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Demonstrating Results of the 'Responding to MARPs in the MENA Region' Project using the Most Significant Change Methodology

Regional Report

April – June 2012

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List of acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
AMSED	Association Marocaine pour la Santé et le Développement
APCS	Association de Protection Contre le Sida
ATL MST/SIDA	Association Tunisienne de Lutte contre les MST et le Sida
CSOs	Civil society organizations
HIV	Human Immunodeficiency Virus
IDU	Injecting drug user
IEC	Information, education and communication
IHAA	International HIV/AIDS Alliance
LGBT	Lesbians, gays, bisexuals and transgenders
MARPS	Most-at-risk populations
MENA	Middle East and North Africa
MSM	Men who have sex with men
MSC	Most Significant Change approach/methodology
NAP	National AIDS Program
NGO	Non-governmental organization
OPALS	Organisation Panafricaine de Lutte contre le Sida
OPV	Oui pour la Vie
PE	Peer educator
PCA	Participatory community assessment
PLHIV	People living with HIV
SIDC	Association Soins Infirmiers et Développement Communautaire
STI	Sexually transmitted infections
STD	Sexually transmitted diseases
SW	Sex workers
UN	United Nations
UNAIDS	United Nations Program on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing

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Executive summary

Documenting of the results of the MENA program using the MSC approach

Since 2004, with support from USAID, the Alliance has been working in partnership with civil society organizations in Algeria, Lebanon, Morocco and Tunisia to implement a regional program that aims to meet the sexual health and HIV/STI prevention needs of men who have sex with men (MSM). Currently, the three intermediate results of the program entitled `Responding to Most-At-Risk Populations in the MENA region' (referred to hereafter as the 'MENA program') are:

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 favorable environment for the response to the sexual health and HIV prevention needs of MSM

This report aims to document the main changes brought about by this prevention program for MSM. It forms part of a cycle of technical support provided to partner organizations between April and June 2012 around the theme of demonstrating the results of community-based projects.

As part of this work, the 'Most Significant Change' (MSC) approach was used to understand the changes generated by the program in the four countries. Five 'areas of change' were identified: (1) changes induced by the program among the target population; (2) changes in access to prevention and care services; (3) changes among peer educators involved in program; (4) changes among partner organizations; and (5) changes within the environment.

Fieldwork took place in May 2012. A total of 84 interviews were conducted with 41 beneficiaries, 23 peer educators involved in supporting MSM, 15 representatives from partner organizations and representatives from five agencies involved in the national HIV response. This report presents and analyzes data from the 19 stories selected as being the most significant during discussion groups organized in each country.

The results of the MENA program in Algeria, Lebanon, Morocco and Tunisia

Association de Protection Contre le Sida (APCS) in Algeria, Association Tunisienne de Lutte contre les MST et le Sida (ATL) Tunisia, Association Soins Infirmiers et Développement Communautaire (SIDC), Helem and Oui pour la Vie (OPV) in Lebanon and Association Marocaine pour la Santé et le Développement (AMSED) and Organisation Panafricaine de Lutte contre le Sida (OPALS) in Morocco are among the very few organizations in the region that respond to the health needs of MSM. They have gradually developed expertise in assisting this population group and facilitating their access to health and social services that are tailored to their needs.

The various beneficiary testimonies gathered during the process highlighted the **personal development** (life skills, self-esteem and self-confidence) of MSM thanks to the establishment of friendly meeting points within most of the partner organizations' offices. Many of the MSM surveyed said they had improved their confidence and self-acceptance and had engaged in the fight against homophobia thanks to the support and coaching received from the organizations. For many MSM, community spaces made available to them

in Rabat, Fez, Oran, Beirut and Tunis are social spaces that give them the opportunity to exchange information and experiences without fear, without feeling judged, and where they can acquire new knowledge and access many services. Many of the beneficiaries surveyed – including MSM living with HIV – said they had found a place where they could speak and be accepted.

The program has also greatly improved **MSM access to relevant prevention, care and support services**: access to condoms and free and anonymous counseling and testing, access to a doctor, referral to specialized services including diagnosis and treatment of sexually transmitted infections (STIs), psychosocial support, and peer education to promote, among other things, safer sexual practices.

The program also contributed to the development of **prevention-seeking behaviors** among the MSM population. Many beneficiaries highlighted the organizations' role in improving their knowledge, information and correcting misconceptions regarding HIV and AIDS. The interviews highlighted the adoption of prevention-seeking behaviors through regular condom use and testing among certain beneficiaries. The availability of condoms and lubricants and the establishment of peer education approaches have proven to be adequate strategies for the involvement and empowerment of MSM.

Community mobilization and MSM involvement are other key elements of the program. Partner organizations have forged links with, trained and integrated MSM into their staff, allowing them to transition from being beneficiaries to fully-fledged actors involved in prevention interventions that concern them. This inclusion helps this population group challenge stigma, as much as the psychosocial support, outreach and advocacy services do. Many of the MSM mobilized through this program have become actors in their country's HIV response (such as MSM Country Coordinating Mechanism representatives, prevention project managers, or others).

Advocacy efforts to create an enabling environment are another important achievement. Partner organizations have conducted numerous activities to create favorable conditions for a better understanding and recognition of the specific needs of the MSM population, which is mostly invisible. Regular advocacy efforts have contributed to making the voice of MSM heard by stakeholders working in the field of health promotion so that they recognize the need to integrate the issue of sex between men in the HIV response and make MSM a public health priority in National HIV and AIDS Programs, both in terms of access to information and care. The authorities have become more aware of the specific vulnerabilities and needs of MSM through this program. Sensitizing religious leaders (in Algeria and Lebanon) also helped to break the silence surrounding the issue of sex between men in the religious sphere.

