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Key Populations in the Middle East/North Africa (MENA) Region

Investing in resilient and responsive services

Authors

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History

With USAID support, from 2005 to 2015, a few key civil society organizations (CSOs) in Algeria, Lebanon, Morocco, and Tunisia implemented HIV prevention interventions reaching men who have sex with men (MSM). Over 10 years of implementation, the Responding to Key Populations in the MENA Region Program (hereinafter “MENA Program” or “the program”), led by the International HIV/AIDS Alliance (the Alliance) under different USAID mechanisms, has supported these partners to strengthen their service delivery and organizational capacity and influence their environments to increase access to population-friendly services in locations that are hostile to key populations, and particularly MSM. The MENA Program is a community-based outreach program for MSM and People Living with HIV (PLHIV). The only continuous MSM-focused service delivery program in the region, it was implemented in nine sites across Algeria, Lebanon, Morocco, and Tunisia by six HIV-thematic organizations, one development

organization, and one LGBT organization.

These partners are now among the few civil society organizations playing a key role in the HIV response in the region, working openly with MSM and hiring MSM staff and hosting and supporting PLHIV groups. Their efforts to promote self-esteem, reduce self-stigma, build solidarity among MSM communities, and increase access to services have played an undeniable role in enhancing the voices, advancing the rights, and improving the quality of life of MSM in the region. Additionally, the program has supported the Regional Arab Network against AIDS (RANAA) which, in 2013, started to strengthen the involvement, care, and support of PLHIV in the region.

The strategic objective of the MENA Program was to increase HIV and AIDS programming that meets the needs, primarily, of MSM and PLHIV in the region. The program was housed first under the AIDSTAR-Two Project and then transitioned to the Leadership, Management, and Governance (LMG) Project, which is led by Management Sciences for Health (MSH), from 2013-2015.

The USAID-funded Leadership, Management, and Governance (LMG) Project improves the quality and sustainability of health services by building the capacity of local, regional, and national health leaders to adopt and institutionalize leadership, management, and governance practices.

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TECHNICAL BRIEF

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Environment

The Middle East and North Africa (MENA) region is a large geographical region of 21 countries. According to the UNAIDS 2015 Global Statistics Fact Sheet,¹ in 2014, an estimated 240,000 people were living with HIV. Despite a low HIV prevalence rate of 0.1%, the number of new HIV infections is steadily rising across the region. The MENA region is now one of the regions with the fastest growing HIV prevalence globally and, since 2000, has been the only region in the world to experience a worrying increase in the number of new HIV infections every year.

Between 2000 and 2014, new infections rose by 26%, from 18,000 new infections in 2000 to 22,000 new infections in 2014, and the number of AIDS-related deaths in the region more than tripled, from 3,600 deaths in 2000 to 12,000 deaths in 2014.² HIV testing and counselling is a serious challenge: an estimated 80% of PLHIV in MENA do not know their status. The coverage of antiretroviral therapy treatment (15%) and prevention of mother to child transmission (PMTCT) (13%) are the lowest in the world. The coverage of prevention programs for MSM, a hidden population, is low, and there is emerging evidence of a concentrated epidemic among MSM (with prevalence rates in Egypt at 5.7% in Cairo and 5.9% in Alexandria; 10.1% in Tunisia; and 5.6% in the south of Morocco).³ High levels of stigma and discrimination (socio-cultural, religious and legal) and of sexually-transmitted infections (STIs) contribute to making MSM highly vulnerable to HIV infections.

