Case study

Pioneering HIV services for and with men having sex with men in MENA

A case study about empowering and increasing access to quality HIV prevention, care and support to MSM in a hostile environment

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Abbreviations and acronyms

AFE	Arab Foundation for Freedoms and Equality (Lebanon)
AIDS	acquired immunodeficiency syndrome
AMSED	L'Association Marocaine de Solidarité et de Développement (Morocco)
APCS	Association de Protection Contre le SIDA (Algeria)
ART	antiretroviral therapy
ASCS	Association Sud Contre le SIDA (Morocco)
ATL	Association Tunisienne de Lutte contre les MST SIDA (Tunisia)
CCM	Country Coordinating Mechanism (for Global Fund grants)
CSO	civil society organisation
IBBS	integrated bio-behavioural survey
HIV	human immunodeficiency virus
ICT	information and communications technology
IEC	information, education and communication
LGBT	lesbian, gay, bisexual, transgender
LMG	Leadership, Management & Governance
MENA	Middle East and North Africa
MSH	Management Sciences for Health
MSM	men who have sex with men
NAP	National AIDS Programme
OPALS-Fes	Organisation Panafricaine de Lutte contre le SIDA, Section of Fes (Morocco)
OPV	Oui Pour la Vie (Lebanon)
PCA	participatory community assessment
PHDP	Positive Health, Dignity and Prevention
PrEP	pre-exposure prophylaxis
SIDC	Soins Infirmiers et Développement Communautaire (Lebanon)
STI	sexually transmitted infection
UNAIDS	United Nations Programme on HIV and AIDS
USAID	United States Agency for International Development
VCT	voluntary counselling and testing

Pioneering HIV services for and with men having sex with men in MENA

About this case study

This case study documents experiences and lessons learned from the implementation of a pioneering community-based programme that created access to quality HIV prevention, care and support services for men who have sex with men (MSM)[1] in the Middle East North Africa (MENA) region. Led by the International HIV/AIDS Alliance (the Alliance), the programme was implemented by eight partner civil society organisations in four MENA countries – Algeria, Lebanon, Morocco and Tunisia. The ten year programme (2005–2015), "Responding to Key Populations in the MENA Region", was the first of its kind in the MENA region to work with MSM to introduce access to information, commodities, services and support needed to improve their health and well-being. Financial support was provided exclusively by USAID through various projects (between 2009 and 2015 successively C-Change, AIDSTAR-Two and LMG).

The case study is intended for national policy-makers and other decision-makers, civil society programme planners and managers, and funders committed to preventing HIV and improving the lives of MSM, other key populations and people living with HIV in the MENA region.

Booklet of background information for MSM peer educators, including on HIV, STIs, sexual health and referrals; ATL, Tunisia.

1. "Men who have sex with men" is a technical phrase intended to be less stigmatising than culturally-bound terms such as gay, bisexual, or homosexual. It describes same-sex behaviours between men rather than identities, orientations or cultural categories. Therefore, the term MSM includes gay men, bisexual men, MSM who do not identify as gay or bisexual despite their behaviours, male sex workers, some biologically male transgendered people, and a range of culture- and country-specific populations of MSM.

Executive summary

In the MENA region, men who have sex with men (MSM) constitute a particularly vulnerable and highly stigmatised community, which bears a disproportionately higher burden of HIV infection in comparison with the general population. From 2005 to 2015, the Alliance worked with eight civil society organisations (CSOs) partners in Algeria, Lebanon, Morocco and Tunisia with the aim to respond to the sexual health and HIV and STI prevention needs of MSM in hostile environments. The three intermediate results of the programme were to:

1. expand access to HIV and AIDS prevention, care and support for MSM
2. improve the quality of prevention, care and support services for MSM
3. help create a more favourable environment for the response to MSM sexual health and HIV prevention needs.

The Alliance started from scratch to initiate a rights-based, integrated and community-led health response designed by and for MSM, following international best practices for HIV and health programming. The programme leaves an important legacy as the first and only continuous MSM programme in the MENA region. It also lives on today thanks to its beneficiaries, MSM and LGBT activists, and the MSM-friendly materials and local expertise it created. Many CSO partners are now respected actors in the national HIV response and in the region. MSM peer educators have become activists, carving a more positive future for MSM and LGBT individuals and communities in their respective countries.

Some noteworthy achievements of the regional programme are to have:

- **created access to MSM-appropriate and -friendly prevention, care and support through peer outreach**. The use of participatory community assessments (PCAs) enabled an unprecedented understanding of and access to MSM communities in each country. PCAs served as the foundation from which peer-based outreach activities were designed and tailored to diverse MSM sub-communities. A comprehensive combination prevention package of activities was delivered, including behaviour change communications, provision of tailored information, education and communication (IEC) materials, distribution of free condoms and lubricant sachets and referrals to HIV and STI testing, care and psychosocial and legal support services. The availability of HIV and STI testing and counselling services was expanded in all countries, through mobile, peer-based and referrals to public and private facilities.

  In the last two years of the programme:[2]

  - an estimated 47,991 MSM were reached through outreach-based interpersonal communication activities
  - 662,111 condoms and 237,593 lubricant sachets were distributed freely to MSM

2. Between August 2013 and September 2015.

  - 8,205 MSM received voluntary counselling and testing (VCT) services for HIV provided by the CSO partners at the CSO reception centres and mobile units
  - 3,509 MSM were tested, diagnosed or treated for STIs[3]
  - 2,106 MSM benefited from psychological support and 388 from legal support.

- **mobilised and empowered MSM communities**. Many MSM reported having gained confidence, both personally and professionally. This happened through an ongoing process, combining capacity-building with programmatic implementation. The self-esteem and capacity of MSM volunteers were raised thanks to their participation in PCAs, training and supportive supervision in tailored peer educational methods and contributions to the design of programmatic activities and communications materials. These provoked profound changes for many, whom having embraced their rights as individuals regardless of their gender or sexual preferences, have now become activists, experts and leaders for MSM and LGBT communities in their countries. New MSM and LGBT rights organisations in the region have since been established by former volunteers or staff of this programme.
- **built capacity of service providers working with MSM communities**. When it came to working with MSM communities, most CSO partners were starting from scratch. Transforming the CSOs' organisational culture and strengthening their capacity in HIV thematic areas and project management were part of both the approach and the objectives of the regional programme. CSO partners have emerged from this experience as credible organisations – recognised nationally and regionally – with rich expertise in tailored, community-based action for HIV prevention, care and support. Today, CSO partners sit alongside National AIDS Programmes (NAPs), UNAIDS and donors, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, as valuable partners in the national HIV and AIDS response.
- **advocated for a more positive environment for MSM and the CSO partners working with them**. Advocacy had three main objectives. The first was to improve attitudes and acceptance of MSM by reducing stigma and discrimination among some of the most important people among whom MSM live and find support: families, healthcare and social workers, lawyers, police and religious leaders. The second was to generate dialogue and stimulate discussion on MSM-sensitive issues at local, national and regional levels to influence policies and programmes and promote the inclusion of MSM as a target priority in national AIDS strategies. The third objective was to stimulate the adoption of human rights-based language by all stakeholders and at all levels of society.

In the last two years of the programme, 3,020 individuals (health providers, religious leaders, police officers, journalists and other community representatives) were reached through stigma reduction activities, and 608 decisions-makers were included in advocacy and awareness-raising initiatives.

3. The referrals made to public HIV and STI testing and counselling services are not included in this figure.

Background

HIV in the MENA region

The MENA region is diverse, spanning 24 countries from Morocco at its utmost western limit to Pakistan in the east.[4] Though HIV prevalence is low in the general population, recent UNAIDS reports place MENA among the two top regions in the world with the fastest growing HIV epidemics.[5] Between 2001 and 2012, the number of known new infections in MENA grew by 52% – the most rapid increase in HIV amongst all world regions.[6] In 2014, it is estimated that 240,000 people were living with HIV[7] and 22,000 new HIV infections occurred.

General population and key population-specific data on HIV is generally scarce in MENA. The few behavioural surveys that have been conducted give growing evidence that HIV prevalence is concentrated in key populations at higher risk, who then transmit the virus to a larger number of individuals who are generally at lower risk of infection. Key populations at higher risk for HIV include people who inject drugs, sex workers and men who have sex with men – people whose behaviours are considered taboo and officially criminalised. New infections are increasing among both women and children.

Despite the global increase in availability of life-prolonging treatment, AIDS-related mortality is also on the rise in the region. AIDS-related deaths more than tripled between 2000 and 2014.[8] Access to antiretroviral therapy (ART) is alarmingly low, with treatment coverage of people living with HIV at only 14% of adults and 15% of children aged 0–14 years, the lowest coverage in the world. Testing and treatment is similarly low for pregnant women, with only 13% having access to prevention of mother-to-child transmission programmes.

HIV testing and counselling is a serious challenge in MENA. UNAIDS estimates that MENA has the lowest number of HIV testing facilities per capita and access to HIV testing is very limited. A regional UNAIDS report published in 2011 notes that between 1995 and 2008 only 4% of tests were undertaken for key populations.[9]

The reasons for this concerning situation are complex and operate at numerous levels. From political, programmatic and financial perspectives,

4. According to UNAIDS and World Health Organization (WHO), the MENA region refers to the following 23 countries or territories: Afghanistan, Algeria, Bahrain, Djibouti, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, United Arab Emirates and Yemen.

5. UNAIDS (2013), *Report for MENA*; UNAIDS (2013), *Global Report: UNAIDS Report on the global AIDS epidemic*.

6. UNAIDS (2013), *Global Report: UNAIDS Report on the global AIDS epidemic*.

7. UNAIDS (2015), *Strategy for 2016–2020. Fast Tracking to Zero.*

8. Ibid.

9. UNAIDS (2011), *Regional Report on AIDS in the Middle East and North Africa.*

the HIV response has been neglected in many MENA countries. Deeply rooted HIV-related stigma and discrimination, apparent in laws, policies, and programmes, and at all levels of society, pose significant barriers to HIV prevention and care, support and engagement of key populations and people living with HIV. As a result, most remain hidden. This situation is exacerbated by personal feelings of low self-esteem and guilt, lack of awareness of the determinants of HIV risk and limited availability of ART and social support mechanisms. Insufficient engagement and capacity of CSOs working with key populations also contributes to this situation. When HIV care is accessed, adherence to treatment and support may be hindered by ART stock-outs, inability to pay for transport, low general and health literacy, poverty and depression.[10]

Men who have sex with men: a highly vulnerable and stigmatised community

Amongst populations most at risk for HIV, MSM constitute a particularly vulnerable community in MENA, as elsewhere. They represent a largely hidden population that bears a disproportionately higher burden of HIV infection in comparison with the general population. A multitude of factors contribute to the vulnerability of MSM and the disproportionate burden of HIV infection within this population. These include laws and policies that criminalise homosexuality, stigma and discrimination, which can lead to depression and other mental health issues, physical violence and a lack of access to quality services.

Authors of the Weill Cornell Medical College's systematic review underline the urgent need to expand HIV-related services to prevent further HIV transmission among MSM in the region.[11] The study found that the HIV epidemic among MSM is present in more than half the countries in the MENA region, with concentrated epidemics in several countries, in particular Tunisia and Morocco.[12] By 2008, transmission via MSM contributed more than 25% of total HIV notified cases in several countries. Certain behaviours among MSM – such as high risk sexual behaviours, low rates of consistent condom use (generally below 25%), relative frequency of male sex work (ranging from 20%–76%) and substantial overlap with heterosexuality, lay the ground for increased HIV transmission. A World Bank report adds to this low knowledge of HIV transmission as another factor influencing high HIV risk among MSM.[13]

Table 1 (page 8) summarises the available data on the estimated HIV prevalence among key populations in the four countries where the programme was implemented.