Finally, the work of these organizations has helped to **educate the general population**. Awareness-raising and networking with health and social services helps break the MSM taboo. By making this population group visible, the program has played an undeniable role in advancing MSM rights and improving their quality of life in the locations concerned.

Introduction

HIV in the MENA Region

The Middle East and North Africa (MENA) Region has a general low HIV prevalence rate (presently 0.2 % in 15-49 year-old adults). Notwithstanding this low rate in the general population, various HIV risk factors are present in the region, including a young and highly mobile population, poverty, inequalities, including gender inequality, drug use, the lessening of social control on individuals and discrimination against key populations. Significant HIV prevalence rates are already reported among injecting drug users, men who have sex with men (MSM) and sex workers in various countries.[1]

In this region, the behaviors facilitating HIV epidemics are mainly sexual. Consequently, the HIV response involves the need to address private behaviors and, in some cases, behaviors regarded as illegal and criminalized, such as sex between men and sex work. However, concerning MSM, socio-cultural taboos as well as the risk of discrimination against them drive many men to hide their practices, even from health workers. This makes testing, care and treatment of HIV and other sexually transmitted infections particularly challenging. In this context, programs in the region targeting MSM are scarce.

Responding to the needs of MSM in the MENA region: the MENA Program

The MENA program, implemented in partnership with associations in Algeria, Lebanon, Morocco and Tunisia, aims to meet the needs of MSM. Since 2008, the program has been implementing STI/HIV prevention activities that take into account the special vulnerabilities of MSM, encouraging the sharing of experiences across the region, and influencing the institutional and organizational environment for a strong response to HIV at the local, national and regional levels.

The program has established outreach programs in more than 10 locations in these countries, where partner organizations implement a global package of prevention services for MSM in accordance with international best practices. Interventions include peer education, providing prevention products such as condoms, voluntary counseling and testing, referral to STI diagnosis and treatment services, and legal and social support, among others.

The 'demonstrating results project' within the MENA Program

Between April and June 2012, the *Responding to MARPs in the MENA Region* program provided technical support to the partner organizations around the theme of 'demonstrating the results of community-based projects,' aiming to train them in collecting, analyzing and using qualitative data, and to support their efforts in documenting and evaluating internal changes at community level.

Mid-term and end of project evaluations typically use traditional quantitative data (outputs/products: immediate effect); however, it is rare to document the more medium-term effects of projects. The key guiding question could be the following: would the

[1] We refer to information as outlined by the World Bank, ref http://web.worldbank.org/WBSITE/EXTERNAL/ACCUEILEXTN/NEWSFRENCH/0,,contentMDK:21563904~menuPK:1082583~pagePK:64257043~piPK:437376~theSitePK:1074931,00.html

situation today be the same if the project had not existed (bearing in mind that other programs and organizations may have played a role in the observed changes)?

To complete their routine information system, the partners of the MENA Program agreed to document the changes brought about by the program at different levels, such as:

- **Individual level**: what has changed in the life of the beneficiaries of the MENA program, both MSM and peer educators?
- **Level of access to services**: what has changed in terms of their access to services? Have users experienced any changes in this area?
- **Institutional and organizational level**: what has changed within the organization? How has it benefited from the program?
- **Environmental level**: what change has the program generated or contributed to generate within the HIV response?

This report is the result of this participatory and qualitative documentation project. It aims to identify the most significant changes brought about by the MENA program.

I. Context

1.1. HIV prevalence among MSM in the MENA region

The MENA region: one of the two regions in the world with the fastest growing epidemic
Only two percent of the total estimated number of people living with HIV (PLHIV) reside in the MENA region, and available epidemiological data across the region points to continued low levels of HIV infection in the general population. However, the epidemiological situation, particularly among MARPs or key populations, has started to raise serious concerns, notably with the release in 2010 of a World Bank report.[2]

More recently, the regional report on AIDS released by UNAIDS in 2011[3] has underlined that although the overall HIV prevalence is still low, recent estimates show that MENA is one of two regions with the fastest growing epidemics. The rise in the estimated number of PLHIV presumably is the result of an increased HIV prevalence among key populations at higher risk and a forward transmission of the virus to a larger number of individuals who are generally at lower risk of infection. Annual estimated new infections have almost doubled in the past decade. Similarly, AIDS-related mortality has also almost doubled in the past decade.
The HIV epidemic reflects the diversity of the region, with different populations more heavily affected in different places and a variety of attitudes, policies, political commitments and availability of and access to HIV services. In some countries, the epidemic is primarily concentrated among people who inject drugs; in other countries, it affects men who have sex with men or sex workers; a large proportion of women living with HIV are believed to have acquired the infection from their spouses who practice high-risk behaviors; and male migrant workers are among the vulnerable populations.

In countries that have better data, the heterogeneity and diversity of the epidemic is visible. In Morocco, for example, there is evidence of a concentrated epidemic among people who inject drugs in Nador, the northern part of the country (where 17.9% of them are living with HIV) and among MSM in the south (*see below*).