Strategic Approach

Stigma, lack of information, and limited access to prevention and treatment services pose formidable barriers to HIV programming for the most-at-risk populations in the Middle East and North Africa. The MENA Program took a multi-faceted approach to increase service access and utilization for PLHIV and MSM in the MENA region. The program focused on four main approaches: (1) conducting outreach and providing prevention and support services to MSM in several cities in Algeria, Lebanon, Morocco, and Tunisia; (2) promoting the Greater Involvement of People Living with HIV (GIPA) principle and supporting PLHIV partners to implement projects in these four countries; (3) contributing to strengthening civil society organizations and their support

to key populations in these countries; and (4) conducting advocacy activities to improve the enabling environment for PLHIV and MSM in the region. This brief describes the program's methods for strengthening the organizational capacity of civil society organizations and networks in the region and advocacy efforts to improve the enabling environment for MSM, PLHIV, and other key populations such as refugees and lesbian, gay, bisexual, transgender, and intersex (LGBTI) individuals. With management support from the USAID-funded LMG Project, the MENA Program provided technical and financial support, trainings, and materials to civil society organizations in each of the four focus countries.

Summary of Interventions

Strengthened civil society and key population engagement in MENA

The MENA Program built the capacity of partner civil society organizations in the region by facilitating regional trainings and workshops to the civil society organizations providing services to key populations. These organizations respond to a critical need for services in the region, so USAID funded the MENA Program to provide technical support to strengthen their services and expand their reach. The program built the capacity of its partners to conduct strategic planning, financial management, grants management and compliance, stakeholder engagement, and monitoring and evaluation (M&E).

Organizational and technical support to nascent PLHIV partners

Much as it did for civil society organizations supporting MSM, the Alliance delivered one-on-one technical support visits, technical workshops, regional workshops, horizontal learning opportunities, and capacity building to nascent PLHIV groups in Algeria, Lebanon, Morocco, and Tunisia. This support helped PLHIV partner groups and organizations mobilize, start their projects, feel empowered, and gain the technical skills to run projects independently and autonomously. The groups implemented small projects focusing on peer-based action, mutual support among PLHIV, antiretroviral adherence, therapeutic education, and advocacy to reduce stigma in health care settings.

Capacity strengthening workshops for PLHIV partners in the region included trainings on basic financial management and M&E, strategic planning, budgeting, project management, proposal writing, action planning, and budgeting, as well as advocacy, peer outreach, and in-depth information about HIV and STIs. The Alliance's partner CSOs also facilitated capacity building workshops for the PLHIV partners in Algeria, on HIV testing and counseling, and in Tunisia, on computer skills and Microsoft Office software.

1 UNAIDS. Fact Sheet. 2015 Global Statistics http://www.unaids.org/sites/default/files/media_asset/20150901_FactSheet_2015_en.pdf

2 UNAIDS. AIDS by the numbers 2015 http://www.unaids.org/sites/default/files/media_asset/AIDS_by_the_numbers_2015_en.pdf

3 Mumtaz, Ghina R., Gabriele Riedner, and Laith J. Abu-Raddad. "The Emerging Face of the HIV Epidemic in the Middle East and North Africa." *Current Opinion in HIV and AIDS* 9.2 (2014): 183–191. PMC. Web. 22 Nov. 2016.



Community outreach and peer education for MSM

The MENA Program applied a targeted approach to increase access of MSM to appropriate information and friendly services by reinforcing civil society in locations that are hostile to them. The program established community-based outreach programs in various sites, where partner CSOs implemented a package of combination prevention, care, and support services aimed at MSM, in accordance with United States Government (USG) guidance. In the early years of the program, CSOs informed program development by carrying out participatory situation assessments of the various MSM communities and identifying their needs. Under LMG Project funding, the CSOs continued to provide refresher trainings for teams of volunteer MSM peer educators, who implemented most prevention, HIV test promotion, and referral activities. They offered rapid HIV testing, pre- and post-test counselling, as well as psychosocial and legal support. In parallel, they tried to challenge stigma and discrimination through stigma reduction activities targeting health service providers and other audiences. Peer educators were trained to provide referrals, promote testing campaigns, provide counseling and distribute condoms and lubricants. Other activities carried out under this program included mobile testing, community testing, voluntary counseling and testing (VCT) campaigns, and referral to public VCT services. Partners supported by the MENA Program provided psychosocial support, legal support, referrals to STI services, and a sexual health clinic for MSM. In addition, outreach work in Lebanon also focused on working with transgender people, young people, and Syrian refugees.

