



Final Report



Advocacy Needs Assessment for Youth and HIV in Lebanon

Beirut, Lebanon
3-22 September 2004

*Prepared by:
Dr Alissar Rady
Consultant, UNFPA*

Table of Contents

List of Acronyms

Definition of the Young People

1. Introduction

2. HIV/AIDS Statistics in the Regional and National Context

- 2.1. Regional Context of the HIV/AIDS Epidemic**
- 2.2. Lebanese National Context of the HIV/AIDS Epidemic**
 - 2.2.1. General HIV Statistics
 - 2.2.2. Vulnerable Groups
 - 2.2.2.a. *Mobile Populations*
 - 2.2.2.b. *Prisoners*
 - 2.2.2.c. *Armed Forces*
 - 2.2.3. High Risk Groups
 - 2.2.3.a. *Female Sex Workers (FSW)*
 - 2.2.3.b. *Men having Sex with Men (MSM)*
 - 2.2.3.c. *Injecting Drug Users (IDU)*

3. Vulnerability of Young people in the Context of HIV in Lebanon

- 3.1. Awareness and Knowledge about HIV/AIDS/STIs**
- 3.2. Practices and Behaviors at Risk for HIV Infection**
- 3.3. Attitudes and Perception of HIV Risk**
- 3.4. Access to Information on HIV/STI**
- 3.5. Availability, Access to and Utilization of Youth Friendly services for HIV/STI**
- 3.6. Socio-economic situation**

4. National Response

- 4.1 The Government Response**
 - 4.1.1. The National AIDS Program (NAP)- response of the MOPH:
 - 4.1.1.a. *NAP Structure, Management and Operational Aspects*
 - 4.1.1.b. *Main NAP Activities*
 - 4.1.2. Response of Other Ministries Concerned with HIV/AIDS and Youth
 - 4.1.3. HIV/AIDS Related Policies and Regulations
- 4.2. The Civil Society's Response**
 - 4.2.1. The response of the Non governmental Organizations
 - 4.2.2. The response of the Private Sector
 - 4.2.3. The response of the Media
 - 4.2.4. Special projects: Success and failure

- 4.2.4.a. *HIV Education Package for School Curricula*
- 4.2.4.b. *Outreach High Risk Group Study*
- 4.2.4.c. *Video by Youth on Sexual and Reproductive Health*
- 4.2.4.d. *Inventory on Research Related to SRH including HIV*
- 4.2.4.e. *Support Group for People Living with HIV/AIDS (PLWA)*

4.3. The Response of the International Agencies

4.4. Financing of HIV Activities

5. Perception of Stakeholders of the Issues on Youth and HIV

6. Advocacy Needs: the Identified Gaps

- 6.1. In terms of Information, Communication and Education**
- 6.2. In terms of availability and accessibility to Services related to HIV**
- 6.3. In terms of Research**
- 6.4. In terms of Budget**
- 6.5. In terms of Policies**

7. Conclusion and Suggestions:

- 7.1. Conclusions: Opportunities and Constraints**
- 7.2. Suggestions**

- Annex 1: List of References
- Annex 2: List of Tables and Graphs
- Annex 3: Questionnaire Regarding Key Informant Interview
- Annex 4: Lebanese Team of the Global Youth Partners Who Took Part in the Interview Process
- Annex 5: Stakeholders Interviewed During the Consultancy

List of Acronyms

AIDS	Acquired Immuno Deficiency Syndrome
ARV	Anti-Retroviral Treatment
FGD	Focus Group Discussion
FSW	Female Sex Workers
GO	Government Organization
GYP	Global Youth Partners
HIV	Human Immuno Virus
HRG	High Risk Group
IDU	Injecting Drug Users
IEC	Information, Education, and Communication
ILO	International Labor Organization
IT	Information Technology
IMR	Infant Mortality Rate
KAP	Knowledge, Attitudes, and Practices
LAS	Lebanese AIDS Society
LFPA	Lebanon Family Planning Association
MDG	Millennium Development Goals
MENA	Middle East and North Africa
MMR	Maternal Mortality Rates
MOSA	Ministry of Social Affairs
MOPH	Ministry of Public Health
MOEd	Ministry of Education
MSM	Men Having Sex with Men
MTCT	Mother To Child Transmission
NAP	National AIDS Programme
NHHEUS	National Household Health Expenditures and Utilization Survey
NGOs	Non Governmental Organizations
PHC	Primary Health Care
PLWHA	People Living with HIV/AIDS
RH	Reproductive Health
STI	Sexually Transmitted Infections
SRH	Sexual and Reproductive Health
SIDC	Soins Infirmiers et Développement Communautaire
STIs	Sexually Transmitted Infections
SW	Sex Workers
UN	United Nations
UNAIDS	United Nations AIDS Program
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNTG	United Nations Theme Group on HIV/AIDS
VCT	Voluntary Counseling and Testing
WAD	World AIDS World
WB	World Bank
WHO	World Health Organization

Definition of the Young People

Youth, Young people, Adolescents, Young Adults are usually used interchangeably in various references, with the age brackets varying depending on the indicator being studied. For example, Infant Mortality Rate (IMR), Children Mortality Rates, are calculated regarding the age groups less than 1 year or less than 5 years or less than 15 years of age. Many a times, age groups are merged as children more than 5 years or youth less than 15 years, or adolescents less than 18 years etc...

*Therefore, for the sake of simplification and maximizing the use of the data available, and in view of the linkages between HIV/AIDS and Sexual and Reproductive Health (SRH), where adolescence is the transition phase when most of the behaviors acquired remain in adulthood, specifically health and health risks related behaviors, the age bracket targeted in this review will be limited between 13 and 24 years, including early adolescence (13-15years), late adolescence (16-19years) and early adulthood (20-24years). The people falling within this age bracket will be referred to as **Young People.***

1. Introduction

For the past two decades, the HIV epidemic has been spreading across the world sparing no country and making no difference as to the ethnic, racial, religious, cultural, age, gender, educational level, political affiliation, or socio-economical status of the people being infected. The HIV/AIDS epidemic has proven to be a complex epidemic where the individual behavior, determined by various social, economical and political factors, added to its fast spread. It is therefore not a typical public health problem, but a myriad of issues interacting and necessitating a multi sectoral, multidimensional coordinated approach at national level as well as international level. In many countries heavily affected by the epidemic, the negative impact of HIV/AIDS has been so severe that it reversed the results of decades of efforts towards development and reaching the Millennium Development Goals (MDG).

On the other hand, data collected all over the world indicates that young people are becoming more and more affected by the epidemic, especially children and adolescents, particularly those that have high risk sexual behaviors or live in environments that aggravate their vulnerability to acquiring HIV. In fact it is estimated that around 8 million young people between the ages of 15 and 24 years are living with HIV/AIDS (1). Note that HIV infection among young people remains tightly linked to their sexual and reproductive life and rights, and often considered too sensitive to be addressed adequately.

Nevertheless, the collective experience has shown that the epidemic can be slowed down if approaches aiming at reducing risks and vulnerability and at alleviating the impact and burden of HIV/AIDS are adopted. The international experience has also shown that pre-emptive efforts and interventions undertaken promptly by governments and civil societies can be effective in halting the spread of the epidemic. Moreover, it has been documented that preventing infection among young people in particular pays off significantly in terms of spread and impact of the epidemic, especially in relation to development issues.

The facts that the HIV/AIDS epidemic is affecting mostly the young people, that it is interrelated to their sexual and reproductive health and behavior, and that young people are an effective instrument of “*change*” and of “*development*”, it becomes imperative that young people be put at the center of the governments and civil societies’ and other stakeholders responses to the epidemic. It becomes also crucial that HIV/AIDS among young people be addressed in the context of their sexual and reproductive health and rights with the perspective of population’s well-being and development.

This bears a particular importance in the Arab region in general knowing that young people under the age of 25 years constitute around half of the population in this part of the world, and that the HIV/AIDS epidemic is steadily progressing in most countries of the region, including Lebanon.

Lebanon has started responding to the epidemic since more than 15 years by now. However, the response remains insufficient in certain areas especially in issues related to young people, and needs to be fostered in that respect. In this context, this review aims at identifying gaps and needs for a better advocacy in order to improve the national response to HIV among young people.

2. HIV/AIDS Statistics in the Regional and National Context

Worldwide it is estimated that by the end of 2003, around 40 million people were living with HIV/AIDS, with approximately one new infection every 14 seconds, and around 3 million persons dead due to the infection.⁽¹⁾

2.1. Regional Context of the HIV/AIDS Epidemic

In the Middle East and North African (MENA) region, it is estimated that around 800,000 to 1,000,000 persons are currently living with the infection ⁽¹⁾.

The HIV/AIDS epidemic in the Arab region shows three patterns of spread:

- ✓ A generalized pattern with high prevalence (more than 3 percent in the general population) namely observed in the countries of the Horn of Africa;
- ✓ A concentrated pattern with a high prevalence among certain high risk groups of the population namely observed in a few North African countries and some Gulf countries; and
- ✓ A low prevalence pattern observed especially in the Near East region (including Lebanon)

Despite the fact that data on HIV/AIDS in the Arab Region is incomplete and irregularly collected, information from selected countries of the Arab Region in table -1- below shows that the main mode of transmission of HIV across the region is heterosexual contact coupled with rising homosexual contacts. There are also outbreaks among Injecting Drug Users (IDU), an increasing percentage of women being infected, and an average age of infection indicating that young people are also increasingly affected.

Table -1-HIV/AIDS Statistics in Selected Arab States (2,3,4)

Country	Total HIV/AIDS Reported	Estimated HIV	% Female	Average age of infection	% Heterosexual contact
Djibouti	30,000	NA	55	15-30	95
Egypt	1552	5,000	12	20-40	44
Jordan	281	500	26	20-45	45
Lebanon	613	2000	21	20-40	54
Oman	600	1200	30	NA	59
Sudan	7867	400,000	33	20-45	97
Syria	230	800	21	15-40	73
Tunisia	608	NA	20	NA	32
UAE**	2300	NA	NA	NA	NA
Yemen	874	NA	33	15-49	75

*NA: data is not available

** UAE: United Arab Emirates

Note: -the data is obtained primarily from the official reports by National AIDS Programs, and completed when needed from other available sources.