Low coverage of prevention programs for key populations
According to the UNAIDS 2011 report, the current response is characterized by a low coverage of prevention programs for key populations, which contributes to the limited HIV knowledge and high levels of risk behavior within these populations. However, there is a growing awareness of the importance of working with these populations in the region, and efforts are increasingly being made to understand the issues and address the shortcomings. The availability, access and quality of health-specific interventions are mixed, although MENA countries have made some progress over the last few years. Nonetheless, HIV testing and counseling remains a serious challenge. The UNAIDS report notes that between 1995 and 2008, only 4% of tests were undertaken for key populations at higher risk. Also, most of the HIV testing in the region is mandatory, and if quality voluntary counseling and testing is available, it is not always readily accessible to MARPs. This is primarily due to stigma and discrimination, the limited engagement and capacities of civil society organizations (CSOs)

[2] Characterizing the HIV/AIDS Epidemic in the MENA. Time for Strategic Action, World Bank, 2010.
[3] Regional Report on AIDS in the Middle East and North Africa, UNAIDS, 2011.

working with those populations, and existing structures not sufficiently tailored to their needs.

Insufficient political leadership and stigma and discrimination exist in all countries in the region. Stigma and discrimination in particular is one of the primary reasons why people living with HIV and key populations do not have access to essential HIV services.

New evidence of a concentrated epidemic among the MSM population

Because of the prevailing stigma, MSM are a largely hidden population and bear a disproportionately higher burden of HIV infection than the general population in the region. Until recently data has been virtually nonexistent, however the evidence on the epidemiology of HIV among MSM in MENA is growing. Weill Cornell Medical College led a study entitled *Are HIV Epidemics among MSM Emerging in the MENA*?[4], published in 2011. The authors found that the HIV epidemic among MSM is evident in more than half the countries of the region, with evidence of concentrated epidemics in several countries, in particular in Tunisia and Morocco (see below). By 2008, the contribution of MSM transmission to the total HIV notified cases exceeded 25% in several countries. The high levels of risk behavior, the overall low rate of consistent condom use (generally below 25%), the relative frequency of male sex work (ranging from 20%–76%) and the substantial overlap with heterosexual risk behavior are concerning and suggest the potential for further spread. The authors indicated that there is an urgent need to expand HIV surveillance and access to HIV testing, prevention and treatment services to prevent further HIV transmission among MSM in the region. Another World Bank report entitled *The Global HIV Epidemics among MSM*[5] underlines that MSM living in MENA are at high risk because of high-risk sexual practices, and low levels of condom use and HIV knowledge.

HIV prevalence among MSM in Algeria, Lebanon, Morocco and Tunisia

The following table summarizes the available data on the estimated number of PLHIV and the HIV prevalence among key population in the four countries where the MENA project operates, as reported in the latest UNAIDS regional report:

Table 1. Data on key populations in the MENA project countries

	Algeria	Lebanon	Morocco	Tunisia
Estimated number of PLHIV (low-high estimate, end 2009 data)	13,000-24,000	2,700-4,800	19,000-34,000	1,800-3,300
HIV prevalence among key populations	IDUs: n/a FSW: 4% **MSM: n/a**	IDUs: n/a FSW: n/a **MSM: 2%**	IDUs:17.9% (Nador) FSW: 3% **MSM: 5.6% (Agadir), 2.8% (Marrakech)***	IDUs: 3% FSW: 0.4% **MSM: 13***

[4] Are HIV Epidemics among Men Who Have Sex with Men Emerging in the Middle East and North Africa? A Systematic Review and Data Synthesis, Mumtaz G, et AL, PloS Med, 2011

[5] The Global HIV Epidemics among Men Who Have Sex with Men, World Bank, 2011

MSM reporting use of a condom during the last sexual intercourse	n/a	46%	59% (Agadir) 31,3% (Marrakech)	36%

Source: Middle East and North Africa Regional Report on AIDS, UNAIDS 2011

Other data has become available. In Tunisia, an estimated 13% of MSM are living with HIV. This finding is from a national bio-behavioral survey conducted in 2011 by USAID's project partner ATL for the Ministry of Health and UNAIDS. Notably, this survey, which had a sample size of 1,100 MSM, employed a stronger sampling methodology and population access than the previous survey in 2009.

The 2009 survey had already showed a worrying prevalence of 5% among MSM. In this survey, active surveillance was completed among 1,778 MSM in Tunisia and high-risk HIV practices were found to be common. Specifically, more than 90% reported having multiple male partners in the previous six months, and nearly 75% of the sample reported unprotected anal intercourse during this time frame. Bisexual practices were also prevalent, with 69% of the sample reporting having sex with women. Furthermore, 92% reported having at least one unprotected same-sex partner and one unprotected female sexual partner in the previous six months. Although access to condoms is moderately high, condom use was inadequate, with less than 20% reporting always using condoms with male partners and about 50% having used condoms during transactional sex. Only 15.6% reported using lubricants during sex with men. Only 34% respondents reported having ever had an HIV test.

Similarly, worrying data is becoming available in Morocco. A recent bio-behavioral survey released by the Ministry of Health shows that the prevalence among the MSM reached 6% in Agadir and 3% in Marrakech, with very low levels of condom use during risky sex and low levels of HIV testing. Prevention programs for MSM are currently increasing in scale in the framework of the 2012-2016 National AIDS Strategy, which for the first time explicitly targets MSM as a priority population. Both the government and several community-based organizations are providing services.

In Lebanon, the limited data available indicates that MSM are a high-risk population. Less than 50% of MSM reported using a condom with their last male partner, and 30% of MSM had been tested for HIV in the last 12 months and were aware of their status. These assessments have confirmed a prevalence of risk practices with limited levels of knowledge among MSM in Lebanon.

This data confirms that some countries in the North Africa region and the Middle East are experiencing a transition towards a concentrated epidemic, particularly among MSM.