10. International HIV/AIDS Alliance (2013), *Strengthening the involvement, care and support of people living with HIV in MENA: a situational overview*. Available at: http://www.aidsalliance.org/resources/281-strengthening-the-involvement-of-people-living-with-hiv-in-mena-region

11. Weil Cornell Medical (2011), *Are HIV epidemics among MSM emerging in the MENA?*

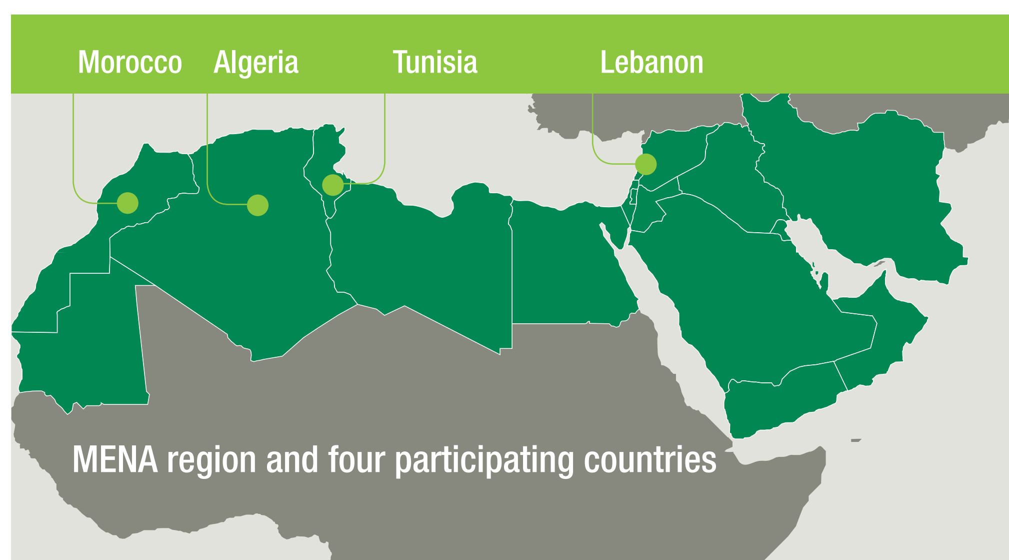
12. Ghina R. Mumtaz et al., "Are HIV Epidemics Among Men Who Have Sex With Men Emerging in the Middle East and North Africa? A Systematic Review and Data Synthesis," *PLOS Medicine* 8, no. 8 (2011):1-15.

13. World Bank (2011), *The global HIV epidemics among men who have sex with men.*

Table 1: Data on key populations in Algeria, Lebanon, Morocco and Tunisia[14]

		Algeria	Lebanon	Morocco	Tunisia
Estimated HIV prevalence among key populations	MSM	13%	2%	5.1%	10.1%
	People who inject drugs	2.3%–11%	No data	14%	3%
	Female sex workers	4.6%–10.4%	2%	2%	0.6%
MSM reporting condom use during most recent sexual intercourse		No data	46%	59% (Agadir) 31.3% (Marrakech)	36%

A United Nations (UN) global review on discriminatory laws and violence against individuals based on their sexual orientation documented that same-sex practice is illegal in 19 countries in MENA. The MENA region includes five of the seven countries where consenting homosexual acts are subject to the death penalty.[15] In the programme's four focus countries, decriminalisation of sex between consenting men encounters strong socio-cultural, religious and political resistance. In a context where policies and programmes are influenced by pervasive homophobia, MSM compounded experience of stigma and self-stigmatisation can lead to depression and other mental health issues, which prevent MSM from accessing sexual health services. MSM who are diagnosed with HIV, face additional challenges, including difficulties in disclosure and lack of peer support, which contribute to poor adherence and retention in care.



14. Sources: UNAIDS Global Report. 2013; UNAIDS MENA Report. 2013; The Global Fund in MENA: Aidspan Regional Report. 2015; the Lebanese data is from UNAIDS MENA Report 2011 as there is no Lebanese data in subsequent reports; the MSM prevalence rate in Tunisia is from the national bio-behavioural survey conducted in 2015 by USAID's project partner ATL for the Ministry of Health.

15. UN General Assembly (2011), *Discriminatory Laws and Practices and Acts of Violence Against Individuals Based on Their Sexual Orientation and Gender Identity. Report of the High Commissioner for Human Rights*.

Homophobia in MENA

LGBT individuals living in MENA countries are commonly rejected by their families, molested and harassed at a community level and in services. They are periodically harmed, beaten by mobs, denounced, humiliated (with forced anal exams until recently in Egypt, Tunisia, Lebanon among others) and arrested by the police. Every year there are cases of individuals prosecuted or threatened with prosecution for having violated the article of the penal code forbidding “homosexual acts”,[16] “acts against nature”,[17] “sexual relations against nature”,[18] and “sodomy between adults”[19]. Prosecution may result in incarceration (e.g. in Lebanon in 2014,[20] in Morocco in 2015–2016[21]). When the law criminalising homosexuality is not enforced, it increases vulnerability and harassment from law enforcement officers; when it is enforced, the individuals outed, shamed and locked up, suffer appalling situations.

> “When I discovered I was homosexual, I discovered homophobia, I experienced my sexuality in isolation, loneliness and concealment and self-withdrawal (I am effeminate). For fear of stigma, rejection by my family, my friends, I lived hidden because of taboos and social prejudices from this conservative society, where homosexual practices are severely repressed.”
>
> ***Ahmed, aged 22, single, Algeria***

Above: A mob gather outside the family house of a young man arrested and outed in the media in Morocco.

Above: Materials produced by Aswat against the criminalisation of homosexuality in Morocco.
L: Cover of a Moroccan magazine asks readers "Shall we burn homos?".
R: A coalition of Lebanese LGBT organisations produced a range of materials to address harassment and violations of rights when arrested or held in Lebanese police stations.

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71 916 146

16. Article 338 of Algerian Penal Code.
17. Article 489 of Moroccan Penal Code.
18. Article 534 of Lebanese Penal Code.
19. Article 230 of Tunisian Penal Code.
20. https://docs.com/helem-lebanon/8266/al-agha-hammam-a-raid-from-another-age-english
21. www.hrw.org/news/2015/03/04/morocco-two-sentenced-homosexuality-charge; www.hrw.org/news/2016/04/08/morocco-victims-attack-jailed-homosexual-acts; www.hrw.org/news/2016/11/25/morocco-drop-homosexuality-charges-against-teenage-girls

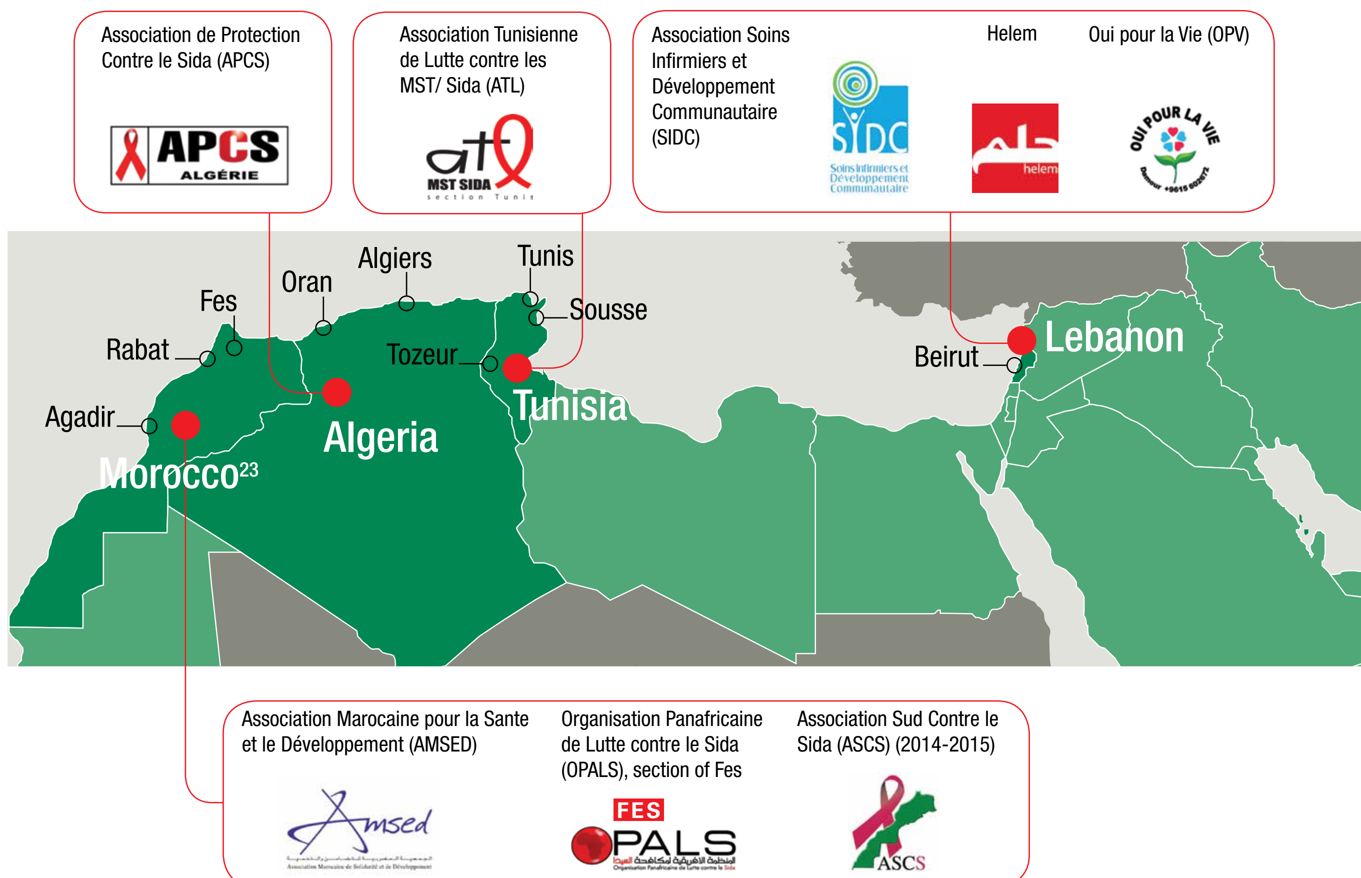
The USAID and Alliance MENA programme

Brief presentation

From 2005 to 2015, with financial support from USAID, the Alliance worked with CSOs in Algeria, Lebanon, Morocco and Tunisia with the aim to meet the sexual health and HIV/STI prevention needs of MSM in hostile environments. The three intermediate results of the programme were to:

1. expand access to HIV and AIDS prevention, care and support for MSM
2. improve the quality of prevention, care and support services for MSM
3. help create a more favourable environment for MSM sexual health and HIV prevention needs.

The MENA programme was implemented with eight partner CSOs, including six HIV-thematic organisations, one development organisation and the only lesbian, gay, bisexual and transgender (LGBT) organisation with legal status in the region when the programme started.[22]



22. At the time of writing, new legal LGBT organisations have emerged.

23. There were some changes among the implementing partners in Morocco: Association de Lutte Contre le SIDA (ALCS) was part of the project during the pilot phase (2005–2007). OPALS-Rabat was part of the project between 2008 and 2013.

The foundations of the programme

When the programme was first introduced in 2005, there were no existing health and HIV-related CSOs or services responding to the needs of MSM. The programme started from scratch to initiate the implementation of a rights-based, integrated and community-led health response designed by and for MSM, following international standards for HIV and health programming.

To begin, the Alliance implemented participatory community assessments (PCAs) led by members of MSM communities and CSO partners in each country. The PCAs enabled unprecedented access to MSM communities. They explored in-depth the knowledge, perceptions, practices and needs of MSM communities, mapped their meeting points and social spots, and inventoried both stakeholders and possible risks for the programme. Finally, the PCAs put forward recommendations that were subsequently used in a participatory design process conducted by the CSO partners and MSM volunteers.

