GLOBAL SURVEY

access to and quality of

HIV CARE & TREATMENT

RESULTS FROM

Lebanon ■ Morocco

JANUARY 2020

Watch What Matters

ITPC
INTERNATIONAL TREATMENT PREPAREDNESS COALITION

About ITPC

The International Treatment Preparedness Coalition (ITPC) is a global network of people living with HIV and community activists working to achieve universal access to optimal HIV treatment for those in need. Formed in 2003, ITPC actively advocates for treatment access across the globe through the focus of three strategic pillars:

- Treatment education and demand creation (#TreatPeopleRight)
- Intellectual property and access to medicines (#MakeMedicinesAffordable)
- Community monitoring and accountability (#WatchWhatMatters)

To learn more about ITPC and our work, visit www.itpcglobal.org.

About this Report

ITPC's *2019 Global Survey on Access to and Quality of HIV Treatment and Care*, available here, focused on barriers to quality HIV care and treatment services across 14 low- and middle-income countries, covering seven regions of the world. This brief summarizes findings of our peer-led research, which was conducted from April to December 2018, focusing on two countries in the Middle East and North Africa region: **Lebanon** and **Morocco**.

Acknowledgements

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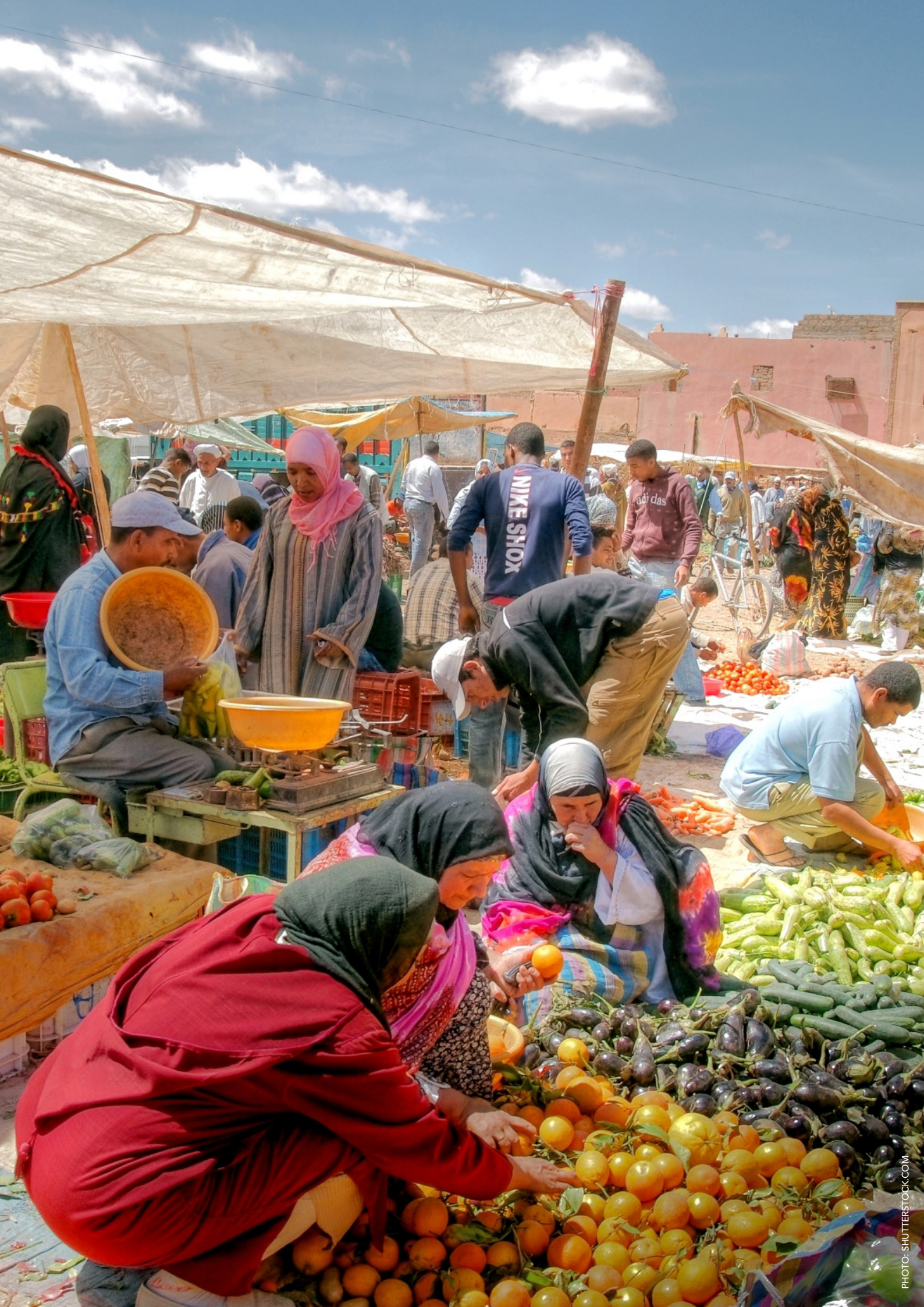