1.2. Legislation on sex between men in the MENA Region

In many North Africa and Middle East countries, sex between men is far from being perceived as private, as the frontier between individual liberties and social and public order remains unclear. As a consequence, sex between men remains forbidden morally and criminalized in law.

In Algeria, article 338 of the Penal Code provides that: "*Any one found guilty of a homosexual act shall be punished with imprisonment for two months to two years and a fine of 500 to 2,000 Algerian dinars [US$7-US$27]. If one of the perpetrators is a minor of less than eighteen years of age, the penalty applicable to adults may be increased to imprisonment for up to three years and a fine of 10,000 dinars*" [US$130].

In Lebanon, the 1943 Penal Code, as amended in 2003, provides in its article 534 that "*Unnatural sexual intercourse shall be punished with a term of imprisonment between one month and one year and a fine between 200,000 and one million Lebanese pounds* [US$170-US$670]."

In Morocco, article 489 of the Penal Code criminalizes "*an indecent or unnatural act with individuals of the same sex*". Homosexuality is punishable by an imprisonment from six months to three years and a fine from 120 to 1,200 dirham [US$14-US$140].

In Tunisia, article 230 of the Penal Code, in its French version, specifies that sodomy between consenting adults may lead to a prison sentence up to three years. The terms of this article do not specify the meaning of sodomy. But the Arabic version, the authoritative text, "translates" sodomy, used as in the French text, in specifying male homosexuality "*al-liouat*" and female homosexuality *"al-mousahaka.*" "*Those details in the Arabic text clearly show a will to criminalize the male or female homosexual behavior.*"[6]

In the four countries, the issue of decriminalization of sex between men seems to encounter strong socio-cultural and political resistance. Policies and programs are still influenced by pervasive homophobia. Stigma and discrimination against MSM is a real obstacle to this group accessing sexual health services and having their human rights respected. According to the study "Homosexualité et bisexualities, mythes et réalités," many MSM in Lebanon experience great sufferings: "*death threats, humiliations, blackmail, assaults, marginalization, discrimination, rejections, depressions, suicide attempts, shame, blame, self-hatred, ruined affective lives, isolation, are the lot of most people openly or secretly homosexual living in such homophobic and heterosexist society as ours.*"[7]

Despite the legal ban, many men in the region still engage in sex with men for several reasons (sexual attraction to men, unavailability of women, search of material gain…). Among them, some have multiple male sexual partners while sometimes having female partners as well.

[6] FERCHICHI Wahid, *L'homosexualité en droit tunisien, Entre l'incrimination du code pénal et le droit au respect de la vie privée*, Tunis, p. 4 (unpublished).
[7] RABBATH Maha, *Homosexualité et bisexualités Mythes et réalités*, Beyrouth, Helem, p. 6.

1.3. The partners of the MENA program

The MENA program is implemented by eight partner organizations. They are presented in the table below:

Table 2. MENA program partners by country

Country	Organization	Principles and mission	HIV interventions
Algeria	**APCS** Association de Protection contre le Sida (Organization for the Protection against AIDS)	**Mission:** Promote the health of individuals, communities and the welfare of the family unit in a healthy and balanced society. **Founding principles :** 1. Human rights and equity 2. Taking into account social and cultural contexts 3. Universal Access 4. Partnership development	- Prevention and awareness-raising of HIV/STIs - Medical and psycho-social care - Advocacy and protecting the rights of PLHIV and key populations, with particular regard to stigma and discrimination
Lebanon	**HELEM** Lebanese protection of lesbians, gays, bisexuals and transsexuals	**Mission**: Helem leads a peaceful struggle for the protection of lesbians, gays, bisexuals and transgenders (LGBT) against all kinds of violations of their civil, political, economic, social, or cultural rights. **Founding principles**: LGBT Rights	- Advocacy for the removal of articles from the Lebanese penal code that criminalize homosexuality and trans-sexuality - Development of specific tools for the education and sexual health of LGBT - Prevention of HIV and STIs, including a telephone helpline - Comprehensive care for PLHIV
	SIDC Soins Infirmiers et Développement Communautaire (Nursing care and community development)	**Mission**: Meeting the health needs of young people and the most vulnerable older citizens through community empowerment. **Founding principles**: rights-based approach to reach the poorest and most marginalized groups in the population	- Raising the awareness of the general population and vulnerable groups - Social, medical and financial support to people living with HIV and their families

	OUI POUR LA VIE (Yes for Life)	**Mission**: Reaching the poor and young people to identify their needs and support their aspirations **Founding principles**: Proactively explore and respond to the needs of key populations	- Helping people with special needs including MSM - Referral of people in crisis to the relevant agencies - Youth education and outreach - HIV prevention
Morocco	**AMSED** Association Marocaine de Solidarité et de Développement (Moroccan Association of Solidarity and Development)	**Mission**: Strengthen the capacities of individuals and community-based organizations to support local human development **Founding principles:** Solidarity; Social Justice; Partnership; Tolerance; Governance.	- **Institutional Strengthening:** contribute to the leadership of civil society in the management and coordination of sustainable human development interventions at local level - **Health:** contribute to the reduction of vulnerability to STIs/HIV by integrating prevention into development programs - **Education**: contribute to establish an enabling environment for a quality education - **Environment:** Strengthen the advocacy capacities of CSOs to preserve environment
	OPALS Morocco Organisation Panafricaine de Lutte contre le Sida (African Organisation of fight against AIDS) Fes and Rabat Sections	**Mission**: Promote sexual and reproductive health and respond to HIV through medical and psychosocial care, prevention, advocacy for the right to health in order to improve the quality of life of the population.	- Community-based action - Prevention of vulnerable populations: youth, women, key populations - Medical care and psychosocial support for people infected and affected by HIV and AIDS
Tunisia	**ATL MST/SIDA – Tunis office**	**Mission**: Contribute to the national response to HIV in Tunisia and reduce its impact at all levels **Founding principles**: Participatory community approach	- Fight against the spread of HIV and AIDS and reduce its impact at all levels - Support people living with HIV and AIDS

