-discrimination laws and regulations, there are no explicit provisions or enforcement mechanisms regarding the rights of people living with HIV.

According to responses received through the NCPIs, responses received from PLHIV and CS outlined the importance of addressing the rights of people living with HIV, in an environment that is now gradually becoming more open to talking about issues of HIV and AIDS. Regulations that were outlined as requiring attention, include the requirement of a health certificate as a precondition of employment and marriage, which often restricts the right of PLHIV to access employment and to marry. Challenges that were identified in terms of quality treatment include policies that are inhibiting people from coming forward for testing, the current strength of counseling services and psychosocial support provided to people living with HIV and their families. Issues of stigma and discrimination, especially in the health care setting, were also mentioned as requiring greater efforts, especially in increasing the awareness of doctor and nurses regarding the medical rights of PLHIV.

Several challenges remain in implementing a set of prevention services, namely to target most-at-risk groups in Libya. There are currently no harm reduction or risk reduction programs for IDUs, sex workers or men who have sex with men. With the expectation of injecting drug use, little is known about these high-risk groups in Libya, and there is a need for programs that can strengthen existing services, especially rehabilitation for HIV-infected IDUs, as well as provide new risk and harm reduction programs for high-risk populations. This is deemed as one of the ways to encourage more PLHIV from most-at-risk populations to come forward and access the available treatment and support.

Free treatment is afforded to all people living with HIV, without restrictions. However, no comprehensive data exists on the number of people in Libya that are actually on treatment or those that actually require treatment but are not yet receiving it. This applies to age and sex disaggregated data on ART, as well as lack of data on HIV-pregnant women who require or are receiving ART to reduce the risk of mother-child-transmission. As such, monitoring and evaluation systems and capacity as the area requiring greatest support in the coming period, and that much needs to be done following the development of the National Strategy to put in place the required guidance and tools, to improve monitoring, surveillance and reporting progress in these key areas of prevention and treatment, care and support.

### **Indicator #3: Blood Safety**

Strengthening blood safety is a core activity currently being undertaken in collaboration with the European Union (EU) to strengthen the national blood safety program. The program is focused on promoting supportive legislation to govern blood safety and infrastructure development, starting with blood banks in Benghazi blood bank, and extending to regions of Sabha and Tripoli. The program is intended to develop procedures, human resource capacity and the reorganization of blood transfusion at the national level.

Currently, there are no nationally representative data available on numbers of blood units donated and screened in a quality assured manner. Blood banking is not centralized, with all hospitals throughout Libya receiving blood donations, carrying out screening, but without adherence to standard operating procedures or external quality

assurance schemes. Nationally representative data on number of units donated, and number of units screened in a quality assured manner is there for not available. Plans are underway in 2010 to ensure standard procedures and external quality assurance is adhered to nationwide.

**Indicator #4: Percentage of Adults and Children with Advanced HIV infection receiving ART.**

There are no national level program monitoring tools in place yet to accurately monitor and report on this indicator, although an effort is currently underway to develop a system that provide estimates on the number of adults and children with advanced HIV infection, and can determine the numbers that are receiving treatment. This system is being developed in 2010. Draft National Guidelines exist for the care of adult HIV positive patients, as well as for the use of ART agents in pediatric HIV infection and the Prevention for mother to child transmission. Field-testing of the National Guidelines for adult HIV positive patients is in process in 2010.

**Indicator #5: Percentage of HIV positive pregnant women who received antiretroviral medicines to reduce the risk of mother to child transmission**

There is currently no nationally representative database in place to monitor PMTCT activities being undertaken in Libya. The NAP is in the process of developing the relevant database for this purpose, and draft monitoring forms have been developed for the purposes of follow-up. The data that currently does exist covers only fifty centers (75% of current antenatal clinics in Libya in hospitals and health centers with the exception of the Eastern region of Libya). Training is also being provided for ANC health care providers as well as the network of community focal points for the program. Health care providers are being provided with a basic training package on HIV transmission, prevention and awareness as well as on care and counseling. Workshops are also being planned on M&E, surveillance and on the tools.

**Indicator #6: Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV**

In 2010, Libya plans on strengthening the system to monitor and follow up on HIV positive incident TB cases and provision of treatment for HIV and TB. Current data provided by the TB Control Program for 2007, 2008 and 2009 reports the number of incident TB in Libyans living with HIV to be 18, 33 and 27 cases respectively. No data is available for the number of Libyan nationals with HIV who received ART and were started on TB treatment in 2009. National Guidelines for treatment of co-infections are under development by the scientific committees at the NIDCC.