Piloting an online peer outreach intervention

The MENA program initiated a pilot web-based outreach intervention to expand prevention services for MSM, as many MSM in MENA are not reached by the outreach activities targeting them. Information and communication technologies (ICTs) in MENA are largely used by MSM to exchange information safely, communicate, support each other, or meet sexual partners, but less often to spread preventive messages and promote access to care services. Data was required to improve the understanding of the online habits and behaviors of MSM, so two anonymous web surveys were conducted to assess technology use and social media behaviors among MSM. These results informed the design of a regional online outreach intervention implemented by trained “online MSM peer educators” and targeting young MSM, which was tested in settings where CSOs already offer a package of services for MSM. During the test phase, online peer educators contacted MSM through the internet and social media, engaged interpersonal communications on HIV and AIDS and STIs, and encouraged them to take an HIV

test. This online activity was documented using M&E tools that were designed during a workshop. For example, the six online peer educators of Association du Sud Contre le SIDA in Agadir, Morocco, reached 546 MSM via chat rooms, websites, apps, and instant messaging. They referred 148 MSM for an HIV test and 86 MSM for an STI consultation. During this test phase, online peer educators noticed that many MSM were eager to engage in an online conversation to learn more about HIV prevention, STIs, and about the associations providing services. However, a significant proportion of MSM contacted online refused any discussion.

Support to resource mobilization for MENA civil society

RANAA was established in 2002 and represents networks of HIV-thematic CSOs from 14 countries including Algeria, Bahrain, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, and Saudi Arabia. The MENA Program had supported RANAA’s advocacy activities, General Assembly (in 2012), and Secretariat costs since 2010. In 2014-2015, the MENA Program supported a regional dialogue and development of a regional concept note to the Global Fund to Fight AIDS, Tuberculosis, and Malaria for a multi-country program targeting MSM, sex workers (SW), and PLHIV in Algeria, Egypt, Jordan, Lebanon, and Yemen.

In 2015, two partner organizations in Lebanon, Soins Infirmiers et de Développement Communautaire (SIDC) and Vivre Positif (VP), submitted an HIV and human rights proposal to the USG Middle East Partnership Initiative, entitled *Speak Up: Human Rights and HIV Monitoring System for HIV Law Reform in Lebanon*, which was approved. The proposal includes piloting a human rights monitoring response system of the Alliance in Lebanon (entitled REAct). The Alliance facilitated a training in Beirut for SIDC, VP, and other community-based organizations working with key populations.

Fostering an enabling environment for MSM and PLHIV

An important component of the MENA Program was to help create a more favorable environment in settings where stigma prevents MSM and PLHIV from seeking medical care and living openly. The Alliance, together with its partner implementing organizations in the region, advocated to create a more favorable environment in places where the levels of stigma and discrimination were preventing PLHIV and MSM from seeking medical assistance. Since the end of the program, some of the partners have continued to conduct anti-stigma work; for example, SIDC held workshops targeting police officers and religious leaders.

The MENA Program also supported partner CSOs and PLHIV groups to develop advocacy materials, such as a facilitator’s booklet developed with SIDC in Lebanon for stakeholders interested in organizing sessions against discrimination



and stigma. The program also supported the development of posters and flyers for health workers to inform them about proper medical care for HIV positive pregnant women and for general audiences to raise awareness about stigma.

Indirect support to LGBTI activists

Given the highly sensitive context in the region, both the donor and the implementing partners agreed to focus on responding to the health needs of MSM using a community-based and a rights-based approach, and promoting primarily the right to health of MSM. However, while focusing primarily on HIV prevention, care, and support, the MENA Program made indirect but significant contributions toward advancing LGBTI rights in the region.