The PCA was an innovative, key defining feature of the programme because it ensured the meaningful engagement of MSM and their insertion into the CSO partners' activities from the programme's inception. Furthermore, it gave CSO partners a first-hand understanding of these otherwise clandestine communities. The 2010 external evaluation of the programme considered PCAs to be "*critical in setting up contextually-appropriate MSM prevention programmes*".[24]

The Alliance, CSO partners and MSM community members subsequently developed a package of combination prevention services in accordance with international best practices. The *right to health* was chosen as an acceptable way of addressing MSM issues in the public sphere and a cross-cutting approach to working with populations vulnerable to HIV. Having selected this approach, the programme became the first HIV prevention programme in the region to express a rights-based discourse using a public and community health lens. This meant that CSO partners employed the right to access safe and appropriate health services as a key entry point for MSM appropriate and friendly HIV prevention, care and support.

The PCA was the first time Helem started looking at sexual health risks for men who have sex with men. As an LGBT rights-based activist organisation, we had no experience in health before our involvement in this programme. It really opened our eyes."

Georges Azzi, former Director Helem, currently Director AFE, Lebanon

"The PCA was one of the key successes and lasting legacies of this programme. It really gave us a tool which we used for years to come, and adapted it to access many other vulnerable communities such as people who inject drugs and people living with HIV. Now it is standard practice when working with key populations in Tunisia."

Bilel Mahjoubi, former Coordinator of the project in Tunisia, currently Director, ATL, Tunisia

24. Institute of Development Studies (2010). *External Evaluation of the MENA Programme*.

A MENA Programme tool: Let's analyse our needs ourselves. A guide to conduct participatory community assessments for men who have sex with men in MENA

The guide *Let's analyse our needs ourselves* is intended for persons conducting a PCA with MSM in MENA or elsewhere. A PCA is the first step in the establishment of a community-based programme. It follows the guiding principles of participation, equity and transparency. By empowering people in identifying problems, prioritising needs and planning for community development actions, the tool helps develop relevant programmes for MSM, mobilises the local MSM community and increases its ownership of the programme. It also encourages organisations to integrate the needs of MSM in their broader HIV prevention work. In the framework of the MENA programme, the PCA was conducted initially and subsequently repeated over the years as the contexts and behaviours of MSM changed. The PCA guide *Let's analyse our needs ourselves* was produced in French and Arabic. CSO partners have adapted it for use with other key populations.

The guide is available at: www.aidsalliance.org/resources/680-mena-analysons-nousmemes-nos-besoins

The PCA guide was first produced in French and then translated in Arabic.

Achievements: creating access to HIV prevention, care and support for and with MSM in MENA

The programme's achievements were evident in four main areas, all of which worked together to foster changes at multiple levels:

1. Creating access to MSM-appropriate and friendly HIV prevention, care and support services through peer outreach
2. Mobilising and empowering MSM communities
3. Using advocacy to promote a more enabling environment for MSM and CSO partners
4. Building the capacity of critical providers of services for and supporters of men who have sex with men

Creating access to MSM-appropriate and friendly HIV prevention, care and support services through peer outreach

The programme filled an important void in the HIV response in the MENA region by creating access to a comprehensive combination prevention package for MSM. Programme activities connected MSM to the following services, either directly or via referrals to public, private or NGO clinics:

Services provided	Outreach work	Community spaces or mobile units of CSO partners	Referral to friendly services (public, private practitioners, or other NGOs)
Awareness-raising on: HIV prevention, 'know your status', STIs, stigma, where to go, knowing your rights	✔	✔	
Hotline		✔	
Commodities: condoms, lubricant sachets	✔	✔	
HIV counselling and testing – rapid		✔	
HIV counselling and testing – confirmation (Elisa or Western Blot)			✔ (public)
Pre- and post-test counselling for HIV		✔	✔ (public and NGO)
STI diagnosis and treatment		✔	✔ (mostly private)
Legal support and advice		✔	✔ (mostly NGO)
Psychosocial support: peer support groups, individual psychologist consultation, family mediation	✔	✔	✔ (mostly NGO)

Through peer-led education, communications and support conducted in targeted locations, MSM volunteers distributed free condoms and lubricant sachets, educated MSM using tailored communications messages and materials and linked them to appropriate STI and HIV services.

Peer-led education, communications and support in targeted locations

Peer-led activities ranged from single outreach sessions – one-to-one or in small groups during which HIV prevention, information, commodities like condoms and lubricant sachets and referral cards were distributed[25] – to regular peer-based mentoring, to build supportive relationships over time. Outreach activities were usually conducted by peer educators working in pairs or small groups to ensure their security and protection and were regularly monitored by a field supervisor. In Tunisia, pairs usually consisted of an experienced peer educator and a junior one, to facilitate mentoring of new peer educators. Peer-based action also took the form of MSM self-support groups, generally moderated by a trained MSM volunteer and held within the organisation's premises.

Outreach took place in different sites, known for being MSM meeting points, including hotels and brothels, cafes, bars, public baths, parks, university campuses, beaches and festivals. Since meeting points often changed, mapping exercises were conducted on a regular basis to ensure that peer educators could continue reaching MSM communities.

The service package delivered during outreach varied depending on the site:

- In night clubs and bars frequented by MSM, where there was little time or interest for long conversations, peer educators distributed leaflets with short messages and referral cards.
- In public spaces, peer educators talked one to one or with small groups in the street, and invited visitors to go on the spot to the mobile unit for a rapid HIV test. Should a person receive a positive result, the counsellor[26] referred him to a local hospital for a confirmation test. MSM who tested positive for HIV or a STI and refused to go to the local hospital were referred to a private practitioner or a hospital outside of the area (city or region).

In the last two years of the programme,[27] an estimated 47,991 MSM were reached through outreach-based interpersonal communication activities.

"A lot of men who have sex with men are still afraid to come to our office because we are an HIV organisation, and they don't want to be labelled as having HIV, so the peer educators went to them, and organised meetings and chats in local cafes and hang outs where men who have sex with men meet, and where they feel more comfortable."

Pr Aziz Tadjeddine, President, APCS, Algeria

25. Condom and lubricant distribution was not in all public spaces, for instance condom distribution is forbidden in universities and beaches in Lebanon.

26. Counsellors included, a public health doctor in Algeria and Morocco, a MSM nurse in Tunisia, and trained MSM counsellors in Lebanon.

27. Between August 2013 and September 2015.

A pilot peer outreach project to reach more men who have sex with men

In 2015, the partners of the MENA programme implemented a pilot online peer outreach project to reach more MSM, in partnership with the South East Asian Foundation B-Change Technology.

In order to improve the understanding of the online habits and behaviours of MSM, two anonymous web surveys were launched online to collect information among MSM (living in Algeria, Lebanon, Morocco and Tunisia), recruited via Facebook and instant messaging channels. The first survey assessed technology use and included questions about mobile devices and tech-based sexual networking. The second survey collected further data on social media behaviours, with questions about using social networks, interpersonal communications, and negative experiences online. The results confirmed the penetration of internet and mobile technologies in urban centres, and highlighted the widespread use by MSM of mainstream social networks (predominantly Facebook) and global gay dating apps, especially in the evening. The predominant website for sexual networking was reported to be Planet Romeo; the predominant smartphone app for sexual networking was Grindr. The results also revealed that while MSM use smartphone instant messaging (SMS and Whatsapp mainly) to communicate and chat with friends, they tend to use the telephone when communicating with health providers. Sexual networking among this cohort demonstrated a preference for web-based methods versus offline (public space) networking. A significant proportion of negative experiences using social media or apps was also reported, in particular cases of breach of confidentiality online.

Based on these findings, the partners designed a pilot information and communications technology (ICT)-based intervention. Experienced peer educators created avatars representing different profiles of beneficiaries, collectively designed an online peer outreach intervention and developed the corresponding standard operating procedures and M&E framework. This was identified as the most feasible output based on existing resources and ICT experience. Building the capacity of community groups for this intervention would result in more effective use of popular social media platforms for MSM-peer outreach activities. Local trainings of 'online peer educators' were organised to strengthen digital security, content creation systems, online outreach procedures, conduct of peer educators online, and M&E framework to measure the outcomes towards the HIV continuum of care.

A regional workshop was held in Morocco to design the ICT-based intervention with peer educators.

The trained 'online peer educators' created 'virtual peer educators' accounts/profiles and contacted MSM though internet and social media in their respective countries, mainly on Facebook, Whatsapp, Grindr, Hornet, Planet Romeo, Badoo, Tango and Babel, and mostly during evening and night shifts. The objective was to contact MSM not reached by the usual outreach in public spaces, and hence continue expanding the package of prevention services available to MSM. They provided interpersonal communications on HIV and STIs, disseminated IEC materials online, encouraged them to take an HIV test and referred them to prevention services provided by the partner organisations, as well as public health services in their country.

This test phase lasted from July to September 2015 in Agadir, Beirut, Tunis and Sousse. The results were promising; during the month of September 2015, the six online peer educators of ASCS in Agadir for instance 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 period ASCS noticed an increase of number of MSM visiting the association to collect condoms and lubricant; ASCS peer educators appreciated this new type of outreach work compared to street outreach, the latter being uneasy due to growing harassment of police. Some challenges that peer educators faced online were similar to 'traditional' or face-to-face outreach work: high interest in sexual health, initially reluctance to visit association or uptake services, or to change risk behaviour.

"The virtual prevention pilot project has allowed us to reach a significant number of MSM, in particular those who remain hidden and aren't reached through our outreach activities in the streets. Personally, I think that MSM of Morocco need these kind of activities, even if challenges are numerous, notably mobilising resources for this kind of projects."

Abdelatif, peer educator and university student, ASCS, Morocco

Examples of different profiles of MSM using social networks and gay dating apps, imagined by the peer educators during the regional workshop to design the ICT-based intervention.

Some of the lessons learned from this pilot project:

- **Overall high acceptability:** many MSM are eager to engage in an online conversation about HIV and STI prevention, rights and services; virtual spaces are perceived as safe to talk freely about sexual practices with no face-to-face bias; however, a significant proportion of MSM contacted online refused any discussion relating to sexual health and HIV.
- **Strong operational procedures and human resource capacity are required** to maintain a high quality ICT tool that maintains privacy and confidentiality; consequently, organisational ICT capacity needs to be assessed and strengthened before initiating an online prevention project.
- **Monitoring and evaluation challenges:** it is not easy to measure service use or user engagement online or to clearly show the link between use of ICT and uptake of services; monitoring of referral pathways between outreach CSOs and friendly providers needs to be aligned to track referral from virtual spaces to services.

The pilot project also confirmed the critical importance of digital safety and security, and demonstrated once again that community engagement in the design and implementation of online prevention activities is essential.

USAID donation makes lubricant sachets widely available for the first time in Morocco

In May 2012, USAID made a donation of 1.3 million sachets of lubricant to the Moroccan NAP through this programme. The sachets were distributed across Morocco by the main HIV-thematic CSOs (ALCS, ASCS and OPALS-Fes) working with MSM and (male and female) sex workers.

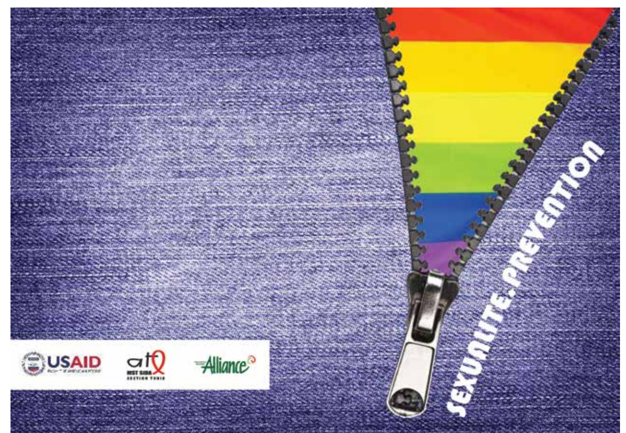
Distribution of free condoms and lubricant sachets

Peer-led outreach activities served as opportunities to discuss and build skills in correct and consistent use of condoms and lubricant to promote safer sexual practices. In addition, the Alliance encouraged CSO partners to lobby for free or subsidised condoms and lubricant sachets. Though regularly requested by MSM communities because they improve condom use, lubricant sachets were frequently unavailable.[28] CSO partners were able to secure free condoms from NAPs, external donors or other suppliers. In the four countries, however, this programme was the main, if not the only, provider of free lubricant sachets.