1.4. Key figures and dates from the MENA Program

Addressing the MSM issue in the national response to HIV and AIDS in Algeria, Lebanon, Morocco and Tunisia has been a long and difficult process, primarily because of the criminalization of this sexual practice. In addition, there does not seem to be a consensus around the terminology used to describe this heterogeneous population group.[8] The program followed two phases, summarized below:

Phase 1 (2005-2007)
Community assessment and capacity building of partner organizations

Capacity building of six civil society organizations and provision of sustainable HIV/STI prevention services to MSM: The International HIV/AIDS Alliance has developed new partnerships with five civil society organizations and introduced specific prevention projects with MSM in Algeria, Tunisia and Lebanon. The existing partnership in Morocco (with AMSED and ALCS/Association de Lutte contre le Sida) was strengthened and the work of prevention targeting MSM was enhanced. The technical support provided enabled to build the capacity of partner organizations in project management, monitoring-evaluation and reporting, as well as in the specific technical areas related to the provision of relevant services to MSM.

Use of participatory community diagnosis tools to develop relevant programs: Detailed participatory community analyses were undertaken in each country, in collaboration with the implementing organizations. They were facilitated by groups of MSM previously trained (190 in total), supported by local partners and with the Alliance's technical support. The members of the community of MSM played a leading role in the decision-making mechanism for each project. This enabled the MENA partners to ensure legitimacy and ownership of the work by the community. This approach also encouraged organizations to integrate the needs of MSM in their broader HIV prevention work.

[8] The expression "men who have sex with men" has the advantage of designating a population not limited to people defining themselves as homosexuals, thus referring more to a behavioral phenomenon than a specific group of people. This is significant because in the HIV/AIDS context, high risk behavior matters more than sexual identity. "MSM" includes various groups such as "homosexuals," "gays," "bisexuals," "men offering sexual services to men." Those terms refer to identity constructions, different from one group to another and from one socio-cultural context to another. Indeed, some MSM do not identify with the conception of "homosexuals." In some socio-cultural contexts, men feel that to keep their male "identity" they must claim to be heterosexual. The silence and stigma surrounding sex between men, even within their own communities, increases the invisibility of MSM in the wider context. Thus, there isn't one single category of MSM, but rather several combinations of sexual practices.

Box 1: The Participatory Community Assessment (PCA)

What is PCA? Participatory community assessment (PCA) is a dynamic process of empowering people in identifying problems, prioritizing needs and planning for community development actions. This exercise is organized through meetings with community members to discuss pre-agreed themes. Once the information is collected, it is analyzed to develop programs or projects that best meet the needs that have been identified with and by the community. A PCA is the first step in the establishment of a community-based program following the guiding principles of participation, equity and transparency. It should always lead to concrete action to carry with and for the target populations.

The PCA carried out in the four countries explored the knowledge, attitudes and behaviors of MSM and their sexual partners in the following areas: sexual health; sexually transmitted infections; HIV and AIDS; homosexuality and sex between men; the information available on these subjects; the role of the family, the community and service providers; the dynamics of relationships between MSM, interactions between them and their environment.

The PCA exercises took a particular interest in the question of MSM vulnerability in relation to STIs and HIV and AIDS. The most serious and most common problems raised during the PCAs were:

- limited availability of condoms and lubricants;
- lack of information about sexuality and STI, HIV and AIDS;
- sexually transmitted infections;
- lack of sexual health services; and
- discrimination against MSM.

Increase access to services for MSM and support the development of an enabling project environment: The projects in the four countries enabled MSM to be directly involved at each step of the program, from the baseline need analysis to the development and implementation of activities and the evaluation of the initial phase. The program provides critical prevention services including condom and lubricant distribution, peer support and the dissemination of basic health information. An integrated referral system was developed or reinforced in each project site in order to improve the access of MSM to health and other services. During the first phase, 20,000 MSM and health partners were reached; around 60 trainings and technical support were provided; and 50,000 condoms and 10,000 lubricant sachets were distributed. The project also helped strengthen links of solidarity and support within the community of MSM involved in the program.

Development of links at the regional level and experience and lesson sharing between countries: Civil society organizations in the four countries developed links in establishing a platform for discussion, mutual support and learning about prevention targeting MSM.

Phase 2 (2008-2012):
Combined prevention, peer education, advocacy against stigma and discrimination

The second phase of the program started in late 2008 and was implemented in the framework of AIDSTAR-Two, with USAID support. This phase builds on the lessons learned from the pilot phase. The partners aim at consolidating, strengthening and expanding the coverage of current activities[9]. The main areas of intervention are: advocacy work at the national and regional levels, capacity building of regional partnerships in prevention targeting MSM and other high-risk populations, and addressing stigma and discrimination. Those actions will enable the MENA partners to reinforce and sustain an HIV response adapted to the needs of this population at the national and regional levels.