2.2. Lebanese National Context of the HIV/AIDS Epidemic

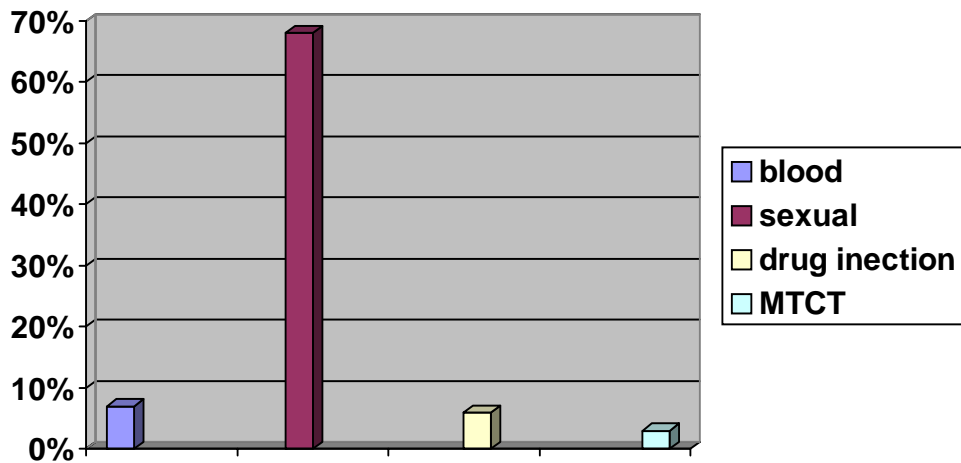
Lebanon is one of the smallest countries of the world, with a total surface area of 10,452 km². Its large coastal shore facing the Mediterranean Sea gave the Lebanese population a well-known taste for mobility and travel since ancient times. In fact although the actual Lebanese population is estimated at around 4 million, it is believed that the size of the diaspora is around 15 million worldwide. The differentiation between rural and urban areas is not clear because of proximity of cities and villages, therefore, estimates are that most of the population lives in urban settings. Moreover, its temperate weather coupled with its urban modernization made it a well-appreciated touristic resort area especially for the populations of the Arab region countries. The country is considered upper-middle income country according to the World Bank classification, and country class C according to the UNFPA Country Priority Classification. Young people between the age of 15 and 24 constitute 18.6% of the population (5).

2.2.1. General HIV Statistics

By the end of 2003 and since the first diagnosed HIV case in 1984, the National AIDS Program (NAP) has counted a total of 710 cases of HIV/AIDS, with an average of around 50 new cases per year over the past few years (6). Note that the data available in Lebanon does not distinguish between HIV and AIDS, and cases are reported, interchangeably, as HIV/AIDS cases. However, there are 180 patients on ARV treatment, assumingly they are AIDS cases. This means that around one fourth of the reported cases are AIDS cases.

Although the epidemic was initially linked to the mobility of the Lebanese population, and the migration of the large Lebanese diaspora to endemic African countries and some European countries, the epidemic seems actually well established and the local spread is well documented. In fact around only 48% of all cases reported are among “travelers” or “migrants”, the rest being acquired in Lebanon (6). Note that data is

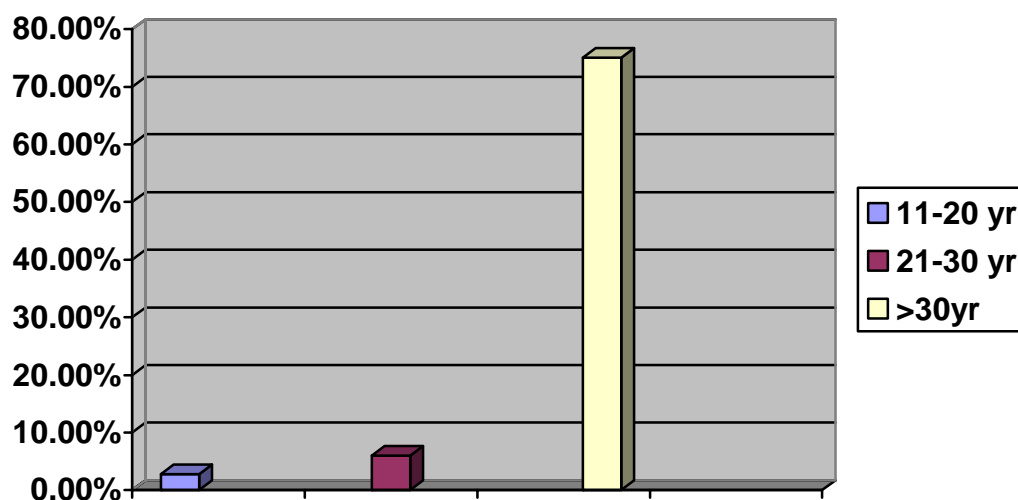
incomplete in general and poorly specified in many cases. An important limitation for that is the stigma associated with the disease in addition to the weak surveillance system in the country. However, available data shows that the main mode of transmission is sexual contact which constitutes around 68% of all cases reported, with rising spread by homosexual contact (6). Transmission through contaminated blood transfusions does not exceed 7%, most of the cases having been acquired before the availability of blood screening tests in the late 80's (6). The relative control of the blood safety is largely due to the vigilance of the private sector that provides the majority of the health services in the country. Transmission by Intravenous Drug Injection (IDU) constitutes around 6% of all cases reported, whereas perinatal (Mother to Child Transmission) does not exceed 3% of all cases reported (6).



Graph 1-Percentages of HIV/AIDS cases per mode of transmission as reported to the NAP

Although the number of women with HIV has been increasing, the epidemic seems to affect mostly men in around 80% of the cases reported, with currently a 3:1 ratio (men/women) (6).

Interestingly, less than 3% of the HIV/AIDS cases are among young people between 11 and 20 years, and around 6% are between the age 21 to 30 years, while the majority of HIV/AIDS cases (more than 75% of cases reported) are above the age of 30, with a large cluster between 31 and 50 years of age (6).



Graph 2- percentage of HIV/AIDS cases by age groups as reported to the NAP

Data on the prevalence of Sexually Transmitted Infections (STIs) among young people is not available. In fact, data on STIs in general is scarce, and among young people is practically inexistent. This is due mainly to the sensitivity of the issues related to STIs from the socio-cultural aspect, as well as the absence of an efficient National Diseases Surveillance System.

2.2.2. Vulnerable Groups

Despite the fact that the current data indicates that young people are relatively spared by HIV, they constitute a significant proportion of the vulnerable and the high risk groups identified at national level. Therefore, there is a national consensus about the prevalence of risk behavior and factors of vulnerability that make young people a priority group regarding HIV and that this needs to be addressed promptly and intensively at national level.

However, and in addition to considering young people as the most vulnerable group of the population in the current situation, other vulnerable groups, which include a significant number of young people, are identified at national level (6). These can be described as follows:

2.2.2.a. Mobile Populations

These include the Lebanese emigrants who acquire the disease in their host countries through casual unprotected sex and transmit it to their wives and partners. These include also immigrant and seasonal workers, informal sex workers under the category of “artists”, tourists and “travelers”.

2.2.2.b. Prisoners

These include namely people in confined areas, including adult prisoners, juvenile prisoners and delinquents in rehabilitation institutions, especially after the detection of a few cases among prisoners, and due to the weak screening system and health care in prisons in general.

2.2.2.c. Armed Forces

Namely because of their mobility and the potential of engaging in casual unprotected sex, as well as their exposure to contaminated blood or secretions (such as the judiciary police)

2.2.3. High Risk Groups

In the last national consensus on the strategic plan for HIV/AIDS, there was an agreement on the groups to be considered High risk for HIV infection. These groups are described as follows:

2.2.3.a. Female Sex Workers (FSW)

With the booming tourism industry, and the deteriorating economic situation, sex trade is becoming an easier and faster way to make money. Although sex trade is illegal in the country, it is well acknowledged. However it is poorly studied and little research as to the practices and prevalence of STIs is available. Sex trade is still tightly linked to young Eastern European, East African and South East Asian women and other immigrant workers, many a times coming from countries with high or rising prevalence of HIV/STIs. The phenomenon of “sugar daddy” is on the rise as well.

2.2.3.b. Men having Sex with Men (MSM)

Although the size of the population of MSM is poorly defined, there is a general acknowledgement that MSM are becoming more expressive, with a frequent feeling that there are more bisexuals than expected due to the social constraints (need to have a family and be socially integrated) and the illegal status of the MSM. Discussing openly issues related to MSM, such as rights and freedom of expression and behavior seem to be, at this point, socially, culturally and religiously unacceptable, which makes advocacy on that particular subject quite difficult. The best approach so far could be perhaps addressing these issues, discretely, from a “Disease Prevention” perspective. This approach has already been tested through selected projects targeting high risk groups for HIV/AIDS/STIs, and has faced minimal resistance and opposition from community and religious leaders.

2.2.3.c. Injecting Drug Users (IDU)

Although data regarding the size of the IDU group is not available at the national level, there is growing evidence of increase of drug abuse in general among the population, especially the young people (7). IDU are considered at high risk because of their sharing needles that can be potentially contaminated by HIV, as well as engaging in casual sex and paid sex as a means for income generation aiming at purchasing drugs.

Data related to *alcohol use and abuse* revealed that around 42% of school students interviewed in one study (8) had ever drunk alcohol at least on one occasion, and that around 35 % reported “binge” drinking (more than 5 glasses on one occasion). Age at first alcohol use ranged between 4 and 20 years, with an average of 13 years to the great majority of users, with no gender differences. Data from the Rapid Assessment of Substance Abuse (7) revealed similarly that the mean age of start of alcohol use is around 13 years, and that around 23% of high school students got drunk the first time before the age of 15 years. The same study (7) revealed that around 71% of university students had ever tried alcohol use.

Data obtained from the same study related to other *substance use and abuse*, such as tranquilizers, amphetamines, medicinal opiates/barbiturates, hashish, cocaine, ecstasy and heroin, revealed that around 8.6% of the high school students and 8.8% of the university students included in the study, ever used, at least once, at least one of these illicit substances, with hashish being the most widely used drug. Other studies (9) indicate that female students are more likely to use and abuse tranquilizers and medicinal opiates.