In the last two years of the programme, 662,111 free condoms and 237,593 free lubricant sachets were distributed to MSM.

Distribution of MSM-friendly materials

Peer educators distributed leaflets and brochures containing safe sex messaging and referral information to MSM friendly services. Materials were written in Arabic and French using easy to understand and appealing language.



Examples of IEC flyers distributed by peer educators in the four countries during their outreach activities.

28. Lubricant sachets are still usually unavailable in the region, except in Tunisia where they are procured with Global Fund funding.

Linking with STI and HIV testing, treatment, care and support services

A critical part of peer-led outreach involved connecting MSM to the HIV prevention, care and support services. A chronic gap in the MENA region, HIV and STI testing and counselling was a priority for the programme. HIV and STI testing services varied between sites: in Lebanon for instance, MSM peer educators trained to offer mobile voluntary counselling and testing (VCT) services also conducted a rapid test for syphilis and hepatitis; in Marsa – a CSO-led sexual health clinic for key populations – and SIDC clinics, syndromic diagnosis of STIs was conducted. The results of the laboratory-confirmed tests were usually sent to the partner CSO, which then communicated the result to the patient, and referred him to the relevant treatment service in the public health system.

Capacity-building activities aimed to ensure the provision of high quality testing and counselling services, adapted to MSM needs. The partner CSOs facilitated regular training workshops for the public sector and CSO testing centre staff and provided necessary expertise during NAP trainings on HIV counselling and testing. Training sessions included MSM peer educators' testimonies of their experiences at testing facilities and sessions on sexual orientation and gender identity.

During the course of the programme, access to HIV testing and counselling services was improved in all four countries. This was achieved thanks to:

- **Increased availability of HIV testing and counselling** through CSO partners. APCS in Algeria expanded opening hours of their HIV and STI testing services and added a second location. SIDC in Lebanon, ATL in Tunisia and OPALS-Fes in Morocco improved access by increasing opening hours, adding more sites and improving the quality of care. Helem in Lebanon helped to establish an independent HIV and STI treatment centre, named Marsa Sexual Health Centre, for key populations.[29]
- **Mobile HIV and STI testing and counselling:** Each CSO partner leveraged other sources of funding to procure and equip mobile units.[30] Staffed by trained medical teams and always working alongside MSM peer educators, mobile units accessed remote or insecure areas where fixed HIV testing and counselling facilities were not available. Ad-hoc HIV testing campaigns were also organised during specific events.
- **Peer-based HIV testing:** In some countries, trained peer educators received permission by the NAP to perform rapid HIV tests[31] outside of formal health centres. In Tunisia and Lebanon, ATL, Helem, SIDC, and Oui Pour la Vie performed rapid HIV tests during outreach activities in the mobile units or within the CSOs' premises.
- **Referrals to public and private HIV testing facilities:** When HIV facilities or services were already available but were hard to access for MSM due to

"The problem in this region is lack of testing, both facilities, and people going to them. Both pre- and post-test counselling is problematic as well. We also need civil society to focus on service delivery to vulnerable populations because they know how to work with them. The government ones are not enough."

Simone Salem, Partnership and Community Mobilization Advisor, UNAIDS Regional Support Team in MENA, Egypt

Oui Pour la Vie saw a huge increase in demand for its HIV testing services when we joined the programme and started proper outreach work. We went from testing around 50 people per year before 2007 to 500 people per year after we got engaged in the Alliance programme."

Rabih Maher, Helem and OPV, Lebanon

29. http://www.marsa.me/

30. In Algeria with funding from the Mairie de Paris. In Tunisia and Lebanon with support from the Global Fund (MENAHRA Project).

31 In most countries in the region, the law states that those providing HIV testing must be medically trained, unless special permission is given by a ministry of health.

Poster campaign for rapid HIV testing produced by ATL in Tunisia. Booklet with information for MSM on HIV, STIs and sexual health; SIDC, Lebanon.

their location or not being MSM-friendly, CSO partners provided stigma and discrimination reduction trainings for facilities' medical and support staff as well as free condoms and lubricant, rapid HIV testing kits and MSM-friendly IEC materials. MSM peer educators frequently accompanied men to these facilities to provide support.

- **New STI diagnosis and treatment services:** Because CSO partners in Algeria and in Tunisia did not have the facilities to provide STI services, the programme worked with existing medical facilities by addressing stigma and discrimination within the facilities, establishing strong referral systems with MSM-friendly staff and providing free or reduced priced STI services. Marsa, was established by members and with the support of Helem to provide key population-friendly and accessible services. In 2015, SIDC also established its own sexual health clinic for key populations in Beirut.
- **Referrals for CD4 count, antiretroviral treatment and support:** All CSO partners actively sought to establish referral networks with public sector HIV care services. MSM diagnosed as HIV positive were referred to a public centre for a confirmation test, and also to the psychologist of the association and to the peer support group. ATL organised support groups of HIV positive MSM, and HIV positive peer educators to accompany newly diagnosed men to the hospital to support their enrolment in care. Reversely in Tunisia, Lebanon or Algeria, public treatment centres refer people living with HIV to ATL, SIDC and APCS and to the peer support groups they host for psychosocial support services.

In addition to facilitating HIV/STI testing and treatment services, the programme pioneered the provision of other supportive services including:

- Psychosocial support services for MSM and other vulnerable groups. At the time of this writing this case study, APCS, SIDC, Helem (via Marsa Clinic), ATL and OPALS employed psychologists who provide free and anonymous counselling and support to MSM. SIDC and its partners in Lebanon also extended psychological support to the family members of MSM.

> "We saw the need for STI and HIV services, and many people, especially the really hard to reach men who have sex with men, were not comfortable going to the few that existed. So we set up the service. As we are essentially an LGBT Rights organisation, we decided to separate out the clinic as an independent service for LGBT, but we continue to be closely linked."
>
> ***Georges Azzi, Director, AFE, Lebanon***

"Providing men who have sex with men with the services of a psychologist helped me fight my shyness, this inferiority complex which I suffered from and that ate away at me all through my teens. The most significant change [for me] remains the work on self-esteem, self-confidence and assertiveness. I have finally come to terms with myself as homosexual, I accept myself, I don't let people insult me any longer, I respond to provocations, I defend myself, I defend the cause of my community and I have the feeling that people respect me more."

Ahmed, aged 22, Algeria

- **Legal counselling, 'know your rights' sessions:** All CSO partners established free access to legal counselling, provided by lawyers who volunteer for the CSOs. For example, ATL in Tunisia regularly provided free legal support to MSM beneficiaries, as did APCS in Algeria, when MSM peer educators were intercepted by local authorities during outreach work.

"Helem saw a real need to work with local lawyers who were sympathetic to the problems criminalisation of homosexuality brought on men who have sex with men, and were willing to offer free or reduced rate services to some of the more serious cases we were supporting."

Rabih Maher, Helem and OPV, Lebanon

In the last two years of the programme, 8,205 MSM received voluntary counselling and testing services for HIV provided at the CSO partners' reception centres and mobile units. 3,509 MSM were tested, diagnosed or treated for STIs[32] and 2,106 MSM benefited from psychological and 388 from legal support.

Creating safe spaces to meet the broad needs, including HIV and sexual health, of MSM

In addition to increasing access to services, the programme created safe spaces for MSM in the CSO partners' premises. Such spaces were critically needed and missing in the region.

"What most attracted me in the MSM programme and the services provided by ATL can simply be summarised in the setting. ATL represents for me a space of freedom and tolerance, even under the dictatorship of the former regime, I really felt some room for freedom within ATL through the meetings, activities and the theme days, since I was able to express myself freely there."

Chaker, beneficiary, Tunisia

"Now I have a place I can go when I feel bad. If something happens to me, now I know where to go, before I had nobody I could tell my story to. I always had a feeling of fear. But now, I feel so relieved to speak with people who understand me and whom I trust."

Said, beneficiary, Lebanon

"We realised that we needed to provide psychosocial support to MSM who wanted to open a dialogue with their families, but were either ostracised or didn't know how to go about it. Our psychologists and social workers provided free sessions, and we even developed a booklet to help families of MSM understand their children better. It's now used by a lot of social workers as a guide."

Nadia Badran, former Coordinator of the project in Lebanon, currently Head of Programmes, SIDC, Lebanon

"Men who have sex with men know they can come whenever they want, and use our offices to meet and learn. It feels like it's their office now! As long as they respect the organisation's policies, it's their home."

Pr Aziz Tadjeddine, President, APCS, Algeria

32. The referrals made to public HIV and STI counselling and testing services are not included in this figure.

The first community centres for and managed by MSM in Tunisia

In Tunisia, ATL established an MSM community centre in 2013, the first of its kind in Tunisia and probably in the MENA region. Entirely managed by MSM staff and volunteers, the centre offers a much needed safe, discreet and confidential space. It is advertised by word of mouth and through personal MSM networks for MSM and serves as a place to meet, receive and exchange information, trainings and services. The success of this community centre led to ATL and the MSM community establishing a second centre in Tozeur in 2014. The community centres organised activities such as:

- Training, coaching and supervision of peer education teams
- Individual counselling sessions
- Participatory design of IEC materials
- Film screenings with guided debates on themes related to homosexuality and HIV
- Language classes
- Community-based VCT services
- Theatre workshops

> "This has been one of our proudest achievements as MSM civil society activists and service providers. The community centres are valuable and unique spaces, in an otherwise very conservative area, where MSM know they are safe, and can develop their skills."
>
> ***Badr Baabou, former Field Supervisor of the project in Tunisia and subsequently Manager of the Sousse community centre, currently President, Damj, Tunisia***

Posters to showcase activities at the MSM community centres in Tozeur and Sousse, Tunisia.

Mobilising and empowering MSM communities

Tailoring outreach activities to MSM communities was key to this programme, and a process which engage MSM volunteers both personally and professionally. Confidence- and skills-building was on ongoing process that combined capacity-building with programmatic implementation.

The PCA: the programme's foundation and community mobilisation tool

PCAs laid the foundation for MSM engagement throughout the programme. Not only did PCAs provide an unprecedented understanding of the complex realities of MSM communities, but they engaged MSM in problem-solving and solution-building.

MSM peer educators contribute to research and improving understanding of MSM communities

Tunisian HIV bio-behavioural survey with MSM, conducted with peer educators from ATL.

There are multiple examples where MSM volunteers trained by the Alliance's programme contributed to national HIV responses. Research is a significant one. In Tunisia and Lebanon, CSO partners worked closely with the country's National AIDS Programme (NAP) to carry out HIV bio-behavioural surveys with MSM. Data collection efforts were led by MSM volunteers, who were specially trained for the research.

In Lebanon, MSM were hired as researchers in studies commissioned by the NAP to increase understanding of the MSM communities. More recently, they were involved in a PCA on transgender communities, in view of informing national strategies and improving services for these highly vulnerable populations.

In Tunisia, the country's very first sero-prevalence rate survey of MSM conducted in 2009, and two subsequent national bio-behavioural surveys implemented in 2011 and 2015, relied on MSM peer educators from ATL enrolled as investigators.

> "It was our MSM peer educators and our volunteers and staff from the programme who went out and carried out all the data collection. Without our access to and understanding of the MSM community, it would have been impossible for the authorities to gather the data that was collected in these studies. They helped shape our national response from then on."
>
> ***Bilel Mahjoubi, Director, ATL, Tunisia***

In Algeria, in 2015, APCS initiated the first national bio-behavioural survey on HIV and STIs among MSM in partnership with a medical university and a pharmaceutical company. Once again, MSM peer educators were the main data collection agents.

