The National AIDS Control Programme

REPUBLIC OF LEBANON
MINISTRY OF PUBLIC HEALTH

A Case Study on Establishing and Building Capacities for VCT Centers for HIV/AIDS in Lebanon

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
FBO	Faith-based Organization
FHI	Family Health Institute
FSW	Female Sex Worker
GO	Governmental Organization
HIV	Human Immunodeficiency Virus
IBBS	Integrated Bio-Behavioral Surveillance Study
IDU	Injecting Drug User
IEC	Information, Education and Communication
ISF	Internal Security Forces
KABP	Knowledge, Attitudes, Behavior and Practices
LAS	Lebanese AIDS Society
LFPA	Lebanese Family Planning Association
LGBT	Lesbian, Gay, Bisexual, Transsexual/Transgender
LL	Lebanese Lira (1500LL = approximately US$1)
M&E	Monitoring and Evaluation
MARPs	Most-at-Risk Populations
MENA	Middle East and North Africa
MOH	Ministry of Public Health
MOI	Ministry of Interior
MSM	Men who have Sex with Men
NAP	National AIDS Control Program
NGO	Non-Governmental Organization
PLHIV	People Living with HIV
SIDC	Soins Infirmiers et Developpement Communautaire
STIs	Sexually Transmitted Infections
SW	Sex Worker
TB-MOH	Tuberculosis Centers of the Ministry of Health
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNRWA	United Nations Relief and Works Agency
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Executive Summary

Lebanon currently has a low prevalence of HIV/AIDS infections, with 1056 reported cases of HIV as of December 2007 (1). The majority of these cases have been through heterosexual contact and occur in males (1). While there is little data on the prevalence of HIV among the most-at-risk populations (MARPs) in Lebanon recently obtained through the IBBS study, the KABP study and outreach interventions have shown that there is a high level of HIV-related risk behaviors (2; 3; 4; 5). These behaviors include low levels of condom use, multiple sexual partners, and sharing of needles among injecting drug users (IDU). Additionally, there are many risk behaviors that also occur among the general population. For example, it was shown that of the sexually active population, between the ages of 15 and 49, 84% of a nationally representative sample had never used a condom (2).

All of these findings have led the National AIDS Control Program (NAP), with the financial and technical support of the World Bank, and additional sustaining support from UNAIDS, UNICEF and WHO to embark on building capacity and establishing new voluntary counseling and testing (VCT) centers in Lebanon.

Preparations for Launching VCT
In order to prepare for launching VCT services within the country, NAP conducted a situation assessment on the organizations that were already offering VCT. The findings from this assessment led to the creation of a Standardized National Protocol and a Standardized Monitoring and Evaluation (M&E) plan for VCT Service Provision in Lebanon. A few of the distinguishing features of this program include that NAP developed criteria that organizations needed to fulfill in order to provide VCT at their centers, as well as qualifications for the staff members that would be providing the service. In order to launch this service, the organizations needed to be trained on providing VCT. Workshops were held for all of the organizations that wished to participate in delivering the service, with follow-up workshops being conducted to work on obstacles and weaknesses discovered in the first workshop. Each of the organizations was required to develop their own framework, list possible obstacles that they may encounter in providing the service, develop solutions to mitigate these obstacles, and create their own personalized marketing plans. These requirements helped create a sense of ownership for the VCT service among the organizations, as well as to strengthen each organization's VCT provision process.

Official Launching
The VCT services were officially launched on World AIDS Day, December 1, 2007 through a press conference, and the unveiling of the marketing plan, including posters, brochures and SMS messages, among others. 19 organizations began offering the VCT services to their communities at this time.

Findings
In the first six months of VCT service provision, 1011 individuals received VCT services. Over half of the beneficiaries who received the service were males, and the majority were single and between the ages of 16 and 35. 29% of those individuals receiving the service belong to the MARPs. The level of risk behaviors among beneficiaries was fairly high; over 50% of the beneficiaries did not use a condom the last time they had sex. 11 individuals tested positive for HIV, with seven of those being considered from the MARPs of men who have sex with men (MSM), IDU and ex-prisoners. All of the individuals who tested positive for HIV exhibited at least one high-risk behavior, including unprotected sex, multiple partners, sharing of needles, and male-to-male sex. All of the individuals who tested positive were males.

Conclusion
The VCT launching in Lebanon has encountered numerous obstacles, has worked through them, and has shown a promising beginning. Over a period of 6 months, the VCT centers in Lebanon were able to provide services to 1011 beneficiaries, of whom 11 tested positive, and distribute over 40,000 condoms and 60,000 copies of IEC materials on the topics of HIV/AIDS. These numbers show that the service has been working in line with the main objectives of VCT of case finding and provision of preventive messages and materials. One of the most beneficial outcomes of this service provision entails having baseline data on risk-behaviors for future comparison, as the NAP will now be able to detect and measure behavior change among target groups. This will also serve as a tool to assist in determining the cost-effectiveness of the service for preventing HIV, risk assessment and reduction, as well as increasing treatment, care, and support, including antiretroviral treatment.

Introduction

On World AIDS Day, December 1, 2007, the NAP launched national VCT services at 19 centers. These centers reach almost all areas of the country, and are found in non-governmental organizations (NGO), governmental organizations (GO) and faith-based organizations (FBO). The aim of the VCT centers includes the prevention of HIV transmission through case-finding and provision of early treatment, care and support. The organizations target both MARPs and any person who feels at-risk of acquiring HIV. Within the first 6 months of the service launching, over 1000 individuals have benefited from the service, including 276 individuals from the MARPs. This report details the process that was undertaken in launching this national preventive service, the strengths of the process, obstacles encountered, and recommendations for further action. Also included is an analysis of the first 6 months of data, including the risk-behaviors of individuals who have received the service, and of those who have tested positive for HIV.

Background

What is VCT? and What is its Purpose?

Voluntary counseling and testing (VCT) is 'the process by which an individual undergoes counseling, enabling him or her to make an informed choice about being tested for HIV' in an environment that ensures confidentiality and consent of the individual (6) (p.3). VCT provides individuals with the opportunity to know their HIV status; and consequently the choice of remaining negative, or seeking early treatment, care and support if the test result is positive. In short, the aims of VCT include the prevention of HIV transmission and acquisition, provision of early treatment, care and support for seropositive individuals, promotion of normalization of HIV and challenging HIV-associated stigma (7).

Most often, the VCT process is composed of pre- and post-test counseling, and the HIV test. During pre-test counseling, the service provider, or counselor, conducts an assessment of the HIV risk of the beneficiary, provides tailored information on HIV/AIDS and other STIs, identifies a tailored risk reduction plan, and provides an explanation on how to interpret the HIV test result in order that the beneficiary is better able to make an informed decision in regard to HIV testing. In post-test counseling, the service provider informs the beneficiary of the test result and its interpretation. Subsequently, the counselor and the beneficiary together will have to identify a harm reduction plan and the beneficiary would be referred to services if deemed necessary (6).

Evidence on the Effectiveness of VCT

The evidence on the effectiveness of VCT services on decreasing risk behaviors in developing countries is mixed (8; 9; 10; 11), and although there is a paucity of data on the long-term impact of VCT on sexual behaviors, those studies that have been conducted have shown that long-term behavior changes from VCT are difficult to maintain (7). In regards to the impact of VCT services on high-risk behaviors among MARPs, studies have been conducted mostly in developed, or industrialized, countries (7).

These studies have been conducted with MSM, IDU and SW. Among MSM, studies have revealed conflicting evidence regarding the impact of VCT on high-risk behaviors, with some showing declining risk behaviors independent of VCT, others associated with VCT (12, 13). The general consensus, however, was that seropositive men had more marked change than seronegative men, or those who were unaware of their status (7). There are similar findings within the IDU community as well. The majority of studies involving IDU recruited the participants from drug harm reduction programs, and therefore the changes seen in injecting behavior change may not be attributable to the VCT services. However, most studies also showed a change in sexual behaviors as well, which were more likely to result from the VCT. Again, behavior changes were more marked among those who knew their seropositive status (7, 14). In the case of the SW

community, studies conducted in developing countries showed that VCT could positively affect high-risk sexual behavior change; however in most areas, the economic and social factors surrounding the sex trade still played a major role (15). This led to recommendations being put forth that it is important to increase access to the clients of the SW, to increase her/his ability to change these behaviors (7).

There is little to no data available for the effects of VCT on HIV transmission or risk behaviors among prisoners. It is important to note that ethical issues arise in some countries where HIV testing is mandatory for prisoners, or where seropositive prisoners are segregated from the rest of the prison population. However, VCT services are available in some countries, but the effects of these services have not been studied (7). In addition, there is little information available as to the impact of VCT among youth in developing countries. Ethical concerns arise with this population as well, as parental involvement, age of consent, confidentiality and accessibility must be taken into account (7).

Benefits and Challenges of VCT

VCT services have been shown to be a cost-effective intervention for HIV prevention (16), and risk assessment/harm reduction, and have been a means to increase access to treatment, care and support, including the provision of medical care (7). Additionally, the counseling services increase coping skills and enhance the ability of PLHIV and others in future planning (7). The most important benefit, however, is the role that VCT plays in preventing the further spread of HIV (17). The main aims of VCT include case finding, assurance of service quality, the provision of confidential and anonymous testing on a voluntary basis, risk assessment and planning for risk reduction.

Along with these benefits, however, come numerous challenges to the provision and expansion of VCT services within a country. Some of these challenges include the following:

- Relatively high start-up costs, which can include difficulties in securing finances to cover training of service providers, the acquisition and distribution of HIV test kits, and marketing or promotion of the service to the target community. These challenges have made VCT unavailable in many developing countries (6; 18)
- Difficulties in demonstrating the effectiveness of VCT in reducing HIV transmission, as there are multiple factors that influence behavior change, and it is difficult to specify specific outcomes to particular aspects of the VCT services (7)
- Barriers to the uptake of VCT, including method of reporting, confidentiality and anonymity, stigma and discrimination, availability of treatment and social support services for PLHIV, and the type of test offered (7)

HIV in Lebanon and Justification for Launching VCT Services

Lebanon has a low prevalence of HIV/AIDS cases. By the end of 2007, the cumulative total number of confirmed cases of PLHIV was 1056, while the estimated number of cases was around 3000 (1). Among the 1056 confirmed cases, 432 are considered cases of AIDS and 92 were newly reported in the year 2007 (1). The major source of transmission of HIV in Lebanon has been found to be through sexual intercourse (70%). Of these cases, over half (56%) have been due to heterosexual behavior, and 20% due to homosexual or bisexual behaviors[1]. Besides sexual transmission, 7% became infected through blood transfusion and 6% through injecting drug use. 17% remain unspecified as to the mode of acquisition of HIV (1). It is interesting to note, however, that the vast majority of cases of HIV in Lebanon (82%) occur in men (1). The estimated antiretroviral therapy coverage for 2007 was 26% (1). The reported antiretroviral therapy coverage for 2007 by NAP is 100% for those who are in need for the medication; note that Lebanon offers free antiretroviral therapy to all Lebanese citizens and Palestinians registered with UNRWA.

[1] The remainder of those cases transmitted sexually are not specified as to the exact mode of sexual behavior.

In 2001, in coordination with the WHO and UNFPA and the assistance of SIDC and other NGOs, the NAP, which is a joint program between the Ministry of Health (MOH) and the WHO, conducted three outreach programs targeting MARPS in Lebanon. These outreach programs were funded by UNAIDS through OPEC and PAF funds. The results of the three projects showed a range of high risk behaviors among the three populations of IDU, SW and MSM (Table 1).