3. Vulnerability of Young People in the Context of HIV in Lebanon

It is an established reality that addressing the risk of acquiring HIV and Sexually Transmitted Infections (STI) among young people must be coupled with addressing their sexual and reproductive health needs and rights. It is also a common observation that young people enter their reproductive life poorly prepared to their sexual needs, and often have to bear the consequences of insufficient awareness about the risks of STIs in general and HIV in particular, culturally determined attitudes, a lot of misconceptions regarding transmission, and risky sexual practices and behaviors. On the other hand, prevention interventions are not enough if not coupled with availability, accessibility, and affordability of credible and quality youth friendly services that allow good counseling, easy provision of protection means and prompt treatment of infections when needed. Of course such an enabling environment for an adequate national response entails carefully designed policies and pertinent strategies and approaches to match these unmet needs and reinforce preventive and pre-emptive efforts.

In Lebanon, young people seem to have many unmet needs adding to their vulnerability to HIV/STI. This is described below as follows:

3.1. Awareness and Knowledge about HIV/AIDS/STIs

Accurate data on youth related to perception of health status and prevalence of diseases and prevalence of health risk behaviors as well as awareness about health risks among youth is often not available and incomplete. Most of the data is obtained from KAP studies or qualitative studies (such as Focus Groups Discussions), on small groups of young people. Most of these studies were done between 1993 and 1996.

Nevertheless, data from selected studies (10,12) in the country revealed that there is a lot of misconceptions among youth regarding HIV and STI transmission and relatively low risk perception. For example, a focus group discussions study conducted by the NAP on out-of-school youth in 1994 (13) revealed that the majority has heard of AIDS but does not have a coherent picture of this problem, that most consider blood, and not sexual contact, as the main mode of transmission, and that it could be transmitted by daily life tasks (sneezing, coughing, shaking hands, mosquito bite...). Very few knew that condoms are protective against HIV/STI.

Another study conducted by the Lebanese Family Planning Association (LFPA) in 1997 (12), revealed that for youth between 14 and 24 years of age, the concept of sexual health concentrated mainly around the reproductive functions rather than around the capacity to enjoy safe sex and absence of diseases related to reproductive organs. Around 85% expressed the need for more information about STIs and HIV.

In a KAP study on the general population in 1996 (10), of those interviewed, aged 15 to 24 years, 94,5% had heard about condoms, 63,7% had seen a condom, and 89,2% know where to find it and buy it. However, only 3% know of a relative with HIV/AIDS.

Another study on military students officers (age 18 to 24) conducted in 1995 (14) revealed that the difference between HIV positive status and AIDS is not clear, and that very few knew about the chain of transmission of STI and HIV. There seems to be also a lot of misunderstanding about the HIV tests and the interpretation of the results and the false security they may give. However, this data dates back to 9 years ago, and it will be better to reassess the knowledge and attitudes and practices of this potentially group at risk for HIV/AIDS/STIs before designing interventions.

3.2. Practices and Behaviors at Risk for HIV Infection

The national KAP study (10) done in 1996 revealed that 15,8% of the population interviewed had their first sexual contact between 11 and 15 years of age, and that 47% had their first sexual encounter between 15 and 20 years of age, and that 16,9% had their first sexual encounter between 20 and 25 years of age. Around 50% of those interviewed between 15 and 24 years of age acknowledged having casual sex, 30% had paid for sex, and only 64% used a condom during the casual sex encounter, while more than 33 % had multiple partners already (10). Data related to sexuality and sexual behavior among secondary school students in Lebanon (11,15) revealed that approximately 15% of the students (age 15-18) included in the study reported that they had at least one sexual

encounter during their life time so far, and that 8.4% were currently sexually active, with on average more prevalence of sexual activity among males than among females.

On the other hand, there is evidence of practice of certain more risky behaviors such as anal sex and sex with sex workers. In fact, a recent study conducted on high-risk groups ⁽⁶⁾ in 2002, revealed that female sex workers tended not to use condoms with their clients (upon the insistence of the client). Similarly, the study showed that men who have sex with men (MSM) tended to have a risky behavior. In fact, around 55% of the MSM included in the study acknowledged having had a commercial sex partner in the last month without using a condom, which adds on tremendously to the risk of practicing anal intercourse. At the same time, the study showed also that Injecting Drug Users (IDU) were having high risk practices including needle sharing (65%), having sex with commercial sex workers (35%) while inconsistently using condoms.

That is, if these figures reflect well the actual situation, by the time they reach 25 years of age, around 80% of young people are sexually active, and only 23% of them would have by then ever used a condom. If we link this fact to the average age of marriage in the country (29 for women and 33 for men), and the booming sex trade, then the evidence of sexual activity at risk and outside the context of marriage becomes an important issue related to prevention of STIs and HIV, due to the potential of having more multiple partners and therefore multiplying the risk of infection with STI/HIV, and perpetuating the chain of infection.

3.3. Attitudes and Perception of HIV Risk

The attitude of young people towards the HIV/AIDS disease and the people living with the virus varies, reflecting probably the socio-cultural diversity of the Lebanese population. Young people in general seem to have rather positive attitudes towards people with HIV. In fact, 73,3% of young people between 15 and 24 years of age interviewed in a KAP study in 1996 ⁽¹⁰⁾ stated that they are ready to take care of a relative with HIV, 79,9% agreed that an HIV positive person should remain in his/her job, and 77,7% would like to see that HIV positive persons are getting better health care. Many young people in a more recent study ⁽¹⁶⁾ would accept to be taught by a teacher who had AIDS, and to study with a friend who had AIDS. In contrast, the study on military schools students (age 18 to 22 years) in 1995 and secondary schools students in a recent study ⁽¹⁶⁾ revealed that the majority of the young people interviewed expressed their desire to isolate the HIV positive people. Interestingly, students from private schools were more tolerant regarding people with HIV than those from public schools ⁽¹⁶⁾. However, data from the same study showed that only 3.4% of young people between 15 and 24 years of age would inform their partner in case they have an STI. In a recent study ⁽¹⁶⁾, over 80% of young people interviewed believed that STIs are a problem facing everybody, and that couples who intend to get married should be well informed about STIs and HIV/AIDS.

Despite the relatively good awareness about HIV/STI among young people, and their generally positive attitudes towards the disease and the people suffering from the

infection, there seems to be inadequate perception of risk by young people. In fact, the study on out-of-school youth done in 1994 showed that many think that HIV “is a disease of others who are not clean” (13). In a KAP study done in 1996 (10), 68,9% of the young people interviewed between the age 15 and 24 stated that there is no way they can get infected with HIV. In a study on high-risk groups done in 2002 (6), 76% of the MSM interviewed considered themselves at little or no chance of acquiring the disease despite their current risky sexual behavior. Similarly, 52% of the IDU included in the same study thought that they have little or no chance of acquiring HIV due to their current behavior.

3.4. Access to Information on HIV/STI

Data from KAP studies also revealed that the majority of secondary schools students (93%) used TV and mass media in general as the most widely accessible awareness diffusion tools for information on health and HIV usually watched in the evenings while a lesser percentage (47%) used conferences in schools or clubs, parents (38%), peers and friends (32%), teachers (31%), doctors (19%), and books (9.6%) (10,15). It also revealed that youth prefer to have information on reproductive health and HIV/STI from doctors or specialized books (12).

With the advent of Internet and the observation of Internet cafés across the country, it is expected that Internet is a potential source of health information, especially by young people who are computer literate. However, there is no data regarding this issue to date.

As for the formal information and education on HIV in the school setting, the issue becomes somehow sensitive. In fact, a whole package on HIV and STI in the context of reproductive and sexual health and rights was developed in 1998, to be integrated in the revised school curricula. However, only selected chapters were integrated and only for third year students in the secondary cycle of the public schools. In the private schools, accommodating the largest cohort of students in the country, HIV is integrated in the curricula at an earlier age, using mainly European books. This created a discrepancy among young people regarding the details of information and the age at which the information is given.

3.5. Availability, Access to, and Utilization of Youth Friendly Services for HIV/STI

The great majority of the health services in general are provided by the private sector. However, the data from the private sector regarding utilization of services by age groups is not available. There is a general perception that young people need the least the health services and therefore are expected to use less the available health services.

In fact, the data obtained from the National Household Health Expenditures and Utilization Survey (NHHEUS) (17) confirmed this observation. The data indicates that a general check up as part of preventive care is provided only to 4.2% of those aged 15 to 39 years. Data from the NHHEUS also indicates that the utilization of outpatient care by

youth is relatively low. On average, the mean number of outpatient visits per individual per year was 2 for those aged 10 to 19 years, and 2.6 for those aged 20 to 24 years. Interestingly, the survey showed that among those suffering from a health problem, around one third of the 10 to 19 years old, and around one quarter of the 20 to 24 years old did not seek health care.

Data from the Primary Health Care (PHC) centers offering reproductive health (RH) services in the public sector also supports this observation. In fact, out of 30,000 visits per year in the PHC/RH centers, only 3% of the users were young people less than 15 years old, and only around 8% were between 15 to 19 years of age (18). Despite these low utilization rates by young people, the data was not validated and the reasons for this low utilization were not investigated by the concerned ministries.

Specialized services for STI do not exist in the country neither in the private nor in the public sector. Data on this subject is mostly anecdotal. Most commonly people with STI either recourse to self treatment or treatment by the pharmacists, and would see a doctor (normally a urologist or a dermatologist/venereal diseases specialist) usually when symptoms do not improve after self-treatment. There are no HIV clinics either. However, there are a few medical doctors, infectious diseases specialists, who follow up persons with HIV/AIDS, in an informal referral system. Shy attempts at establishing voluntary counseling youth friendly services are made, mainly by the PHC/RH centers under the Ministry of Social Affairs (MOSA) and a few NGOs. A counseling and follow up center is established at the National AIDS Program (NAP), with a main function to coordinate the provision of Anti-Retroviral Treatment (ARV) to people with AIDS, with no specific adaptation to youth needs. However the experience is just beginning and it is early to judge the utilization rate by the young people at this point.

On the other hand, condoms are available, but restricted to either the pharmacies or the PHC/RH centers. Attempts to have condoms available outside these two settings have failed so far, mainly because of socio-cultural issues. Interestingly, the young people's adequate knowledge about condoms and where they could be found does not correspond to their utilization. Whether this is due to the inconvenience of work hours of the pharmacies and PHC/RH, to the non-affordability by the young people of the cost of condoms (around 1 USD per condom), or to their low perception of STI/HIV risk needs to be further determined and researched more in-depth.