> "Thanks to the MENA programme, we had a pool of 40 trained and sensitised MSM volunteers, who were ready to support this national survey across 20 wilayas [governorates]. The first of its kind to target MSM behaviour in Algeria. We reached over 1,000 MSM in this first study."
>
> ***Pr Aziz Tadjeddine, President, APCS, Algeria***

Peer education training and tailored outreach to diverse MSM communities

Evidence shows that targeted community HIV prevention and treatment interventions are effective in reaching MSM.[33] Findings from the PCA enabled CSO partners to recognise the diversity that exists within the MSM community; knowledge which they then used to segment MSM into sub-communities and tailor their peer education activities. Target groups were defined based on a variety of factors, including socio-economic level, age, occupation, place of residence, lifestyle, migrant status, self-identification (being openly gay or not, for example) and relationship with sex work (client or sex worker).

33. Mulongo S et al. 'Applying innovative approaches for reaching men who have sex with men and female sex workers in the Democratic Republic of Congo'. *Acquir Immune Defic Syndr.* 1;68 Suppl 2:(Mar 2015) 248-51.

Teams of peer educators were selected from each sub-community in response to the diversity of MSM profiles: discrete MSM 'in the closet', married, gays, sex workers, etc. received training in tailored outreach techniques, HIV and STI transmission and prevention, interpersonal communications skills and a variety of other life skills. During their training, peer educators practiced different outreach scenarios employing the appropriate language and behaviour in each setting: one-to-one in a bar, in the street, in a public bath, etc. They also received supportive supervision throughout. MSM peer educators designed and used IEC materials in Arabic, tailored to distinct MSM communities.

Though the main prevention messages and the services offered were similar, the places and spaces visited to reach them varied, as did the language:

- Street youth, for instance, were met in cruising areas. Often poorer and less educated, simple messages were delivered in local dialect. Because they tended to be victims of discrimination and violence in their families and local environment, peer educators referred them more frequently to health services and psychosocial support.
- Wealthier young people socialised in bars, nightclubs or at university. More educated, they tend to be better integrated both socially and professionally. More elaborate messages and written flyers in French or English (in Lebanon) were more appropriate.

Similarly, group sessions offered by CSO partners took into account the needs of each sub-community to facilitate high levels of participation. For example, trainings including both discrete MSM and male sex workers were avoided. Activities with 'poorer' MSM – often sex workers suffering from low self-esteem and interested in the small financial incentives of the programme – and 'wealthier' MSM – having higher self-esteem and confidence and motivated more by the cause of promoting MSM human rights – were conducted separately because of mutual distrust.

Despite the use of tailored activities, MSM communities worked together towards a common cause. A significant achievement of the programme was the increase the solidarity among the diverse MSM communities and its efforts to reach all MSM: discrete, gay, young and adolescent, older and married, transgender, drug users, sex workers, poor and homeless, migrants and refugees.[34]

"In my position as a peer educator, what has changed is that I met other groups and communities who are different from the people I knew and I have learned how to work with approaches adapted to each of those groups. The way of working, of speaking, the content of the information destined to street youth are different from those used with young people in bars and night clubs. I am no longer limited in using one single method or approach. (…) This was very important because it made my interventions more useful and increased my self-confidence and trust in the quality of the information I am providing and when I feel that the people I am talking to accept easily, ask more questions and are interested in the issue, this makes my work more significant and more useful."

Walid, 31 years old, MSM peer educator, Lebanon

"It was really important for us to be the ones designing the information leaflets, because we knew the language to use, and what would keep people interested in reading them."

Amin, SIDC/Helem, Lebanon

"As MSM ourselves, we are able to recognise other MSM amongst the general public, through our existing networks, or just discreetly observing. This allowed us to reach them with IEC materials, and just chat to them about HIV and safe sex without raising suspicion, as other volunteer colleagues (who were not MSM) were doing the same with the general public."

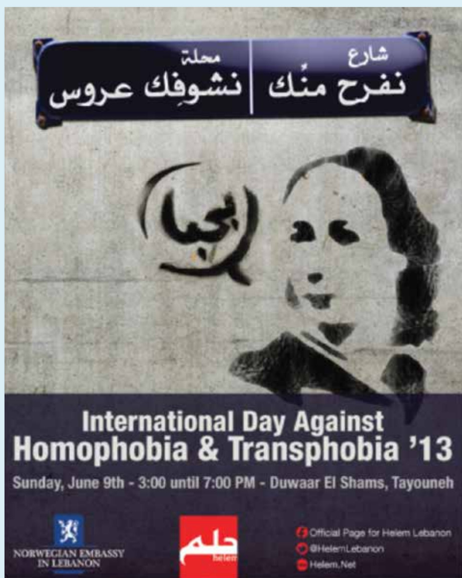
Ouafi, APCS, Algeria

34. Especially in Beirut: first Iraqis around 2008, Syrians more recently.

The pioneer legal organisation for LGBT rights in MENA: Helem

Helem started as a small group of LGBT activists with no experience in programme management, little to no financial and administrative systems and rejected by wider civil society and authorities alike. Today, Helem is a recognised LGBT rights organisation working alongside other organisations to emerge in Lebanon. As the only CSO supporting LGBT rights in the region since 2000, it has played a critical role in fostering dialogue across the region in areas such as gender equality, LGBT rights and HIV and sexual health of key populations.

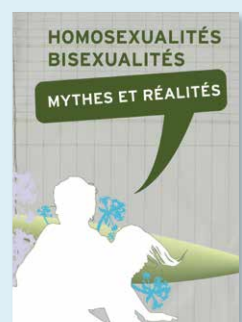
Poster for 2013 International Day Against Homophobia and Transphobia (IDAHOT), campaigning against Article 534 of the penal code that criminalises homosexuality. Below, poster for an event in 2016 at the Helem community centre.



"For Helem, this project was extremely significant. (…) The project gave us a legitimate platform to connect with authorities such as the NAP and decision-makers. It gave us credibility we didn't have before as a group of LGBT activists. Before, no one would talk to us, but the only way of talking about MSM issues was under the guise of the HIV programme. It opened the doors to better advocacy for us, both behind the scenes such as with police, and in public, calling for legal reform of discriminating laws. Our experience working with the Alliance and other partners in the programme helped us get more organised, become more professional, and helped Helem develop an internal strategy."

Georges Azzi, Director, AFE, Lebanon

Above: 2012 campaign against forced anal tests by police. Below L: Poster for 2012 IDAHOT, "I vote too; the law must protect me." Below R: Information booklets were produced in English, French and Arabic.



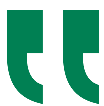
Opportunities for personal development

In addition to being trained and contributing their knowledge and experiences, peer educators received opportunities for personal growth and skills development. MSM volunteers were offered training in areas that improve life skills, self-esteem and self-confidence, such as interpersonal communications, conflict and stress management, negotiation skills and, in some cases, information technology, first aid, theatre and languages.

By involving MSM in all aspects of the programme, it nurtured leadership skills among volunteers and staff and established MSM volunteers as respected advocates and representatives in the HIV response. As an example of this, some MSM volunteers have since become CSO programme coordinators, investigators, managers, board members and speakers at national, regional and international conferences. Other volunteers' professional competencies were used in the programme, such as nursing, social work or graphic and web design.

Profound personal change for MSM volunteers

Volunteers voiced that the programme profoundly impacted their personal lives in multiple ways including how they viewed themselves and their sexual orientation.



I was at first seeking acceptance and understanding, but over time I realised I was learning a lot, and changing how I saw myself. I was participating in helping other MSM, not just myself." ***Dany, SIDC, Lebanon***

They report that the programme increased awareness and knowledge of risky sexual practices and increased their motivation to adopt safer behaviours.

Today, I feel responsible for [my] sexual behaviours; I am aware of the importance of prevention and of the risks faced by our community, starting with the high risks of HIV infection since we have a concentrated epidemic in our community." ***Bassem, ATL, Tunisia***

It furthermore encouraged them to view their health and well-being as a human right.

Building awareness and ownership amongst MSM groups initially around health, led to an increase in 'knowing your rights' among MSM, and we took this beyond the health framework. We became stronger at advocating for safe spaces, more dialogue and more initiatives for MSM and other vulnerable populations beyond the programme." ***Rabih Maher, Helem and OPV, Lebanon***

New activists, new leaders, new organisations for MSM

The programme nurtured the development of a strong network of activists and leaders. Some volunteers and peer educators have since founded their own organisations.

"Through the social development component of the MENA programme, I have benefited from individual coaching sessions, which have greatly helped to increase my confidence in myself and trust in my capacities to exist and act upon several areas of my life"

Rachid, peer educator leader, ASCS, Morocco

"Since my first visit to ASCS as a peer, suffering from an STI, and before becoming project coordinator, I have found a human space dedicated to us, as MSM. A space where efforts were made to ensure a greater access to knowledge and information on HIV and STIs, and where we can share our experiences. Many MSM came to ASCS unable to express themselves or talk about their suffering, but I have witnessed a clear improvement. The MSM prevention projects have facilitated our access to prevention, capacity-building and psychosocial support services, but all this remains dependent on funding opportunities that are becoming scarce."

Ali, Coordinator of MSM project, ASCS, Morocco

> A lot of the current MSM and LGBT rights activists in the region were born out of the programme. The Alliance inadvertently created a sort of 'school', providing training and mentoring to teams of peer educators and volunteers. Look at us now. We are establishing our own organisations, we are being hired by UN agencies as professional experts to train civil society organisations, we are standing in front of CCMs and NAPs and educating them about MSM needs and how to work with key populations." ***Badr Baabou, President, Damj, Tunisia***

MSM peer educators have also shaped the organisations they first started working with as volunteers. Other activists serve as technical experts on community mobilisation, key population and MSM issues for national AIDS programmes in countries including South Sudan, Saudi Arabia, Egypt, Jordan, Kuwait and Oman, and for regional UN programmes.

> We need to keep reminding everyone that HIV is not owned by the Ministry of Health. We all have an important role to play."
>
> ***Rabih, Helem and OPV, Lebanon***

Former volunteers or staff from the programme are currently prominent leaders in the LGBT rights movement in the region. In Tunisia, a prominent LGBT organisation (Damj) was created by former peer educators. Similarly, many founding members of the M-Coalition (the first Arab network on MSM and HIV), created in 2014, are former or current staff or peer educators involved in the MENA programme.

> "We were not only a network of organisations, we were a network of people, a support group. We kept contact and supported each other, and watched each other grow into activists, and technical experts. For me it was a gold mine. I learnt so much, and now I'm using it to improve the rights of my community the LGBT community in Tunisia."
>
> ***Badr Baabou, President, Damj, Tunisia***

A young activist holds a lone placard with the Aswat slogan 'Love is not a crime' during a pro-democracy demonstration in Rabat, Morocco, 2015. He was subsequently vilified in the press and forced to move from his home.
© Soufyane Fares

Lebanese demonstrators in Beirut protest against anal tests on men suspected of homosexuality and so-called 'virginity tests' for women, Protest organised by Helem, 2012. © AFP Photo/Anwar Amro

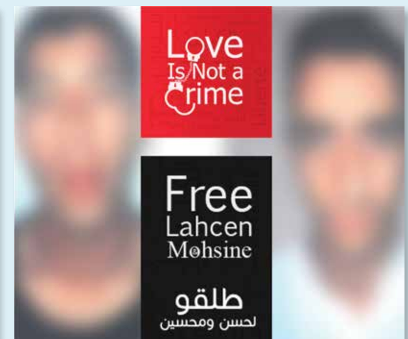
A new LGBT organisation in Tunisia: Damj

Several LGBT organisations have flourished after the Arab Spring in Tunisia – Chouf, Mawjoudin, Shams and Damj. Damj (Tunisian Association for Justice and Equality) is a non-profit organisation founded by a group of young activists who were mostly former peer educators from the MENA programme. Damj, which was legally registered in 2011 but existed informally before, works for the inclusion and defence of minorities and marginalised groups, including the LGBT community, by supporting individuals, strengthening the community and promoting its integration in society. Damj is also openly engaged in an advocacy campaign challenging the non-constitutionality of the Tunisian Penal Code article that criminalises homosexuality. See: www.facebook.com/damj.tunisie/

Graphic for the campaign against Article 230 Penal Code criminalising homosexuality in Tunisia.