Table 1: HIV Risk Behaviors among MARPS

	IDU	SW	MSM
Condom Use in the Past Month*			
Always	31.4%	34.1%	37.3%
Never	16.8%	9%	21.1%
Consistent condom use with regular partner	5.8%	11.9%Ω	47.1%
Consistent condom use with commercial sex partner	43.6%	28.1%Ω	54.5%
HIV knowledge, modes of transmission and prevention*	61.3%	64.8%	69.8%
Have ever been tested for HIV‡	79.5%	21.8%	34.7%
HIV test in the past year†	49%	34%	47%
Perceive no chance of having been exposed to HIV‡	10.6%	21.5%	43.3%

‡2002 (19), †2005 (5), *2007 (20)
Ω Condom use with regular partner signifies with a non-client sexual partner, while condom use with a commercial sex partner signifies with a non-regular client.

Additionally, among the IDU population, it was noted that almost two-thirds of the population had ever shared needles, with 13% always sharing needles (20). The practices that all three of these populations are involved in, include not only high-risk behaviors, but behaviors that are considered illegal within the country. Therefore, these practices are often practiced in secret or in haste, which can increase their vulnerability to HIV infection. This has led, in part, to the level of knowledge of HIV and high-risk behaviors not translating into safer sex practices.

While this information deals with the MARPs, it is also important to note that the youth and the general population also are involved in risk behaviors, and lack perceived susceptibility regarding HIV. Among youth, the KABP study conducted in 2004 revealed that 33.3% had their first sexual experience between 15-20 years, and the average age to start sexual activities was 15 years (2). Additionally, 84% of the sample (n=3200; age between 15-49) had never used condom, although 87.3% of them knew that it protects against HIV transmission. Within the general population, the same KABP study revealed that 24.2% of men and 7.4% of women had extramarital affairs (regular or casual), and only 23% of the total sample ever used condoms (2). These findings are revealing, as national data indicated that 61.9% of HIV-positive women in the country became infected from their husbands (1).

The above analysis portrays that MARPs, youth, men and women living in Lebanon, and those who have traveled abroad are susceptible to acquiring HIV, due to risky behaviors. In addition, according to Family Health International (FHI) only 10% of the population globally knows their serostatus (21). Studies have also shown that MARPs are hesitant to seek medical services and HIV testing due to their fear of arrest and imprisonment (22; 23). The high level of stigma and discrimination that surrounds the topics of HIV and AIDS also might deter the general population from seeking HIV testing. If 84% of the sample that was discussed above have never used a condom and have not sought HIV testing, then it is possible that they may unintentionally be infecting others, which would increase the number of PLHIV in Lebanon. Moreover, due to the scarce number of VCT centers in Lebanon, fewer people may seek the service, especially within the MARPS as they are often a hidden and hard-to-reach population. Thus, fewer people have the opportunity to receive risk assessment, risk reduction and counseling services that all serve as preventive tools.

In addition, the four VCT centers in Lebanon that were offering the service prior to the national launching do not ensure coverage in all areas of Lebanon and do not follow one National Standardized Protocol and M&E plan. Moreover, there was not one coordinating body which ensured quality service or the needed resources to ensure sustainability; therefore, these centers have encountered some difficulties, which are discussed below. By launching VCT centers that are easily accessible to beneficiaries and ensuring a wider coverage, confidentiality, anonymity and free services, we would be offering a wider range of services that aim at case finding and prevention. We would also be giving a larger proportion of the population, especially of the MARPs, to receive professional VCT services that ensure high quality of performance, anonymity and confidentiality.

Thus by the financial and technical support of the World Bank, NAP embarked on building capacity and establishing new VCT centers in Lebanon as of early 2007. In addition, UNAIDS, UNICEF, and WHO supported these services financially in order to sustain their activities and trainings.

National Launching of VCT Services in Lebanon

Situation Assessment

In early 2007, NAP conducted a situation assessment, with the support of the World Bank, on organizations that had been providing VCT services in Lebanon. At that time, there were two NGOs providing VCT services. Soins Infirmiers et Developpement Communautaire (SIDC) was offering these services at their center in Sin el Fil, Beirut, and the Lebanese Family Planning Association (LFPA) had two centers, in Achrafieh and Saida. Prior to this date, the Baabda[2] Governmental Hospital had also offered VCT, however due to administrative problems, their VCT services had been closed. In 2003, NAP and the Lebanese AIDS Society (LAS) proposed and planned for the provision of VCT services in Lebanon, through financial support from the Merck Sharp Dome (MSD). Out of this, the above-named centers received training on providing VCT services from Dr. J. Mokhbat, an infectious disease physician and the director of LAS, in 2004.

Soins Infirmier et Developpement Communitaire

SIDC has a history of providing HIV awareness activities to the general public in Lebanon. They have done this through the distribution of educational materials, establishing a hotline for inquiries regarding HIV, and providing training to other NGOs on the topic of education and awareness for HIV. SIDC began offering the HIV test in 1997. In the year 2000, one of their staff received VCT training in the United States, and started to apply pre and post test counseling for HIV at SIDC center. In 2004 SIDC received their training on VCT by Dr. J. Mokhbat; four staff members were trained, including a social worker, a psychologist, a registered nurse and an aid nurse. The VCT and hotline services were available from 8am- 4pm, although the VCT was only open three alternate days per week. SIDC also created a support group for PLHIV, in order to assist the individuals who tested positive for HIV. SIDC receives around 14 hotline calls per month.

While SIDC used forms for monitoring and collecting data from the 'Guide for Training on Counseling for HIV/AIDS', they did not have a clear monitoring and evaluation (M&E) plan. The forms used for monitoring and collecting data were filled, but not analyzed.

[2] Achrafieh and Baabda are located in the greater Beirut area, and Saida is located in the south of Lebanon.

In 2006, rapid HIV tests were provided by NAP for the organization. In cases where a beneficiary tested positive on the rapid test, a confirmatory test was conducted by a laboratory that was contracted by SIDC to carry out this work. While the rapid test was provided for free, the beneficiary had to pay the cost of the confirmatory test (~$14.60 USD). That same year, through financial support provided by NAP, the International HIV/AIDS Alliance and SIDC developed a protocol for a comprehensive health and social services' referral system, including the provision of hotline services and a referral guide listing the names and addresses of all organizations that provide related services (Figure 1). These guides enhanced the services available for individuals seeking VCT services.

SIDC did not have a clearly articulated marketing plan for their VCT services, and they relied on outreach, word-of-mouth, volunteers and the hotline services to bring individuals in for the services. However, the services were facilitated by a few contextual factors, including the location of the center in a densely populated area, inhabited mostly by families and individuals from the low-middle socioeconomic class. This and the provision of various health services at the center eased the burden of stigma and discrimination for those individuals seeking VCT services, as they were able to blend in with the rest of the beneficiaries being seen at the center. Additionally, through coordination by the SIDC staff, they provided prompt and sensitive service to the beneficiaries. They did run into a few obstacles as well, including the lack of a room designated specifically for VCT, and inadequate finances for marketing and human resources.

Lebanese Family Planning Association, Achrafieh and Saida

LFPA is an NGO that provides medical services focusing on family planning and reproductive health, including prevention and protection from STIs. LFPA began providing VCT services at two of its six branches in early 2004. Within each branch, one nurse was trained to provide the services. Due to this, VCT was only available on Tuesdays and Thursdays, from 8:30 am-1:30 pm. The organization provided an ELISA test for free for individuals, with the laboratory testing being completed in a nearby hospital. This resulted in individuals needing to return to the center after two days to receive their results. In the case of a positive result, the individual would have to pay for the confirmatory test.

Figure 1: Protocol on the Referral System: Social, Health and Hotline Services

LFPA, like SIDC, did not have a clearly articulated M&E plan and a standardized protocol for VCT provision. An annual self-evaluation was conducted on all operations by one of the head administrators for internal reporting. Also like SIDC, LFPA did not have a clear marketing plan. The organization relied on the distribution of information, education and communication (IEC) materials, conducting educational and awareness sessions for the youth, and word-of-mouth to bring in beneficiaries. Through these methods, the Achrafieh branch saw approximately 80 beneficiaries each year, who were mostly homosexual males.

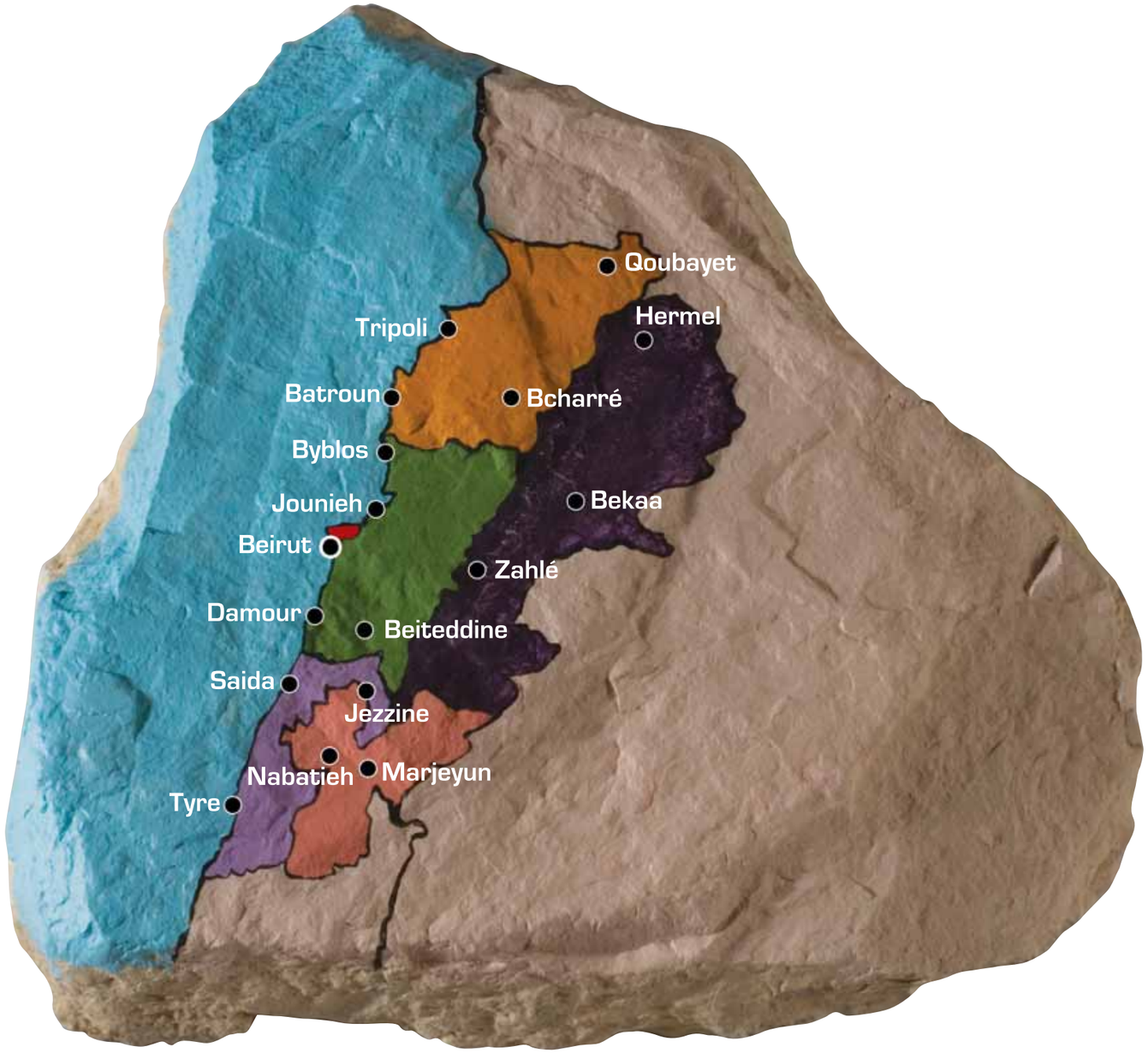
The provision of reproductive and family planning services made it easy for LFPA to include VCT within their range of available services, and helped individuals feel more comfortable coming for services to the organization. The staff nurse also felt that having contact with NAP eased some of the burden that she felt, as she could call NAP for any inquiry regarding the provision of the service. However, they also ran into a few obstacles, which included the following:

- Lack of a designated room for the VCT
- Shortage of materials for conducting the HIV test (gloves, needles, etc...)
- Lack of tailored IEC material for MARPS
- The necessity for a registered nurse or laboratory technician to withdraw the blood sample, as required by Lebanese rules and regulations; thus they were limited with staff who could offer the service

Minimum Standards for VCT

Based on the findings of the situation assessment, with the technical support of the World Bank, NAP presented practical recommendations to improve VCT with a set of minimum standards that should be in place in order for organizations to offer VCT services.