3.6. Socio-economic Situation

In addition to the individual factors, many environmental factors affecting spread of HIV among young people are often challenges by themselves. The risks these factors add on the sexual and reproductive health and rights of young people in general cannot be dissociated from the risks of aggravating the vulnerability of young people to HIV/STI. Although data linking social to economic changes is not readily available at national level, there is evidence of socio-cultural and economic changes in the post war period over the past 15 years.

Many of the sexual behavior changes observed in Lebanon lately, such as earlier sexual activity, sexual activities outside the context of marriage leading to multiple and casual sexual partners, a more expressive growing “gay community”, are often attributed to factors like “westernization of the society”, the development of the media and the overall effect of Globalization, and inadequate access to structured culturally adapted sexual and RH information. On the other hand, religion and religious norms, stigma and fear of discrimination, seem to keep sexuality among young people a taboo subject and HIV an “Immoral disease” rarely discussed openly, leaving room to the young people’s imagination. At the same time, Lebanon is witnessing an economic recession over the past decade, worsening the economic dependence of the young people in particular. In fact, estimates indicate that the highest unemployment rate, 15.2%, is observed among the age group 18 to 21 years (19), highly encouraging young people migration for better “life chance”. All these socio-cultural and economic factors and changes interact to add on the psychological stress of the young people going through the adolescence “transition”, an additional stress that needs strong coping mechanisms not necessarily facilitated for the young people. This kind of stress could often lead to a change in sexual behavior increasing the likelihood of casual sexual encounters because of abuse or for stress relief, and subsequent potentiation of STIs/HIV risks among the young people.

4. National Response

The national response to HIV started shortly after the first diagnosed case of AIDS in 1984, with initially a national committee on HIV/AIDS, from which emanated the National AIDS Program (NAP) in 1989. Since then, the circle of stakeholders in HIV/AIDS/STIs keeps enlarging, with some stakeholders actively and continuously involved in HIV/AIDS/STIs interventions, while others remain involved only on ad hoc basis.

What is evident is that, at the grass root level, the NGOs sector, with recent involvement of youth NGOs, is a major player in the fight against HIV. The private sector and the NGOs seem to be the most active advocates for HIV/AIDS patients’ rights and providers of services (medical care and psychosocial counseling). With the epidemic becoming more visible, the religious leaders have adopted an attitude of “non opposition”, as long as the religious and cultural norms are respected in the prevention activities. The National AIDS Program is a strong leader of all the efforts. The recently reactivated UN Theme Group on HIV/AIDS, under the chairmanship of UNFPA, is also investing more technically and financially into prevention and advocacy issues. The weakest stakeholders seem to be the HIV/AIDS people themselves and their families/care givers.

Overall, a more coherent and coordinated response is needed, and more attention to the people affected by HIV/AIDS should be provided, as demonstrated by the analysis below.

4.1. The Government Response

The government response was relatively quick and materialized into two major steps: the establishment of the National AIDS Program (NAP), and the issuing of certain policies and regulations related to HIV/AIDS.

4.1.1. The National AIDS Program (NAP): Response of the MOPH:

Since then all the HIV/AIDS related activities have been coordinated through the NAP across the country. The NAP is currently leading all the national response, based on the National Strategic Plan (NSP) for HIV/AIDS developed in 2003 for the years 2004-2009.

4.1.1.a. NAP Structure, Management and Operational Aspects

When it was initially established, the NAP was managed and financed by the WHO office in Beirut. Although the contribution of WHO in financing the NAP has progressively been reduced to barely a nominal amount yearly, the administration of the NAP is still under WHO control, with the MOH having mainly a facilitating role.

The NAP currently functions with a national NAP manager, a health educator, a secretary, a research project assistant and a driver. The NAP has had its own premises since 1998 and has its own vehicle for transportation.

The NAP is essentially responsible for coordinating the HIV related activities, in terms of planning, implementation and monitoring of interventions. Two consultative committees support the NAP: the *Technical Consultative Committee* including experts from various disciplines related to HIV, and the *IEC Consultative Committee* including experts in communication and education from concerned ministries and the private sector. In the decision making process of the NAP activities, the NAP team prepares a plan of action for every biennium, in consultation with the *National Consultative Committees* and selected stakeholders. The final approval for the biennial plan of action is made by the MOPH (usually the Director General, overall supervisor of the NAP) and the WHO Representative (the administrative supervisor of the NAP). Based on the plan of action, the MOPH allocates a yearly budget for the activities, under a separate budget line. All policy and strategy decisions are to be approved by the MOPH before their implementation. The implementation of the NAP activities is coordinated by the NAP, with usually active involvement of the NGOs and the private sector.

Multi-sectorality implicating most of the main stakeholders in the response to HIV (such as the Ministry of Social Affairs, the Ministry of Education) in addition to a wide network of NGOs have been the main pillars of the successful leadership of the NAP.

4.1.1.b. Main NAP Activities

The NAP has defined in its Strategic Five years plan the priority areas where interventions need to be focused. These are summarized in Table -2- below:

Table -2- Priority Areas, Goals and Objectives of the National Strategic Plan for HIV/AIDS (16)

<i>Goals</i>	<i>Objectives</i>
Priority Area: Advocacy, Human Rights and Coordination	
1. Sensitize leaders to HIV/AIDS related issues	1.1. Increase political government and societal commitment to the national HIV response
	1.2. Create a legal and policy environment which protects the rights of all persons infected and/or affected by HIV
	1.3. Review, modify and issue policies and legislations related to HIV, SW, MSM and IDU
2. Reducing stigma and discrimination	2.1. Increase public awareness to protect human rights and to reduce stigmatization in relation to HIV
	2.3. Integration of PLWHA in the community and public life
3. Develop a coordinated response between all sectors and at all levels	3.1. Re-establish the National AIDS Committee for coordination of NSP in partnership with the public and private sectors and the community and the PLWHA
	3.2. Establish and reinforce civil society and NGO partnership
	3.3. Identify opportunities for regional collaboration and participation
Priority Area: Prevention	
4. Promote safe and healthy sexual behavior in the general population	4.1. Improve preventive education to focus on socio-behavioral changes
	4.2. Improve access to and use of male condoms
5. Increase awareness to prevent HIV/STI among youth	5.1. Increase awareness and reinforce preventive behavior of youth in school, including empowerment of young people with knowledge and life skills to avert HIV/AIDS
	5.2. Increase awareness and reinforce preventive behavior of youth out of school, including empowerment of young people with knowledge and life skills to avert HIV/AIDS
6. Reduce the Vulnerability of specific sub-populations to HIV/STIs	6.1. Reduce the vulnerability of migrants to HIV/STIs
	6.2. Reduce the vulnerability of prisoners
	6.3. Reduce the vulnerability among uniformed (armed) forces
7. Prevent HIV/STIs transmission among risk groups	7.1. Promote Voluntary Counseling and Testing among risk groups
	7.2. Prevent HIV/STI transmission among sex workers and their clients
	7.3. Prevent HIV/STI among MSM

	7.4. Prevent HIV/STI transmission among drug users
8. Maintain and minimize low level of HIV transmission through blood safety, infection control and MTCT	8.1. Reduce HIV and other blood borne infections through safe blood transfusion
	8.2. Reinforce universal precautions in health care settings
	8.3. Maintain low level of Mother to Child Transmission (MTCT)
Priority Area: Treatment, Care and Support	
9. Improve the management and control of STIs	9.1. Promote establishment of STI management, care and support in the private and public sectors
10. Improve access to support treatment and care to reduce the impact on PLWHA	10.1. Ensure quality and continuous care and support to those infected and affected by HIV
	10.2. Provide adequate prevention, care and support services in underserved areas
	10.3. Provide counseling services as part of Anti Retroviral Treatment (ARV)
Priority Area: Monitoring, Surveillance and Evaluation	
11. Develop a comprehensive and integrated monitoring-evaluation and surveillance system	11.1. Develop a second generation surveillance system on HIV and STI
	11.2. Assess the socio-economic impact of HIV on the country
12. Expand surveillance and reporting activities	12.1. Promote epidemiological and socio-behavioral research on HIV
	12.2. Establish national surveys on HIV and STI risk related behaviors for young people
	12.3. Improve access to accurate and reliable information on HIV trends, situation, response and impact
	12.4. Strengthen national capacities to conduct HIV/STIs surveillance and research

The interventions proposed can be grouped under the following categories:

- Capacity building of all sectors, be it government or non government or private institutions and organizations;
- Development of Information, Education and Communication (IEC) material;
- Monitoring the epidemic (surveillance and epidemiology, and behavioral and action oriented research);
- Alleviating the impact of HIV affected people by improving care and support; and
- Advocacy for policies and regulations.

4.1.2. Response of Other Ministries Concerned with HIV/AIDS and Youth

Although the national response was initially lead by the MOPH, the multi-sectoral approach adopted by the NAP has succeeded in attracting ministries to reinforce the response to the epidemic at national level.

One main ministry actively involved in the fight against HIV/AIDS is the Ministry of Social Affairs (MOSA), which developed several activities related to HIV/AIDS and youth. In fact the MOSA is well placed through its dynamic Reproductive Health Programme (RH) supported by UNFPA and its large and active network of social development centers to reach out for the most deprived communities across the country. In the IEC unit established through the RH, HIV/AIDS prevention material was produced, taking into consideration the context of safe sex and prevention of Sexually Transmitted Infections (STIs). The material produced is well diffused and used throughout awareness and education activities. Also under the leadership and direct involvement of the MOSA the “Youth Media Awareness Campaign on Sexual and Reproductive health including HIV” was developed. The project included activities such as the development of a video “by youth for youth” on SRH, as well as organizing peer education activities on SRH during summer camps all over Lebanon, in addition to developing a newsletter for the duration of the project.

Under the leadership of the Ministry of Education the “School Health and Environment project” targeting school students mainly in the public sector with its component on sexual and reproductive health including HIV is one of the projects’ demonstrating the interest and involvement of sectors other than health in the national response to HIV/AIDS.

The involvement of other ministries such as the Ministry of Interior (dealing with prisoners and drug users and sex workers from the legal point of view), the Ministry of Justice, the Ministry of Defense, the Ministry of Youth and Sports, and the Ministry of Communication, has been limited and essentially restricted to their representation in the national committees supporting the NAP.