Presently, the three intermediate results of the MENA Program are:

1. Extending access to HIV and AIDS services for key populations – for prevention, care and support;
2. Improving the quality of prevention, care and support services;
3. Developing an enabling environment for HIV responses and prevention, care and support services.

Partner organizations offer a package of combined prevention services to MSM: peer education, providing prevention products, voluntary counseling and testing, referral to STI diagnosis and treatment services, and legal and social support. These services are summarized in the following table:

Table 3. Services offered by MENA partner organizations

Services provided	Outreach work	Welcome centers within partner organizations	Referral to services (public or other NGOs)
Information and awareness-raising: prevention, knowing your status, STIs, stigma, where to go (mainly by peer educators)	√	√	
Condoms	√	√	
Lubricants	√	√	
HIV testing – rapid	√	√	
HIV testing – non rapid			√
Pre and post-test counseling for HIV	√	√	√
STI diagnosis and treatment			√
Legal support/advice		√	√
Psycho-social support: peer support groups, individual counseling by a psychologist, family mediation, legal advice from a lawyer	√	√	√

[9] In Morocco, ALCS/Association de Lutte contre le Sida withdrew from the project and AMSED established a partnership with OPALS/Organisation Panafricaine de Lutte Contre le Sida

2. Methodology for the project on demonstrating the results of the MENA program

The 'most significant change' approach was chosen to identify the changes brought about by actions undertaken in favor of MSM in Algeria, Lebanon, Morocco and Tunisia. This approach focuses on the qualitative method: it is concerned with the meaning given by the stakeholders involved to the changes that have been perceived and experienced. It involves partner organizations in the data collection process, the analysis and validation of results.

2.1. The most significant change approach

The most significant change (MSC) approach[10] is a means of participatory monitoring and evaluation. It is used in the context of community and development, notably in adopting the qualitative methodology. It aims at gathering respondents' points of view (stories) and inductively analyzing them. It gathers the respondents' ideas and perceptions, based on individual data. The collected "stories" of respondents constitute the database; they are analyzed and discussed in order to identify the key changes that occur during a project. Interview content must be processed confidentially and unless authorized by the respondents, all the content must remain anonymous.

The MSC approach aims to capture effectiveness and impact through:

- ✓ Collecting stories about the most significant changes on the ground;
- ✓ Selecting key stories;
- ✓ Thorough discussions about the changes identified in the chosen stories, in one or more groups.
- ✓ Verifying key stories to ensure that they are true.

Figure 1. Model of Most Significant Change story and feedback flow

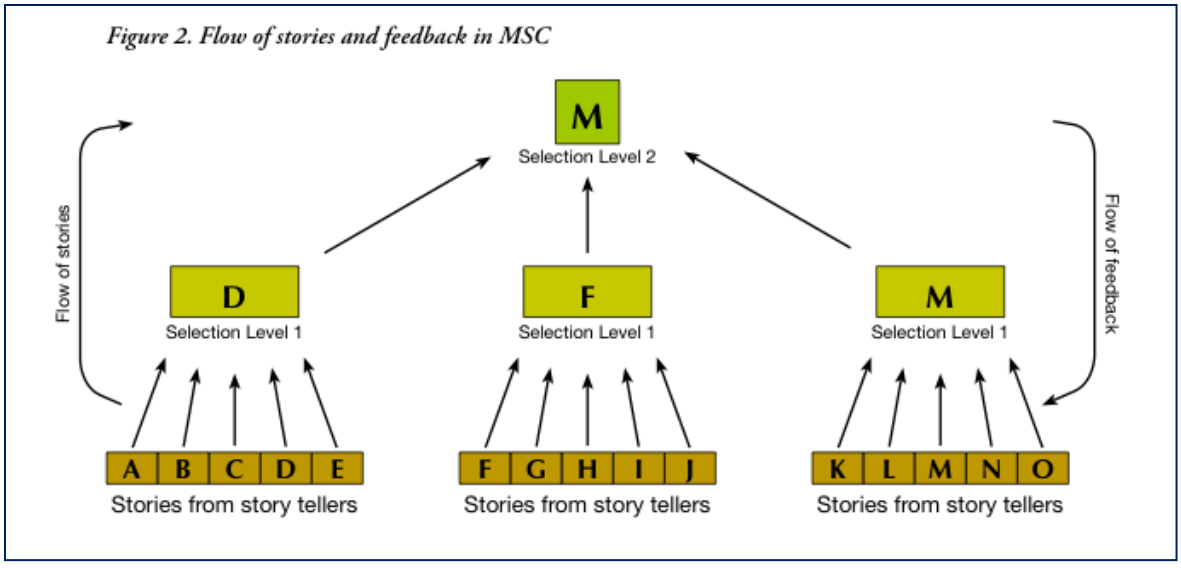

Figure extracted from "The MSC Technique. A guide to its Use." See footnote 10.

[10] For this section of the work, we have drawn from "The 'Most Significant Change' (MSC) Technique. A Guide to Its Use" by Rick Davies and Jess Dart, April 2005

When using the most significant change approach, it is recommended that themes be identified early on in the process of data collection; these themes are known as 'areas of change' or, in other words, major themes for which data will be collected. In order to reflect the three intermediate outcomes of the MENA program mentioned on page 17, five areas of change were identified:

1. Changes in the lives of MSM - **Beneficiaries**
2. Changes in their access to relevant services (e.g., condoms/lubricants, testing, legal support, etc.) - **Access to Services**
3. Changes in the experiences and lives of peer educators who are mobilized and involved in the project - **Peer Educators**
4. Changes in the level of capacity and experience of the organizations involved in the project – **Organization**
5. Changes in the Environment - **Environment**.