- Develop a Standardized National Protocol for VCT (24), which serves as an in-depth guide on VCT service provision
- Develop a Standardized M&E plan
- Increase geographical coverage of the service to cover all parts of Lebanon
- Link the VCT service with preexisting services offered by organizations, such as reproductive health services in NGOs, and TB-MOH centers in the MOH
- Emphasize working with NGOs that provide services to MARPS
- Encourage NGOs and GOs to become involved in providing this service, however, emphasize on working with NGOs, as there might be a lack of trust, especially among MARPS in seeking services at government facilities, which may deter individuals from seeking services in these institutions
- Provide participating organizations with material needed to offer VCT services for free; such as HIV-rapid tests, gloves, alcohol swaps, waste disposal baskets, alcohol swaps, condoms, and syringes to ensure sustainability
- Build capacity and strengthen the hotline and referral services of participating organizations
- Mobilize resources from various UN and funding agencies to support VCT activities and aid sustainability
- Offer free rapid tests and provide free confirmatory tests
- Develop tailored IEC material for MARPS
- Develop IEC material that would advocate for the service
- Develop a marketing and advocacy plan for VCT, at both a national level and among each individual organization
- Enter and analyze data on a systematic basis and disseminate results
- Conduct trainings on VCT delivery with systematic refresher meetings
- Include NGOs, FBOs, the Internal Security Forces (ISF), Bureau of Drug and Crime, TB-MOH in VCT training workshops and dissemination of VCT results



Distribution of NGO - VCT centers by Administrative Provinces (Mohafazat)

Province	NGOs
North Lebanon	Tuberculosis Health Center MOH (Tripoli)
Mount Lebanon	Hariri Foundation (Aramoun) Soins Infirmiers et Developpement Communautaire (SIDC) Dar Al Amal Association Jeunesse et Misericorde (AJEM) Jeunesse Contre La Drogue (JCD) Armenian Relief Cross (ARF) Jeunesse Anti Drogue (JAD)
Beirut	Tuberculosis Health center (Manasfi) Tuberculosis Health center (Quarantaine) Hariri Foundation (Tariq el Jdideh) Hariri Foundation Directorate of Health & Social Services (Karem el Zaytoun) HELEM SKOUN Anwar El Mahabba Association Rafic Hariri University Hospital General Health Center Dar El Fatwa
Bekaa	Lebanese Red Cross
South Lebanon	Lebanon Family planning Association (LFPA) Saida NGO's Platform of Saida
Nabatieh	Amel Association

Distribution of UNRWA - VCT centers by Administrative Provinces (Mohafazat)

Province	UNRWA CENTER
North Lebanon	Naher El Bared Clinic (Beddawi Camp) Naher El Bared Clinic Beddawi Clinic
Mount Lebanon	Dbayyeh Clinic (Bourj Hammoud) Bourj Al Barajneh Clinic
Beirut Health	Department (Lebanon Office) Mar Elias Clinic Central Beirut Clinic Chatila Clinic
Bekaa	Center to be opened in 2009
South Lebanon	Ain El Helwe Clinic "1" (Saida) Ain El Helwe Clinic "2" Central Saida Clinic El Bass Clinic (Tyre) Bourj El Chemali (Tyre) Al Rachidiyyeh Clinic (Tyre)

Standardized National Protocol for VCT

A Standardized National Protocol was created for the provision of VCT services in the country. A draft was completed prior to the training workshops, and was revised based on suggestions from end-users, and prospective VCT service providers from among the workshop participants. The protocol introduces the topic of VCT in Lebanon, a glossary of key terms, and the minimum standards, major components and logistical requirements of providing VCT services, in addition to other important information. Additionally, this protocol includes the national framework for VCT service provision in Lebanon (Figure 2). This section of the report details some of the most important sections of the protocol.

Significant features of VCT include privacy and confidentiality, free services, accessibility, valid and reliable HIV tests, tailored and target-specific provisions of services, a focus on the provision of life supporting skills, problem solving and decision making skills.

The major VCT components included in the protocol comprise (Figure 3):

- Confidentiality, anonymity, and privacy of service delivery
- Pre-test counseling, including the provision of information and IEC materials, risk assessment, test result interpretation, and benefits and risks of testing
- Informed consent
- Rapid HIV testing
- Post-test counseling, including the provision of the test result and interpretation, a risk or harm-reduction plan, provision of information and IEC material
- Follow up, support, and referral

One of the important aspects of the protocol includes the specifications of organizations wishing to offer VCT services, and the qualifications for service providers and counselors. These criteria are delineated in Figure 4.

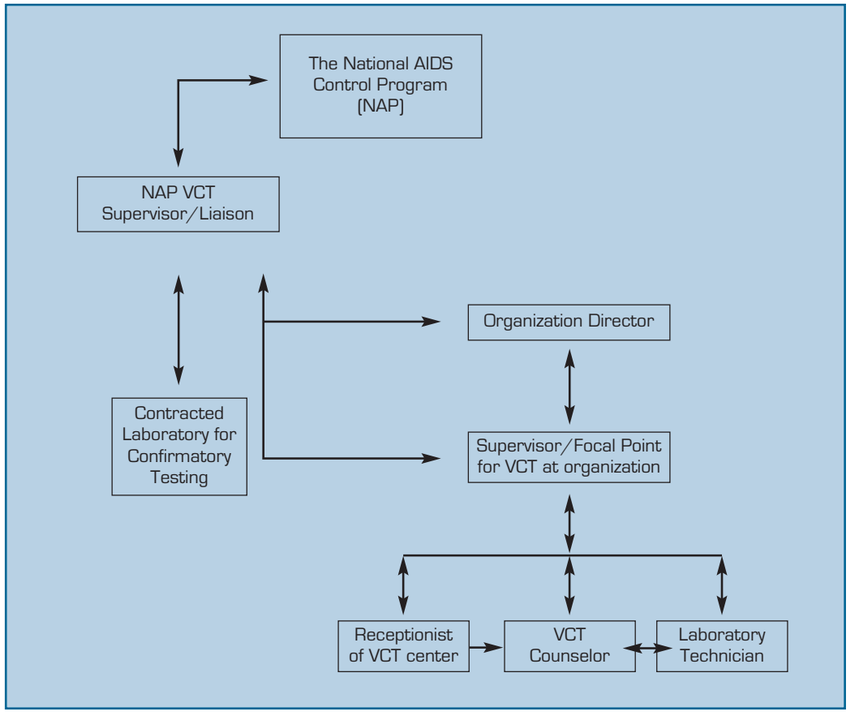


Figure 2: National Framework for VCT Services

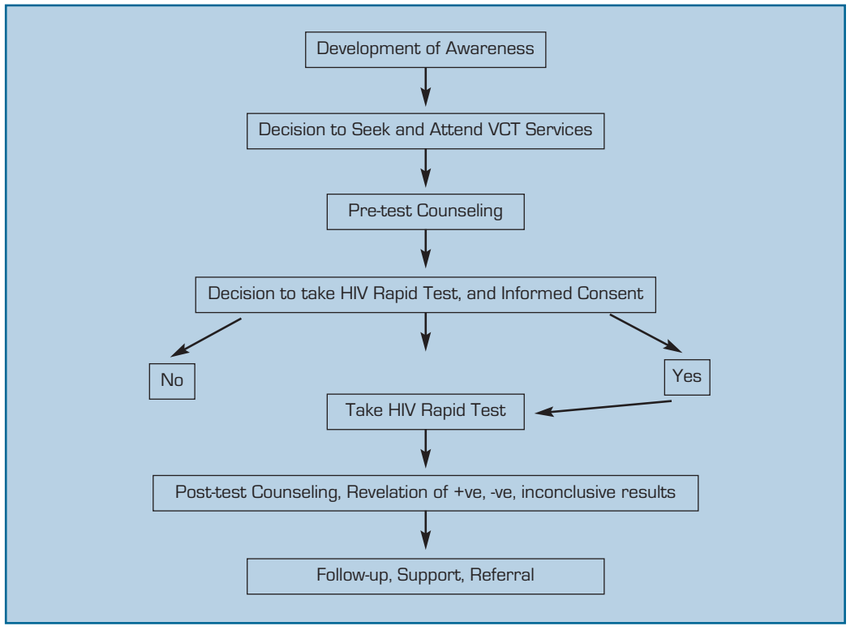


Figure 3: Flowchart of VCT Service Components

Requirements for the Location where VCT will be offered

- Private and confidential location
- Signs indicating directions and facilitating access to the designated VCT center that respects and allows privacy of beneficiaries and protects them from stigma and discrimination
- Accessible for target population
- Comfortable waiting room with space for IEC materials on diverse health issues, including HIV and other STIs
- Incorporate VCT services within other pre-existing services
- Designated room for VCT
- Signs indicating room and time schedule of service delivery to avoid embarrassment, stigma or discrimination
- Required to have a locked cabinet to keep beneficiaries" records, forms for M&E, testing materials, condoms, safety precaution materials
- Must have a computer for record keeping, as well as to keep track of stock of IEC materials, condoms, leaflets, and other necessary materials

Qualifications of VCT Service Providers/ Staff Members of Organization

- All Staff trained on VCT delivery and following the National Standardized Protocol and M&E plan
- All VCT providers must sign the confidentiality oath
- Trained on how to perform the HIV rapid test
- Trained on how to follow Universal Safety Precautions
- Trained and sensitized about MARPs, and how to provide respectful, sensitive and MARPs-friendly services
- Able to set aside preconceptions and judgments, as well as to work with acceptance and understanding of the target population
- Service providers should be specialized in either social work, psychology, or another health-related field
- Must demonstrate maturity and objectivity
- Must respect VCT ethical principles and the confidentiality of the service provision
- Receptionist needs to be knowledgeable of the VCT service and the National Standardized Protocol and sign the confidentiality oath

Figure 4: Specifications of Organizations and Qualifications for Services Providers and Counselors for the Provision of VCT Services

Target Populations

In addition, the specification of target populations for the VCT service was an important inclusion to provide services specific to the needs of the country. It was stipulated that VCT centers should target specific populations, especially those groups which are hard-to-reach, including MSM, IDU, SW and prisoners. The organizations should also try to reach sexual partners of individuals who are seropositive, MARPs and those who believe they may have been infected due to high-risk behaviors. However, it was also noted that it is important not to discriminate against certain populations, and to understand the stigma and discrimination associated with many of these groups, as well as with PLHIV. Lastly, it is critical that there is understanding about possible legal issues surrounding many of the hard-to-reach or hidden populations, and that it is important to provide sensitive and confidential care so that these populations are reached.