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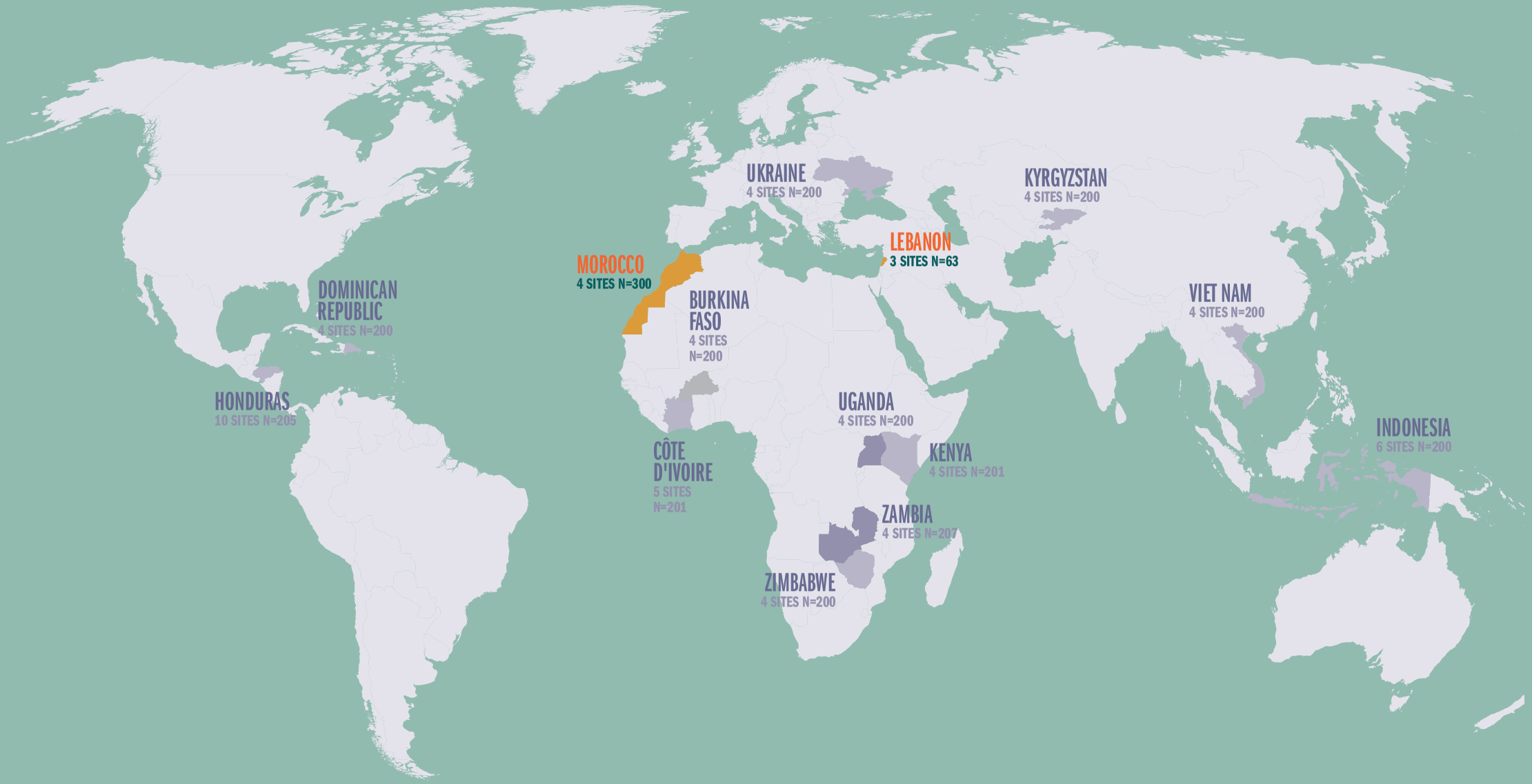
ABBREVIATIONS AND ACRONYMS

ABC	Abacavir
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
DSD	Differentiated service delivery
DTG	Dolutegravir
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
IRIS	Immune reconstitution inflammatory syndrome
ITPC	International Treatment Preparedness Coalition
MENA	Middle East and North Africa
NGO	Non-governmental organization
OI	Opportunistic infection
OST	Opioid substitution treatment
PLHIV	People living with HIV
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

FIGURE 1: Number of Sites and People Living with HIV included in the survey from Morocco and Lebanon



EXECUTIVE SUMMARY

The International Treatment Preparedness Coalition (ITPC) conducted its first Global HIV Treatment Access Survey in 2018 to assess the current state of HIV/AIDS care and treatment services in 14 countries and to document the challenges and barriers facing people living with HIV who seek to access these services. This report gives a snapshot of two countries in the Middle East North Africa (MENA) region: Lebanon and Morocco. Interviews were conducted with 372 participants, including 363 people living with HIV, seven healthcare workers and two key stakeholders from the national AIDS programme in each country.

Since 2015, the World Health Organization (WHO) has recommended antiretroviral therapy (ART) for all infants, children, adolescents and adults living with HIV, regardless of CD4 cell count, both for its individual health and quality of life benefits and for its potential to reduce HIV transmission[1]. Despite this recommendation, persistent gaps exist across the HIV care continuum, and progress reports fail to capture complex clinic- and social-level experiences of people living with HIV.

Key Findings

- Timely diagnosis is still a challenge in Morocco: 38.7% people (116/300) were not diagnosed until they developed advanced HIV (a CD4 count of <200 cells/mm3), putting them at risk for serious illness and death. In Lebanon, 11.1% (7/60) of participants were diagnosed with advanced HIV.

- In Morocco, 52.7% (158/300) of participants reported being tested for HIV after being ill or experiencing HIV-related symptoms. In Lebanon, 27% (17/63) of participants reported being tested after being ill or suspecting that they were having HIV-related symptoms.

- The distance to HIV services is still a challenge in Morocco: 23.7% (71/228) of participants reported that it took over an hour to reach the ART clinic, and 24% (72/228) reported travelling for over two hours. In Lebanon, 25.4% (16/63) of participants reported travelling up to an hour to reach the ART clinic.

- In Morocco, 10.7% (32/300) of participants stated that they were denied access to healthcare on more than one occasion due to their HIV status; in Lebanon, only one person reported this.

- In Morocco and Lebanon, HIV programmes face problems with sustainable funding and high prices for CD4 and viral load testing. Morocco faces challenges with medicine shortages and incomplete test kits, while in Lebanon, financing for testing is insufficient.

- In both countries, participants reported high adherence rates and mentioned the value of psychosocial support, underscoring the importance of providing counselling and mental healthcare within HIV services.

- In Morocco, testing for sexually transmitted infections (STIs) and viral hepatitis co-infection is limited; only 45.7% (137/300) of participants reported sexually transmitted infection testing and only 53.3% (160/300) reported hepatitis B virus (HBV) testing. In contrast, 92% (58/63) of participants in Lebanon were tested for STIs and 93.6% (59/63) for HBV.

- In Morocco, women have poor access to contraception; 18.3% (29/160) of women reported having no access at all. Also, women in Morocco reported a significant gender-based disparity in access to condoms: 34.4% (55/160) of women did not have access to condoms versus 14.7% (20/136) of men.

In both countries, rates of self-stigma were high. In Morocco, 61% (183/300) of people living with HIV blamed themselves for having HIV, as did 54% (34/63) of people living with HIV in Lebanon.

1 INTRODUCTION

The rapid scale-up of antiretroviral treatment (ART) has saved millions of lives and advanced the global AIDS response towards a goal that not long ago seemed unim aginable – ending the AIDS epidemic by 2030. Yet despite the World Health Organization's (WHO's) "treat-all" recommendations$_2$ and the global commitments to ending the epidemic, some regions are lagging. In 2018, only 32% of people living with HIV in the MENA region were receiving ART and only 27% (21,286 of 78,838) of this group were virally suppressed[3].

