Dialogue Summary

Addressing Limitations to Equitable Access to Healthcare Services for People Living with HIV in Lebanon

K2P Policy Dialogue convenes key policymakers and stakeholders to capture contextual information, tacit knowledge, views and experiences including potential options to address high priority issues.
K2P Policy Dialogues are informed by a pre-circulated K2P Policy Brief or Briefing Note to allow for focused discussion among policymakers and stakeholders.

Dialogue Summary

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United Nations Population Fund

National AIDS Control Program

Knowledge to Policy Center K2P

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Dialogue
The policy dialogue about Addressing Limitations to Equitable Access to Healthcare Services for People Living with HIV in Lebanon was held on December 4 2015 at the Gefinor Rotana Hotel, Beirut, Lebanon. The policy dialogue was facilitated by Dr. Fadi El-Jardali, the director of the K2P Center.

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Contents

Content

Preamble

The K2P Policy Dialogue that was conducted on December 2015, was attended by diverse stakeholders: policy and decision makers, representatives from relevant ministries (ministry of public health (MOPH) and ministry of labor (MOL)), UN agencies representatives (UNHCR, UNIFIL, UNRWA, UNICEF, ILO), local non-governmental organization representatives (SIDC, Skoun, LAS, MARSA, AJEM, ALFM, Vivre positif, and others), and law firms, as well as researchers and public health scholars. The policy dialogue hosted 21 people and was facilitated by Dr. Fadi El-Jardali, Director of the K2P with the presence of Dr. Moustafa Nakib, the Director of the National AIDS Control Program and Mrs. Nada Naja, the UNFPA representative.

Deliberations about the problem

Dialogue participants discussed the overall framing of the issue of access of People Living with HIV (PLHIV) to healthcare services in Lebanon. All participants endorsed the existence of the problem and most agreed about the need to focus on the many factors that are leading to the limited access of PLHIV to healthcare services. Some participants mentioned that the problem is mainly due to financial issues, stigma and the lack of testing. Other participants mentioned that another major problem is the gap between the community and the healthcare system, where PLHIV are unaware of the services provided by healthcare centers, and about the available centers that provide these services. The gap is also due to stigma and fear of being exposed. Few participants noted that the problem no longer resides in seeking care at late stages. This trend has been changing because of the efforts done by the National AIDS control Program (NAP) and Non-Governmental Organizations (NGO) to increase awareness, early testing and

Background to the Policy Dialogue

The Policy dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action.

Key features of the dialogue were:

1) Addressing an issue currently being faced in Lebanon;
2) Focus on different underlying factors of the problem;
3) Focus on three elements of an approach for addressing the policy issue;
4) Informed by a pre-circulated K2P policy brief that synthesized both global and local research evidence about the problem, elements and key implementation considerations;
5) Informed by a discussion about the full range of factors that can inform how to approach the problem and possible elements of an approach for addressing it;
6) Brought together many parties who would be involved in or affected by future decisions related to the issue;
7) Ensured fair representation among policymakers, stakeholders, and researchers;
8) Engaged a facilitator to assist with the deliberations;
9) Allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"; and
10) Did not aim for consensus. Participants' views and experiences and the tacit knowledge they brought to the issues at hand formed key input to the dialogue. The dialogue was designed to spark insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue and by those who review the dialogue summary.

provide treatment for all. In addition, men who have sex with men, which is the most affected at risk group, is well aware about starting the treatment at early stages.

The underlying factors that are causing the problem were discussed separately under three health system arrangements: governance, financing and delivery.

Governance Arrangements

The key topic that was first discussed under governance was that of the absence of a law that protects PLHIV rights. Participants mentioned that the good thing is that there is no law that acts against or penalizes PLHIV. However, there was unanimous agreement that it is important to either amend or remove laws that marginalize most at risk groups such as; men who have sex with men, sex workers and injected drug users. And if needed to develop a new law, it should be non-discriminatory in order not to increase stigma against PLHIV, and can stem for the humans' rights principle.

Another law was mentioned during the deliberation, this law allows employers to perform pre-employment medical test. The law's vagueness, does not specify which tests are supposed to be done, and although is supposed to be used to ensure appropriate work environment to the employee, it might be used against them if the employer asks for an HIV test. The test can be done without taking the employees consent and might cost them their job. Some suggested creating internal organizational policies that are monitored by the government to control the type of tests that are performed. Yet the policy might not be implemented due to stigma.