Ethical Principles of VCT

The next important subject tackled in the national protocol included the many ethical issues that could arise through the provision of these services. First, it is important to note that there are explicit specifications regarding the age at which VCT services can be provided without the consent of a parent. However, there are conditions attached to this specification, in that victims of rape or sexual abuse, members of the MARPs and those exhibiting possible STI symptoms below the age of 16 are able to benefit from the VCT services as well. Each individual who completes the pre-test counseling must go through an informed consent procedure prior to being given the HIV rapid test. The informed consent includes a form, specifically identifying the rights of the beneficiary and the responsibilities of the service provider and the organizations.

Each service provider must sign an oath of confidentiality, stating that all of the services that they provide are to be treated with privacy, respect, confidentiality and anonymity. They must ensure that they abide by all of the regulations placed forth in the confidentiality oath. There are also conditions regarding the confidentiality and anonymity of the services, the rare exceptions when this confidentiality can be breached, and stressing on the importance of partner notification. Instances when a breach in confidentiality is allowed are delineated below:

- When an individual conveys an intention to harm themselves or another individual
- If an individual is seen as being incapable of estimating harm or making appropriate decisions, the counselor can solicit additional mental, social and psychological support services for this individual. In the rare case when these services are not available, partner or family notification may be allowed

The VCT Service Provision Process

The protocol also details the VCT service provision process, including a flow-chart detailing the steps that are taken from the moment of the beneficiary's arrival at the center, to the final procedures of referral and support (Figure 5).

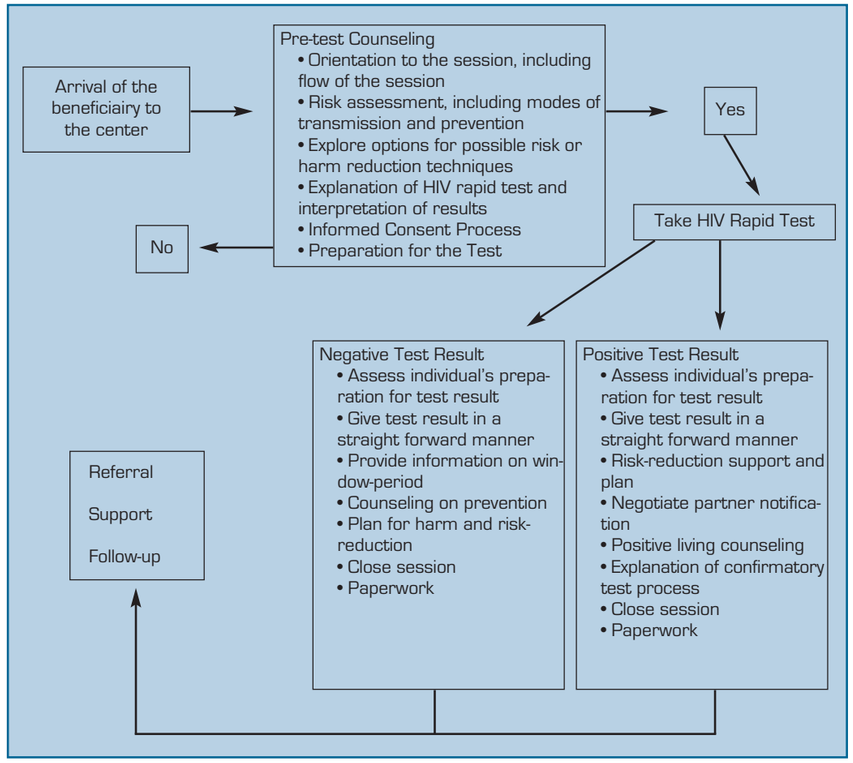


Figure 5: Flowchart of the VCT Provision Process

Once each organization has received the trainings from the 5-day workshop and 3-day follow-up workshop, the organizations are to sign a letter of agreement, which entails their terms-of-reference, a confidentiality form stating that they will abide by the Standard National Protocol and will offer all services in a confidential manner, and a paper specifying the type and quantity of materials that NAP will be providing the organization for the provision of VCT.

Once these criteria have been achieved, each organization receives tailored IEC material, supporting documents, and the materials needed for delivering the VCT service, including the M&E forms and coupon books. Within the process, there are six forms that need to be filled out, per beneficiary, as well as the coupon book (Figure 6). The forms include the following:

- Pre- and post-test forms which cover topics that the counselor should cover within the pre- and post-test counseling. These forms are meant to serve as a guide for quality assurance of the service provision
- Assessment sheet, which provides baseline data on the demographics of each beneficiary, including risk behaviors. This serves to pinpoint at the aspects or concerns where more effort should be exhausted, for example, where to refer beneficiaries to and how to reach more members of the MARPS
- Informed Consent form, which assures that the beneficiary understands the whole process, accepts taking the test voluntarily, and upon which the beneficiary will receive his/her designated number, which will connect the beneficiary to the rapid test, if he/she decides to take the HIV test.
- Referral form
- Beneficiary evaluation form that beneficiaries fill out after receiving the service; in the case that the beneficiary is illiterate, another member of the VCT team (not the counselor who offered the service) would assist him/her in filling the form

In addition, there is an inventory form, which each organization must fill in order to keep track of materials that they have received and used.

Through the course of the provision of the rapid HIV test, in the case of accidental exposure to HIV in the workplace, such as through an accidental needle prick, service providers need to contact NAP as soon as possible in order to be provided with post-exposure prophylaxis within 2 to 24 hours of the incident.

In Case of a Positive Test Result

If a beneficiary tests positive with the HIV rapid test, he/she will be referred to one of the selected and assigned laboratories to conduct the confirmatory tests. These tests are offered for free, as NAP reimburses the laboratories with an agreed cost per test. The laboratories have been provided with the VCT protocol, have received a briefing on the VCT service, and have been trained on filling the coupons and informing NAP on the results of the confirmatory test.

Each organization has been provided with a coupon booklet to fill out a coupon for each beneficiary, and each coupon is divided into three parts to track the service process. The counselor providing the VCT service has been trained to fill out a three-part coupon for each beneficiary. The first portion remains within the coupon book, at the organization, to keep track of the number of beneficiaries who have received the service[3]. The other two sections of the coupon are given to the beneficiary to take with him/her to the laboratory for the confirmatory test in case a beneficiary receives a positive rapid test result. The beneficiary takes the two sections of the coupon to the laboratory, which stamps the coupon, and returns the last section of the coupon to the beneficiary. This coupon is needed for the beneficiaries to obtain their results from the organization where they received their initial rapid HIV test.

When the laboratory completes the confirmatory test, it would then fax the coupon to NAP (Figure 7) with the positive or negative test result. NAP then relays this information to the original VCT center, so that the center provides the beneficiary with the test result. Note that this is all completed with a number that was given to the beneficiary, as there are no names provided during the VCT process. In order for the beneficiary to receive his/her test result, he/she must go to the center with his/her section of the coupon, which contains the beneficiary's number. Results are not provided over the phone or email, only in person, so that the individual can receive additional post-test counseling, referral and care, as well as to ensure confidentiality. Additionally, written results are not provided for beneficiaries in any case, and this service does not substitute for any mandatory testing required prior to marriage, prison entry, or any other circumstance.

It is important to note that each coupon has a beneficiary number and the name of the counselor and center who offered the VCT service to the beneficiary. No one has the name or identity of the beneficiary. Each coupon book has 100 coupons, and an inventory sheet is filled by NAP to keep track of the coupon books provided to each organization.

Preparations for Launching VCT

Workshop Preparations

Through support from the World Bank, NAP planned and organized training workshops on VCT services to be held starting in June of 2007. Participants from each organization were required to attend both a 5-day training workshop and a 3-day follow-up workshop before launching VCT services at their center.

In preparation for the training workshop, organizations were selected based on their mandate, background, general field-experience and specific working experience on HIV/AIDS and the issues surrounding the topic. Through this, invitation letters were sent to NGOs, GOs, hospitals and other institutions that cover most geographical areas of the country. Each organization was asked to fill a form for each participant that would be attending the workshop to obtain information on their background and experience relevant to HIV/AIDS in order to tailor the workshop to the needs of the individuals that would be attending the workshop.

[3] The coupon book has aided NAP in determining the number of beneficiaries that have received the VCT service; some organizations have been keeping track of their beneficiaries through at least the coupon book, even if they did not fill out the forms, due to participation in the IBBS study that will be elaborated on later in this case study, or lack of staff.

Background Information for VCT

Code number № 05301
NGO/Hospital/GO
Date of birth (dd/mm/yy)
Gender ☐Male ☐Female
Nationality
Place of residence
Marital Status ☐Single ☐Married ☐Divorced ☐Widowed
Employment
Date of pre test counseling (dd/mm/yy)
Date of test (dd/mm/yy)
Test result (RT)
Date of post test counseling (dd/mm/yy)
Counselor name
Signature

All information is required and should be filled by NGO/Hospital/GO, except for*
*To be filled only by laboratory staff

Coupon for Confirmed Test (VCT)

Code number № 05301
NGO/Hospital/GO
Laboratory
Date of birth (dd/mm/yy)
Gender ☐Male ☐Female
*Date of confirmatory test (dd/mm/yy)
*Type of test
*Confirmatory test result
Counselor name
Signature
*Lab technician name
*Signature

Please fax to NAP at 01-566102

Coupon for Obtaining Confirmed Test Result (VCT)

Code number № 05301
NGO/Hospital/GO
Laboratory
Date of birth (dd/mm/yy)
Gender ☐Male ☐Female
*Lab technician name
*Signature
Upon delivery of confirmed test result
• Date
• Counselor name
Signature

All information is required and should be filled by NGO/Hospital/GO, except for*
*To be filled only by laboratory staff

Figure 6: Page of Coupon Booklet

Coupon for Confirmed Test (VCT)

Code number № 01301
NGO/Hospital/GO
Laboratory
Date of birth (dd/mm/yy) 10.5.83
Gender ☐Male ☐Female
TRAD HOSPITA
KHALI
Medic
*Date of confirmatory test (dd/mm/yy) 15-12-07
*Type of test HIV
*Confirmatory test result Positive
Counselor name
Signature
*Lab technician name
*Signature

Figure 7: Coupon from Confirmatory Test Faxed to NAP

Prior to launching the workshops and the service, NAP met with the directors of each of the invited organization to discuss with them the importance of the VCT service. This meeting included information on the materials that NAP would be providing to the center, the TORs of the center, and the necessity to ensure confidentiality and anonymity of the service. Additionally, the directors of the organizations were invited to provide their opinions on any issues that they believed should be included in the workshop, or important issues for NAP to consider prior to launching the service. This step was important, as it personally involved the directors of the organizations in the process of training and delivery of the service, as well as sensitizing them to the topic.