A new generation of LGBT activists: Aswat

Aswat is an independent non-profit group that aims to contribute peacefully to the fight against discrimination based on gender and sexuality at the institutional and socio-cultural levels in Morocco. The initiative started in April 2012, with the launch of an electronic magazine called *Aswat* (meaning "voices" in classical Arabic) in reference to the voices of LGBT individuals expressed through its publications. In 2013, members of *Aswat* magazine were joined by civil society activists who shared the same concerns – struggling against social, cultural and institutional homophobia. The clandestine group conducted awareness-raising activities for sexual minorities among migrants and refugees in Morocco and awareness sessions for young activists. Aswat has two main goals: raising awareness in Moroccan society on the rights of sexual minorities and themes related to sexuality and gender, and documenting the human rights violations experienced by sexual minorities in Morocco. They are at the frontline of documentation and denunciation of the periodic arrests and prosecutions of homosexuals in Morocco.



Above L: Anti-criminalisation of homosexuality poster. Above R: In 2015 Aswat campaigned for the release of two Moroccan men, Lahcen and Mohsine, imprisioned for being gay. R: 2015 campaign to denounce the arrest and trial of two young women for kissing.

2016 candlelit vigil in solidarity with the victims of the Orlando shooting. Aswat held the vigil in front of Parliament buildings despite the illegality of homosexuality and the generalised homophobia.

Building the capacity of critical providers of services for and supporters of MSM

Strengthening CSO partners' capacity to work with key populations was both an approach and an objective of the programme. CSOs joined the programme with varying levels of skills and thematic experience in HIV and in programme management. When it came to working with MSM communities, all CSO partners were starting from scratch.

Becoming an MSM-friendly CSO: changes in organisational culture

At the very start, it was CSO partners themselves who first identified the need to transform their own attitudes and perceptions in order to create safe and genuine spaces for meaningful engagement of MSM community members. The level of homophobia varied among CSOs and among staff: sometimes open, sometimes hidden, and most often expressed as embarrassment. Hesitancy was initially addressed on a case-by-case basis, however what radically changed staff perceptions was simple: interpersonal communication with MSM at the time of the first Alliance workshops and throughout the initiative. By getting to know MSM and working closely with them, feelings of mutual trust and respect were born. The following quote offers a sincere testimony of this change:

> Before, I'm ashamed to say we were quite a homophobic organisation, despite being an HIV NGO. We knew nothing before about working with MSM, and we didn't know how to, we were scared. We had to acknowledge this, and we worked at addressing stigma internally, before we took it to our partners. Now, thank God for the MSM staff and volunteers! They have brought life back into the organisation, and today they are the backbone of our staff and active volunteer base."
>
> ***Pr Aziz Tadjeddine, President, APCS, Algeria***

> "There were multiple levels of benefits to SIDC. We were already a respected organisation in Lebanon before working with the Alliance, but this partnership took us to another level. We learned about planning cycles, using indicators to track progress and impact, we introduced financial protocols and procedures, and we formalised our volunteer management systems."
>
> ***Nadia Badran, former Coordinator of the project in Lebanon, currently Head of Programmes, SIDC, Lebanon***

Building the capacity of partner CSOs and facilitating South-South learning

The Alliance put into place a systematic cycle of trainings and continuous one-on-one mentoring to strengthen CSO partners' development in specific areas: programme management, financial management, governance and policy systems, monitoring and evaluation, donor regulations, volunteer management, and thematic HIV and health prevention approaches, including PCA, behaviour change communications and stigma reduction strategies.

Drawing on its founding approach for community engagement, fostering participation across CSO partners was an intrinsic part of the organisational development approach. Regional exchanges and peer CSO mentoring were facilitated to ensure mutual sharing, learning and support, and joint ownership of the programme. For example, ATL (Tunisia) coordinators worked with APCS (Algeria) teams to revise their field outreach and monitoring tools. SIDC (Lebanon) shared their peer educator training materials with ATL so that they could be adapted to the Tunisian context. AMSED (Morocco) shared its financial systems and policies with other CSO partners.

Peer support was also promoted at senior leadership level: CSO presidents and board members and senior staff from the Alliance discussed governance, strategic planning and advocacy during regional planning meetings. The regular exchanges and horizontal learning between partners working in similarly hostile environments were greatly appreciated.

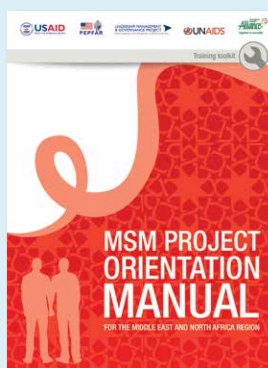
A MENA programme tool: the MSM MENA training toolkit, in collaboration with UNAIDS

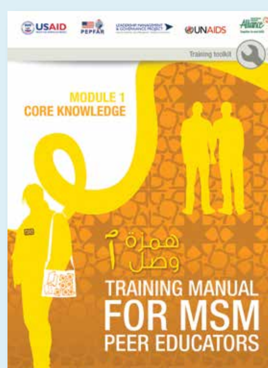
In 2015, UNAIDS, the Alliance and CSO partners jointly developed a training toolkit on MSM programming in MENA informed by global best practices and this programme's experiences. In four complementary manuals, it provides HIV programme planners and managers working MENA with the necessary information to develop appealing, evidence-based and comprehensive HIV prevention and support services for MSM. Its key messages are:

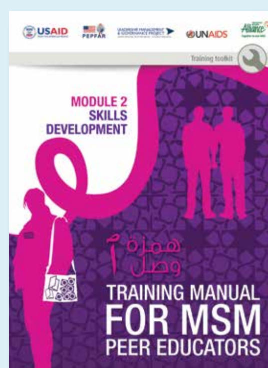
- Scaling up of community-based, quality prevention, care and support programmes is needed to respond to the health needs of MSM in MENA.
- Experiences from existing MSM programmes in MENA and international good practice help to build strong programmes that increase MSM access to appropriate prevention, care and support services, and contribute to a healthier environment.

"The Alliance has the technical 'know how' and we strongly value the partnership with them at the regional level. There are not many international NGOs who are interested in the region sadly, and the good practices and experience the Alliance brings are extremely valuable to developing appropriate programming in this region with high prevalence rates amongst certain key populations, and largely ineffective testing across the region."

Simone Salem, Partnership and Community Mobilization Advisor, UNAIDS Regional Support Team in MENA, Egypt







"This partnership took us to another level"

Significant changes in the organisational culture and capacity of CSO partners are a noteworthy achievement of this regional MSM programme. CSO partners reported having become more confident and capable in programme and financial management, governance, national and regional networking, and in HIV thematic areas. This led to increased funding for some from international sources such as the Global Fund.

"ATL is a professional, credible organisation with expertise in working with key populations that has become a resource for technical support and capacity-building of NGOs in the MENA region."

Bilel Mahjoubi, Director, ATL, Tunisia

> For ATL, it was a huge change. We used to be a volunteer-based and -led organisation, scrabbling for small pots of funds, doing HIV prevention work with general population. With the programme and with the Alliance, we grew to becoming one of the strongest and most respected civil society organisations in Tunisia, and certainly the lead voice for key populations, starting with MSM, but then we extended our work with people living with HIV people who inject drugs and sex workers. We are now a sub-recipient of the Global Fund, with strong systems, a strong leading voice of civil society in Tunisia, and a respected partner to our government."
>
> ***Bilel Mahjoubi, Director, ATL, Tunisia***

CSO partners become experts and trainers

CSO partners have emerged as strong, credible organisations that are now recognised by other CSOs and national programmes as experts in community-based action for HIV prevention, care and support tailored to key populations. As such, CSO partners such as SIDC in Lebanon, AMSED in Morocco and ATL in Tunisia have been called upon to provide technical support to other local CSOs in order to scale up meaningful engagement of key populations through participatory community-based approaches.

> "When the Ministry of Social Affairs wanted to review its strategy, they called upon us to help them facilitate the process in a participatory way using some of the tools we had developed."
>
> ***Nadia Badran, Head of Programmes, SIDC, Lebanon***

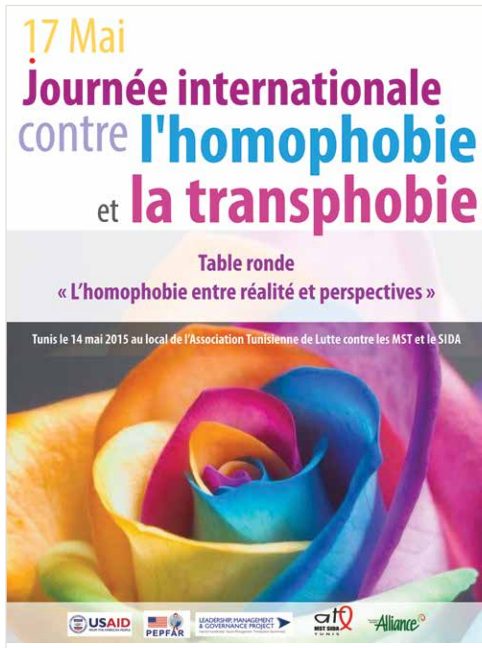
Promoting a more favourable environment for MSM and CSOs working with MSM

Advocacy efforts to generate a more positive environment for MSM took place at national and regional levels.

Advocacy had three main objectives. The first was to improve attitudes and acceptance of MSM by reducing stigma and discrimination among some of the most important people among whom MSM live and find support. CSO partners worked with families, healthcare and social workers, lawyers, police and religious leaders to raise awareness of the extreme marginalisation of MSM and their rights to health and dignity, and to mobilise them to take positive actions to improve their health and well-being.

The second was to generate dialogue and stimulate discussion on MSM sensitive issues at a national level to influence policies and programmes and promote the inclusion of MSM as a target priority in national AIDS strategies.

The third objective was to stimulate the adoption of human rights-based language by all stakeholders, including MSM, and at all levels of society. To achieve this objective, advocacy was intrinsic to all the activities CSO partners and the Alliance carried out, with the belief that a change in official language regarding MSM and other key populations would instil a change in attitudes and beliefs, and would ultimately effect favourable changes in services, programmes and policies for MSM. In Lebanon, for example, CSO partners worked with journalists and other media specialists to achieve this.



Examples of posters produced by ATL and SIDC for their stigma reduction campaigns.

> "The programme is a success story of civil society finding ways of building resilience and counter-acting the negative changes and waves of conservatism sweeping across the region in the past few years."
>
> *Enrique Restoy, Alliance*

Community level advocacy: Families, civil society & duty bearers

Initial stigma and discrimination reduction activities focused on transforming CSO partners into MSM-friendly organisations that would fully accept, support and engage MSM in all aspects of their work. These initiatives were then expanded beyond the walls of CSO partners, amongst community representatives including: service providers, lawyers, religious leaders and police. In 2008, the Alliance conducted a training-of-trainers in stigma and discrimination reduction for CSO partners and MSM peer educators from the four focus countries.

A MENA programme tool: Understanding and challenging HIV stigma in the MENA region. Toolkit for action

This toolkit is a training resource containing participatory exercises used to understand and challenge stigma. MSM are the main target group, but it is also intended for other key populations. This version was designed to use in the MENA region, and includes adapted exercises and stories relevant to this context. The original toolkit, *Understanding and challenging HIV stigma: Toolkit for action (Module H: MSM and stigma)*, was developed by and for African trainers. It has been used extensively around the continent to support HIV stigma reduction programmes.