4.1.3. HIV/AIDS Related Policies and Regulations

Most of the regulations and policies were issued in the early nineties, aiming essentially at prevention from HIV/AIDS. To date, there is no evaluation as to what degree these laws and regulations are implemented. However there are observations and anecdotes regarding the application of these laws. The main problem is ensuring the compliance of the private sector the majority of the HIV related services (testing and care). Lately, a few regulations have been issued to ensure care and treatment of people with HIV. These are summarized in table -3- below as follows:

Table-3- Policies and Regulations Related to HIV/AIDS (20)

Policy/ Regulation Reference	Date	Topic Concerned	Status of Implementation
<i>Circular 1/35</i>	20 July 1988	National declaration that HIV is a public health threat	Done once
<i>Decree 1/148</i>	11 July 1990	Mandatory screening of blood units for HIV for blood transfusion safety	Well implemented
<i>Decree1/150</i>	11 July 1990	Mandatory confidential reporting of HIV	Implemented to a good degree by the private sector. Cases are reported by codes known only to the reporting physician and the NAP manager
<i>Circular 91</i>	29 November 1990	Confidentiality of HIV testing and non discrimination against sero-positives	Testing is relatively confidential more so in the reference academic medical centers. Non-discrimination is not guaranteed.
<i>Decree 1/236</i>	2 September 1991	Mandatory screening for high risk groups	Implemented on prisoners, on “known “sex workers, and on the MSM and IDU when caught by the police
<i>Decree 1/99</i>	25 March 1992	Mandatory screen of high risk groups	Implemented on prisoners, on “known “sex workers, and on the MSM and IDU when caught by the police
<i>Circular 1/985</i>	24 September 1993	Control of testing kits for testing for HIV	Implemented, especially because of the quality concern of the private sector
<i>Decree 1/438</i>	29 April 1993	Reporting procedures on HIV cases detected through blood donations	Implemented
<i>Decree 1/439</i>	29 April 1993	Reporting procedures on HIV cases by the treating physician	Implemented, with a close follow up on the private sector by the NAP.
<i>Decree 1/270</i>	20 March 1996	Updating reporting Infectious diseases form to include HIV	Implemented
<i>Decree 2/70</i>	30 January 1997	Updating the reporting procedures of HIV/AIDS	Implemented

Note that since 1998, all patients with AIDS needing hospital care are to be admitted to hospital at the expense of the MOPH. Moreover, since 1999, ARV treatment

is to be dispensed by the MOPH through its central warehouse drugstore free of charge, based on the treating physician prescription. The protocols for treatment with ARV are periodically revised by national experts.

4.2. The Civil Society's Response

The initial national response was triggered by the civil society when a physician in the private sector diagnosed the first case of AIDS back in 1984, and lobbied intensely for the establishment of the national AIDS committee which was followed by the establishment of the NAP shortly after.

In fact, Lebanon has a long-standing history of civil society active presence in Health related issues. This tradition was well exploited in the national response to HIV as explained below:

4.2.1. The Response of the Non governmental Organizations

The first and currently the only specialized NGO in HIV/AIDS, the Lebanese AIDS Society (LAS), was established in the late 80s. With the help of this NGO, whose members are medical doctors (MD) and researchers in the field of Public Health, the NAP was able to set standards for care and support, as well as pressure on the decision makers to have issues related to HIV (such as blood safety, confidentiality, free treatment with ARV, free hospital care for AIDS patients, stigmatization, etc...). The LAS also helped in fund raising for treatment and social support of HIV affected people. Over the past few years, like many other NGOs, the LAS seems to be losing momentum and intensity of its interventions.

Another HIV specialized NGO, the SOS Sida, was quite active in promotion and advocacy in the early 90s, but not anymore.

On the other hand, the NAP counts currently around 40 NGOs not specialized in HIV/AIDS, but in health and development in general, from all over Lebanon, who are, at some point in time, implementing activities and interventions in partnership with the NAP (21). Most of these NGOs implement awareness and education activities, trying to target youth in the majority of the interventions. Some NGOs participated in research on HIV, such as the Lebanese Health Society (implemented several KAP studies on HIV), the Lebanese Family Planning Association (implemented the Youth Perception and Attitudes towards Reproductive health and HIV), and the Soins Infirmiers et Développement Communautaires (contributed to the rapid appraisal studies on HIV and drug users). However, there are a few special projects that are innovative in terms of intervention or approach. These are summarized in table -4- below:

Table -4- Special Projects on HIV/AIDS with NGOs

Project	Leading NGO	Target	Comments
Action-oriented research targeting vulnerable groups	Soins Infirmiers et Développement Communautaire	Drug users, sex workers, men having sex with men	Project started two years ago with funds from UNAIDS and is

			now supported partially by UNFPA
Hotline for HIV/SRH	<ul style="list-style-type: none"> • Armenian Relief Cross • Lebanese Family Planning Association • Soins Infirmiers et Développement Communautaire 	Young people	Project successful, stopped because of shortage in funding in the late 90s
Development of HIV and RH booklet for secondary female school students	Amel association	Young girls in semi private schools, secondary students	Project successful over one year only; stopped because of shortage of funds
Peer education on HIV	LEMSIC	Young people aged 15 to 24	Project successful, applying the peer education approach through the association of medical students; still on-going
Integration of HIV/STIs in Illiteracy Eradication Program	René Moawad Foundation	Women starting age 12	Project limited to geographic area of the North. Stopped when funds expired
Awareness on RH and HIV in summer camps	Lebanese Scouts Union	Youth aged 12 and above	Project stopped because of shortage of funds
Youth Peer Education on SRH	MOSA with NGOs	Youth 12 to 24 years	Ongoing, subject to yearly funding
School Health Education Program/school health clubs	MOEd	Youth 6 to 18 years	Ongoing. Mainly in public schools

Note that the sustainability of the majority of these projects is based mainly on integrating these projects into the national programmes and in securing funding. This issue of sustainability needs a lot of advocacy and capacity building in terms of strategic planning and fund raising.

4.2.2. The Response of the Private Sector

The private sector became sensitized to the epidemic quite early. In fact, the first case of HIV was diagnosed by a physician in the private sector, and the person affected then was taken care of by an NGO (Caritas). The private sector also contributed in fund raising to support people with HIV/AIDS, either through donating money directly to the

NGOs or through artistic events (theatre production since 1997 by Nadine Makdessi private theatre group, and painting exhibition by volunteers sympathizing with the PLWHA in 1998). The private sector also contributed in prevention activities (Durex and Mappa agents for condoms did promotion activities in pharmacies and on TV spots). Since the introduction of ARV by the MOPH, the contribution of the private sector in fund raising and in promotion activities was reduced.

4.2.3. The Response of the Media

The media was sensible to the HIV problems since the early phases in the epidemic, and took many initiatives towards promoting prevention and advocating for the rights of people living with HIV/AIDS. Except for one TV station and one radio station in the public sector, all the audio-visual and written media is in the private sector. Every few years, the NAP organizes training workshops for media people to increase the awareness on HIV emerging issues and enhance their interest in keeping HIV among their priority topics. The input of the media people in the elaboration of the National Strategic Plan on HIV in 2003 was active.

To date, the media participates actively and intensively in the World AIDS Day (WAD) campaign on yearly basis. The broadcasting time on TV and radio is free of charge, based on a gentleman's agreement between the MOPH and the media sector. The media is also represented in the IEC and national committees. In addition to the WAD campaigns, the media initiated production of a soap opera program promoting the rights of young people with HIV to marry and found a family (1999). Also a patient with HIV (acquired through contamination from her husband) was filmed on video, and broadcasted on TV, upon her request, in an effort to sensitize others to the risk of HIV. The video won the CNN International award for Health promotion video spots (in 1997). This video is being used to date as a start for group discussions and awareness on HIV by many NGOs. Other programs include live TV shows and articles on issues related to HIV/AIDS that are sporadic and left to the interest of the media people.

However, over the past few years the media interest and intense participation in HIV promotion and prevention seems to be fading away, perhaps because HIV is becoming more of a chronic disease, and the drama of death due to HIV/AIDS is not obvious any more.

The involvement of religious leaders in the national response to HIV/AIDS was given a lot of attention, mainly because of the sensitivity of Religion as a subject in a society that contains 16 different sects of three religions (Christians, Muslims and Druze). Most efforts geared towards the religious leaders aimed, since the early 90's, at securing the religious leaders' "non opposition" to HIV prevention messages. To date, religious leaders are not involved in HIV prevention activities and awareness. However, it is understood that all the religious leaders are opposing the public and open sexual education of young people, and advocate for displaying the information on HIV/AIDS in the disease prevention setting and respecting the morals in that context.

4.2.4. Special Projects: Success and Failure

Some national projects developed regarding HIV/AIDS are considered to be special, either because of their innovative approach, their importance in sustaining of and improving access to information on the long run, or their capacity to reach out difficult population groups. While some of these special projects are considered successes, some are unfortunately a good illustration of failure. These projects are described as follows:

4.2.4.a. HIV Education Package for School Curricula

In collaboration with the Ministry of Education (MOEd), a package on HIV and STIs was developed to be included in the revised school curricula in 1998. The package included basic information about the reproductive track anatomy and physiology, the immune system, the STIs transmission, the HIV transmission, and an innovative section on Life skills. The package was prepared in three languages (Arabic, French and English) in consensus with the private and public schools. It was agreed that the package will be integrated as of the middle complementary (age group 13 and above). However, this package was not finally integrated because of the objection of certain religious leaders, a posteriori, and the political pressure on the minister at that time to delete it from the curricula. As mentioned earlier, the religious leaders consider HIV/AIDS/STIs a very sensitive and taboo subject that touch the values of the society at large. The lesson learned from the deletion of the HIV package from the schools, despite the involvement of all religious community representatives, is to make the messages on HIV/AIDS and SRH as neutral as possible, and as discreet as possible, and also to keep a certain flexibility in the education messages so that every religious community can adapt them to its own “cultural context”.

Currently, HIV/STI transmission and prevention is being taught in most of the private schools at secondary students’ level only, and based on chapters included in books of sciences and biology, and left to the discretion of the teacher in the public school.

This failure to integrate the package in school curricula is actually creating a discrepancy in access to information and education, depriving most of the students in the public schools from knowledge and skills on HIV prevention and protection, and subsequently worsening social equity in that respect.