The list of supporting materials created for the workshop was extensive, and included the following, in addition to others:

- IEC material on HIV/AIDS, and target-specific IEC materials for MARPS
- Advocacy brochure on VCT service, aiming at informing society on the objectives and benefits of VCT service delivery and increasing their perceived susceptibility. The brochure pinpointed data on a variety of populations (MARPS, youth, females, males, general population) that show the vulnerability of each of these groups to acquisition of HIV. The brochure also included details of the testing process, and ensured that the test was provided for free, and that confidentiality, anonymity, accessibility, and sensitivity of the service provision were emphasized
- Brochure of useful resources and links to obtain information and services on HIV/AIDS (Figure 8)
- List of materials to be provided by NAP for the delivery of VCT services
- Forms and booklets for the VCT service provision
  - Coupon booklet
  - Confidentiality form
  - Material inventory form
  - M&E and data collection forms for service delivery
- Draft version of the National Standardized Protocol for VCT Service Delivery and M&E plan
- Referral lists of physicians and laboratories for confirmatory testing, including a referral form (Figures 9 & 10)
- Soft copy of all workshop presentations, pictures of participants taken in the workshop, UNAIDS and UNICEF AIDS Glossary
- Protocol for a comprehensive health and social services' referral system, including the provision of hotline services
- 'Guide for Training on Counseling for HIV/AIDS' (Figure 11)
- 'Guide for Counseling over the Phone using Hotline' (Figure 12)
- 'Knowledge, Attitudes, Beliefs and Practices of the Lebanese Population Concerning HIV/AIDS', 2004 (Figure 13)
- Evaluation forms, including pre- and post-tests for testing knowledge and attitudes of participants, and evaluation forms for each session and day of the workshop, as well as a final overall workshop evaluation form

Various IEC Material

Figure 8: Guide on Useful Resources for HIV/AIDS

Figure 9: Referral Brochure


UNAIDS

SIDC
جمعية الحالة المسبقة

البرنامج الوطني لمكافحة السيدا في لبنان

مشروع

التوعية للفئات الأكثر تعرضا للإصابة بعدوى السيدا والالتهابات المتناقلة جنسيا

في لبنان

دليل الإحالة

المؤسسات الاجتماعية والصحية المشاركة في نظام الإحالة

وفي تقديم خدمة الخط الساخن

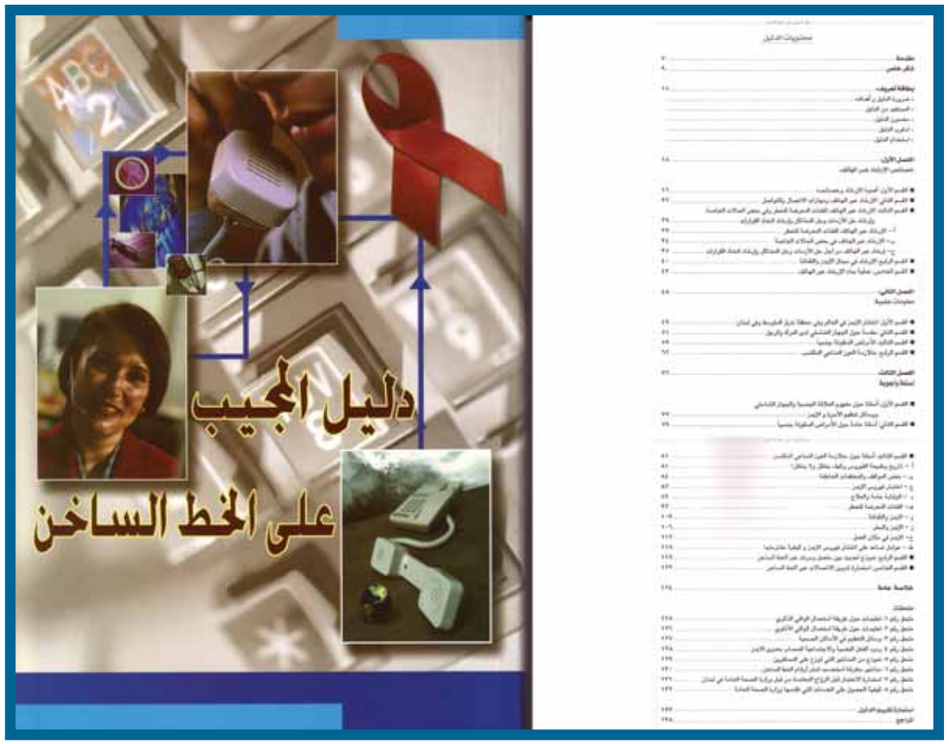
كانون الأول ٢٠٠٦

هذا المشروع بالتعاون مع جمعية حـــلـــم

بدعم من Alliance Internationale Contre le SIDA

Reprinted With The Support of The World Bank

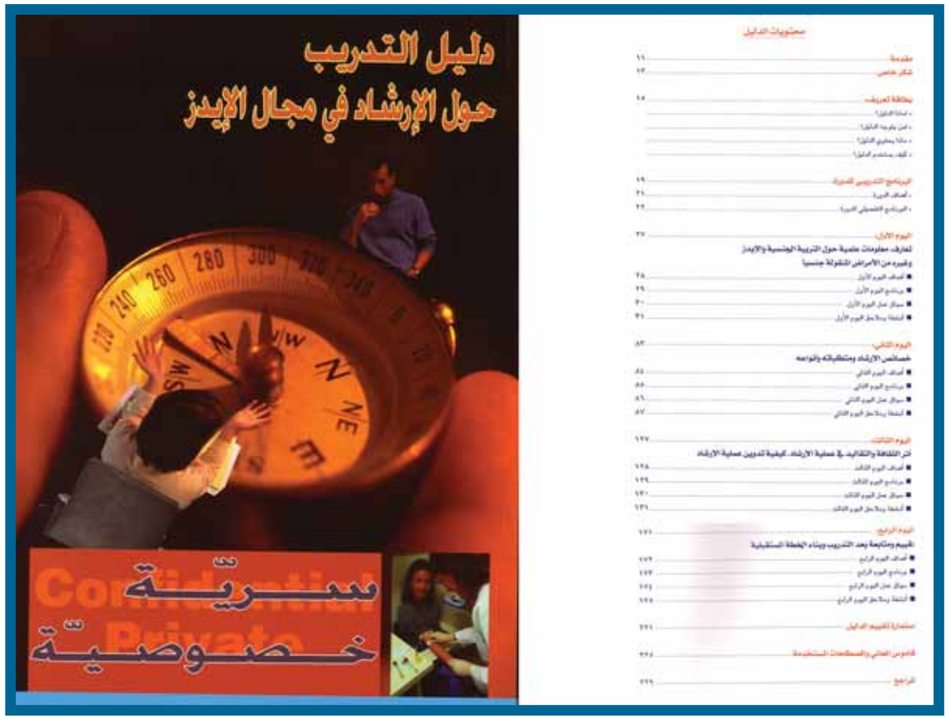
Figure 10: Directory of Social & Health Organizations Participating in Referral System & Provision of Hotline Services


دليل المجيب

على الخط الساخن

محتويات الدليل

Figure 12: Guide for Counseling Using Hotlines


دليل التدريب

حول الإرشاد في مجال الإيدز

سرية

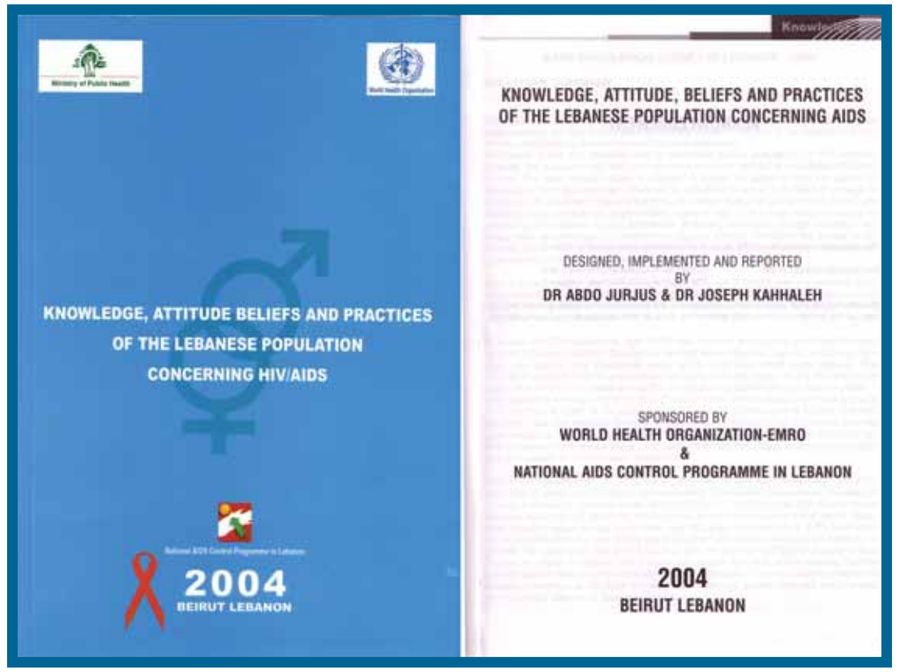
خصوصية

Confidential

Private

محتويات الدليل

Figure 11: Guide for Counseling HIV


Ministry of Public Health

World Health Organization

KNOWLEDGE, ATTITUDE BELIEFS AND PRACTICES OF THE LEBANESE POPULATION CONCERNING HIV/AIDS

2004

BEIRUT LEBANON

KNOWLEDGE, ATTITUDE, BELIEFS AND PRACTICES OF THE LEBANESE POPULATION CONCERNING AIDS

DESIGNED, IMPLEMENTED AND REPORTED BY

DR ABDO JURJUS & DR JOSEPH KAHHALEH

SPONSORED BY

WORLD HEALTH ORGANIZATION-EMRO

&

NATIONAL AIDS CONTROL PROGRAMME IN LEBANON

2004

BEIRUT LEBANON

Figure 13: KABP Study, 2004

VCT Training Workshops

Goals and Objectives

The primary goal of the VCT training workshops was to strengthen the VCT services in Lebanon, and expand coverage of VCT with a minimum set of standards according to the National Standardized Protocol and M&E plan. However, there were also many specific objectives. Some of these objectives included the following:

- Present the Global, Regional and Local statistics on HIV/AIDS
- Increase participants' knowledge on HIV/AIDS and other STIs; including definition, symptoms, complications, modes of transmission and prevention
- Identify target groups (MARPS) for VCT services and sensitize participants to the situations and difficulties experienced by these groups
- Sensitize participants on the issues of stigma and discrimination regarding HIV/AIDS, PLHIV, and MARPS
- Describe the relationship between MARPS and HIV/AIDS, including connections with drug use, sex work, MSM, and the prison population; stress on increased vulnerability of MARPS to acquiring HIV/AIDS
- Introduce participants to the framework of VCT in Lebanon
- Introduce and elaborate on VCT service: concept, basics, principles, and components, with a focus on issues of anonymity, confidentiality, and privacy
- Strengthen the participants' skills in: communication, assessing risk behavior, introducing risk reduction plans, and the provision of VCT services, pre- and post-test counseling and conducting rapid HIV testing
- Introduce and emphasize the important role of hotline use, outreach and the referral system in VCT provision
- Introduce the National Standardized Protocol for VCT in Lebanon, as well as the M&E plan for VCT
- Share experiences, including obstacles and lessons learned, of organizations that have been providing VCT services within Lebanon
- Ensure a participatory approach through a positive, dynamic and energetic atmosphere throughout the workshop

Workshop Content

Sixty-eight participants attended the initial five-day VCT training workshop held in June of 2007. These individuals came from a variety of institutions, including 20 NGOs, two GOs, an FBO, hospital, local university, a pharmaceutical company, and the ISF. In total, individuals from 28 centers came to the training and 22 were willing to offer VCT services at their premises.

The initial workshop was conducted over five days with the participants from all of the organizations mentioned above. This primary workshop was followed closely by two follow-up workshops that were funded by WHO, where the participants were split into groups of approximately 20 people per workshop. These follow-up workshops were held to ensure a high quality of VCT service delivery, by including additional hands-on training for the pre- and post-test counseling, as well as with the application of the rapid HIV test, and to individualize the VCT services to their specific organizational context, by presenting their own organizational framework, obstacles, solutions to these obstacles, and their marketing plan. One of the organizations could not make it to the follow up workshop because of instability in the country, and two organizations wanted to expand their services to multiple branches that would cover the Bakaa and Sidon, so it was agreed with NAP to provide their training in the near future; thus 19 centers received the initial and follow up training.