Ending the HIV epidemic will require dramatic improvements in addressing both clinical and non-clinical barriers to care – and improving its quality. In much of the world, stigma and discrimination are facts of life for people living with and affected by HIV, with very real consequences for their health, safety and ability to access services. For key populations – including men who have sex with men, sex workers, people who inject drugs and transgender individuals – violence and criminalization create additional barriers.

To characterize access to and quality of HIV services and treatment, ITPC surveyed more than 2,700 people living with HIV, healthcare workers and other key stakeholders in 14 low- and middle-income countries[4] in seven geographic regions[5]. The three objectives of the survey were:

- To measure access to quality HIV care and treatment by people living with HIV
- To identify barriers to each step of the care cascade experienced by people living with HIV
- To describe the challenges encountered by healthcare workers and political stakeholders involved in HIV care.

This report is a snapshot from the survey, with data from two countries in the MENA region: Lebanon and Morocco. Although HIV prevalence in these countries is low, the MENA region is home to one of the world's fastest-growing epidemics, and access to treatment is poor[6].

PHOTO: SHUTTERSTOCK.COM

2 METHODS

Adults (age 18 and above) who had been diagnosed with HIV for at least three months were eligible to participate. They were selected randomly from seven healthcare facilities that provide HIV services in Morocco (n=300) and Lebanon (n=63). Although we made efforts to diversify healthcare facilities by location, size and populations served, the three health facilities selected in Lebanon were non-governmental organizations (NGOs). Indeed, public facilities were harder to reach, and we did not manage to obtain authorization to conduct the survey in them.

We performed a quantitative survey to evaluate access and barriers to HIV care and treatment and conducted qualitative interviews to characterize challenges in accessing and delivering HIV care among a convenience sample of six people living with HIV (qualitative), 363 people living with HIV (quantitative), seven healthcare workers and two political stakeholders who were selected from each country site. In total, we conducted 15 interviews (six in Lebanon and nine in Morocco).

Regional and Country Contexts

The MENA region has one of the fastest-growing epidemics in the world. Access to HIV testing, treatment and care is still below average. Less than half of people living with HIV, especially members of key populations, are aware of their serostatus. Regionally, this has led to a 10% increase in HIV incidence and a 9% increase in AIDS-related deaths from 2010 to 2018. A few countries in the MENA region, such as Lebanon, Morocco, the Republic of Iran and Somalia, have shown exceptional progress in lowering HIV incidence.

Morocco has shown a strong political commitment to implementing services across the continuum of HIV care[7]. Although Morocco's National Strategic Plan is mostly aligned with current 2019 WHO guidance on HIV prevention, testing, care and treatment, these services do not reach all who need them. Numerous legal and social barriers to accessing health services exist, particularly for members of key populations (men who have sex with men, people who inject drugs and sex workers). There are no available data on the national implementation of WHO guidance for HIV services in Lebanon.

Morocco

Since 2010, HIV incidence in Morocco has decreased by 25% and AIDS-related deaths have dropped by 40%. As of 2018, Morocco was home to an estimated 22,000 adults living with HIV (12,000 men and 8,500 women) and less than 1,000 children under the age of 14[8]. Among key populations, an estimated 5.9% of men who have sex with men, 7.1% of people who inject drugs and 1.3% of sex workers were living with HIV as of 2018; no data are available on HIV prevalence among transgender people.

In 2018, 900 people were newly infected with HIV: 94% occurred among people aged 30-49 years, with 60% among men and 40% among women[9].

Although Morocco has adopted the 2015 WHO guidelines on HIV testing services, self-testing policies have not been implemented yet. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), in 2018, an estimated 24% of people living with HIV in Morocco were unaware of their status; 36% of them were adult males, which reflects limited access to HIV testing services and possibly high levels of stigma and discrimination against people living with HIV. To address this, Morocco's

National AIDS Control Programme is working to gradually integrate HIV counselling and testing services into primary healthcare facilities.

Although the Ministry of Health provides ART10 free of charge[11] and Morocco has adopted the 2015 WHO HIV "treat-all" policy, only 65% of people who have been diagnosed with HIV are receiving ART; 59% of them are virally suppressed[12]. Routine viral load testing is available on a bi-annual basis, either on site at ART clinics or by referral.

Men who have sex with men and people who inject drugs report that stigma and discrimination have led them to avoid HIV services in Morocco. No national-level data are available about laws that criminalize sex workers and transgender people, while same-sex partners are criminalized under Article 498 of the Penal Code, with sentences between six months and three years in prison[13].

Lebanon

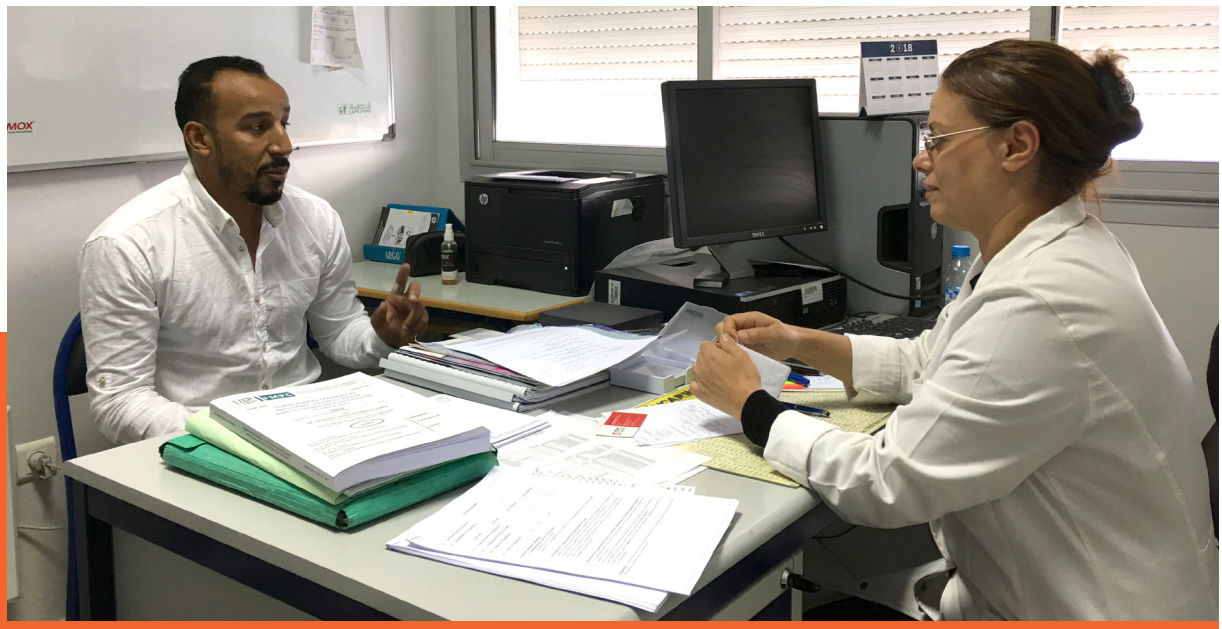
Since 2010, new HIV infections have decreased by 16% in Lebanon and AIDS-related deaths have decreased by 33%. By the end of November 2018, Lebanon was home to an estimated 2,500 adults living with HIV (2,100 men and >500 women). Prevalence among the general population was >0.1%14. Among key populations, 12% of men who have sex with men and 0.9% of people who inject drugs were living with HIV. The HIV prevalence rate among female sex workers was reported to be 0% in 2018; no data were available on HIV prevalence among male and transgender sex workers or for transgendered people in general[15].