It is available in French, English and Arabic: www.aidsalliance.org/resources/305-toolkit-understanding-and-challenging-hiv-stigma-in-the-mena-region

A MENA programme tool: "I LOVE THEM… BUT" … A guide for parents on how to deal with their gay/lesbian children

In Lebanon, SIDC, Helem and OPV teamed up with social workers to develop an educational booklet for families of LGBT people to help guide them in accepting and providing support to their sons and daughters. The booklet addresses common fears and misconceptions regarding homosexuality, responds to frequently asked questions, recognises frequent homophobic reactions and presents the different 'stages of acceptance'. It was used by CSO partner staff and social workers during counselling sessions with parents, which are occasionally conducted upon request of MSM beneficiaries.

Cover of the Arabic version of the booklet "I LOVE THEM… BUT…".

Health service providers. Raising awareness of stigma and discrimination in institutional settings aimed to improve the quality of services provided to MSM. CSO partners in all four countries worked with healthcare providers, auxiliary health staff and social workers involved in HIV prevention, care and support services to increase the quality of their support to and better serve MSM and other key populations. In the course of the programme, the programme reached hundreds of health professionals.

Police and security personnel. Establishing a safer environment for MSM also meant ensuring the personal safety and protection of the peer educators who reach out to them. Operating in a context which criminalises homosexual practices was challenging and there were cases of arrests of peer educators in all countries, in particular after the Jasmine Revolution in Tunisia. Examples of such initiatives included:

- Regularly inviting police and security services to attend progress meetings along with government officials and service providers.
- Training local police forces on HIV prevention, health and human rights and key populations needs.
- Welcoming police and security personnel to public events such as World AIDS Day and national campaigns for zero discrimination.

"The stigma and discrimination reduction component was one of the most significant things we did in the programme. We, MSM peer educators, were leading trainings for healthcare workers and other staff of health centres. We really noticed a change in how MSM were received, and the type of support they got from government clinics we worked with."

Badr Baabou, President, Damj, Tunisia

"We cannot target police to change the laws, they just enforce them. And of course it's their job. But what we did manage to do is help them understand our work, under the umbrella of an HIV and health promotion programme, and the negative impact of enforcing some laws has on us and the communities we serve. This did create a more trusting relationship with them."

Rabih Maher, Helem and OPV, Lebanon

Above: A sensitisation workshop with police officers on HIV and stigma held in Oran, Algeria (2014). Left: A training of police officers' trainers on HIV and AIDS, STIs and related stigma and discrimination, held in Beirut, Lebanon (2015).

In Lebanon, with the support of police representatives, CSO partners introduced an official identity card showing NAP and SIDC logos that MSM peer educators carried during outreach activities. This protected MSM peer educators against arrests and random searches when they worked in known MSM meeting places and carried condoms and lubricant sachets as part of their prevention work.

The positive impact of continuously sensitising police forces was palpable: the number of police interrogations or arrests of MSM peer educators decreased: once frequent, they almost disappeared.

> "The safety of the MSM volunteers was a major concern, and these identity cards gave our volunteers a certain degree of security."
> ***Nadia Badran, Head of Programmes, SIDC, Lebanon***

Religious leaders. During the PCAs conducted in the first years of the programme, many MSM confessed to finding it difficult to accept their sexual preferences while being true to their faith. Generating support from knowledgeable, tolerant and respectful religious leaders who were open to listening and guiding MSM was viewed as extremely important.

In Algeria, APCS led a significant initiative with religious leaders to promote dialogue around HIV prevention and key populations while promoting values such as tolerance, acceptance and humanity through religious texts that religious leaders could relate with. In 2012, over 20 religious leaders participated in meetings with APCS. These meetings continued on an *ad hoc* basis to keep the dialogue open: Imams were invited to the 'Annual Assises' of APCS where they met MSM volunteers. The positive impact was evident: in Oran mosques, sermons against homosexuality ended and a few imams referred MSM who were in need of support to APCS.

> "We put a lot of effort into our engagement with the religious leaders, male and female, because we know they can be an important source of stigmatising language towards vulnerable groups such as MSM, but also strong allies. We used the umbrella of the right to health and dignity to touch upon taboo subjects. Even talking about HIV with them is difficult, but with a public health approach, it was more acceptable to them. The involvement of Imams, while homosexuality is forbidden by Islam, was significant." ***Pr Aziz Tadjeddine, President, APCS, Algeria***

In Lebanon, SIDC engaged religious leaders to serve as champions for tolerance and dialogue within religious communities. Special IEC materials with appropriate messaging and language were created to support religious leaders to engage their peers.

Religious leaders from all dominant faiths met to discuss HIV and HIV-related stigma and discrimination. The meeting was held in Beirut, Lebanon, 2014.

It has opened dialogue among people who were not thinking of these things before, or couldn't speak of them. Our society is full of vulnerable people who we find it easier to work with (e.g. out of school young people, women being married under age, people who use substances), so it really helps to be able to have an honest discussion with professionals about more sensitive topics like HIV, and together find ways of taking them to my peers. SIDC was the only organisation who took us religious leaders seriously, who wanted to talk to us. They invite us to their activities, and respect that we have an important role to play in people's lives."

An Islamic religious leader, Lebanon

National-level advocacy: National AIDS Programmes (NAPs) and the general public

National level advocacy efforts took place with two main target audiences: national decision-makers and policy-makers, and the public, working through journalists and other media channels.

Advocacy with national decision-makers and policy-makers. Activities aimed to raise awareness of the urgent need for evidence-based HIV prevention programming specially tailored to MSM and other key populations among representatives from the NAP and various ministries (health, social affairs and justice) whose strategies and policies affect the lives of MSM. They also advocated for the engagement of key populations in programme planning, design and assessment through the use of participatory approaches. Finally, advocacy efforts focused on the need to increase the availability of affordable, quality prevention commodities, such as condoms and lubricant in each country.

In Lebanon for instance, stakeholders working in the HIV sector now talk about MSM and their vulnerabilities to HIV in national level meetings and they are now a clear priority target group in the Lebanese AIDS Strategy. This was not possible a few years ago, and this programme greatly contributed to this acceptability. It helped stakeholders to better understand the needs of MSM and the challenges in increasing their access to services. Health authorities have enough evidence now, largely thanks to this programme, to show that MSM are one of the most vulnerable groups to HIV transmission in Lebanon.

CSO partners were successful in informing, adapting and improving the national AIDS strategies in their respective countries. In Tunisia for instance, ATL is a leading CSO on the National HIV/AIDS Agenda. Since 2009, two MSM representatives sit on the National Strategy Development Committee. With Tunisia's acceptance as a Global Fund recipient, ATL simultaneously became a lead CSO partner with a seat on the Global Fund's Country Coordination Mechanism (CCM). Its advocacy for prioritisation of key populations resulted in increased funding for scaling up prevention activities in key populations, increased procurement of condoms and lubricant sachets, and positioning MSM as a priority group in the national HIV response. Two MSM peer educators from the programme have been elected as key population representatives on the CCM.

"The Global Fund changed the organisation, but we also changed how it worked in Tunisia. We were active in the development of the proposal from day one, and ensured the participation of the communities affected, from the beginning with the methodologies we had learnt from the MSM programme. With the Global Fund, we saw a significant increase of resources, which gave us more opportunities to scale up the programmes we had started. We expanded to work with other vulnerable groups, using the same methodologies, and were able to advocate for a continuum of care for people living with HIV and those affected by HIV." ***Bilel Mahjoubi, Director of ATL, Tunisia***

Advocacy with journalists and other media representatives. CSO partners conducted stigma and discrimination trainings with TV and radio presenters, journalists and programme producers. Lebanon-based SIDC was particularly active in this area: SIDC organised annual meetings with 30 to 40 journalists and maintained regular contact with approximately 50 journalists. The aim of these sessions was to impact the root cause of stigma in MENA societies and to transform the stigmatising language commonly used in the media into positive language and messaging that respects the dignity of MSM and promotes their self-esteem.

CSO partners' main entry point for their anti-stigma media campaigns was HIV and the impact of HIV-related stigma on key populations' health and access to services, including MSM. In Tunisia, ATL worked with TV celebrities and journalists for World AIDS Day, International Day Against Homophobia and Human Rights Day to promote equality, tolerance, anti-discrimination and human rights of key populations. In Algeria, APCS teamed up with popular singers, actors and TV personalities in a national anti-stigma public campaign entitled 'If I was HIV positive'. Messaging focused on tolerance, raising awareness around HIV vulnerability and promoting VCT, as well as the importance of addressing HIV-related stigma in Algerian society.

The results from such efforts were most noticeable in Lebanon, where HIV and LGBT activists reported a significant positive change in the language used (less offensive) and framing (less scandalous) by media when covering stories related to HIV and/or homosexuality. In other countries, working with media remains sensitive and challenging. Most Arabic speaking media representatives in Algeria, Tunisia or Morocco are openly homophobic.

"At the beginning even journalists were scared to talk about rights of LGBT, they really only talked about HIV when we worked with them. We see a big different now, of course spaces have opened up for other organisations, both HIV and human rights, to raise their voices, but a degree of awareness was created with journalists and the media around MSM and HIV through programme advocacy towards them that is undeniable. The language became less stigmatising, less accusatory towards MSM. It softened the terrain for others to continue working with them."

Georges Azzi, Director, AFE, Lebanon

"Changing behaviours of the general public, or even journalists takes time, and in a context like Algeria, it's a huge challenge. We managed to lead a successful public awareness raising campaign, with local celebrities and media, around stigma, and how discrimination affects the individual, and we brought in stigma around HIV and inferred key populations in the messaging. We are not able to talk about same sex relations on national TV just yet." *Pr Aziz Tadjeddine, President, APCS, Algeria*

In the last two years of the programme, 3,020 individuals (health providers, religious leaders, police officers, journalists etc.) were reached through stigma reduction activities, and 608 decisions-makers were reached through advocacy efforts.

Regional-level advocacy

The Alliance, CSO partners and MSM representatives participated in regional events alongside UN agencies, government, ministries of health, NAPs and regional networks such as RANAA to promote access-related issues of MSM and other key populations.

A significant milestone took place in 2011 when the Alliance and partners were invited to Saudi Arabia to co-facilitate with UNAIDS a regional dialogue with the League of Arab States to develop the Arab AIDS Strategy.

In 2015, two CSO partners in Lebanon, SIDC and Vivre Positif initiated a new human rights project specifically focusing on human rights in Lebanon, funded by the US Government Middle East Partnership Initiative "Speak up: Human Rights and HIV Monitoring System for HIV Law Reform in Lebanon".

"We saw what the Alliance managed to do with its partners around MSM prevention and using acceptable rights-based language, and we wanted to bring these good practices into other countries, like Egypt and Jordan to help scale up some of our efforts with civil society groups."

Simone Salem, Partnership and Community Mobilization Advisor, UNAIDS Regional Support Team in MENA, Egypt

Supporting the Regional Arab Network Against AIDS (RANAA)

The programme's reach went beyond the four implementing countries thanks to its partnership with RANAA, the regional network of CSOs engaged in HIV prevention, care and support. RANAA engaged in regional meeting and training focused on working with MSM for HIV prevention and increased regional exchanges on this topic with its partner CSOs.

"The added value of RANAA is that it is a platform for sharing experiences and good practices across the region, but it is also at national level, its members, who are all civil society organisations capable of working on MSM issues. RANAA can help coordinate and engage its members further." *Simone Salem, Partnership and Community Mobilization Advisor, UNAIDS Regional Support Team in MENA, Egypt*

Lessons learned, challenges and the way forward

Lessons learned

The joint USAID and Alliance regional programme leaves behind an important legacy as the first and only continuous MSM programme in the MENA region. It also lives on thanks to its beneficiaries, their communities, and the MSM-friendly materials, toolkits and local expertise it created. Many CSO partners are now respected actors in the national HIV response and in the region. Numerous MSM peer educators have become activists, carving the way forward towards a more positive future for MSM and LGBTs in their respective countries.