Additionally, in June 2008, a five-day training workshop was conducted for staff members of UNRWA health centers, and was followed by a three-day follow-up workshop within one month. Thirteen nurses were trained on VCT delivery through these workshops. In July, an additional follow-up training was provided for five NGOs that had participated in the initial training in June 2007. These organizations were involved in an integrated bio-behavioral surveillance (IBBS) study, which aimed to obtain a baseline prevalence of HIV among MARPS. As this study was being conducted from August 2007 to July 2008, it was agreed that these participants would receive follow-up training once the IBBS study had completed. This was agreed upon to ensure that the VCT services did not hinder the recruitment of subjects for the IBBS study[4].

[4] It was felt that the VCT services would compete for subjects, as the VCT service provides a rapid HIV test, which means that results are available in 10 minutes, and the assessment forms are fairly short, and are filled through the pre- and post-test counseling sessions. In the IBBS study, the HIV tests utilized were sent to a laboratory, and therefore the participants had to return to get their test results after 10 days. In addition, the questionnaire involved in the IBBS study was much more intensive than the VCT assessment forms.

Facilitators emphasized the MARPS, their vulnerability to HIV, and their (unintentional) role in the spread of HIV. They believed this information was important as these populations are highly stigmatized and discriminated against, and some organizations are not comfortable working with these groups. Due to this, it is important that the organizations are sensitized to their situations and backgrounds, and that they begin to understand the importance of offering and providing these services to the MARPS. In order to achieve this understanding and sensitivity, professionals who are currently working with these populations were invited to share their experiences, and to delineate the wider cultural, social, and environmental factors that influence the behaviors of these populations. They also outlined the impact that stigma and discrimination, and the laws pertaining to MARPS, have on these populations and their ability to seek health and social services. They emphasized the nature of these hard-to-reach populations, and the importance of reaching out to them through outreach and referral services. Additionally, SIDC and LFPA, which had prior experience in delivering the VCT services shared their experiences with the participants and pinpointed the obstacles they had encountered, and the strategies they had used to overcome these obstacles.

Time was spent in hands-on demonstrations of the HIV rapid test, and in practicing pre- and post-test counseling. Each participant was involved in applying these skills through case studies, role plays and demonstrations. Emphasis was placed on practicing the provision of the harm reduction plan, dealing with critical and intense situations, and providing referrals. The facilitators provided a box where participants could place questions that they had, to ensure that all questions were asked, if individuals were embarrassed or did not want to ask the questions in front of all of the participants. The role plays and case studies often had a competitive component to them, in that the 'winner' would receive a gift, which created an energetic atmosphere during the workshops.

Within the follow-up workshops, participants were required to put in additional up-front effort for their organizations. Each organization was to identify, discuss, and submit the framework and plan that they would be using for the VCT service, as well as how to ensure that the measures were adopted to ensure confidentiality, anonymity and the free provision of services. All of these individualized frameworks and measures had to be in line with the National Strategic Protocol and approved by NAP. Additionally, each organization needed to identify any possible obstacles specific to their context, and the means that they have created in order to overcome these obstacles. Lastly, they were to discuss their location and schedule of service delivery, as well as the organization's personalized marketing plan to attract beneficiaries to their center. After discussing these issues within the follow-up workshop, each organization received comments and recommendations on their submitted plans from NAP. These comments and suggestions were taken back to the managers of the organizations for discussion and amending. This personalized attention to the specific context of each organization greatly enhanced the ability of each organization to work with their specific target population.

An important aspect of the agreement between each organization and NAP, included the letter of agreement between the organizations, the list of materials to be provided by NAP, terms of reference and the oath of confidentiality. Each participant, and each organization, had to swear and sign on the oath of confidentiality that they would keep all information regarding beneficiaries confidential, and would not discuss them with anyone outside the VCT service team. Each individual would be held responsible if they broke this commitment.

After the presentation and discussion of the individualized frameworks and details of the VCT services for each organization, the facilitators focused on tackling stigma and discrimination through role plays and case study applications. Time was spent developing and practicing the provision of pre- and post-test counseling, administering the rapid test, and practicing on filling the M&E forms. Each participant was required to show their ability to follow through the whole process of the VCT service provision. Communication skills were emphasized within these sessions.

For the aim of promoting participation in the workshop implementation and evaluation, participants who volunteered were divided into three committees. The evaluation committee was asked to assess accomplishment of the workshop's preset objectives at the end of each day, while the documentation committee was asked to provide an overview of the main topics and feedback comments each morning, from the prior day's activities. The third committee was responsible for promoting an agreeable atmosphere among the participants of the workshop, and energizing the sessions as participants became tired, as the content was intense.

Evaluation of Workshops

The workshops' outcome were evaluated through a combination of pre- and post-tests completed by the participants to assess any change of knowledge and attitude of the participants in relation to HIV/AIDS and MARPs, evaluation forms filled out for each session, each day, and the overall workshop, and through discussions between the facilitators. The facilitators met at the end of each day to look at suggestions, strengths and weaknesses of the day's sessions in order to make improvements for the following days. In general, the knowledge level of the participants on HIV/AIDS and other STIs, and on VCT services improved over the course of the workshops. However, at the end of the workshops, there were still a large number of participants who exhibited stigma and discrimination against PLHIV and MARPS. This high level of stigma and discrimination present among the service providers led the facilitators to require attendance at the follow-up workshops, before they could become certified for service delivery. The follow-up workshops lessened the levels of stigma and discrimination, as assessed by the facilitators and the participants through observation of practical activities and role plays.

Strengths

There were numerous strengths that added to the success of these VCT training workshops. These include:

- A participatory, hands-on approach that involved all participants
- Follow-up sessions that built on prior knowledge and skills building, and focusing on sensitization to MARPS and decreasing stigma and discrimination
- Small number of participants in the follow-up workshops that enabled individuals to become more involved in practicing the skills
- Individualized tailoring of the VCT services to each organization that are in line with the National Standardized Protocol, including identification of obstacles and solutions, and individualized marketing plans
- Focus on MARPS, and the wider social determinants affecting their behavior change choices
- Flexibility of the workshop design to allow for additional time spent on topics that were deemed important by the participants
- Trainers employed diverse methods to deliver the program content, including lecture presentations, case studies, group discussions, competitions where prizes could be won, and practice sessions where participants were engaged in simulation exercises and role plays
- Provision of supporting material on hotline, counseling and outreach, Lebanese KABP study results (Figure 13), tailored IEC materials, and a CD with all power point presentations and pictures from the workshop
- Extensive training of the two facilitators of the workshops[5]
- Inclusion of specialized professionals to present technical information dealing with VCT service provision and MARPs
- Participatory approach used in tailoring the framework, marketing plan and resolving anticipated obstacles gave the participants a feeling of ownership of the VCT service
- Sensitization meeting with the directors of the organizations prior to the workshops increased the rate of participation and commitment of participants in these workshops , despite all the political instability at that time (see obstacles for explanation)

Obstacles

In addition to the numerous strengths that were identified for the workshops, a variety of obstacles were also encountered. All of these obstacles were encountered in the first five-day workshop, which led to the provision of the follow-up workshops, and all individuals were able to learn and apply these skills.

- While the workshops were being conducted, Lebanon was experiencing a period of political instability which resulted in numerous bombings around the country, and led to a decrease in people's ability to travel in certain areas. Due to this, a few of the participants missed one or two days of the training workshops because they did not feel that it was safe to come. However, there was still a large turn-out at each session, which signifies the commitment that these organizations have to offering this service
- Lack of time available to spend on increasing awareness on some subjects, due to limited time available within the workshops. Five days were not enough time to deliver all of the necessary material, and led to some condensing of the material
- Due to the large number of participants in the 5-day workshop, each person was not able to apply the various components of the VCT service provision process and to obtain the necessary hands on experience
- Necessity to further develop knowledge and skills for creating risk reduction strategies with beneficiaries and referrals

[5] Both facilitators received an extensive training from FHI in Egypt on VCT delivery.

Barriers to VCT delivery

The following barriers to VCT delivery were mentioned by members from a variety of organizations, as well as from the facilitators of the workshop. These three barriers are seen as extremely important topics that need to be worked on within future trainings, as well as in the society as a whole.

- Perception of difficulties on embarking on a project such as VCT, as the subject of HIV is still a taboo in some communities, and highly stigmatized
- Persistent negative attitudes, stigmatization, discrimination and prejudice against PLHIV and MARPS were shown among few participants. This could greatly inhibit the provision of the VCT services, especially as members of the MARPS would be seeking the service at a time when they may be feeling vulnerable
- Many participants already had full work-loads, which raised concerns as to whether the VCT service would receive the time and attention that is needed to provide appropriate services, as money was not made available to the NGOs for hiring additional staff members for the purpose of VCT
- Some NGOs had a problem with distributing condoms. They were very enthusiastic to open VCT centers, but refused to distribute condoms. It is important to note that as risk reduction and preventive methods, including the provision of condoms, is extremely important in the VCT service, and therefore these organizations did not open VCT centers
- UNRWA had their own regulations that were necessary to overcome prior to service delivery. For instance, in order to receive services individuals must present an identification card, which defeats the purpose of VCT being anonymous. Additionally it was important to sensitize religious and political leaders, and conduct awareness sessions prior to launching the service in the Palestinian camps. These sessions were important to increase the perceived susceptibility to and severity[6] of HIV among the camp residents. One strategy that may help to increase the reception of the services was to link VCT to the existing family planning program, as it has been a highly successful program in the camps. As an additional note on the UNRWA VCT service, although 13 employees are currently trained, an additional 30 employees will be trained in order to increase coverage throughout Lebanon, and prevent burn-out among the staff members

Recommendations

Delivery of Material/Workshop Content

These recommendations come from the first workshop, as they were incorporated into the follow-up workshops.

- Ensure enough time spent on practicing the delivery of each step, including the pre- and post-test counseling, working with the M&E forms, and developing individualized frameworks for each NGO
- Make sure the sessions are not condensed, and enough time is given to each session
- Provide follow-up training to ensure quality application of VCT components and to provide additional practical sessions
- Include examples/sharing of experiences by personnel who have worked with MARPS and VCT
- Emphasize the National Standardized Protocol, including practice on application of M&E forms and filling out the coupons booklets
- Ensure that the number of participants is feasible to increase participation, and more personalized attention
- Ensure that enough time is allocated for all sessions for more comprehensive coverage of diverse subjects

[6] These concepts are based on the Health Belief Model of individual behavior change. This theory basically states that a person is more likely to change their behavior if they perceive themselves as susceptible to a condition, if they believe the consequences of the condition to be severe, and if the benefits of making the change are more than the barriers preventing them from making the change (27).