Interview guides were developed to gather information on the most significant changes related to these themes (see Annex 3).

2.2. Conducting the demonstrating results project (April-June 2012)

The table below summarizes the main activities carried out between April and June 2012 to complete the documentation of the results of the MENA program using the MSC approach (detailed plan is presented in Annex 1):

Table 4. MENA program MSC activities

Activity	Main objective	Location	Period
Regional Training of Trainers Workshop	Presentation of the MSC approach, design of data collection tools, planning of fieldwork	Tunis	April 23-26,2012
Data collection	Conduct, translate and transcribe the interviews	Algeria, Lebanon, Morocco, Tunisia	May 2012
Discussion groups : participatory data analysis and story selection	Select stories gathered and share lessons learned	Beirut, Oran, Rabat, Tunis	May 2012
Regional workshop to validate the selected stories and exchange lessons learned	Validate stories and exchange lessons learned	Rabat	June 21-22, 2012
Secondary analysis and writing of reports	Write regional and country reports	Desk work	July-September 2012

3. Results of the MENA program from the analysis of the 'most significant change' stories selected

This section presents data on the 19 stories chosen by the partners of the MENA regional program for this report at the workshop held in June 2012.

3.1. Changes in beneficiary experiences

Concerning the "beneficiaries" area, 54 stories were collected in the four countries among 39 beneficiaries and 15 peer educators. The issues raised by respondents are varied. Several respondents discussed the improvement of their knowledge on HIV and AIDS and their awareness of risks. In many testimonies, the most significant changes in the lives of respondents included: condom and lubricant use, reduced isolation, and improved self-confidence and self-esteem.

During the regional workshop held in June 2012, the MENA partners selected four stories which reflect the most significant changes in beneficiary lives and experiences.

Table 5: List of topics raised by the respondents of the four selected stories:

N°	Code	Respondent profile	Most significant changes in beneficiary experiences
1	AB3	Ahmed, 22, unemployed, single, defines himself as a bisexual	• Improved knowledge about STI, HIV and AIDS • Reduced isolation, loneliness, concealment and withdrawal • Greater self-confidence, self-esteem and self-acceptance • Involvement in fight against homophobia • Sensitization of anti-gays to respect MSM • Greater courage to defend themselves • Increased sense of responsibility to defend MSM cause • Improved client negotiation skills • Adoption of safer sex • Awareness of HIV and AIDS-related risks
2	LB4	Said, 28, unemployed, single, defines himself as a MSM and homosexual (Sex worker)	• Increased attachment to/trust in association • Reduced isolation (being afraid, feeling ill at ease…) • Social assertiveness (increased self-confidence and self-esteem and increased client negotiation skills) • Increased knowledge (HIV and AIDS, VCT, human rights) • Adoption of safer sex
3	MB1	Najib, 26, student, single, defines himself as a homosexual	• Greater awareness of risks • Adoption of preventive behavior (condom, testing) • Responsibility • Greater self-confidence • Involvement of sexual partner for prevention
4	TB1	Chaker, 31, manager, single, defines himself as a gay	• Attachment to/trust in ATL MST/SIDA – section de Tunis • Greater freedom of expression

			• Greater solidarity between MSM • Greater self-confidence • Greater self-esteem • Reduced isolation • Involvement in NGO life and rights activism

Story of Ahmed in Algeria

The APCS Team in Algeria selected the story of Ahmed, 22, unemployed, single, based on the insight which it provided on the most significant changes generated by the program developed for MSM. The story of Ahmed was also deemed by APCS to be the most descriptive and detailed among the beneficiaries' stories collected in Algeria.

As in the story of many MSM, the selected story of Ahmed reveals that self-esteem would be difficult to develop in this population in a context which is hostile to sex between men. Indeed, the feeling of rejection experienced by many MSM might explain their mistrust of others and their lack of self-confidence; the feeling of guilt would increase self-rejection. In his statements, Ahmed expresses his uneasiness with society's rejection of MSM, in particular those perceived as effeminate. He describes his former life:

> "*When I discovered I was homosexual, I discovered homophobia, I experienced my sexuality in isolation, loneliness and concealment and self-withdrawal (I am very effeminate) for fear of stigma, rejection by my family, my friends, I lived hidden because of taboos and social prejudices (in this conservative society, where homosexual practices are severely repressed).*"

The selected story demonstrates that some MSM engage in practices that lead them to deny their individual freedom, dreams and aspirations in exchange for social acceptance. In this context, sexual health and protection in sexual life is far from being a priority. This APCS beneficiary describes his life before he met the association:

> "*Contempt, psychological harassment, and poor self-esteem undermined my personality and led me into a depression, which in turn led me to take risks in my sexual encounters. In other words, it is difficult to feel like protecting yourself and protecting others when you think you are not worth it.*"

Because of their fear of stigma and discrimination, MSM often withdraw into themselves; they do not trust institutions, especially governmental ones. Correcting this situation was a major challenge for APCS. For Ahmed, self-acceptance required not only personal determination, but also the psychosocial support provided by APCS. He says:

> "*Providing MSM 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.*"

In the story of this beneficiary, self-acceptance and increased self-confidence and self-esteem would be critical factors in the awareness of risks related to sexually transmitted infections, including HIV and AIDS and the adoption of safer sex. The beneficiary states:

> "*What has changed in me: I learned about the necessary and useful precautions I should take to protect myself and my partners, as well as (the necessary arguments) to negotiate condom use, to know how to resist client pressure, and how to best face the frustration resulting from refusal with a casual partner.*"

APCS involvement with MSM continues to grow. The organization took part in the personal development of many MSM through the provision of psychosocial support. This is a pioneering experience in Algeria that contributed to bringing this population from underground, where it was regarded for a long time as invisible, to a safer place, where MSM are now enabled to benefit from specific actions that support their sexual health.