According to Lebanon's Ministry of Health, there were 160 new HIV infections in 2018, with 49.4% among people aged 30-49 years and 94.4% among men[16].

Lebanon has adopted the 2015 WHO HIV "treat-all" policy17, and the Ministry of Public Health provides ART at no charge through the National AIDS Program. According to UNAIDS, 91% of people living with HIV in Lebanon were aware of their status18, 60% of them were receiving ART (1,354 men and 146 women) and 56% of this group had achieved viral suppression[19].

Although Lebanon has adopted routine viral load testing for adolescents and adults, no data are available on how often testing is done or where it is provided.

Unfortunately, there is no national-level data available on stigma and discrimination in the community or in healthcare settings. Also, there is a lack of data about criminalization of sex work; sex between same-sex partners is criminalized under Article 534 of the Penal Code, with imprisonment of up to 14 years[20].



ITPC MENA implemented the survey in Morocco, where approximately half of the respondents presented with advanced HIV disease

PHOTO: ITPC MENA

3 SURVEY FINDINGS

TABLE 1. Socio-demographics

Socio-demographics and individual characteristics (N=363)		MOROCCO		LEBANON		TOTAL	
		N	%	N	%	N	%
TOTAL NUMBER		**300**	**82.6**	**63**	**17.4**	**363**	**100**
SEX	Male	136	45.3	60	95.2	196	54
	Female	160	53.3			160	
	Transgender	4	1.4	3	4.8	7	1.9
AGE	Mean/std.	39.3	10.1	30.1	5.9	37.7	10.1
	Median		38.5		29		37
	Range		18-70		20-47		18-70
	18-24	17	5.7	11	17.5	28	7.7
	25-49	235	78.3	52	82.5	287	79.1
	<49	48	16.0			48	13.2
AREA	Rural	28	9.3	1	1.6	29	8.0
	Semi/peri-urban	25	8.3	12	19.0	37	10.2
	Urban	247	82.4	50	79.4	297	81.8
CURRENT RELATIONSHIP STATUS	Married	107	35.7	5	7.9	112	30.9
	Not married but living with a partner	3	1.0	4	6.4	7	1.9
	In a relationship but not living together	8	2.7	6	9.5	14	3.9
	Single	106	35.3	45	71.4	15.1	41.6
	Divorced/separated	52	17.3	2	3.2	54	14.9
	Widow/widower	24	8.0	0	0	24	6.6
	Missing	0	0	1	1.6	1	0.2
HAVING A SPOUSE OR A STEADY PARTNER (i.e., in a relationship for more than 3 months)	Yes	147	49.0	27	42.9	174	47.9
	No	153	51.0	36	57.1	189	52.1

TABLE 1. Socio-demographics (cont'd)

Socio-demographics and individual characteristics (N=363)		MOROCCO		LEBANON		TOTAL	
		N	%	N	%	N	%
TOTAL NUMBER		**300**	**82.6**	**63**	**17.4**	**363**	**100**
EDUCATION	No formal education	92	30.7	1	1.6	93	25.7
	Primary	82	27.3	3	4.8	85	23.4
	Secondary	89	29.7	12	19.0	101	27.8
	Tertiary	34	11.3	47	74.6	81	22.3
	Other	0	0.0	0	0.0	0	0.0
	Missing	3	1.0	0	0	3	0.8
INCOME	Yes	104	34.7	43	68.3	147	40.5
	No	196	65.3	20	31.7	216	59.5
HOUSEHOLD INCOME IN US DOLLARS ($)	Mean/median	2,653.1	1,700	1,849.1	1,350	2,522.9	1,500
	Range		0-30,000		0-10,000		0-30,000
	0-1,000	103	34.3	23	36.5	126	34.7
	1,000-2,000	86	28.7	20	31.8	106	29.2
	2,000-3,000	46	15.3	7	11.1	53	14.6
	3,000-4,000	15	5.0	4	6.4	19	5.2
	3,000-4,000	50	16.7	4	6.4	54	14.9
	Missing	0	0.0	5	7.8	5	1.4
HOUSEHOLD SIZE (NUMBER OF PEOPLE)	Mean/median	4	4	3.5	4	4	4
	1-3	146	48.7	28	44.4	174	47.9
	4-6	114	38.0	32	50.8	146	40.2
	7-9	31	10.3	3	4.8	34	9.4
	10-12	7	2.3	0	0	7	1.9
	>12	2	0.7	0	0	2	0.6
HEALTH INSURANCE STATUS	Yes	99	33.0	37	58.7	136	37.5
	No	199	66.3	25	39.7	22.4	61.7
	I do not know	2	0.7	0	0	2	0.5
	Missing	0	0	1	1.6	1	0.3
NGO AFFILIATION	Yes	27	9.0	9	14.3	36	9.9
	No	273	91.0	54	85.7	327	90.1

TABLE 1. Socio-demographics (cont'd)