4.2.4.b. Outreach High Risk Group Study

A dynamic outreach action oriented research on Practices of High Risk Groups (HRG) was initiated in the year 2001, with the support of UNAIDS (technically and financially), coordinated by the NAP and in collaboration with a local NGO (SIDC). The project is using the snowball technique where peers from high risk groups (SW, IDU or MSM) reach out for their peers, obtain the information on risky practices for HIV/STIs and promote safe sex. The project is currently being sustained with the support of UNFPA, and there are attempts to reproduce it in a few countries of the region. The

project has provided so far a good insight regarding the particularities of the HRG in Lebanon, and their unsafe practices regarding HIV and STIs.

4.2.4.c. Video by youth on Sexual and Reproductive Health

The Reproductive Health project at the MOSA, with the support of UNFPA, has produced a 20 minutes video on HIV/STIs “by youth for youth”. The video shows young people talking about their concerns and practices and attitudes regarding HIV, RH and STI. It is very well appreciated by young people and is being used as a trigger for discussions on HIV/SRH in several youth activities.

4.2.4.d. Inventory on Research Related to SRH including HIV

With the support of the Reproductive Health Programme at the MOSA, in coordination with the MOPH, the technical support of WHO and the financial support of UNFPA, an inventory of all research on SRH including HIV was developed, and printed as a booklet for distribution to concerned institutions and stakeholders. The inventory is already available on the web page of UNFPA office. There are attempts at reproducing this exercise in several countries of the region.

4.2.4.e. Support Group for People Living with HIV/AIDS (PLWA)

The NGO Soins Infirmiers et Développement Communautaire (SIDC) has developed a project for creating a support group for PLWHA. The project is ongoing. Because of the novelty of the approach and the sensitivity of the issue of confidentiality in the Lebanese culture, especially when it touches upon health matters, the support group is still limited in number. However, the experience seems to be rewarding for the PLWHA, although the lobbying potential for such a group is not yet fully exploited.

4.3. The Response of the International Agencies

Since the introduction of the epidemic in the late 80s, the national response for HIV/AIDS was initiated by efforts and advocacy done by WHO (under the Global Program for AIDS, GPA). After the creation of UNAIDS in 1996, other UN agencies joined the efforts, which materialized in the creation of the UN Theme Group (UN TG) on HIV/AIDS. The UN TG was chaired by WHO until two years ago, when UNFPA became the chair, after the recommendations of the UN General Assembly Special Session on HIV (UNGASS) in 2001.

The UNTG meets periodically, and the HIV/AIDS activities are followed up based on the UNTG common workplan. Except for UNFPA, none of the UN agencies has a clear plan of action for HIV/AIDS activities. Although coordination efforts have improved, the UN agencies still have different degrees of involvement, and mainstreaming is inconsistent.

4.4. Financing of HIV Activities

Initially the NAP and the HIV related activities were financed by WHO (under the GPA). Since 1994, a special budget line was created at the MOPH for the NAP, amounting to a yearly contribution of around 250,000 USD that was progressively reduced to around 100,000 yearly over the past few years. Since the MOPH started financing the NAP, the contribution of WHO was reduced progressively to practically only some in kind technical assistance when requested by the NAP over the past two years. Meanwhile, and in addition to the MOPH funds, donor agencies and UN agencies started increasing their contributions to the financing of selected interventions led by the NAP, the UNFPA having been the largest contributor over the past two years.

The information regarding direct contributions is available and relatively easily obtained mainly through the UNTG. However, there are some indirect contributions such as when HIV activities are integrated in on-going interventions and programs (SRH activities, media activities...) or when bilateral donors support directly certain NGOs that are not precise and relatively more difficult to obtain. The various known direct contributions are summarized in table-2- below (22)

Table-5- Known Budget Contribution by various Stakeholders to HIV/AIDS

Stakeholder	Contribution for 2002	Contribution for 2003	Current proposals *
ILO	---	2,000\$	---
SRC	4,000\$	585\$	---
UNAIDS	3,500\$	40,000\$	75,000\$
UNESCO	3,000\$	3,000\$	---
UNFPA	3,000\$	47,700\$	---
UNICEF	4,000\$	13,200\$	---
UNV		300\$	---
World Bank	---	32,000\$	300,000\$
WHO	---	---	---
Global Fund	---	---	2,000,000\$
Subtotal UN contribution	17,500 \$	138,785 \$?**
Private (Pharmaceuticals)	2,700 \$	---	---
NAP prevention activities	100,000\$	100,000\$	---
NAP/MOPH treatment with ARV	200,000\$	200,000\$	---
Total Budget	320,200 \$	438,785\$?**

*: These are project proposals either recently submitted or currently being prepared for submission for funding to the concerned agencies.

** : The final amount of money is not yet decided

5. Perception of Stakeholders of the Issues on Youth and HIV

In order to complete the information and assess the perception of various stakeholders to the issues related to HIV/AIDS/STIs and youth in Lebanon, semi structured interviews (see annex 1) were done with 22 stakeholders either in ministries and other GO, NGOs, private sector, parliamentarians, media, and private physicians.

The interviews were conducted by young persons from the GYP (see annex 2). The following table -6- summarizes the main ideas and perceptions obtained through the interviews with the stakeholders

Table-6- Summary of Main Findings from the Stakeholders Interviews

Perception of/ knowledge of	Main Answers/ Ideas
HIV statistics and risk factors	<ul style="list-style-type: none"> • Data is only on reported cases, no true national estimates • No idea about statistics • Data is available through the NAP • Mainly between age 30 and 35 years • HIV is mainly in the cities and linked to migration • Fewer cases among youth age 12 to 25 years • Youth at risk include prisoners and out of school
Social and behavior changes affecting HIV among youth	<ul style="list-style-type: none"> • Stigma and discrimination • Globalization • IT technology and access to Satellite TV • Insufficient awareness about HIV and SRH • Alcohol and drugs abuse • Conservative society not allowing open discussion about HIV risks • Early sexual relations and multiple sexual relations (homo and hetero) and delayed age of marriage • Awareness may be there but safe practices are not applied • Easy access to condoms in general • Role of the media in facilitating access to information • Peer pressure • Poverty and unemployment and ignorance and poor access to correct information on HIV • Men more at risk because females are “observed” more closely by their families • Poor dialogue between parents and children on taboo subjects such as Sex and HIV • Booming sex trade with the booming of tourism • The fashion of “tatoos” • Inaccessibility of recreational activities for youth to divert them from sex
Policies and strategies for protecting Youth from HIV	<ul style="list-style-type: none"> • National Strategic plan on HIV in general does exist, but not widely distributed • National Strategy on RH exists but is not distributed at large scale. • Collaboration between NAP and UN agencies but not very clear • Not aware of special strategy for Youth and HIV • The Government does not consider HIV a priority issue • The ministries do not cooperate well in HIV • Rapid Assessment on Drug and Crime • NGO collaborative on- going work to develop youth friendly policies
Project laws for Youth and HIV	<ul style="list-style-type: none"> • No laws specific to Youth and HIV • The Parliamentarian committee on Youth is inactive in that sense
Special programs or projects targeting Youth	<ul style="list-style-type: none"> • HIV and youth through the RHP • Lebanese AIDS Society • SIDC projects on vulnerable groups

and HIV	<ul style="list-style-type: none"> • Hotlines • The program with UNFPA on HIV and Violence against women • The LFPA program on HIV and Youth • Caritas projects • World Vision projects • IEC project with the MOSA and UNFPA • Activities by the NAP are varied and include awareness, education training, peer education, school clubs, health fairs, media campaigns • Collaboration of several NGOs in awareness activities all over the country • A few TV programs every now and then
Annual budget spent on HIV	<ul style="list-style-type: none"> • No details about available funds but general impression that it is insufficient • Not specific but the MOPH subsidizes for ARV medications • Budget not more than 500,000 USD a year
Priorities issues related to HIV and youth	<ul style="list-style-type: none"> • Continuous program targeting HIV awareness among youth • Ensure availability and accessibility of prevention and protection means • Programs on awareness on HIV for parents as well • ARV treatment availability and accessibility • Laws against discrimination • Legalize DU, SW and MSM • Always link HIV to STIs • Integrating HIV in school curricula • Training and developing activities based on Peer education • Have a detailed situation analysis n Youth and HIV
Suggestions to improve national response regarding HIV and youth	<ul style="list-style-type: none"> • Integrate RH and Sexual Health and HIV in school curricula as of age 6 years • Sensitize religious leaders • Create support groups for HIV affected people • Create Youth Friendly services • Involve youth more in planning and implementing the activities targeting youth and HIV • Facilitate access to anonymous testing and counseling • Long term projects with NGOs • Intensify lobbying for HIV and Youth • Involve media more and upgrade their skills in addressing HIV and youth issues • Involve HIV positive people in HIV activities • Capacity building of youth on life skills

Note that the sample interviewed was relatively small, and that the youth - main stakeholders on the issue of HIV - were not interviewed. Therefore, the interviews can only give impressions and trends in thinking and perception on issues related to youth and HIV/AIDS.

The *main conclusions* drawn from the review of the stakeholders interviews are the following:

- Most of the stakeholders interviewed acknowledge the fact that the NAP is the leader in HIV activities, especially in statistics and monitoring the epidemic,
- Most of the stakeholders have no clear idea about the funds allocated or spent on HIV

- Most of the stakeholders are not aware of policies or regulations regarding youth and HIV
- Most of the stakeholders believe that more intense awareness activities should be carried out especially targeting youth
- Most of the stakeholders acknowledge the social changes and the relation between sexual behavior permissiveness and augmenting the risk of exposure to HIV.
- Most of the stakeholders acknowledge the role of the civil society in the fight against HIV/AIDS

6. Advocacy Needs: the Identified Gaps

The above mentioned analysis allows the identification of certain gaps between the needs felt by the youth themselves, the perceived needs by the stakeholders and the real needs in order to improve the national response to prevent HIV/AIDS among the youth in Lebanon.

The advocacy efforts should concentrate on bridging these gaps, focusing on the following main areas:

6.1. In terms of Information, Communication and Education

From the above-mentioned analysis, it is evident that youth knowledge on HIV risk does not match the unsafe practices among youth. It is also evident that the stakeholders are aware of the importance of the risks of HIV among youth, but have no clear idea about the epidemic trends. It is therefore important that IEC activities focus on risk perception, and promotion/sensitization on youth issues for decision makers.

The above-mentioned analysis revealed also that the intensity of the awareness activities has faded relatively over the past few years, perhaps because HIV is becoming more a chronic disease than a deadly disease that causes precipitated premature death. That is, the drama and tragic course of the AIDS disease is now being attenuated with the advent of ARV treatment. It is therefore important to keep the momentum of IEC activities, and keep the media sensitized and alerted to the epidemic at all times.