The continuous training and support to teams of MSM peer educators (10 to 20 in each of the four countries) was an important contribution as some of these young people, trained on peer education, interpersonal communication skills, stigma reduction, and coached through the MENA Program, acquired the self-esteem, confidence, skills, and motivation to become rights activists. There are other LGBTI groups active in social media in MENA, but most operate from outside the region. On the ground, the activists organize activities during International Day Against Homophobia, Transphobia, and Biphobia with their own or other resources and manage Facebook pages for networking or monitoring human rights violations, at least in Tunisia and Lebanon.

In Lebanon, the program provided financial support to Helem, the only LGBTI organization with legal status in the region when the program started in 2005 (since then, other LGBTI-

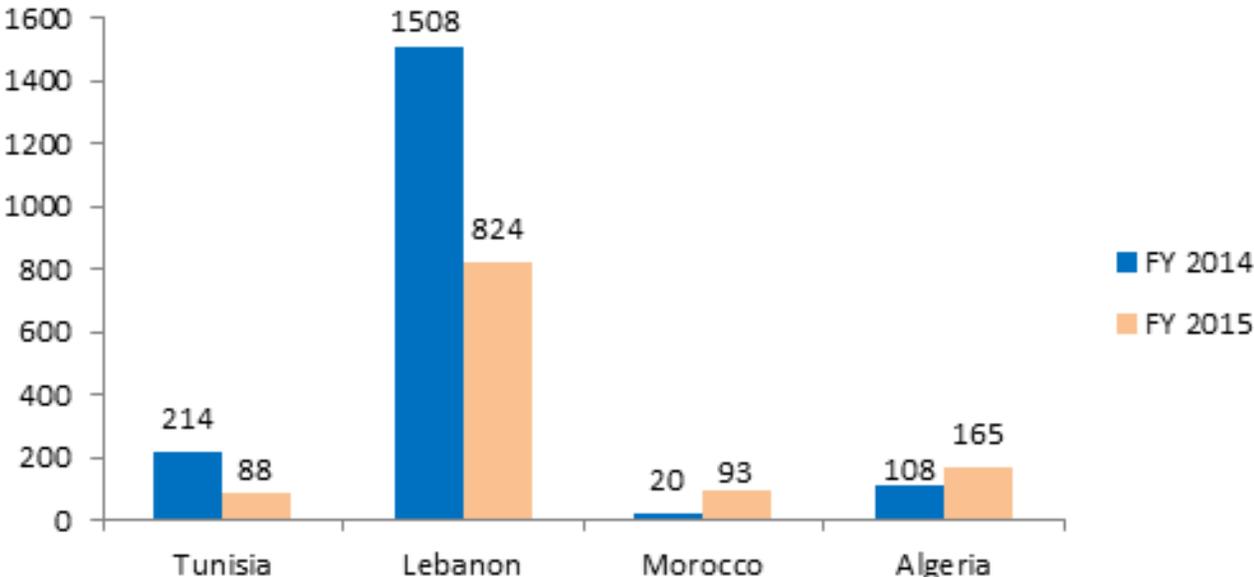
led organizations have emerged, particularly in Lebanon and Tunisia). The program covered a modest portion of Helem’s running costs and mainly supported their HIV outreach activities for MSM. This steady funding contributed to sustaining Helem’s LGBTI advocacy work and their defense of gay men and transgender people who have been episodically arrested and prosecuted. The organizations SIDC, Helem, and Oui Pour la Vie worked specifically with the Lebanese transgender community, running information, education, and communication sessions with groups of transgender people on sexual health, condom use, drug use, and human rights. Finally, for each quarter of the program in Lebanon, the organizations SIDC, Helem and Oui Pour la Vie reached 10 to 20 transgender people and provided or referred them to HIV care and support services.