One participant proposed that the NAP collaborates with tuberculosis programs, since there is high prevalence for patients who are infected with tuberculosis to be HIV positive. These centers can also help in testing and providing the treatment for PLHIV.

Financing Arrangements

Participants mentioned that providing free medication and having the support of NGOs and VCTs is alleviating the financial burden on PLHIV. They also noted that financial burden is a national problem for all patients with chronic diseases; the only difference here is that NGOs are supporting PLHIV with their medical expenses. However, members from NGOs pointed out that they are facing financial sustainability

concerns, since funders are no longer allocating large funds to HIV/AIDS, as they previously did. Participants expressed concern in regards to the issue of financial sustainability when it comes to covering refugees as well. It was mentioned that in patient hospitalization is what is most costly, and what burdens patients financially especially for those who do not have any form of financial coverage.

Collaboration between governmental bodies and NGOs (national and international) is being suboptimal due to the inappropriate management of this partnership. Participants agreed that there should be better management to coordinate the work done and avoid duplication of work and wasting resources.

Delivery Arrangements

Participants agreed that one of the most challenging issues is reducing stigma and discrimination of healthcare workers. They also mentioned that discrimination is not only against PLHIV, but against most at risk populations. And this might be addressed by integrating clear and explicit policies within institutions to remove stigma.

Dialogue participants disagreed that there is centralization of services. NGOs and physicians are available in various areas of Lebanon and are ready to offer their services at any time, especially that the NAP is allowing NGOs to collect the treatment and distribute it wherever they are located.

One participant mentioned that it is important to look at the underlying factors and link them to statistical findings about the HIV/AIDS situation in Lebanon, to better understand and address the situation.

Some argued that the problem in delivery of services is also due to the scattering of services. PLHIV need to go to several centers to obtain care; be it the: NAP, VCTs, NGOs, clinics and others. It was suggested to create centers that provide comprehensive care to PLHIV.

It was mentioned again by some participants that the problem is also related to PLHIV limited awareness about the services provided. PLHIV are unaware of centers that provide HIV care, and do not know which services they need for their continuum of care, and this is due to the limited “marketing” done at the national level. This is also coupled by fear of being stigmatized, which makes them reluctant to seek care. There needs to be better healthcare education at a national level, to be able to solve this problem, stated some of the participants.

Media was also addressed, and some participants agreed that media only focuses on HIV during the month of December of each year, and that there is a need to partner with media so that it plays a role in awareness all year long.

Deliberations

Deliberations about Policy Options

Dialogue participants discussed several options that had been examined in the policy brief.

Option 1› Integrate HIV care within primary healthcare centers (PHC), such as centers that provide Sexual and Reproductive Health (SRH) services, to reduce loss to follow up and ensure the continuum of care.

Deliberation about this option started by stating findings from systematic reviews, where evidence shows that integrating HIV care into PHC reduces stigma, ensure continuum of care and increases HIV testing and retention of PLHIV into care.

One participant started the deliberation by pointing out that the Ministry of Social Affairs and the Ministry of Public Health do not have the adequate capacity, resources or initiative to accommodate such healthcare services. They mentioned that this is mainly due to structural, capacity and commitment problems within the healthcare system.

However, deliberations allowed participants to suggest a solution to be able to implement this option. Although not all PHCs have the appropriate capacity, resources or services to provide HIV care, there are 75 PHC that are well funded, scattered around Lebanon and offer "universal coverage". Participants suggested tackling these centers, and provide them with capacities, resources and trainings, so that they can provide HIV services. It was also mentioned that it would be more sustainable to provide HIV care through PHC than through NGOs or other centers. In addition, these centers have a shared network, which makes monitoring their activities easier. Some participants also stressed the need to incentivize PHC for commitment, since the NAP has had previous experiences in training VCTs healthcare workers, but not having them committed to the trainings and provision of care. Incentives can be provided through continuous training, certifications and creating activities that allow the staff and the management to commit. There is yet still a need for a governing body to oversee the work of all these centers, to have a better management and follow up on the services delivered. Some said that there first needs to be a study to assess the number of PLHIV who access PHC versus those who access private

centers. Since, there might be a need to also consider integrating care into private centers (hospitals and clinics). Another idea mentioned was the importance of integrating specific HIV services from the continuum of care, in order not to over-burden PHC with HIV services. Therefore, there is a need to look at which part of the continuum of care needs to be integrated within PHC. Participants agreed that PHC might be a good entry point for testing and referral of PLHIV. This requires the need for resources to create a strong referral network, which could be managed by the governing body that oversees PHC activities.