Since the implementation of the programme, CSOs and the Alliance gained valuable expertise in key population programming. There are many lessons learned from the ten years of programming. Here are just a few:

- **The community engagement approach works and is needed**. The Alliance's approach of working with national CSO partners and engaging the communities they serve through participatory processes produced results, despite the hostile environments. Access to MSM-friendly services increased, MSM and LGBT communities were engaged in the assessment, design and implementation of programmes for them, community systems were strengthened, the adoption of rights-based principles was initiated and changes were observed in national environments both among the public and national decision-makers and policy-makers. (See box on page 39, EMPAD Policy Framework.)
- **ICTs help to reach hidden communities.** Given increasing numbers of police raids and rising homophobia, the ICT virtual prevention project offers a promising alternative to traditional outreach activities. Applications, such as Grindr, are frequently accessed by MSM in the MENA region and provide virtual venues for disseminating information on HIV prevention, treatment and support services. A current information gap can be filled by providing information in Arabic on these platforms.
- **Creative methods are needed to coordinate advocacy and anti-stigma campaigns tailored to diverse audiences.** Through practical work with religious leaders, police officers, media and health care providers, CSO partners learned to carefully tailor their approach and methodology to each target audience.
- **Working with and for MSM can be expanded to other populations vulnerable to HIV** who remain in the shadows in MENA. They include transgender people, people living with HIV, sex workers, undocumented migrants and refugees. Partner CSOs have already started working with other key populations.

"The Alliance approach is key, community focus is key, and this is what the Alliance offers and does best. It is not the right time to move out. We are finally getting somewhere".

Simone Salem, UNAIDS MENA Regional Office, Egypt

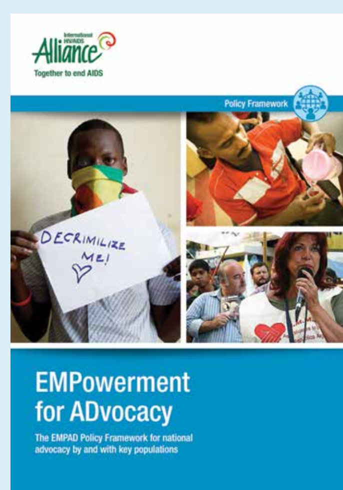
"You should be looking at integrating other key populations into the program. Scale up best practices of working with men who have sex with men and expand to other populations in the region. We need it and civil society is key."

Simone Salem, UNAIDS MENA Regional Office, Egypt

An Alliance tool. EMPowerment for ADvocacy. The EMPAD Policy Framework for national advocacy by and with key populations

In some settings, established decision-makers strive to ensure that key population representatives have a voice in HIV policy processes, but in many settings, key populations must lobby persistently to be included. In response to this situation, the Alliance developed the EMPAD (Empowerment for Advocacy) Policy Framework. This tool is intended to support national-level advocacy as an element of HIV programmes designed with and for key populations. The framework fosters change by positioning key populations to influence national HIV policies and programmes in ways that prioritise community needs. The framework identifies five high-level strategies that are intended to collectively achieve this broad advocacy goal.

Available at: www.aidsalliance.org/resources/307-advocacy-toolkit-for-key-populations



The EMPAD Policy Framework and (below) the five high-level strategies for change.

Challenges

There were numerous challenges faced throughout the implementation of the programme. These were related to:

- **Quality of sexual healthcare for MSM.** Across all implementing countries, healthcare professionals, from both public and private sectors, lacked basic training and appropriate understanding to properly respond to the health needs of MSM, including among the ‘friendly’ health providers.
- **Referral data.** Obtaining data of MSM referred to specific public health services was challenging due to the lack of cooperation from health facilities. This rendered reported referral data vulnerable to duplication and manipulation.
- **Security.** Political instability and terrorist acts in Tunisia in 2015 had negative repercussions on the MSM programme. Political insecurity led the Society for AIDS in Africa to move the 2015 ICASA conference from Tunisia to Zimbabwe, a disappointment for the Alliance and MENA partners as the conference was to be a first-time opportunity to focus attention on the needs of the MENA region. Furthermore, increased instability and attacks in Tunisia have caused police to restrict the movement of people, through use of curfews and breaking of group gatherings or any public demonstrations.

- **Rising homophobia.** Homosexuality is punishable by law in the MENA region, and MSM "caught in the act" are imprisoned. Discriminatory laws, regulations or policies coupled with high levels of stigma and discrimination continue to count among the most important obstacles to effective HIV prevention, treatment, care and support for key populations in MENA.
- **Cultural beliefs and taboos.** Social-stigma and self-stigmatisation are other important obstacles to more effective prevention for key populations. Social and religious norms prevent discussions around sexual health and rights and HIV, including homosexuality among individuals, families and within communities. Owing to gender inequalities and the low status of women in the region, women living with HIV experience a double stigma. Addressing these issues requires continued attention and time.
- **HIV funding in the MENA region.** Financial resources for HIV programming are limited. Classified as middle income countries, most countries are not eligible for financial assistance from the larger funders (i.e. Global Fund and PEPFAR). On the other hand, governments view the HIV response and public health systems as lower priorities in national spending plans. What is more, the region is affected by spreading poverty, social instability, unemployment and a refugee crisis, which increase obstacles for local populations and people living with HIV to access clinics for care and treatment.
- **Stability and sustainability.** In the absence of political leadership and financial support for MSM and other key populations, it is challenging to implement stable and sustainable HIV programmes. Short-term (annual) financing and subsequent lack of financial visibility for the programme remained a challenge throughout the programme. As a result, some activities were not completed.

The way forward

The few HIV focused interventions targeting MSM in MENA have made significant achievements, however the needs of MSM in MENA remain widely unmet. In every MENA country, gay, bisexual men, other men who have sex with men and transgender people (and, in particular, transgender women) shoulder disproportionate HIV incidence and prevalence, lack equitable access to HIV services, are criminalised, and face unrelenting stigma, discrimination and violence. MENA countries will not be able to stop the progression of the HIV epidemic unless they effectively address HIV in the MSM population. However, the needs and rights of MSM remain largely ignored. Men who have sex with men living in MENA need, more than ever, more safe spaces, more empowerment, more MSM-friendly services, increased access to treatment and a more enabling environment. It is of utmost importance to sustain and expand HIV programming for gay and bisexual men, other MSM and biologically male trans-diverse persons across the MENA region.

The following areas of action are recommended for the immediate future:

- **Scaling up and further rolling out of community-based HIV prevention and testing for gay, other MSM and transgender communities in MENA**. This includes expanding standard MSM programming in countries where they are still invisible, not reached or served, and modelling quality and innovative combination prevention services for them in countries with MSM programming experience (mainly Morocco, Tunisia, Algeria and Lebanon). It also includes maintaining and expanding community testing and counselling and improving the quality of the clinical healthcare (public or private) for MSM and transgender people. The package of services available for MSM should systematically include legal services as well as quality tailored clinical services.
- **Piloting pre-exposure prophylaxis (PrEP).** PrEP is an emerging and increasingly important tool for controlling the HIV epidemic and a recommended element of combination HIV prevention strategies, particularly among MSM. In the MENA region, access to PrEP is currently extremely limited. Civil society can play an important role in understanding the benefits of PrEP for those most at risk of HIV in MENA, in particular MSM. Opportunities to explore advocating for PrEP, examining lessons learnt from other regions, and initiating pilot studies, should be created.
- **Using ICT to increase access to MSM-friendly HIV prevention, testing and care services.** The small pilot online peer outreach project (see box, page 15) has demonstrated the high potential of ICT for reaching MSM in MENA and increasing their access to HIV prevention, testing and care services. Various types of interventions could be piloted in MENA, for instance social media-based campaigns to promote access to accurate and appropriate information about men's sexual health, HIV prevention, and HIV testing. Technology could support remote clinical consultations and referral via video conferencing, web-based sexual health consultation and advice, mapping human rights abuses or provision of psychosocial support. Internet-based programmes and cell phone-based programmes (SMS and Whatsapp platforms) could play a role in motivating and sustaining behaviour change, supporting and referring MSM to healthcare and psychosocial services, networking, and data collection. As a result of these interventions, more uptake of services, more HIV awareness, more support and guidance and more empowerment and resilience among MSM communities could be achieved.
- **Uncovering transgender health.** Transgender people are a hidden population in MENA, except in Lebanon. Pioneer community-based programmes are needed to increase understanding of the needs of the transgender people, respond to these needs, and start mobilising and empowering this community.

First tailored interventions for transgender people in Lebanon

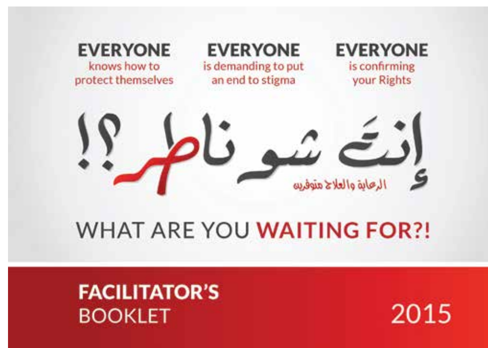
Gravely ostracised and stigmatised, transgender people remain a hidden community in the MENA region. In Lebanon, SIDC, OPV and Helem worked directly with the transgender community by facilitating specific learning sessions with groups of transgender people on transgender sexual health, drug use and human rights. Between 2013 and 2015 ten to twenty transgender people were reached on average every quarter in Beirut and provided (or referred to) HIV care and support services. SIDC in addition produced the first brochure on sexual health for the transgender community in Arabic.

Booklet on transgender sexual health from GenderDynamix translated and produced in Arabic by SIDC, 2015.

- **Countering social norms that feed enduring stigma and discrimination.** Changing mentalities and in particular the negative perception of homosexuality is an extremely challenging goal. Next steps for advocacy must include working for the best possible outcomes and countering any adverse effects, including promoting the inclusion of members of gay, other MSM and transgender communities in the design and implementation of programmes, community-based programming, and working to end stigma and discrimination and violence against these communities. Several approaches should be attempted and combined, including working with the media to produce media coverage of HIV and sexual minorities that is accurate and non-stigmatising. Working with the

media could involve sensitising and involving journalists from newspapers, TV, radio and social media. There is evidence from existing initiatives that this kind of partnering can be very beneficial in reducing stigma and discrimination. Alliances and partnerships with religious leaders, health institutions, and human rights organisations need to be developed or expanded. Calls to address punitive legal and policy frameworks, including laws and policies that criminalise same-sex behaviour, may become the focus of advocacy efforts where feasible.

Examples of materials produced by ATL and SIDC for their stigma reduction campaigns.



From top to bottom: Educational group session on HIV organised by OPALS-Fes in a discrete backyard, Fes, Morocco. © OPALS-Fes

Estimating outreach population size in Sousse, Tunisia. © ATL

Planning meeting of ASCS team of peer educators, Agadir, Morocco. © ASCS

ATL's HIV prevention booth Tunis, Tunisia. © ATL

www.aidsalliance.org

About the International HIV/AIDS Alliance

We are an innovative alliance of nationally based, independent, civil society organisations united by our vision of a world without AIDS.

We are committed to joint action, working with communities through local, national and global action on HIV, health and human rights.

Our actions are guided by our values: the lives of all human beings are of equal value, and everyone has the right to access the HIV information and services they need for a healthy life.

International HIV/AIDS Alliance
91-101 Davigdor Road
Hove, East Sussex
BN3 1RE
United Kingdom
Tel: +44 1273 718 900
Fax: +44 1273 718 901
Email: mail@aidsalliance.org

Registered charity number
1038860