Moreover, the analysis suggests inequity in access to education and information about HIV among youth, especially among the poor section of the youth population (mainly in the public schools). It is therefore important to review the decision of integrating HIV in the school curriculum in the public schools, in terms of content and age group, to offer all youth equal opportunities of information and prevention of HIV integration. As for the youth who are out of school and at increased risk of acquiring HIV, IEC out reach activities at grass root level through the NGOs need to be intensified.

6.2. In terms of Availability of and Accessibility to Services Related to HIV

The above analysis suggests that the current system of health services, be it the primary health care or the private system, although available and spread all over the country, is not readily accessible and used by the youth population, especially when it relates to sensitive issues pertaining to HIV/STIs (addiction, STIs, SRH...). It is therefore important that advocacy be focused on improving access for youth to youth friendly services. It is also important that the quality of these services matches the expectations of the youth in terms of counseling, referral to or provision of voluntary anonymous and free testing for HIV, which necessitates a lot of training and capacity building of the health care personnel and the social and community workers.

It is also important to improve the availability and accessibility of the condoms across the country, and diversify the types of outlets for distribution at a reasonable cost so that youth are encouraged to use it in cases of exposure to risk of transmission.

Because HIV and STI are tightly linked in terms of sexual behavior and social sensitivity, efforts should concentrate on integrating HIV services into sexual and reproductive health services (which include STI).

6.3. In terms of Research

The analysis revealed that a lot of data and information is missing or incomplete regarding social, cultural, environmental and individual/behavioral determinants of risk of HIV among youth in Lebanon, especially among those who are most vulnerable. More attention should be given to research on these areas as well as on health seeking behavior of young people in Lebanon.

On the other hand, many IEC activities and promotion and prevention campaigns have been carried out so far, but without real evaluation of the impact of these activities on the changes in behavior among youth. There are essentially periodical KAP studies to monitor the improvements in terms of knowledge, attitudes and practices. More in-depth behavioral and larger scale research should be done in that direction.

6.4. In terms of Budget

It is evident that there is insufficient budgets available for HIV in general, although the funds allocated by the MOPH to cover treatment with ARV to all HIV/AIDS patients is an important step forward in improving the national response and alleviating the impact of the epidemic.

However, the budgets allocated for prevention and promotion of safe behavior seem to be shrinking over the past years. The NAP spends a lot of energy looking for funds to support NGOs projects and promotion/prevention activities. Effort should focus on convincing decision makers in increasing their contribution to the preventive aspect in general and support services such as counseling and voluntary anonymous free testing.

On the other hand, there is evidence that many of the HIV/STI prevention and services and promotion are done through the NGOs, a partnership that proved to be quite effective in Lebanon. Efforts should be made towards increasing the financial support to the NGOs to intensify their activities targeting youth. In order to sustain this partnership with the NGOs on the long run, there is need to advocate for continuous building of the capacity of these NGOs in fund raising and management of projects.

On the other hand, little information is made available to the public and to the NGOs and private sector regarding the available funds for HIV/AIDS. More transparency and accuracy in that sense should be advocated for.

6.5. In Terms of Policies

Although there are some decrees and laws regulating certain issues regarding HIV, none of these laws and regulations specifies youth as such. In particular, there is a need to tailor certain regulations that facilitate access for youth to certain services (work hours of PHC centers and clinics, distribution of condoms, integration of VCT in health services...). There is also no national policy regarding youth, especially youth in vulnerable situations adding to the risk of HIV (delinquents, street kids, out of school...), and more efforts should be geared towards stimulating a serious national reflection in that direction.

7. Conclusion and Suggestions

The general atmosphere at this point with respect to HIV and youth offers some opportunities to improve the response at national level, but also a few constraints in that respect.

7.1. Conclusions: Opportunities and Constraints

In fact, one important opportunity is the undoubted political commitment of the Government at large to foster the national response, a commitment that translated into the elaboration of a five year strategic plan on HIV, and the provision of ARV treatment to all PLWHA, free of charge. However, a main constraint in this respect is that youth are not specifically the subject of a policy, nor there is a clear mention at political level of a specific youth and HIV strategy. The proposed discussion issue here is a well-stated youth policy mentioning clearly youth and HIV/STDs.

Another main opportunity is the established special budget line at the MOPH for HIV/AIDS activities. The constraint is the fact that multi-sectoriality and subsequent active involvement of other ministries remains ad hoc and poorly structured mainly because of the unexpressed assumption and label that HIV is a “health problem”. In addition, the budget allocated yearly poses the problem of sustainability of the activities,

and the matching of the amount of money allocated to the needed activities. The proposed discussion issue is the sustainability of the HIV efforts at national level.

Another main opportunity is the well-established leadership of the NAP in HIV/AIDS activities, allowing a good coordination and mainstreaming of resources. However, this leadership can be by itself a constraint that limits the initiatives and sustainability of the civil society's involvement in HIV/AIDS and youth. The proposed issue for discussion here is the representation of Youth and PLWHA in the national Consultative committees.

Another important opportunity is the relative permissiveness of the Lebanese society in general, allowing free expression and a strong well-heard media sector that can be used as a good lobby and pressure group for issues related to youth and HIV. However, a main constraint in that respect is also the societal diversity and the need to respect extremes of socio-cultural norms, which could limit certain interventions among certain groups. The proposed issue for discussion here is the uniformity and acceptability and pertinence of the awareness and education messages

Another additional opportunity is the relatively high literacy rate and availability and accessibility of Information Technology and communication tools. The constraint in this respect is the negative connotation associated among certain communities regarding globalization and the attribution to the societal changes to the "westernization" of the country. The main issue for discussion here is the respect to the societal diversity and adaptation of HIV prevention efforts to the communities' particularities.

The current UNTG with a rotational chairmanship (currently under UNFPA chair) and the NAP as its secretary constitutes a good opportunity to put HIV/STI on the agenda of all the UN agencies and mainstream all the resources. However, possible constraints include the availability of "know-how" within the UN agencies teams as well as the availability of special funds for HIV/AIDS, and the risk of impeding competition for visibility of the various UN agencies. The proposed issue for discussion here is the mainstreaming and coordination and standardization of the "quality norms".

The active and long standing presence of NGOs in the implementation of HIV/AIDS activities is a good opportunity to build on, especially in terms of care and support for PLWHA and VCT and prevention. However, the dependence of these NGOs on the immediate support of the NAP and donors is a serious constraint for the sustainability and viability of the activities beyond the life of projects funded by the NAP or donors. The proposed issue for discussion here is the capacity building of NGOs to ensure the continuation of their contribution in the HIV prevention efforts.

The availability of academicians and scientific societies is an opportunity by itself for obtaining data regarding youth and HIV/STIs. However, a minor constraint related to data is the poor coordination, the absence of sharing information, and the poor representativeness of the available studies. The proposed issue for discussion here is the

improvement in quality, representativeness and variety of studies on Youth in general and youth and HIV/STIs in particular.

7.2. Suggestions

It is therefore recommended that advocacy be mainly geared towards the following issues:

- Advocate for ensuring that **multi-sectoriality** is applied, and flexibility in co-funding is allowed: This could be done by reviewing the structure of the NAP for the possibility of having it outside the direct administration of WHO and attached to the council of ministers rather than to the MOPH only. Advocacy is to be directed essentially towards the government, the NGOs and the UN organizations,
- Advocate for ensuring the **sustainability** of the HIV related activities: this could be done by reviewing the yearly budget allocated by the government (to MOPH and other concerned ministries) to match the needs of sustaining the NAP staff and prevention activities. Advocacy is to be directed essentially towards the council of ministers, the MOPH and the UN organizations and donors,
- Advocate for developing and reinforcing the partnership with the **media**: this could be done by supporting the development of a well-structured partnership with the media with a long-term goal and plan of action on issues related to youth and HIV/AIDS/STIs. Advocacy is to be directed essentially towards the private sector, the media people, the syndicate of press,
- Advocate for ensuring the **mainstreaming of resources**: this could be done by reviewing the UNTG strategy of coordination with the various stakeholders to ensure mainstreaming of resources, avoid duplication, and be more pertinent to the national needs of youth and HIV, and support funding for major projects. Advocacy is to be directed essentially towards NAP, MOPH, NGOs, UNTG, donors,
- Advocate for ensuring the **involvement of youth and PLWHA in HIV/AIDS activities planning and implementation**: this could be done by reviewing the composition of the national committees on HIV/AIDS to include the end beneficiaries (Youth and PLWHA) and reactivate these committees so that more appropriate, acceptable and pertinent planning is made. Advocacy is to be directed essentially towards NAP, MOPH, Government, NGOs,
- Advocate for ensuring the **integration of HIV/AIDS in STI/SRH related activities and programs**: this could be done by testing the integration in selected pilot sites initially, then generalizing it at national level. Advocacy is

to be directed towards MOPH, private sector, NGOs, UNFPA/RHP, and MOSA,

- Advocate for improving the data related to youth and behavior affecting their risk for HIV/STIs: this could be done by developing research on socio-behavioral determinants of youth sexual and reproductive behavior increasing risk of HIV/STIs. Advocacy is to be directed towards MOPH, scientific associations, academic centers, MOSA/RHP, UN agencies,
- Advocate for improving access to youth friendly services: this could be done by developing strategies and regulations for improving access to youth friendly services offering anonymous and free of charge VCT for HIV and STIs. Advocacy is to be directed towards MOPH, MOSA/RHP, NAP, NGOs,
- Advocate for improving access to HIV/STIs protection means: this could be done by increasing the number and variety of outlets providing condoms and education on protection. Advocacy is to be directed towards NGOs, MOPH, MOSA, private sector,
- Advocate for the initiation of national dialogue on youth SRH rights and issues: this could be done by encouraging the national dialogue on rights of PLWHA, vulnerable, and High Risk Groups in terms of knowledge, protection and non discrimination, and risk reduction. Advocacy is to be directed towards UN agencies, NGOs, media and activists,
- Advocate for the improvement of the capacity of NGOs in project management: this could be done by building the capacity of the NGOs in terms of fund raising, planning and management of large-scale projects in partnership with the NAP and NGO. Advocacy is to be directed towards UN agencies, and international NGOs, and
- Advocate for the finalization and adoption of the Youth National Policy: this could be done by preparing a draft policy and submitting it for national consensus. Advocacy is to be directed towards Ministry of Youth and Sports, MOH, MOEd, MOSA, parliamentarian commission for youth, media, and youth associations.