**Indicator #7: Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results.**

No population-based survey has been conducted in Libya. Libya undertakes pre-employment and pre-marital testing, as well as testing for hospital admissions. Approximate number of HIV tests undertaken during 2009 are not available, but approximates obtained from the Center for Documentation and Information in the General Secretariat of Health and Environment indicate that a total of 774, 704 tests were undertaken in 2008. This data is collected from 82 hospitals throughout Libya.

**Indicator #8: Percentage of most at risk populations that have received an HIV test in the last 12 months and who know the results**

No behavioral or special surveys have been conducted to date on at risk groups. The 2010-2011 BBSS is expected to provide this information in the future.

**Indicator #9: Percentage of most at risk populations reached with HIV prevention programs**

No behavioral or special surveys have been conducted to date on at risk groups. The 2010-2011 BBSS is expected to provide this information in the future.

**Indicator #10: Percentage of orphans and vulnerable children aged 0-17 whose house-holds received free basic external support in caring for the child**

Libya is not facing a generalized epidemic and therefore number of orphans in country is considered few. Care and support for orphans are generally provided by extended family, and those children who are in orphanages are provided free health and education. This is a law that is protective of the rights of orphaned children, but with slight exceptions due to implementation of the law, with some difficulties in admission to orphanages depending on status of children with infectious diseases.

**Indicator #11: Percentage of schools that provided life skills-based HIV education in the last academic year**

No life skills-based HIV education was introduced in schools during the last academic year. An annual plan guides the implementation of school health activities, in collaboration with social workers and the *Awkaf/Islamic Affairs Institution*, in order to provide contextually appropriate messages to students in schools. The focus of school health activities during 2009 has been on providing general information on prevention to school students in all public and private education facilities. The program also focuses on training of social workers in each to the different districts provide the medical, social and religious perspectives to students regarding HIV and AIDS. The program therefore aims at ensuring that there are trained personnel within all schools and has to date, been able to reach up to 121, 976 students in 549 schools and teaching institutions.

As part of the school health efforts towards HIV prevention, approximately 7,000 mothers of student in schools were provided general health awareness on HIV prevention within the initiative called 'For Safer Family Health' conducted in collaboration with NIDCC, *Weetasemu* NGO, and the Department for Combating Drugs. A campaign was also launched in 2009, with focus on the harms associated with drug use, and links issues of HIV prevention in all in and out of school campaign messages. Participant in this campaign include religious figures, social workers, and PLHIV. In 2009, the campaign targeted approximately 679, 121 students and was followed by the administration of a knowledge and attitude questionnaire to ascertain the effectiveness of such health awareness activities. Results of the 26,000 responses obtained have yet to be analyzed.

**Knowledge and Behavior**

**Indicator #12: Current School attendance among orphans and among non-orphans aged 10-14**

NA-See Indicator #10-Relevant for generalized epidemics.

**Indicator #13: Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission**

The 2008 National Study on Family Health, covering a sample of 19, 426 families (18, 629 respondents), included a question on knowledge of HIV and AIDS with 87% of respondents between the ages of 15-25 stating that they know what HIV and AIDS is. The study however, does not provide information on respondents' knowledge of modes of transmission or prevention methods of HIV and AIDS.

The study on 'HIV-related knowledge and stigma among high school students in Libya' to ascertain the levels of knowledge of transmission of HIV as well as measure indicators of HIV-related stigma amongst 1, 082 male and female students in the North West region of Libya. It is important to note that the five standard UNGASS questions to ascertain levels of knowledge regarding prevention and regarding misconceptions were not included in this study and focused primarily on knowledge rather than behavioral questions. Responses also revealed that students, the majority of whom were between the ages of 15-18 years, had low level of knowledge of STIs and HIV/AIDS, their symptoms and transmission. Out of the total, 450 (42%) students agreed that HIV can be transmitted through use of public toilets, while 330 students (31%) stated that HIV infection can be transmitted by getting near to an HIV-infected individual while sneezing or coughing, and 327 students or (30%) stated that HIV can be transmitted by looking after an HIV infected individual. In total, 632 students or (64%) recognized that two out of the three statements used to probe levels of knowledge, do not expose an individual to HIV infection.

Results revealed that there is high level of stigma among the students towards HIV infected individuals. Students were asked if HIV infected individuals were dangerous to other, to which some 371 students (34%) strongly agreed and 295 students (27%) agreed. Students were also asked if HIV infected individuals should be banned from entering the country, to which 503 students (47%) strongly agreed and 151 students or (14%) agreed. Despite high level of stigma, 91% of students support providing free care to HIV infected individuals. Because understanding the behavior of risk groups in a society, such as young people, is essential in order to draw effective prevention strategies, stigmatizing and the discriminatory perceptions of HIV infected individuals were deemed as essential to the IEC and education campaigns in Libya.