Results and Achievements

Enabling environment

Advocacy efforts have contributed to making the voice of MSM heard by stakeholders working in the HIV response and to reducing stigma in clinical and health care settings. National health authorities and national AIDS programs now better understand the specific vulnerabilities and needs of MSM. Sensitization of religious leaders (in Algeria and Lebanon) has helped to break the silence in the religious sphere surrounding the issue of sex between men. Stigma reduction and advocacy activities, including workshops and trainings with policy makers, lawyers, and police, meetings with journalists, religious leaders, social workers, health providers, educators, and psychologists and media campaigns reached 3,020 individuals (see Figure 1) and 608 decision makers.

Figure 1. Number of Individuals Reached Through Stigma and Discrimination Reduction Initiatives in FY14 and FY15



Empowerment of PLHIV groups

The program helped some PLHIVs to implement their own advocacy, care, and support activities. The Alliance provided support to partner CSOs, including AMEL, GS++, and Vivre Positif, which then facilitated capacity building workshops for PLHIV partners, for example training outreach peer workers on HIV testing and counselling in Algeria. The PLHIV groups have become more engaged in the national HIV response and regularly participate in advocacy events. For example, Association Marocaine de Santé et de Développement organized a national forum to promote the greater involvement of PLHIV. PLHIV also became more confident, empowered, and able to stand up for

their rights. In Tunisia, they have created their own independent organization, Association Tunisienne de Prévention Positive, which has rapidly become a sub-recipient of the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

Access to services

MSM access to life-saving prevention, care, and support services has improved. The program increased access to condoms and lubricants, to free and anonymous counselling and testing, to MSM-friendly doctors and psychologists, legal support, referral to specialized services including diagnosis, and treatment of STIs and psychosocial support.

Figure 2. Indicators of Increased Access to Services for MSM

Indicator	Definition	Data Source and Frequency	FY 14 Aug. 2013 to Sept. 2014	FY15 Oct. 2014 to Sept. 2015
Number of MSM tested, diagnosed, and/or treated for STIs	Number of people attending supported projects or facilities who are tested for STIs other than HIV. It also measures the number of people with an STI who are appropriately diagnosed and treated according to national guidelines. The organization should assess these STI services to check that they reach adequate national and/or international standards. An example of a supported clinic is one whose staff have been financially supported to undergo training in STI management. Disaggregation: Gender, actual/new, key population group.	Quarterly reports of partners	1,107	2,385
Number of condoms distributed to MSM	Total number of condoms distributed through any channel by projects supported by the organization. Condoms given to an organization which is supported financially by the reporting organization should not be included in this indicator, as these should be reported by the supported organization. Numbers included in this indicator include condoms distributed, free or sold through any channel such as community-based sales agents or retail outlets.	Quarterly reports of partners	223,292	438,819
Number of MSM who received testing and counseling services for HIV and received their results	Number of individuals who come in for counseling and testing and receive their results. This indicator monitors trends in the uptake of VCT services over time.	Quarterly reports of partners	2,573	5,632
Number of MSM who received psychological support	Number of MSM who benefit from one or several consultations with a psychologist.	Quarterly reports of partners	794	1,312
Number of MSM who received legal assistance	Number of MSM who benefit from legal support from a lawyer.	Quarterly reports of partners	100	285

Development of tools and resources

Alongside partner CSOs and PLHIV groups, the Alliance produced advocacy materials, toolkits, and facilitator guides that can be used in the region by peer counsellors and other service providers. These include case studies on PLHIV and MSM, a four-volume training toolkit on MSM programming for the MENA region developed jointly with UNAIDS in both English and Arabic, a participatory community assessment guide, and a guide on sub-award management for CSOs.

Community spaces

For many MSM, safe community spaces made available in Sousse, Tunisia; Fez, Morocco; Oran, Algeria; Beirut, Lebanon; or Tunis, Tunisia, gave them the opportunity to form social bonds with others, exchange experiences without fear or judgement, and acquire new skills and knowledge as well as access appropriate information and services. Through community mobilization and continuous training and support to teams of young MSM peer educators, the program empowered MSM, gave them skills, and boosted their self-esteem and confidence.