- Focus on M&E and its importance, and continue to provide bi-monthly refresher meetings to discuss the forms and obstacles and means to overcome them
- Opt for methodologies of participatory approach in delivery of follow-up training sessions
- Emphasize the creation of tailored HIV risk reduction plans

Selection, Assessment and Capacity Building of NGOs

- Select organizations that have experience working with HIV/AIDS and/or MARPS, and organizations that are linked to other related services such as family planning, reproductive health, or TB. Also select organizations that have experience on providing hotline services, outreach and referral services. If these are not present, work on strengthening the capacity of these organizations to provide these services
- Increase coverage of VCT by inviting organizations from areas where VCT is currently not available
- Ensure that more than one staff member is trained per organization to receive the VCT training in order to prevent burn-out
- Emphasize the integration of VCT services into already existing service provision to decrease stigma upon beneficiaries wishing to receive this service
- Conduct field visits to the sites of all organizations to better assess: a) the readiness and suitability of the organization to set up VCT in line with the recently developed national guidelines and protocol, b) the available resources to ensure monitoring and follow-up of the VCT service, and c) participants' perceived adequacy of their selection, training, support and work satisfaction
- Conduct regular meetings with the VCT service providers to examine their practices, ensure quality control of service delivery, and reflect on barriers to optimal service delivery
- Conduct unannounced visits to the center to ensure and evaluate the quality of service delivery
- Hold monthly meetings with the VCT service providers to facilitate exchange of experiences, identification of gaps and barriers to service delivery, and reflection on possible ways to overcome them
- Seek increased financial support and mobilization of resources to ensure sustainability, durability, and high quality of service delivery
- Hire one staff member at NAP whose sole responsibility is to work with the national VCT services, to ensure continuous monitoring and evaluation and quality assurance

World AIDS Day, December 1, 2007: Offical Launching of the National VCT Program

NAP officially launched the VCT service through a press conference that was held on World AIDS Day, December 1, 2007. Media kits were distributed to more than 20 local newspapers and media outlets. Additionally, billboards, posters, advocacy brochures and red ribbons were developed to advocate for this service. Furthermore, the MOH sent short SMS messages promoting the VCT service. Additionally, the majority of the VCT centers submitted their own marketing plan to advertise for the service. This was conducted as it was believed that they would know how to better reach their target population and community, as Lebanon is diverse, and tailored messages were needed to ensure the success of the service. On World AIDS Day, 2008 a press conference will be held and the results of VCT will be disseminated. There will also be emphasis on enhancing active VCT by increasing outreach to hard to reach population. Additionally the organizations currently offering VCT will have stands and will be providing materials and information on their services.

Monitoring and Evaluation of VCT[7]

Rationale for M&E

Monitoring and evaluation of a program serves multiple aims, among which are to find out if the program's objectives were met, and to assess available resources and needs for proper service delivery.

Table 2: Definitions Utilized in M&E (25)

Input	All resources (finances, human, supplies, equipments, etc.) that were made available to deliver VCT
Output	Immediate results of VCT delivery
Impact	Short and intermediate term benefits of VCT, including changes brought about by service[8] delivery
Outcome	Long term benefits of VCT (measured 5-10 years after start of service delivery)
Monitoring	The process of follow-up on all related input and output, plus follow-up on service quality (equivalent to implementation evaluation)
Evaluation	The process of measuring attainment of impact and outcome objectives (equivalent to impact and outcome evaluation)

Process/Implementation Evaluation

For the aim of assessing implementation of VCT, the objectives of the process were defined, indicators were developed, and data was collected and analyzed. As VCT was launched in December 2007, the centers began offering VCT services in early January, 2008. The data referred to herein was collected from January through July.

The objectives for the process evaluation include the following:

- Provide information on HIV/AIDS, including modes of transmission and prevention, to beneficiary
- Assess HIV-related risk behavior of beneficiary and set a risk reduction plan
- Provide care and support to the beneficiary
- Provide target-specific referral services to the beneficiary
- Encourage partner notification about HIV status, whether positive or negative

Input indicators include:

- Number of supplies and commodities procured to deliver VCT the service
  - Rapid HIV test kits
  - Male condoms
  - IEC materials
  - Gloves
  - Disposal baskets
  - Referral leaflets, etc...
- Indicators of staff training completed in order to deliver the service

Table 3: Input Indicators

Indicator	Number
Number of VCT training workshops conducted	Two 5-day training workshops Four 3-day follow-up workshops
Number of staff trained in VCT delivery*	61
Number of staff trained on rapid HIV testing	61
Number of VCT centers providing VCT service	19

*68 individuals attended the initial five-day training, however 61 received both the initial five-day training as well as the three-day follow-up training

[7] The majority of the indicators used within this section have been adapted from (26; 29; 30)

[8] Within the section on monitoring and evaluation of VCT, the term "service" is used to mean VCT

Output indicators include:

- Indicators of supplies and commodities used during service delivery
  - 40,000 condoms distributed from January to July
  - 60,000 IEC materials distributed from January to July
- Indicators of service provision, including information on beneficiaries who have received the service

Table 4: Number of Beneficiaries who Received VCT Services

Indicator	Number
Number of total beneficiaries (with and without Assessment forms)	1011
Number of beneficiaries with National Assessment forms	568
Number of beneficiaries with Helem Assessment forms	43

It is important to explain how the number of beneficiaries was reached. A total of 1011 beneficiaries were provided with the VCT services. While only 568 of the national assessment forms were filled out, the other data came from the following organizations:

- Dar al Amal NGO filled out the coupon books, but did not fill out the forms because of their involvement in the IBBS study. From the coupon booklets, NAP received 120 filled coupons, of which all were noted to be from the FSW population
- Helem NGO also participated in the IBBS study. However, they had forms that they had received from SIDC for their VCT services. These forms do not contain the same data as the National Assessment Forms, and therefore were not utilized in the full data analysis. Even though Helem did not begin promoting their VCT service due to their participation in the IBBS study, they began receiving individuals seeking the service through word-of-mouth
- Both of the TB-MOH centers did not fill out any forms or coupons for the VCT services provided. However, from the inventory form the number of rapid HIV tests provided to the organization, it has been estimated that they have served over 300 individuals. Therefore, the number was left at 300. This center was not filling out the forms due to a shortage of personnel
- In addition, the actual number of beneficiaries reached may be higher than this amount, as one organization had not yet returned their beneficiary forms for these months

VCT Service Quality Assurance

To assure quality of the VCT service delivered, several measures were implemented, which include:

- Conducting VCT training workshops plus follow-up and refresher workshops as deemed necessary
- Carrying out on-site visits to VCT centers: a staff member responsible for VCT from NAP has visited VCT centers to examine the logistics and operations of the centers, and has had meetings with staff members appointed to deliver VCT services regarding obstacles and mitigation measures
- Conducting group meetings for VCT service providers at the NAP premises: monthly meetings have been conducted to share experiences, discuss obstacles and means to overcome them
- Conduct exit questionnaire to evaluate beneficiary's satisfaction with service delivery: beneficiaries were asked to voluntarily fill in a questionnaire upon exit from the VCT center

Table 5: Data on Beneficiaries from the Filled National Assessment Forms

Indicator	%	Description of Numerator (N) and Denominator (D)
% of beneficiaries who received pre-test counseling	98%	N= number of beneficiaries who received pre test counseling D= number of beneficiaries from the filled National Assessment forms
% of beneficiaries who received rapid testing for HIV	99.8%	N= number of beneficiaries who received rapid testing for HIV D= number of beneficiaries who received pre-test counseling and filled the National Assessment forms
% of beneficiaries who tested positive for HIV rapid test	1.9%	N= number of beneficiaries who tested positive for the rapid test D= number of beneficiaries who received rapid testing from the filled National Assessment forms
% of beneficiaries who returned for their confirmatory test results	90.9%	N= number of beneficiaries who took the confirmatory test D= number of beneficiaries who tested positive for the rapid test
% of beneficiaries who received post test counseling	100%	N= number of beneficiaries who received post test counseling D= number of beneficiaries who were tested
% of beneficiaries who tested positive for HIV and who intended to notify their partner	100%	N= number of beneficiaries who tested positive for HIV and intended to notify partners D= number of beneficiaries who tested positive
% of beneficiaries who were referred to other services	30%	N= number of beneficiaries who were referred to other services D= number of beneficiaries from the filled National Assessment forms

Table 6: VCT Service Quality Assurance Indicators

Indicator	%
VCT services satisfactory	83.2
Welcoming staff	80.3
Waiting room was available and welcoming	82.4
HIV information was available	90.8
Did not have to wait more than 30 minutes to see a service provider	86.3
HIV test information was available, as well as information on the results	87.9
Counselor was able to answer all of my questions	85.2
Certain that your personal information and test results will be kept private and confidential	88.5

Obstacles and Barriers to VCT Service Provision

Several factors were identified that could have negatively impacted the number of beneficiaries receiving the service. These include:

- One NGO did not have a direct phone line for inquiries about the service. Prospective clients would have to be referred from one operator to another before having the chance to communicate with the person in charge of VCT delivery. This deterred prospective clients from coming to the center, and therefore NAP suggested that they obtain a direct phone line for the service
- One NGO had some administrative issues, one of which was relocation and another pertaining to decision-making on which centers they wanted to offer the service at across Lebanon, which led to further delay in service provision
- One of the NGOs, which works with prisoners and ex-prisoners, attended the VCT training workshop and wanted to offer the service; however, they had to change their target for services to ex-prisoners and families of inmates, as the rules and regulations within the prison system demand mandatory testing upon entry, and any individual who tests positive for HIV is segregated from the rest of the population. As this goes against the principles of the VCT services, they are trying to change their strategy and target population for the service. NAP has suggested that when inmates exit the prison that they are informed of the services, including VCT, offered by the NGO. It was also suggested that the service be promoted among family members and friends of the prisoners, who often visit the NGO
- One NGO, which works with IDUs, declined to offer the service, although it participated in the VCT training workshop, as it did not want to distribute condoms during the service delivery process.
- Several organizations, including one GO, could not keep up with filling in all of the M&E forms for the VCT service because of a shortage of staff
- Five organizations which work with MARPS have been participating in an IBBS study, which caused a delay of service provision and led to these organizations not filling in the M&E forms, which led to a lower number of filled National Assessment Forms
- Some organizations who attended the first VCT training workshop could not attend the follow-up workshop due to unforeseen political turmoil in one part of the country, hence the number of organizations dropped from 22 to 19, which received the follow-up training
- It was not possible to conduct frequent on-site visits to VCT centers and monitor actual service delivery (i.e. conduct direct observation of counseling sessions and testing) because of a shortage of staff members at NAP

Impact and Outcome Evaluation

Impact and outcome objectives deal with the intermediate and long-term evaluation of a program.

Impact and outcome objectives include[9]:

- Increase the percentage of MARPs who received an HIV-test in the last 12-months and who know their results
- Increase the percentage of individuals who received an HIV-test in the last 12-months and who know their results
- Decrease prevalence of HIV-related risk behaviors. For example:
  - Needle sharing practices
  - Unprotected sex
  - Multiple sexual partners
- Increase prevalence of HIV-related risk reduction or harm reduction practices. For example:
  - Consistent condom use
  - Needle Exchange services
  - Opioid Substitution Therapy
- Decrease prevalence of negative attitudes, including stigma and discrimination, towards HIV/AIDS, MARPS and PLHIV
- Decrease incidence of HIV
- Decrease HIV/AIDS-related morbidity and mortality
- Decrease incidence of STIs
- Increase the percentage of MARPs who are reached by HIV prevention programs

[9] Currently the objectives are broad, without specification of percentages of increase or timelines. Now that baseline data is available, these specifications need to be determined by a specialized group of experts on M&E

Findings of VCT Based on Analysis of Beneficiaries' Assessment Forms

The findings on the beneficiaries of VCT were obtained using the assessment forms. There are a few exceptions; however these exceptions are mentioned when appropriate, below. As mentioned above, 1011 individuals received VCT services, and 1.09% of those who received the services tested positive for HIV.

The majority of the beneficiaries were between the ages of 16 and 35, with around two-thirds of them being male. It is important to note that females are more difficult to reach for VCT services, and so it is a positive finding that nearly 35% of the beneficiaries were females. Noticeably, 60% of the beneficiaries had attained or reached a university-level education. As to their marital status, almost three-quarters of them were single (Table 7).