Socio-demographics and individual characteristics (N=363)		MOROCCO		LEBANON		TOTAL	
		N	%	N	%	N	%
TOTAL NUMBER		**300**	**82.6**	**63**	**17.4**	**363**	**100**
PERSONAL CELL PHONE	Yes	286	95.3	63	100.0	349	96.1
	No	14	4.7	0	0	14	3.9
USING THE INTERNET FOR HIV-RELATED INFORMATION	Never	185	61.7	14	22.2	199	54.8
	Only once	7	2.3	11	17.5	18	5.0
	Few times	42	14.0	17	27.0	59	16.3
	Every time or almost	51	17.0	21	33.3	72	19.8
	I do not know where to find an internet connection	15	5.0	0	0	15	4.1

TABLE 2. Key population data

		MOROCCO		LEBANON		TOTAL	
		N	%	N	%	N	%
TOTAL NUMBER		**300**	**82.6**	**63**	**17.4**	**363**	**100**
HAVING SEX WITH SPOUSE/STEADY PARTNER IN THE PAST 6 MONTHS	Yes	126	42.0	27	42.9	153	42.1
	No	22	7.3			22	6.1
	NA	152	50.7	36	57.1	188	51.8
	Total	**300**	**100.0**	**63**	**100.0**	**363**	**100.00**
SAME-SEX INTERCOURSE	**Yes (total)**	**76**	**25.3**	**58**	**92.1**	**134**	**36.9**
	No (total)	**224**	**74.7**	**5**	**7.9**	**229**	**63.1**
	Yes (male)	73	53.7	55	91.7	128	65.3
	No (male)	63	46.3	5	8.3	68	34.7
	Yes (female)	1	0.6	0	0	1	0.6
	No (female)	159	99.4	0	0	159	99.4
	Trans (yes)	2	50	3	100	5	71.4
EVER WORKED AS A SEX WORKER	**Yes (total)**	**84**	**28.0**	**7**	**11.1**	**91**	**25.1**
	No (total)	**214**	**71.3**	**54**	**85.7**	**268**	**73.9**
	Yes (male)	41	30.2	6	10.0	47	24.0
	No (male)	94	69.1	53	88.3	147	75.0
	Yes (female)	40	25.0	0	0	40	25.0
	No (female)	119	74.4	0	0	119	74.4
	Yes (trans)	3	75.0	1	33.3	4	57.1
	No (trans)	1	25.0	1	33.3	2	28.6
EVER HAD SEX WITH A SEX WORKER	**Yes (total)**	**64**	**21.3**	**20**	**31.8**	**84**	**23.1**
	No (total)	**235**	**78.3**	**42**	**66.7**	**277**	**76.3**
	Yes (male)	46	33.8	90	31.7	65	33.2
	No (male)	90	66.2	41	68.3	131	66.8
	Yes (female)	17	10.6	0	0.0	17	10.6
	No (female)	142	88.8	0	0.0	142	88.8
	Yes (trans)	1	25	1	33.3	2	28.6
	No (trans)	3	75	1	33.3	4	57.1

TABLE 2. Key population data (cont'd)

		MOROCCO		LEBANON		TOTAL	
		N	%	N	%	N	%
TOTAL NUMBER		**300**	**82.6**	**63**	**17.4**	**363**	**100**
OTHER SEXUAL PARTNERS THE PARTICIPANT HAS EVER HAD IN THE PAST 6 MONTHS	None	194	64.7	21	33.3	215	59.2
	One	6	2.0	3	4.8	9	2.5
	More than one	100	33.3	39	61.9	139	38.3
	Total	**300**	**100.0**	**63**	**100.0**	**363**	**100.0**
HOW FREQUENTLY DID THE PARTICIPANT USE CONDOMS WITH THEIR OTHER SEXUAL PARTNERS IN THE PAST SIX MONTHS?	Never	30	10.0			30	8.3
	Sometimes	26	8.7	20	31.8	46	12.7
	Always	51	17.0	22	34.9	73	20.1
	NA	193	64.3	21	33.3	214	58.9
	Total	**300**	**100.0**	**63**	**100.0**	**363**	**100.0**
GETTING CONDOMS WHEN NEEDED	Never	75	25.0	1	1.6	76	20.9
	Sometimes	49	16.3	12	19.0	61	16.8
	Always	176	58.7	50	79.4	226	62.3
	Total	**300**	**100.0**	**63.0**	**100.0**	**363**	**100.0**
DRINKING ALCOHOL EVER	Yes	70	23.3	50	79.4	120	33.1
	No	230	76.7	13	20.6	243	66.9
DRINKING ALCOHOL IN THE LAST 30 DAYS	Every day			2	3.2	2	0.5
	At least once a week	22	7.3	26	41.3	48	13.2
	Less than once a week	12	4.0	20	31.7	32	8.8
	I did not drink last month	32	10.7	2	3.2	34	9.4
	I don't know/ No answer	5	1.7			5	1.4
	NA	229	76.3	13	20.6	242	66.7
USING ANY NON-PRESCRIPTION DRUGS (e.g., marijuana, cocaine)	Yes, currently	40	13.3	21	33.3	61	16.8
	Yes, in the past	22	7.3	21	19.1	34	9.4
	No	238	79.4	30	47.6	268	73.8

TABLE 2. Key population data (cont'd)

		MOROCCO		LEBANON		TOTAL	
		N	%	N	%	N	%
TOTAL NUMBER		**300**	**82.6**	**63**	**17.4**	**363**	**100**
EVER INJECTED DRUGS	Yes, currently	0	0.0	0	0.0	0	0.0
	Yes, in the past	1	0.3	2	3.2	3	0.8
	No	299	99.7	59	93.6	358	98.6
	NA			2	3.2	2	0.6
RECEIVED A CLEAN NEEDLE AND SYRINGE FOR EACH INJECTION IN THE PAST THREE MONTHS	Yes, every time I needed						
	Most of the time						
	Sometimes						
	Never	1	0.3	1	1.6	2	0.5
	NA	299	99.7	62	98.4	361	99.5
SHARED ANY INJECTION EQUIPMENT IN THE PAST 3 MONTHS	Never	1	0.3	1	1.6	2	0.5
	Once						
	More than once						
	NA	299	99.7	62	98.41	361	99.5
EVER ENROLLED IN OPIOID SUBSTITUTION TREATMENT (OST)	Yes, currently						
	Yes, in the past			1	1.6	1	0.3
	No	2	0.7	1	1.6	3	0.8
	NA	298	99.3	61	96.8	359	98.9

4 DIAGNOSIS

Only one-quarter of all people living with HIV worldwide do not know their HIV status[21]. While global trends indicate that, on average, people are getting tested and presenting earlier, a substantial number continue to be diagnosed with advanced HIV, putting them at risk of serious illness and immune reconstitution inflammatory syndrome (IRIS) after starting ART[22 23 24]. Timely diagnosis and linkage to care are vital first steps towards better health and quality of life for people living with HIV.