Annex 1

List of References

- 1- *Aids Epidemic update*. UNAIDS and WHO, December 2003
- 2- *Selected country reports from National AIDS control Programmes in the region-December 2000-2002*
- 3- *Global summary of HIV/AIDS epidemic*. UNAIDS/WHO report-December, 2002
- 4- *Overview of HIV/AIDS situation in the Middle East and North Africa and East Mediterranean region*. Main report by the World Bank, WHO and UNAIDS-June 2002.
- 5- *Country profiles for Population and Reproductive health: policy development and indicators for 2003*. UNFPA, New York, 2003
- 6- *National Strategic Plan of action on HIV/AIDS for 2004-2009 in Lebanon*. Ministry of Health, National AIDS Program, Lebanon, January 2004.
- 7- *Lebanon Substance Abuse Rapid Situation Assessment and Responses*. UNODCCP and IDRAK-St Georges Hospital. Beirut, 2001
- 8- *Youth Health Risk Behavior Survey among secondary School Students in Lebanon: Prevalence and Clustering of Risk Behaviors*. A. Sibai and N.Kanaan, Beirut, February, 1999.
- 9- *Women and War in Lebanon*. University Press of Florida. Edited by L. Shehadeh, 1999
- 10- *Knowledge, Attitudes and Practices related to HIV among General population- NAP Lebanon, (1996)*
- 11- *Knowledge, attitudes Practices and Beliefs related to HIV/AIDS among secondary school students in Lebanon*. Ministry of Public Health, National AIDS Control Program, Beirut, 1994
- 12- *Survey on Youth and Reproductive Health*. Dr Z. Hatab for the Lebanese Family Planning Association, Beirut, 1996
- 13- *Out-of- school youth and HIV/AIDS in Lebanon*. Ministry of Public Health, National AIDS Control Program, Beirut, 1994
- 14- *Military Academy students-officers and HIV/AIDS in Lebanon*. . Ministry of Public Health, National AIDS Control Program, Beirut, 1995

- 15- *Youth Health Risk Behavior Survey among secondary School Students in Lebanon: Prevalence and Clustering of Risk Behaviors*. A. Sibai and N.Kanaan, Beirut, February, 1999.
- 16- *Inventory of KAP studies related to Sexual and Reproductive Health of Young persons in the Arab states*. UNFPA/ American University of Beirut Regional Project. Beirut, 2004
- 17- *National Household Health Expenditures and Utilization Survey*. Ministry of Health, Lebanon, October, 2001
- 18- *PHC annual report for 2002*. PHC program, Ministry of Public Health. Beirut, 2002
- 19-* *Youth in Lebanon: a document paper for the African Arab parliamentarians meeting*. Parliament of Lebanon. Cairo, July 2003
- 20- *AIDS/HIV National Strategic Plan, Lebanon 2004-2009*. Ministry of Public Health, NAP, UN Theme Group on HIV/AIDS. Lebanon, 2004.
- 21- *List of NGOs involved in HIV activities in Lebanon*. Courtesy of the National AIDS Program at the Ministry of Health, Beirut, Lebanon, 2004
- 22- *Summary of Financial Contributions of members of the UN Theme group on HIV/AIDS in Lebanon for 2002-2003*. Courtesy of UNTG chair, Beirut, September 2004.
- 23- * *Survey on opinions of community leaders on Issues related to Population Policies in Lebanon*. MADMA for the Ministry of Social Affairs/ UNFPA program on Population, Beirut, Lebanon, 2004 .
- 23- *An Overview of the Sexual /reproductive health of Young People in the Arab World Region: an IPPF perspective*. Lina Chichakli .June 2003
- 24- *Advocacy guide for Sexual and Reproductive Health and Rights*. International Planned Parenthood Federation. August 2002
- 25-* *The family, Gender and population policies: opinions from the Middle East*. International Populations Council. 1995
- 26-* *Idhafat soukania*. Directorate of Population Councils at the Arab League. May 2003.
- 27- *Declaration of Commitment on HIV /AIDS*. United Nations General Assembly Special Session on HIV/AIDS. June 2001.
- 28- *The State of Children and women in the Middle East and North Africa*. UNICEF Regional Office for the MENA. September 2001

29- *The Impact of HIV/AIDS: a population and development perspective*. United Nations Population Fund, series number 9, 2003.

30- *DALYs and Reproductive Health: a Report of an Informal consultation-WHO-* April 1998

31- *PAPCHILD Survey*. Republic of Lebanon, Ministry of Social Affairs, Beirut, October, 1996

32- *Towards new partnerships for health development: the contractual approach as a policy tool- the Lebanese experience*. Dr W. Ammar, for the WHO, Geneva, 1998.

33- *La Situation des Enfants au Liban pour l'an 2000*. Republique Libanaise, Administration Centrale de la Statistique et l'UNICEF. Beirut, March, 2001.

34- *Youth and Development*. The National Human Development Report for Lebanon. UNDP, Beirut, 1998

35- *School Health and Environment education project*. National Center for Educational Research and Development and the WHO. Beirut, 1998.

36- *Child Labour in Lebanon*. Ministry of Social Affairs and UNICEF. Lebanon, 1997

37- *Physical and Mental Health of Working Children*. Ministry of Social Affairs and UNICEF. Lebanon, 1998

38- *Youth Unemployment in Lebanon*. International Labour Organization, Beirut, January, 1998.

39- *Evaluation of NGOs role and contribution in the NAP activities*. Randa Slim, National AIDS Control Program. Beirut, 1997

Note:

-References labeled with * are available in Arabic

- References labeled with **are a compilation of national figures published in various sources by National AIDS programs in the region.

Annex 2

List of Tables and Graphs

Tables

Table 1	HIV/AIDS Statistics in Selected Arab States (2,3,4)
Table 2	Priority Areas, Goals and Objectives of the National Strategic Plan for HIV/AIDS (16)
Table 3	Policies and Regulations Related to HIV/AIDS (20)
Table 4	Special Projects on HIV/AIDS with NGOs
Table 5	Known Budget Contribution by Various Stakeholders to HIV/AIDS
Table 6	Summary of Main Findings from the Stakeholders Interviews

Graphs

Graph 1	Percentages of HIV/AIDS Cases per Mode of Transmission as Reported to the NAP
Graph 2	Percentage of HIV/AIDS Cases by Age Groups as Reported to the NAP

Annex 3

استمارة استطلاع رأي السيدا والشباب

1- ما هو برأيكم واقع السيدا لدى فئة الشباب (12-25 سنة) في لبنان؟
- بالنسبة للاحصائيات: معدل الانتشار، سرعة الانتشار، نسبة الاصابات بين الشباب، تفاوت بين الذكور و الاناث، تفاوت جغرافي.....

- بالنسبة لعوامل الخطر: الادمان على انواعه بما فيه تعاطي المخدرات بالابر، نقل دم ملوث، العلاقات الجنسية المختلطة و المثلية.....

2- هل برأيكم هنالك تحولات او عوامل اجتماعية و سلوكية مساعدة لانتشار السيدا بين فئة الشباب في لبنان؟ ما هي؟

-مثلا: العلاقات الجنسية المبكرة، استعمال الواقي الذكري، تجارة الجنس، الفقر و استغلال الفتيات، توفر و سهولة الوصول الى الخدمات و المعتومات و سبل الوقاية المتعلقة بالصحة الجنسية و الانجابية لدى الشباب

3-ها انتم على علم بسياسات او استراتيجيات وطنية خاصة تتعلق بالشباب و حمايتهم من السيدا؟ ما هي؟

4- هل انتم على علم بمشاريع قوانين تتعلق بالشباب و السيدا؟ ما هي؟

5- هل انتم على علم او تشاركون في برامج خاصة حول الشباب و السيدا؟ ما هي؟

6- ما هي بتقديركم الميزانية السنوية التي تصرف على برامج و أنشطة تستهدف الشباب و السيدا؟ و من هي الجهات المشاركة بالدعم المادي؟ و بأية نسب؟

- مثلا: الدولة اللبنانية والوزارات، القطاع الخاص، القطاع الاهلي، المؤسسات الدولية، الدول المانحة.....

7- ما هي برأيكم الاولويات في مجال السيدا و الشباب؟

- مثلا: استراتيجيات خاصة، خدمات صحية مناسبة لاحتياجات الشباب، توعية، زيادة الموازنة، بناء القدرات.....

8- هل لديكم اقتراحات خاصة لتفعيل المشاركة و التجاوب الوطني في مجال السيدا و الشباب؟ ما هي؟

Annex 4

Lebanese Global Youth Partners

The following young Lebanese GYPs participated in the interview process of the Advocacy Needs Assessment for Youth and HIV/AIDS in Lebanon:

- **Ms Mona Hasouna**
- **Ms Jessica Said**
- **Mr Ayman El Bouz**

Annex 5

Stakeholders Interviewed During the Consultancy

Government Sector	
Ms Joumana El Kadi	Reproductive Health Programme, Ministry of Social Affairs
Ms Joumana El Kadi	Reproductive Health Programme, Ministry of Social Affairs
Ms Nina Lahham	Ministry of Education and Higher Education
Ms Elisa Aslanian	Ministry of Youth and Sports
Ms Peggy Hanna	Health Education Unit, Ministry of Public Health
Ms Joumana Kalot	Social Development Training Center, Ministry of Social Affairs
Mr Ali Chaddad	Social Development Service Center, Ministry of Social Affairs
Dr Mostafa El Nakib	National AIDS Control Program, Ministry of Public Health
Non Governmental Organizations	
Mr Fadallah Hassounah	Secours Populaire
Dr Abdel Rahman Bizri	Lebanese AIDS Society
Mr Elie Aaraj	Soins Infirmiers et Développement Communautaire
Mr Kamal Chayya	Save the Children Federation
Mr Toufic Osseiran	Lebanon Family Planning Association
Mr Pierre Filfli	Young Men Christian Association
Ms Ghida Annani	Lebanese Council to Resist Violence Against Women
Media	
Ms Elsa Yazbek	Future TV
Ms Suzan Birbary	Al Diyar Newspaper
Ms Nawal Abboud Licha	Radio Voice of Lebanon
UN	
Dr Ziad Mansour	World Health Organization