Challenges

Quality of sexual health care for MSM

Across the implementing countries, the program observed that health care professionals often lacked basic training and appropriate understanding to properly respond to men's sexual health needs, especially considering MSM, the transgender community, or sex workers. Efforts are needed to train doctors and health clinic staff to build a cohort of MSM-friendly health care professionals who understand the complexities of men's sexual health, sexual identity, and HIV.

Characteristics of middle-income MENA countries

Made up of middle-income countries and countries with low HIV prevalence, the MENA region is often excluded from accessing funds available to low-income countries. Simultaneously, their governments do not prioritize the HIV response, and public health systems remain a low priority in national spending plans. The region is also affected by growing poverty, social instability, unemployment, and a refugee crisis, all of which make it difficult for local populations and PLHIV to buy medications or to travel for treatment. However, the Global Fund to Fight AIDS, Tuberculosis, and Malaria is funding many countries in the MENA region with HIV grants.

Referral data

Public health systems do not share information with CSOs, thus making it difficult for CSOs to obtain the referral data of clients they have referred to specific services. NGOs have created ways to try to track this data, but they are vulnerable to duplication and manipulation. Without access to data from the public health system, it is difficult to fully measure the service uptake achieved by this program.

Cultural beliefs and taboos

Effective HIV prevention for key populations is hindered by the stigma and discrimination associated with HIV, including denial of specific risk behaviors by the populations themselves. This stigma is related to social and religious norms and traditions prevalent in the MENA region—making it difficult for national governments to mobilize and sustain the political leadership and financial support that is vital for effective prevention programs for the most vulnerable and highly stigmatized populations. With tenuous political will, civil society groups working with key populations have had to adapt their approaches to reach populations that are accustomed to hiding, such as delivering services via peer outreach and mobile efforts. Even some civil society groups working on HIV demonstrate stigma against PLHIV and do not foster their empowerment or involvement opportunities, as the Alliance found to be the case with some HIV-thematic organizations in Morocco.

Sustainability

Short-term, one-year financing and lack of clarity from the donor about future program funding remained a challenge throughout the program and affected the implementation of the activities. Due to the short implementation periods and the need to prioritize service delivery, some activities were not finalized, such as the Participatory Community Assessment with PLHIV in Morocco and Algeria, the workshop on MSM sexual health with Health 4 Men, or the stigma reduction workshops for dentists in Lebanon.



Lessons Learned

Since the implementation of the program, CSOs and the Alliance gained valuable expertise in both key populations programming and the limitations of its work. Throughout the last three years of its implementation, the program understood that:

ICT has a large potential for reaching hidden communities

As traditional outreach work remains risky and occasionally becomes more dangerous (following police raids and rising homophobia), the ICT virtual prevention project has proven to be a successful alternative. It is also an effective tool to reach hidden communities that are not reached during usual outreach field work. Young people are spending more and more time online communicating with each other and arranging to meet. Apps such as Grindr (“the world’s largest gay social network”) are specifically designed to facilitate access to diverse communities of people and are readily used. However, information online regarding men’s sexual health, sexual identities, and HIV in MENA and in Arabic is extremely limited or non-existent.

Working with PLHIV

Since broadening the scope of the MENA Program to include three PLHIV partners three years ago, the program noticed that the involvement of PLHIV in the HIV response has been very weak. There are not many programs that work to strengthen the meaningful involvement of PLHIV in the response. The groups are still very fragile and require regular direct technical and organizational support. Coordination between PLHIV and other strategic partners, such as GNP+ and UN agencies, is critical to the success and sustainability of the PLHIV project activities. Such cooperation can bring financial security and other necessary technical support.

Working with MSM

The MENA Program and its focus on the MSM community helped CSOs gain relevant experience on MSM programming and how to coordinate different advocacy and anti-stigma campaigns for different audiences. Through their work on the MENA Program, CSOs had a chance to work with religious leaders, police officers, members of the media, and health care providers. CSOs learned that every audience is different, thus each audience requires a specifically tailored approach and methodology to address HIV and AIDS issues.

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