**Indicator #14: Percentage of most at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission**

Libya is taking important steps in 2010-2011 to undertake its Bio-behavioral Surveillance Survey, within which critical information is being gathered regarding most-at-risk and vulnerable populations nationwide. The BBSS will include the key UNGASS questions on most-at-risk populations. Information on these populations in Libya is currently scarce, and is predominantly focused on IDUs. The most recent related study was the Rapid Assessment of HIV/AIDS and Injecting Drug Users Report<sup>4</sup>, was carried out between August 2003 and May 2004, the country's largest city and the one most affected by drug use. The quantitative study was for 169 drug users, and revealed that more than (90%) of the 169 IDUs surveyed had heard of HIV or AIDS. As was the case with the Libya National Health Survey, this should not be taken to denote that they are aware of modes of transmission. Additionally, the report reveals that out of the drug users surveyed who had ever been tested for HIV, nearly one quarter (22%) had tested positive. About 70% of drug users surveyed said they had engaged in behaviors that put them at great risk of contracting blood-borne diseases such as HIV and HCV.

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<sup>4</sup> Rapid Assessments of HIV/AIDS and Injecting Drug Use in Algeria, Egypt, Iran, Libya, Morocco and Oman: Findings and Lessons Learned. AIDS Project Management Group, 2008.

**Indicators #15, 16, and 17: Sexual intercourse before the age of 15, sexual intercourse with more than one partner in the last 12 months, and reported use of a condom during last intercourse.**

No Population Based Surveys have been conducted to provide data for the above-mentioned indicators, with concerns expressed over religious and cultural appropriateness of related questions.

**Indicators#18, 19, 20: Percentage of female and male sex workers reporting the use of a condom with their most recent client, use of condom at the last time anal sex with a male partner and use by IDUs of condom during last sexual intercourse.**

No Special Behavioral Surveys have been conducted to provide data for the above-mentioned indicators. The BBSS 2010/2011 is looking to include questions related to these indicators.

**Indicator # 21: Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected**

According to UNAIDS Notes on AIDS for the MENA region in 2008, levels of needle sharing in Libya is reported at 44% amongst IDUs in Libya. There appears to be a growing trend in percentage of IDUs who are injecting or sharing injections appears, however, Libya has yet to conduct behavioral surveys for IDU to determine and report on this percentage.

The most recent information regarding use of sterile injecting equipment during last injection by IDUs is through the Rapid Assessments Report for Libya which reveals that nearly all (99%) of those 169 IDUs interviewed said they had taken drugs up to a month (at least) before being questioned. With regards to HIV transmission risk factors, nearly half (44%) of the 169 IDUs surveyed said they had shared needles with others more than one time. Eleven percent reported rarely if ever using new needles when injecting. They also said they did not perceive a risk in sharing needles and were unaware of the possible negative health consequences. More than a third (40%) of drug users surveyed said they rarely, if ever, cleaned needles before reusing—even though they knew of the health risks involved. More than one in ten (13%) of drug users surveyed said they had shared needles with HIV-positive users.

**Indicator #22: Percentage of young women and men aged 15-24 who are HIV infected**

No HIV Sentinel Surveillance. Indicator applicable for generalized epidemics.

**Indicator # 23: Percentage of most at risk populations who are HIV infected**

Libya BBSS is being planned for 2010-2011.

**Indicator #24: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy**

This data is not available for 2009. The NAP is in the process of developing a database to include this information starting 2010.

**Indicator #25: Percentage of infants born to HIV infected mothers who are infected.**

There are no spectrum projections for the Libyan Arab Jamahiriya.

#### **IV. Best practices**

**National AIDS Sub-Committees:** There are 19 National AIDS Sub-Committees throughout Libya, affiliated to the National AIDS Program. The committees are representative of five different sectors, namely Health, Education, Religious Affairs, General Security and NGOs and assist in the implementation of the NAPs annual AIDS plan. The main role of these sub-committees is to spread awareness and knowledge regarding HIV, including transmission, prevention, knowledge of availability of treatment and care, as well as to help reduce stigma and discrimination. Sub-committees play an active role during World AIDS Day, and the national week for HIV and AIDS, which includes a mass information, education and communication activities. The sub-committees meet on an annual basis to provide updates on HIV activities, share experiences that are unique to their region, as well as discuss challenges and propose solutions.