HIV testing services are free in Morocco and Lebanon, provided by the Ministry of Health and certain NGOs. There were differences by country in access to timely testing and where and why people were tested. The most common reasons for getting an HIV test in Morocco were illness or suspected HIV-related symptoms, accounting for 52.7% (158/300), followed by referral from a healthcare professional (17%; 51/300). Most participants were tested at a publicly funded healthcare facility (64.5%; 194/300), followed by private sector healthcare (14%; 42/300) and an NGO (11.3%; 34/300).

In Lebanon, the most common reasons for getting tested were being at risk for HIV (28.6; 18/63) and illness or suspected HIV-related symptom (27%; 17/63). The most common sites for HIV testing were NGOs (46%; 29/63) and through private sector healthcare (44.4%; 28/63); only 6.4% (4/63) accessed testing at a publicly funded healthcare facility.

Linkage to Care: CD4 Cell Count

Linkage to care is a crucial step in the HIV care continuum. It is also crucial for early initiation of treatment and viral load suppression[25 26]. In Morocco, 38.7% (N=116/300) presented with a CD4 count of <200 cells/mm3. This indicates a gap in reaching people with early HIV testing. Only 48.2% (120/249) received their CD4 cell count test results on the day of diagnosis and 29.7% (74/249) did so within a month. The remaining 12.4% (31/249) did not have a CD4 cell count test for an interval ranging from one to 12 years after being diagnosed with HIV.

In Lebanon, only 11.1% (7/63) of survey participants showed test results of a CD4 cell count of <200 cells/mm3. Currently, CD4 cell count tests are not provided at publicly funded facilities in Lebanon; healthcare providers advise people to go to a private lab, reflecting the contradiction between political commitments and their implementation. Participants cited having to self-pay for CD4 testing as a barrier. Overall, 95% of survey participants received a CD4 count result less than three months after their HIV diagnosis; 6.4% (N=4) received a CD4 count test on the same day as their diagnosis; 33.3% (21/63) received their first CD4 count test two weeks to one month after their diagnosis; and 28.6% (N=18) received a first CD4 count test one to three months after their HIV diagnosis.

Pedro Garcia, Monitoring and Evaluation Manager, ITPC Global, meets with collaborators in Marrakech,Morocco, May 2018

PHOTO: ITPC MENA

TABLE 3. ART

ART medicines taken now/the last time		MOROCCO		LEBANON		TOTAL	
		N	%	N	%	N	%
TOTAL NUMBER		**300**	**82.6**	**63**	**17.4**	**363**	**100**
ARV1	Abacavir	1	0.3			1	0.3
	Stavudine	1	0.4			1	0.3
	Tenofovir	143	47.7	13	20.6	156	43.0
	Zidovudine	55	18.3			55	15.1
	No ARV1/did not recognize the treatment	100	33.3	50	79.4	150	41.3
ARV2	Emtricitabine	87	29.0	13	20.6	100	27.6
	Lamivudine	57	19.0			57	15.7
	NA	156	52.0	50	79.4	206	56.7
	Emtricitabine	87	29.0	13	20.6	100	27.6
	Lamivudine	57	19.0			57	15.7
	No ARV2/did not recognize the treatment	156	52.0	50	79.4	206	56.7
ARV3	Atazanavir/ ritonavir	2	0.7			2	0.5
	Darunavir/ritonavir						
	Dolutegravir						
	Efavirenz (600mg)	152	50.7	13	20.6	165	45.5
	Efavirenz (400mg)	18	6.0			18	5.0
	Lopinavir/ritonavir	16	5.3			16	4.4
	Nevirapine	1	0.3			1	0.3
	Raltegravir/ lopinavir/ritonavir	1	0.3			1	0.3
	No ARV3/did not recognize the treatment	110	36.7	50	79.4	160	44.1
WERE YOU REFERRED FROM YOUR OST TO ART, OR VICE VERSA?	Not referred from one or another			1	1.6	1	0.3
	NA	300	NA	62	98.4	362	99.7
	Total	300	NA	63	100.0	363	100.00

Morocco and Lebanon have aligned their national treatment guidelines with the WHO "treat-all" recommendation, and both countries provide free ART.

> *I have no idea about the DTG and, with regard to the other ARVs, we have all the ARVs that PLHIV need except that sometimes we experience situations of [being] out of stock of the paediatric formulas.*
>
> *- Nurse at the infectious diseases hospital ward in Morocco*

Yet HIV programmes in both countries face problems with securing sustainable funding and the affordability of CD4 and viral load testing. In Lebanon, financing for CD4 and viral load testing is a major challenge while in Morocco, there are problems with medicine shortages and incomplete test kits. Managerial challenges with purchase orders, notably for paediatric ARV formulations and co-trimoxazole, prevail in Morocco, alongside stigma in health facilities.

Overall, 95.9% of the participants in the survey (348/363) were on ART. Access to ART has significantly improved over the past five years in Morocco, from 16% in 2010 to 48% in 2016[27]. Of note, 11.8% (22/186) of surveyed people living with HIV started their treatment within two weeks of receiving their diagnosis; 23.1% (43/186) received their treatment two to four weeks after being diagnosed; and 25.3% (47/186) received ART within one to three months of their diagnosis. However, there was not much difference in time to initiation of ART between people tested before versus after 2015.

In Morocco, 80.7% (242/300) of survey participants reported that they had never stopped ART for more than one week, while 17.7% (53/300) reported stopping ART for longer intervals. Many participants cited lack of resources for travelling to the treatment centre as their reason for stopping treatment. Overall, 24.7% (74/300) changed their ARVs at least once; the most common reasons were treatment failure (8.3%; 25/300) and side-effects (7.7%; 23/300).

In Lebanon, all participants were diagnosed and initiated ART before 2015. Many of them (44.6%; 25/56) initiated their treatment within one to three months of receiving their diagnosis. Dolutegravir (DTG) was secured through the Ministry of Health budget. Other medicines were provided through global donors. Participating health professionals and people living with HIV were satisfied with the availability of the drugs and the treatment regimens. However, at the level of the policymaker the sustainability of global funds for the national AIDS programme was a concern.