Table 7: Sociodemographic Characteristics of Beneficiaries

Indicator	%	**Indicator**	%
Age (n=552)		Gender (n=483)*	
<16	0.9	Male	65.2
16-24	33.3	Female	34.8
25-35	49.4		
>35	16.3		
Education		Marital Status	
Illiterate	7.5	Single	74.1
Primary	4.3	Lives with partner	1.7
Intermediate	11.6	Has steady sex partner	8.5
Secondary/Technical	17.6	Widowed	1.3
University	59.0	Separated/Divorced	4.6
		Married – one spouse	7.6
		Married – >1 spouse	2.2

In the VCT service provision, individuals can receive the pre-test counseling, without taking the HIV rapid test. Over 90% of the beneficiaries who came for the service requested both the counseling and testing. As for the reasons for seeking the VCT service, only 15% sought VCT because they had a risky behavior, another 28% had a new sex partner, and 3.7% had unprotected sex during travel. When asked about how they knew about the service, almost 50% of them mentioned poster announcements (Table 8).

Table 8: How did the Beneficiary find out about the VCT services provided by the Organization?

Method	%	**Method**	%
Newspaper	1.3	AIDS Hotline	5.2
Poster	48.7	Pamphlet	1.3
Relative/Friend	33.2	Internet	5.8
Spouse/Sexual Partner	0.6	Radio/Television	3.9

With regard to sexual experiences, 13.9% of the beneficiaries had sexual intercourse before the age of 15. In the last three months, only 29.3% always used a condom with a non-steady partner, and 19.2% always used a condom with a steady partner. Additionally, almost 39% of beneficiaries had never used condoms with non-steady partner in the last three months, and 49% had never used condoms with steady partners. Consistent condom use was reported by only 46.9% of the beneficiaries. Concerning injecting drug use, 3.5% of beneficiaries stated that they had ever used drugs; yet, almost 60 % of these individuals had shared needles. 30% of the beneficiaries had been tested for HIV in the past 12-months, with one of them having had a positive result.

Table 9: Risk Behaviors of Beneficiaries

Question and Answers	N	%	Question and Answers	N	%
Had sex before the age of 15 (n=445)			**Had sex in the last 3 months (n=536)**		
Yes	62	13.9	Yes	303	56.5
No	383	86.1	No	233	43.5
Used condom with steady partner, last 3 months (n=271)			**Used condom with casual partner, last 3 months (n=232)**		
No	134	49.4	No	90	38.8
Sometimes	85	31.4	Sometimes	74	31.9
Always	52	19.2	Always	68	29.3
Used condom last time they had sex, steady partner (n=269)			**Used condom last time they had sex, casual partner (n=319)**		
No	146	54.3	No	192	60.2
Sometimes	52	19.3	Sometimes	44	13.8
Always	71	26.4	Always	83	26.0
Consistent condom use (n=307)			**Ever used injecting drugs (n=541)**		
Yes	144	46.9	Yes	19	3.5
No	87	28.3	No	522	96.5
Yes, but condom broke	16	5.2			
Did not have sex	60	19.5			
Ever shared needles (n=19)			**Ever had sex for drugs (n=302)**		
Yes	11	57.9	Yes	2	0.7
No	8	42.1	No	300	99.3

Table 10: Data on MARPs who Received VCT Services

Indicator (these are all a percentage of the total number of beneficiaries)	Percent (or number)*
FSW who received the VCT service	133†
% FSWs who received the VCT service	13.2%
MSM who received the VCT service	120‡
% MSM who received the VCT service	11.9%
IDU who received the VCT service	19Δ
% IDU who received the VCT service	1.9%
Ex-prisoners who received the VCT service	4
% ex-prisoners who received the service	0.4%

* The denominator in this table is the total number of beneficiaries who visited the VCT centers
†120 of the 133 FSW reached were contacted through Dar Al Amal, an NGO for FSW, which was one of the 6 NGOs who participated in the IBBS study and were exempt from filling in the National assessment forms
‡ 120 MSM were contacted, 50 from the National Assessment forms, and 43 from the Helem assessment forms, which are different from the National Assessment forms, and are therefore analyzed separately. The other 27 were also from Helem, although the forms were not filled due to their participation in the IBBS study.
ΔThe number was low as NGOs which work with IDUs were participating in the IBBS study,and did not begin offering VCT services until July 2008

Helem, which is an NGO that provides services for the MSM and LGBT communities, filled out assessment forms that were different from the National Assessment forms in the first two months of service provision, which were analyzed separately. Out of 43 individuals who came to the center for the service, all were between 16 and 39 years of age, and 85% were males. They had almost all heard about the center from their friends, and almost 40% of the beneficiaries had chosen to come to this specific center because they perceived that it was confidential, tailored to the MSM community, and free. Almost 85% of the beneficiaries admitted to having practiced unprotected sex, with 61% practicing unprotected anal sex. Almost half of the beneficiaries had previously tested for HIV. Of these 43 beneficiaries two tested positive.

On those who tested positive

The 11 beneficiaries who tested positive for HIV included the following individuals:

- 5 MSM who had multiple partners and practiced unprotected sex
- 1 IDU who had shared needles and had unprotected sex, although sometimes used condoms
- 2 beneficiaries who were bisexuals and had unprotected sex, although sometimes used condoms
- 1 ex-prisoners who had unprotected sex who had been tested for HIV upon entry to prison and had received a positive test result, but did not believe it
- 1 beneficiary who had multiple sexual relationships, and had a new sexual partner
- 1 beneficiary who had unprotected sex and multiple partners

Discussion of VCT Findings

The MARPs are generally considered hard-to-reach populations; due to this, the number of MARPs reached in the first 6 months of the VCT service is encouraging. 27.4% of the 1011 beneficiaries reached were from the MARPs, despite the IBBS study. However, it is known that a larger number could have been reached if the organizations that were involved in the IBBS study had been conducting VCT services during this time, as these organizations work specifically with the MARPs, and are the most active organizations that work with these populations. It is also important to note that the number of IDUs that were reached needs to be enhanced. It is important to work with organizations that are currently providing other services to this population to begin offering VCT as well, in addition to extending outreach among this population, and working on more active VCT.

Another positive finding from this first six months was that there were a large percentage of the beneficiaries who were female. This is an inspiring finding, as it has been noted in the region that women are less likely to seek VCT services.

NAP conducted a broad marketing campaign for the VCT services, and the majority of the organizations utilized posters for their marketing plans, which both proved to be successful, as most of the beneficiaries who received the services noted that they learned about the services from posters. There was also a large percentage that learned about the services from a friend, which means that there was a positive assessment of the programs by beneficiaries, and that they trusted telling their friends and referring them to the centers.

It is important to note a few startling findings as well. The percentage of HIV-positive individuals, at 1.09%, is much higher than the national average. This is something that needs to be kept in mind in the future for working on HIV/AIDS prevention and awareness, even though this is a biased sampling, and not nationally representative. Additionally, over 50% of individuals did not use condoms the last time they had sex, which indicates a high level of risk behavior among both the general population and MARPs. Therefore, we need to work on campaigns that specifically aim to increase condom use through increasing individual's perceived susceptibility to HIV, as well as their belief in the severity of the disease.

Recommendations for National Launching of VCT Centers

- Conduct needs assessment for VCT (Desk review of research studies on MARPS, KABP of the country, outreach reports, interviews with organizations)
- Review other VCT service delivery programs on the regional and international levels and tailor these according to the context of your country
- Develop a draft of minimum National Standards for service delivery with a projected M&E plan, including quality assurance indicators
- Selections of organizations to offer the service that ensure national coverage and accessibility to targeted populations; also ensure that some of those organizations are currently working with MARPs
- Sensitize directors of organizations on the importance and objectives of VCT service delivery
- Conduct training and follow up workshops for all service providers from selected organizations
- Assess possible obstacles with organizations and devise possible solutions prior to service launching
- Advise participating organizations to adapt a framework for their context within the National Standards Framework
- Develop a National Marketing Plan for VCT and advise NGOs to develop their own marketing strategies as they can better reach their own community
- Link the VCT service to complementary services, such as family planning and reproductive health
- Consider the use of an HIV rapid test as it provides additional incentives to beneficiaries as they only have to come to the center once, and their results are available in 10-15 minutes. There is an exception in the case of positive tests where they must receive a confirmatory test, which entails a longer time process
- Ensure ample stock of materials needed for provide VCT services
- Offer the needed materials for service delivery for free to participating organizations including covering the costs of the confirmatory test
- Encourage coordination and collaboration between NGOs
- Strengthen hotline, outreach and referral system
- Assess cost benefit and cost effectiveness of the program after one year of service provision
- Continuous monitoring and evaluation throughout the process
- Ensure ample financial and human resources for VCT service delivery

Creating a Supportive Environment for Establishment of VCT

- Advocate VCT service delivery among the local community and in particular authorities who could influence the uptake of the service
- Sensitize the targeted communities on HIV and MARPS by conducting tailored awareness sessions to increase perceived severity and susceptibility of becoming infected with HIV
- Develop an advocacy action plan, including inviting decision makers to a one-day workshop aiming to promote VCT, and solicit their involvement in VCT promotion and implementation
- Conduct awareness sessions on HIV/AIDS among various communities to increase knowledge about HIV, addressing misconceptions, raise perceived susceptibility, and address HIV and MARPS-related stigma and discrimination
- Develop context and culture appropriate marketing campaigns for VCT

Conclusion

The VCT launching in Lebanon has encountered numerous obstacles, has worked through them, and has shown a promising beginning. Initially, through the financial support of the World Bank and UN agencies such as UNAIDS, UNICEF and the WHO, the difficulties of securing funds for the start-up, training and sustaining of VCT service provision were overcome. This financial support is important to ensure durability and sustainability of the program.

Over a period of six months, the VCT centers in Lebanon were able to provide services to 1011 beneficiaries, of whom 11 tested positive, and distribute over 40,000 condoms and 60,000 copies of IEC materials on the topics of HIV/AIDS. These numbers show that the service has been working in line with the main objectives of VCT of case finding and provision of preventive messages and materials.

Within the literature on the impact of VCT, numerous barriers to the provision of VCT have been mentioned. The VCT service has been able to overcome many of these barriers. For instance, through the reporting system created between the testing laboratory, NAP and NGO, confirmatory test results are able to be tracked more easily. In addition, although the literature states that individuals are often afraid that their information will not be kept confidential, 87% of the beneficiaries reached through this service have stated that they trust in the confidentiality and anonymity of the services provided by the organizations. Additionally, 30% of beneficiaries were referred to additional services, and Lebanon has provision for the treatment and support of PLHIV, currently providing 100% antiretroviral treatment coverage for those in need. Any individuals who tested positive have been referred to a support group for PLHIV offered by SIDC.

Some of the stigma and discrimination that individuals seeking VCT services might face has been mitigated prior to the launching through the provision of intensive trainings on decreasing stigma and discrimination, as well as trying to create more MARPs-friendly services. Beneficiaries were also attracted to the service, due to the use of the rapid HIV test. Through this, the individuals were able to receive their results quickly and did not need to return to the center on a later date except for the cases of positive result. As the majority of the centers were located in NGOs, this also assisted in reaching hard-to-reach populations, and to provide more sensitive services. This could be part of the reason why over a quarter of the beneficiaries were from the MARPs, and a third were female.

One of the most beneficial outcomes of this service provision entails having baseline data on risk-behaviors for future comparison, and the NAP will now be able to detect and measure behavior change among target groups. This will also serve as a tool to assist in determining the cost-effectiveness of the service for preventing HIV, risk assessment and reduction, as well as increasing treatment, care, and support, including antiretroviral treatment.

Through the collection of data and analysis for this case study, it has become apparent that there is a need to allocate duties for the VCT to one staff member at NAP, whose sole responsibility would be to work with the VCT centers, monitoring and evaluation of the centers, as well as quality assurance. This is important if the program wishes to expand coverage and ensure that the services are provided in a manner that is in line with the Standardized National Protocol. It was also realized that enhancing referral services, outreach and hotline services is a necessity. In order to continue providing a quality service and to extend the services to reach more individuals from the targeted populations, continuous financial support must be ensured.

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