## **V. Major challenges and remedial actions**

### **A National Strategic Plan for HIV and AIDS**

Libya is currently in the process of developing its National Strategy for HIV and AIDS. This national response effort will largely be based/informed by findings of nationally led studies, such as the National Sero-Prevalence Study, but also by the soon-to-be launched Bio-Behavioral Study and KAPB studies for key community groups. In the absence of a unifying strategic plan, program implementation has focused on increasing public awareness on HIV, maintaining awareness in schools, carrying out programming on VCT and PMTCT. However, much remains to be done to ensure that there is a multi-sectoral, comprehensive national response, which includes a number of line ministries, and which articulates a framework for monitoring and evaluating progress towards nationally set targets. The National Strategy for Libya is planned for 2011, and based on findings of these major studies.

### **Reaching Most at Risk Groups in Libya**

Libya currently does not have any programs that specifically reach and target most at risk groups, access to such populations, obtaining size estimations, understanding risk factors and risk behaviors, and getting an accurate description of the drivers of the epidemic in Libya remains a challenge. Because injecting drug use represents a major mode of HIV transmission, with IDUs constituting up to 91.7 per cent of the 4,439 HIV/AIDS cases registered among Libyan nationals up to the end of 2001, it is important to obtain more nationally representative figures of this high-risk group. A challenge remains with regards to undertaking special studies and surveys in a contextually appropriate manner and using the information generated by such studies to develop programs that specifically target high-risk groups. Additionally, cultural and social sensitivities have limited the initiation of programs or initiatives for other high-risk groups such as sex workers and men who have sex with men.

### **Prevention**

Prevention efforts have been geared to providing accurate knowledge on HIV through the school based health education system. However, there is a lot of cultural sensitivity associated with the issue. Teachers and social workers require greater skills in tackling such sensitive issue areas, and as such students are may not be receiving the information that they need. As evidenced by responses (unpublished) of 26, 000 students surveyed, and the KAPB study in two districts in Tripoli (UNGASS knowledge and behavior questions not asked) there is a high degree of misconception amongst students with regards to prevention and modes of transmission amongst students at secondary school level. As recommended by the KAPB study on HIV-related knowledge and stigma among high school students in Libya "Education represents the best opportunity for delivering crucial information on HIV and AIDS but also for chipping away at ignorance and fear that perpetuate stigma and discrimination". An assessment of school based education programs, provided by the Ministries of Health and Education, has not yet taken place.

### **Monitoring and Evaluation**

M&E is the area largely unknown to many stakeholders who informed the NCPI, the extent of the information that is gathered is not clear and the way in which HIV-related information is used is the area of least clarity. As such, it was cited as ones of the areas requiring more substantial attention in the short to medium turn, with one of the challenges being the existing capacity and resources to develop and implement an M&E Plan. Without a comprehensive M&E plan, this is hindering the ability to obtain, and appropriately use, the data to the benefit resource allocation, development of programs or at the policy level.

## **VI. Support from the country's development partners**

### **WHO**

The WHO in Libya provides on going technical support to the National Infectious Diseases Control Center, most recently in its efforts to promote voluntary testing and counseling. A special mission from WHO EMRO provided both technical input into the proposed pilot voluntary counseling and testing program, soon to be launched in 4 different geographic locations across Libya. It also provided specialized training for social workers and counselors on the different aspects associated with implementing the VCT pilot program.

### **UNDP**

The United Nations Development Program is currently collaborating with the NIDCC, under the Program to Strengthen the National Response to HIV and AIDS. Within this partnership UNDP has carried out a series of workshops to strengthen the national response effort amongst religious leaders, the media, people living with HIV, youth, legislators, IDUs, and civil society organizations. Additional workshops have taken place for the heads of school education activities at sub-regional level as well as on the rights of children living with HIV. The collaboration with UNDP will continue to focus on strengthening the capacity of NIDCC to implement the national response to HIV.

### **EU Program**

Two strategic goals currently guide the EU cooperation with the NIDCC, namely the development of the National Strategy on HIV and AIDS and the Strategy to Promote Blood Safety. The four components of this cooperation effort include providing continued support for Benghazi Hospital, development of the NAP capacity, supporting a comprehensive package of care for 5 Hospitals and 5 Labs as well as addressing stigma and discrimination in the health sector. The EU is also providing training and capacity building through medical training curriculum.

### **The Liverpool School of Tropical Medicine**

Libya's Bio-behavioral Surveillance Study and an additional three special KABP studies are being planned for 2010, upon which Libya's National AIDS Strategy will be built. This effort is being led by the Liverpool School of Tropical Medicine (LSTM) in collaboration with the National Center for Infectious Diseases Prevention and Control. Important to note is that the BBSS that is planned has taken into consideration all of the key UNGASS indicators on most-at-risk populations. Depending on resource availability, the LSTM will carry out three KABP studies for youth and religious leaders.