In Lebanon, 85.7% (54/63) of survey participants reported never stopping ART for more than a week, while 14.3% (9/63) had stopped it for a longer interval, mainly because they lacked resources for travelling to the ART centre. Overall, 39.7% (25/63) of participants reported changing ARVs at least once, mainly due to side-effects (38.1%; 24/63).

Psychological challenges, such as sadness and depression, were cited as major barriers to treatment access, with participants reporting experiences of denial or shock following HIV diagnosis. Understaffing at ART centres created an additional barrier as it led to long waits for treatment, especially in Morocco.

> *I don't have [concerns about] treatment or access [to] treatment, and I always take my medication on time, and I always receive psychosocial support too.*
>
> *- PLHIV, 24 years old, diagnosed in 2016*

Viral Load Monitoring

Over the past decade, routine viral load testing has slowly replaced CD4 cell testing for monitoring response to HIV treatment. WHO recommends viral load testing six and 12 months after treatment initiation and once yearly thereafter for people who are stable on ART[28]. Access to routine viral load testing is vital for letting people know whether their treatment is working and for prompting action (including switching to a new regimen, counselling and adherence support), as well as clinical care for people with advanced HIV. In Morocco, viral load tests are available for free in public health facilities; in Lebanon, people living with HIV have to pay for these tests.

> *The results of testing are still slow to come. Sometimes we do not even receive them. This poses a real problem. During the month of November, we received viral loads [for] March in the laboratory. Half of the viral loads are not sent.*
>
> *- Head of nurses in the infectious disease department*

The vast majority of surveyed people living with HIV in Lebanon and Morocco received a viral load test after their initial HIV diagnosis: 98.4% (N=62) and 80.7% (N=242), respectively. In Morocco, 48.7% (146/300) received their first viral load test results before ART initiation, 5% (15/300) received the results within a month of ART initiation, and 11% (33/300) received them after they had been on ART for six months. In Lebanon, 91.4% (53/58) received their first viral load test result before ART, and only 5.2% (3/58) received a viral load result months after initiation of treatment. A steep drop-off in the proportion of respondents who knew their viral load within six months of their diagnosis indicates that timely viral load monitoring remains a challenge: only 18.6% (N=8) of respondents in Lebanon and 17% (N=40) in Morocco received their first viral load test results within six months of their HIV diagnosis.

In Morocco, the regimen includes two viral load tests and two CD4 cell counts per person per year. However, this policy is not closely followed. It is unclear whether this is because healthcare providers do not order these tests or because people do not undergo them for various reasons.

The time between diagnosis and having the first viral load test ranged from the day of diagnosis to nine years later: 34.1% (N=80) of participants had a first viral load test on the same day as their diagnosis, 47.2% (N=111) within one month to a year of their diagnosis, and 13.2% (N=31) more than a year after their diagnosis. Only 30.9% (N=94/304) of participants who received their viral load test result stated that they were told by their healthcare provider that their viral load was undetectable. Delays in viral load testing and delivery of results can pose a barrier to achieving viral suppression.

In Lebanon, regular CD4 cell and viral load testing are not covered in the management plan. Moreover, each hospital decides upon the pricing of these tests, which has created a considerable barrier for people living with HIV, who reported that they were initially supported by their insurance or NGOs to finance their tests.

In Lebanon, 30.2% (N=13/63) of participants had their viral load test on the same day as diagnosis, 43.6% (N=33/63) a month to a year after their diagnosis, and 18.6% (N=8/63) more than a year after diagnosis. In Lebanon, the proportion of participants who were informed that their viral load was undetectable was similar to that in Morocco (27%); this lack of access to viral load testing and results could lead to poor health outcomes among people living with HIV and delay achievement of the 90-90-90 targets.

> *Sometimes we are out of stock – tests kits – but the last break was due to [delays in] the international market. But we buy CD4 and viral load tests from the state budget and so there are usually [few stock-outs], just supply market delays. In principle, it is two viral load or CD4 kits per patient per year.*
>
> *- Head of the National AIDS Program in Morocco*

Quality of Comprehensive Package of Care

People living with HIV require a comprehensive package of care, including access to testing, prophylaxis and treatment for opportunistic infections (OIs), access to condoms and contraception, and adequate counselling for pregnant women, as advised by WHO and each country's national HIV guidelines.

In Morocco, testing for syphilis, hepatitis B virus (HBV) and hepatitis C virus (HCV) is offered in public hospitals, although some healthcare workers reported that sometimes it is not available. When results are available varies according to the workload and availability of technicians, and this is the main barrier to providing prompt test results.

In Lebanon, most healthcare workers reported that testing for OIs, such as hepatitis and tuberculosis (TB), is available, but people must pay for it out of their own pockets. Testing is not covered by the Ministry of Health, and each hospital decides on their own fees for testing. Since 2015, treatment for common OIs, such as TB and pneumocystis, has been provided at no charge. Treatments for less common OIs are not covered, leaving people living with HIV to pay for their treatment and, in some cases, the travel to obtain it.

Access to Sexual and Reproductive Health Services

Overall, 14% (42/300) of survey participants in Morocco do not have access to modern contraception (other than condoms). Women reported poorer access than men: 34.4% (55/160) could not get condoms versus 14.7% (20/136) of men. Access to contraception remains challenging for women in Morocco: 18.3% (29/160) reported that they did not have access to hormonal contraception.

In Morocco, six women were pregnant when they were diagnosed with HIV, and 30 became pregnant after their diagnosis. Yet only 20 women had taken ART during pregnancy. Two women did not take ART because it was either unavailable or not offered in the medical setting. One woman could not afford to go to the ART centre to receive treatment. Overall, 44.4% (71/160) of women responding to the survey did not receive any counselling on reducing the risk of vertical transmission, and 49.4% (N=79/160) were not given any information about safer breastfeeding.

In Lebanon, 19% (12/63) of respondents reported that they decided not to have children because of their HIV status; 3.2% (2/63) reported that they were advised by their healthcare provider to not have children.

Adherence

A single-item visual analogue scale was used to collect adherence data from survey participants. A score of above 90% was considered to be optimal adherence. When available, medical records were reviewed to obtain information on viral suppression.