Another issue to address as specified by the participants is stigma at PHC. There is a need to train healthcare workers so that key populations do not feel stigmatized when accessing PHC for care. PLHIV often seek care in centers that are away from their area of residency, so that they are not recognized and stigmatized, and therefore there is a need to reduce stigma and create an appropriate environment for the most at risk populations to seek care at the closest PHC. It is also important to teach healthcare workers at PHC about the reality of HIV/AIDS so that they are encouraged to treat PLHIV instead of fearing them.

Some participants mentioned that providing HIV care can be integrated into the national PHC accreditation standards, to ensure the provision of care to PLHIV.

Option 2› Ensure implementation of existing laws and/or new laws protect PLHIV rights so that accessing care becomes their legitimate right.

The facilitator of this dialogue introduces this option by mentioning that the existing evidence is inconclusive about this option, since some evidence found that laws to protect PLHIV might increase stigma and discrimination.

Most participants confirmed that there should not be a law specific for PLHIV, as some countries laws oblige PLHIV to disclose their sero-positivity creating further stigma and discrimination.

Participants agreed that a law should be formulated to tackle larger issues, maybe not PLHIV in specific but the most at risk populations. There is a need to also amend or remove laws that marginalize these people, such as law 534 that criminalizes lesbians, gays, bisexuals, and transgenders, laws against drug users, laws that allow pre-employment and pre-marital medical examinations.

One participant suggested that if it is difficult to amend laws, maybe it could be added to the labor law that "HIV does not preclude anyone from doing any kind of job", some argued that this might lead to discrimination against PLHIV.

All participants agreed that there is a need to conduct a gap analysis to identify loopholes of existing laws. This will allow amendment, creation or even cancellation of laws based on a solid legal analysis.

To be able to work on laws, there is a need to add an advocacy element, to persuade policymakers and key people about the importance of amending or creating new laws and later on ensure the implementation of these laws in a correct manner.

Participants argued that there is a need for the Ministry of Labor to overlook internal policies at the different institutions, to eliminate any policy that might jeopardize PLHIV's work. This helped emerge the idea that this option should not only target laws, but policies, decrees and regulations as well.

Another problem that was discussed is that people are unaware of their rights. There needs to be a "one stop shop", such an initiative will guide PLHIV and help them understand and learn about their rights. In addition, there is a need to strengthen the labor union role so that it is able to defend PLHIV rights.

Option 3› Ensure that private insurance companies develop and provide comprehensive insurance schemes that cover PLHIV healthcare expenses.

The deliberation regarding option 3, started by mentioning that evidence supports the importance of private insurance companies covering PLHIV since private insurance, according to the evidence, allows PLHIV to have a better quality of care.

It was agreed by all participants that HIV should not be an exclusion criteria for private insurance companies. Since some companies might not hire employees who do not receive private insurance coverage.

One participant mentioned that Globemed, a private insurance company, recently removed HIV as an exclusion criterion. Other participants expressed that this company can be used as a reference and its success story can be disseminated to other private insurance companies so that they can do the same.

Some participants suggested creating mutual funds for PLHIV that will cover their health finances. The majority opposed this suggestion, since this it will not be sustainable due to the small number of people who will take part of it. And this is already being done by NGOs, however there needs to be good coordination and proper channeling or earmarking so that their work is sustainable.

Option 4› Develop a multisectoral national strategic plan related to PLHIV.

The facilitator mentioned that this option addresses multisectoral collaboration between stakeholders from various entities, this collaboration also targets: education, training, media and awareness campaigns. Evidence points out that collaboration achieves sustainability and improves health outcomes, through enhancing HIV prevention and treatment.