## VII. Monitoring and evaluation environment

### Overview of Monitoring and Evaluation System

The Libyan Arab Jamahiriya currently does not have a HIV and AIDS National Strategy, with an accompanying M&E framework or annually costed operational plan. Plans are underway to launch the development of Libya's National Strategy, largely based on information generated through nationwide surveys and studies as well as the Bio-Behavioral Surveillance study among high-risk groups, planned for 2010-2011 in Libya. In the absence of a national strategic plan on HIV and AIDS in Libya, a monitoring and evaluation framework is not yet in place to guide the different stakeholders involved in the national response effort or to assess the effectiveness of current programs such school education or the PMTCT programs.

As outlined throughout this report, there is also limited epidemiological data on current most at risk populations in Libya, with the exception of a growing body of knowledge on injecting drug use in Libya and its growing impact on the HIV epidemic. As such, Libya is still in the process of building a critical mass of information about the drivers of the epidemic. Because IDUs has accounted for the majority of persons known to be HIV infected in Libya, plans are underway to execute comprehensive surveys on drug-taking and the transmission of infectious diseases in order to monitor the prevalence of drug use and infectious diseases.

### Challenges and Remedial Actions

As a result of bi-lateral meetings as well as the broad consultative process that took place for the two-month reporting plan for UNGASS, several key M&E strengthening needs emerged for which remedial actions are being planned over the course of 2010/2011:

#### ***Conducting an M&E Systems Assessment and using outcomes to help inform the development of the M&E framework and guide for Libya's National HIV and AIDS strategy.***

There is a need for assessing and strengthening the monitoring and Evaluation systems and capacity in Libya. A core activity requiring support during 2010 is a comprehensive assessment of the current Monitoring and Evaluation system that is currently in place and recommendations for improvement. This will be done concurrently with the process to develop the National Strategy on AIDS so that the development of an associated M&E Framework take into consideration the recommendations made by the assessment. Integral to this, is aligning this process with the current thinking within one component of the EU-funded program to build the capacity of the NIDCC in monitoring and evaluation. This component includes an emphasis on building the capacity of existing NAP staff in M&E. As such, an M&E assessment will provide an outline of the exact capacity needs that are required for 2010 and 2011.

#### ***Monitoring Support of current Programs on AIDS***

The M&E systems of current and soon-to-be launched programs such as the PMTCT program and the VCT program require the strengthening of their monitoring and reporting systems, based on nationally set targets. For the current PMTCT program, a strong monitoring system and database is not yet in place for the PMTCT program. A

review the tool and formats is currently underway so that the system can be further developed. Likewise, a pilot voluntary counseling and testing program is soon to be launched in 4 different geographic locations across Libya. The VCT pilot does not yet have a monitoring and reporting system in place. With the aim of ultimately take this pilot to scale, integrating the services into 26 regional existing branches, developing monitoring system is a critical need for replication and reporting purposes. Monitoring and reporting formats are currently being developed to 1) capture the required information, 2) provide accurate figures at 'Chabia' (province) levels, and are ultimately 2) align with national level indicators.

### ***Bio-Behavioral Surveillance and Special Studies***

During 2010-2011, the National AIDS Program will be largely involved in the Bio-Behavioral Surveillance study (BBSS) and in additional special KABP studies that are being planned, and upon which Libya's National AIDS Strategy will be built. Led by the Liverpool School of Tropical Medicine, the BBSS will include questions to address the UNGASS indicators directly related to most-at-risk populations. Also depending on resource availability, the LSTM also intends to carry out three important KABP studies for youth and religious leaders. Both these efforts will provide the National AIDS Program with ample information to develop the National Strategy on AIDS as well as its associated M&E Framework. The LSTM will work towards the development of an M&E system, including an assessment of M&E needs, and recommendations for activities. Further support will be required to develop target programs and interventions that respond to the findings, an M&E Framework to monitor progress.

### ***Institutional Capacity***

As outlined above, there is expressed need for M&E human resource capacity strengthening within the NIDCC, for the purposes of monitoring, evaluation and learning, but also in light of extensive NIDCC staff future involvement With 2010 being the focus of such specialized studies, to inform the national strategy, human resource capacity development is a priority for 2010. The NIDCC has recently established a Planning, Monitoring and Evaluation Unit within the AIDS Program, which will support the national AIDS Program's M&E efforts in the next phase. A comprehensive needs assessment of M&E priorities for systems strengthening will take place in 2010.