In both countries, self-reported adherence to ART was high: 93.8% (270/300) of participants in Morocco and 92.1% (58/63) in Lebanon self-reported optimal adherence. In Lebanon, 98.4% (62/63) of respondents had their last viral load test in 2017 and 2018; 82.5% (52/63) of respondents had suppressed viral loads (>1,000 copies/mL). However, all CD4 count tests were performed before 2018, reflecting problems with the regularity of tests and follow-up.

In both countries, people living with HIV and healthcare workers highlighted the importance of psychological support and psychosocial services for adherence to treatment, including receiving psychological preparation for treatment and information about possible side-effects before starting ART. In Morocco, 68% (204/300) of respondents were informed by their healthcare provider about possible side-effects.

Despite receiving information about ART, many participants felt that they did not have full power to make their own decisions about treatment initiation. In Morocco, 79.6% (239/300) reported that their healthcare provider did not give them enough time to decide whether or not they were ready to start ART, and 27% (82/300) thought it was difficult to ask their healthcare provider questions about things they did not understand.

In Lebanon, 95% (60/63) reported that their healthcare provider informed them about possible side-effects of ART. Only 47.6% (30/63) of the respondents reported that their healthcare provider gave them enough time to decide whether they were ready to start ART, although 77.7% (49/63) agreed that it was easy to ask their healthcare provider about things they did not understand.

In both countries, after getting proper counselling and psychological support, participants reported high rates of adherence, reflecting the importance of providing mental healthcare within HIV services. Most survey respondents mentioned the value of counselling and support groups for adherence to treatment and for healthy initiation and maintenance of healthy practices.

> *"This kind of thing means discrimination … it has become normal for me to suffer any kind of discrimination within the health structures, whether it is [by] the security officer or healthcare workers.*
>
> *- PLHIV, 39 years old, diagnosed in 2003*

Stigma and Discrimination against People Living with HIV

The fear of stigma and discrimination among people living with HIV can affect their integration into the community and how they manage their day-to-day activities. Stigma can prevent people living with HIV from accessing life-saving HIV services[29]; some healthcare workers have negative and discriminatory views towards people living with HIV that are influenced by, and often similar to, those among the general population[30].

In both countries, internalized stigma was common among people living with HIV. In Morocco, 61% (183/300) of participants said that they blamed themselves more than once for having HIV, and 35.6% (107/300) decided not to see family and friends on more than one occasion. In Lebanon, 54% (34/63) also reported blaming themselves more than once for having HIV, with 25.4% (16/63), blaming themselves at least once, and 20.6% (13/63) deciding to avoid family and friends on at least one occasion.

Retention in Care

In Morocco, the most common type of stigma is being perceived as the subject of gossip. Indeed, 31.7% (95/300) of respondents reported being gossiped about more than once, and 7% (21/300) at least once. Overall, 16.3% (49/300) of respondents endured verbal harassment, insults and threats on more than one occasion, and 3% (9/300) at least once. Multiple physical assaults were reported by 5.7% (17/300), and 1.3% (4/300) of respondents were assaulted at least once.

> *I work as a volunteer in an organization that raises awareness in the public. People need to know HIV is not a deadly disease and PLHIV can live normal lives too.*
>
> *- Person living with HIV, 44 years old, diagnosed in 2011, Morocco*

In Lebanon, being the subject of gossip was a major form of stigma: 22.2% (14/63) of respondents were gossiped about on more than one occasion, and 19.1% (12/63) experienced this at least once. Verbal harassment and insults were reported by 6.4% (4/63) more than once and by 20.6% (13/63) at least once. Multiple physical assaults were reported by 1.6% (1/63) of respondents and by 3.7% (2/63) at least once.

> *When I go to take my medication from the National AIDS Program, and [I am treated badly] by others, not the employee but the other HIV+ guys, [it] is very annoying. But it is OK. I am trans and proud.*
>
> *- 24 years old, diagnosed in 2016*

In Morocco, people living with HIV have repeatedly experienced discrimination, stigma and confidentiality when they seek healthcare services: 16% (48/300) of respondents were denied access to healthcare because of their HIV status, 10% (30/300) felt insulted/offended while talking to a healthcare provider, and 17% (51/300) reported that their healthcare provider disclosed their HIV status without consent.

In Lebanon, 6.4% (4/63) of respondents were denied access to healthcare based on their HIV status, and 15.9% (10/63) had a healthcare provider who disclosed their HIV status without consent to do so. However, some people living with HIV in Lebanon appreciated the opportunity to access stigma-free health facilities, although they sometimes experienced discriminatory acts among the HIV community.

Both health professionals and people living with HIV suggested training and community participation as tools to combat stigma. They also suggested recruiting people living with HIV and key population as workers and peer supporters to improve the status of services and eliminate stigma.

5 RECOMMENDATIONS

Significant progress has been made in the response to HIV. However, our survey reflects persistent access gaps and shortfalls in the quality of care that people living with HIV face. Based on the findings of the study, ITPC recommends the following key steps to be taken to improve access to and quality of HIV services, which will bring the region closer to ending AIDS:

- Strengthen outreach and screening programmes that encourage people to get tested and promptly linked to care; most people living with HIV were not tested until they were already experiencing HIV-related symptoms.
- Provide CD4 and viral load testing, as recommended by WHO, at no charge.
- Decentralize HIV service delivery so it is available throughout the country, including in remote and rural areas.
- Simplify access to CD4, ART and viral load testing and eliminate unnecessary delays in getting test results.
- Provide fully integrated, holistic healthcare care without user fees, including prevention, testing, care and treatment services for HIV, common co-morbidities, OIs and sexual and reproductive healthcare (which includes access to contraception, condoms, lubricants, HBV and HPV vaccines), harm reduction (that is, access to clean needles, syringes and opioid substitution therapy) and social support.
- Women, especially those of childbearing potential, need sexual and reproductive services to be available with HIV care.
- Train healthcare workers about WHO guidelines and the policies in their respective countries for treatment, services and how to deliver them. This is especially important for those who work in public hospitals, so that they have current information about the available treatment, dosing and delivery of other services, as well as the National AIDS Program strategy and national goals.
- Improve the quality of HIV services in public hospitals, particularly the waiting time for people living with HIV, by hiring more healthcare providers and lab technicians to reduce their workload.
- Monitoring mechanisms and tools should be in place to assess, follow up and deal with any cases of stigma and discrimination towards people living with HIV, with meaningful participation of people living with HIV in these activities.
- Cooperation of civil society, HIV/AIDS activists and national AIDS programmes is needed to advocate for policies that do not discriminate against people living with HIV, especially key populations.

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