Participants confirmed the need to create a network that allows collaboration between all key stakeholders influencing HIV/AIDS care in Lebanon, including NGOs, VCTs, ministries and others. It was mentioned that there is such network, the "Lebanese AIDS Network Association", but is still inactive and ineffective in monitoring and evaluating the work of the different parties. This network should be part of the NAP 2016-2020 National Strategic Plan (NSP), and should be supported by the NAP to allow stronger collaborations. The participants also mentioned that it is important not only to develop the NSP but to ensure its effective implementation. The network should play a role in the dissemination the NSP, and in dividing the role each stakeholders has to enhance HIV/AIDS care and ensure continuity of care and awareness of PLHIV. In order for the different stakeholders to engage and commit, their participation and partnership in the development of the NSP will allow them to take "ownership" of the plan and will encourage them in its implementation. It was mentioned by some of the participants the importance to look at the previous NSP and look at failures and successes to develop the new NSP accordingly. And have regular reporting, whether quarterly, biannual, or annual to keep on monitoring the implementation of the NSP and its effectiveness.

Next Steps

Recommendations and Next Steps

Participants discussed and agreed on the following recommendations and next steps:

Recommendations

1. Create centers that provide comprehensive care throughout the whole continuum of care spectrum, from: testing, treating and retaining.
2. Strengthen and leverage on the scope of services delivered by 75 PHC that provide universal coverage, to provide HIV care, through:
   - ⇢ Collecting data about the number of PLHIV who seek care at PHC, to understand the current situation and act upon it.
   - ⇢ Providing these centers with the appropriate: capacity, resources, and trainings.
   - ⇢ Providing the staff and management with incentives so that they commit to providing HIV care.
   - ⇢ Creating a governing body that oversees the work of all these centers, to have a better management and follow up on the services delivered.
   - ⇢ Making these PHC as entry points for testing and referral. This requires the creation of a strong referral system that could be managed by the governing body that manages the 75 PHC.
3. Integrate HIV services and continuum of care into the national PHC accreditation system.
4. Conduct gap analysis to identify loopholes of the Lebanese laws. This will allow:
   - ⇢ The development of a law that protects most at risk populations (men who have sex with men, drug users and sex workers).

- ⇢ The amendment or cancellation of the laws that penalize most at risk populations.
- ⇢ The amendment of the labor law that is vague and allows pre-employment medical examinations to test for HIV.

5. Develop and implement advocacy strategy to persuade policymakers and key people about the importance of amending or creating new laws and ensure the implementation of these laws in a correct manner.
6. Inform PLHIV about their rights, through:
   - ⇢ Creating a "one stop shop" that will allow PLHIV to learn and understand their rights.
   - ⇢ Strengthening the labor union role so that it is able to defend PLHIV rights.
7. Ensure the development and implementation of the 2016-2020 NSP, through:
   - ⇢ Creating a network that manages the collaboration between all key stakeholders influencing HIV/AIDS care in Lebanon, including NGOs, VCTs, ministries and others. This network should be supported by the NAP and should be part of the NAP 2016-2020 National Strategic Plan (NSP).
   - ⇢ Involving stakeholders in the development of the NSP so that they commit to its implementation.
   - ⇢ Assessing the failures and successes of the previous NSP, and develop the new NSP accordingly.
   - ⇢ Conducting regular reporting (quarterly, biannual, or annual), to monitor the implementation of the NSP and evaluate its effectiveness.
8. Strengthen the role of media so that it can help in spreading a yearlong awareness to PLHIV, on what services are provided and where to find them.
9. Collaborate with tuberculosis programs so that they are also integrated in the provision of HIV/AIDS services.

Next Steps

It was agreed that the K2P dialogue summary report along with the revised K2P Policy Brief will be used by each stakeholder organization as guiding policy document and that they will communicate internally and externally with relevant bodies, agencies and department, in order to push agendas and advocate for improvements. The deliberation and policy brief will as well help in the development and the implementation of the 2016-2020 National Strategic Plan. Also, the need to operationalize key recommendations and put them into action was discussed in the dialogue.

Knowledge to Policy Center draws on an unparalleled breadth of synthesized evidence and context-specific knowledge to impact policy agendas and action. K2P does not restrict itself to research evidence but draws on and integrates multiple types and levels of knowledge to inform policy including grey literature, opinions and expertise of stakeholders.

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