Story of Said in Lebanon

For the Lebanese team, the story of Said, 28, unemployed and single, who defines himself as an MSM and homosexual, was selected because it was thought to be the most informative and detailed among the beneficiaries' stories collected.

In their stories, many MSM live with an underlying fear. In the course of his life, Said has experienced fear linked to his sexual orientation. His access to Helem in Lebanon as a beneficiary has helped him relieve this feeling. For him, Helem represents a point of reference he can turn to in case of need; it is an open space for diverse populations he would probably not have met otherwise. Reflecting on this, he declares:

> "*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.*"

MSM feel ashamed and do not accept themselves. A reclusive attitude would develop in some of them because of the stigma and discrimination they experience daily. As a consequence, it would be difficult for them to access adequate sexual health services and develop skills for protecting themselves against sexually transmitted infections. Said's access to multiple services helped him redefine the way he views himself and his environment. This evolution also enabled him to practice safer sex. He says:

> "*I got more self-confident after the psychological and social service. I feel more protected thanks to my knowledge and the use of condoms and STI testing. I feel more confident and more empowered to demand my conditions from clients.*"

In Said's story, accessing services and increasing his self-confidence and self-esteem have made him more aware and more responsible. Thanks to the support of the association, he rediscovers and claims his rights. He declares:

"This project reminded me that I have rights as a human being and yet I had forgotten this for such a long time, especially as I am not Lebanese: I was often called bad names by clients for that reason."

Said's testimony shows the importance of the NGO as a point of reference in supporting MSM in their search for identity: the efforts undertaken by Helem in empowering their beneficiaries help the latter to adopt a more responsible sexual behavior.

Story of Najib in Morocco

The Moroccan team selected the story of Najib, a 26-year-old student. He defines himself as homosexual. His testimony evokes HIV and AIDS knowledge and how the association succeeded in giving him information in sexual education. The testimony of Najib underlines that before his encounter with OPALS peer educators, he had no knowledge about sexually transmitted infections including HIV and AIDS. For him, somebody with a nice body could not carry a sexually transmitted infection: for him, physical appearance was a marker distinguishing infected people from non-infected people. Thus, an attractive person symbolized the lack of risk and Najib was not aware of the HIV asymptomatic phase.

"Let me be frank, I relied a lot on appearance in selecting a partner, I trusted a nice body! I have already attended an awareness-raising session with peer educators in the organization. With the physician, the discussion about STI and AIDS brought us to the visible signs of HIV and at this point, the physician insisted a lot on the HIV-positive phase when the infected person does not "show" any sign. And now, I am aware of the mistakes I used to make […] I understood a lot of things. […] since I know R.A, my peer educator, we see each other often and every time he tells me real stories: MSM who do not protect themselves and end up catching sexually transmitted infections. This is frightening. I do not have many sexual encounters; I am looking for stable relations, but who knows!"

After his contact with OPALS and his participation in various activities, Najib has acquired information and has become aware of the actual risks of HIV transmission, and reports using condoms during his sexual encounters.

This change was selected as significant at the level of the OPALS project as representative of the importance of their field work. Thanks to outreach work and awareness-raising by peer educators, MSM adopt HIV and AIDS preventive behaviors. This awareness was reflected in the story through another prevention approach, since Najib specifies he went with his partner for HIV testing at OPALS.

"I sensitized my partner, he was very understanding and he even agreed to get tested for me, I went with him to OPALS, he met the physician and took the test: negative and then I said, even if your test is negative, condom first and foremost. Why this change? Being HIV positive is a one-way journey, and now for my protection I am the one who decides."

This story highlights the role of the peer educator in identifying the beneficiary's vulnerability and adapting their work to that person's situation. Najib's testimony shows

how outreach is critical in improving knowledge related to STIs and HIV testing, but also in sensitizing beneficiaries' sexual partners to the risks involved in unprotected sex.

Story of Chaker in Tunisia

For the Tunisian team, the story of Chaker, 31, manager, was selected because it testifies, among other things, to the importance of listening, psychosocial support and the space for discussion provided by ATL-Tunis in the course of life of a man who has sex with men. For Chaker, an attitude of withdrawal had developed, before his involvement in the program for MSM. The feeling of rejection experienced by many MSM would explain their mistrust of others and their lack of self-confidence. It would be hard for some MSM to develop self-esteem because of the "disrespectful" perception of others.

> "*Before I got involved with ATL and the MSM program, I lived in great social loneliness and I didn't have much contact with the gay community, except through some sexual encounters.*"

After a few lonely years, Chaker started opening up to the outside world. In his story, he has developed links with his peers, with whom he shared a lifestyle, concerns and aspirations, thanks to the program for MSM. ATL-Tunis has provided him safety and has helped him assert himself.

> *"What most attracted me in the MSM program and the services provided by ATL can simply be summarized 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. I spoke of my sexual practices freely and with much ease and I was able to share my concerns naturally with the other members of the gay community.*"

Like many MSM, this respondent feels the need to belong to a peer group. Indeed, the development of a social network based on sexual affinity plays an important role in the definition of identity for many men who are looking for means to cope with their homosexuality. For many MSM, the circle of friends would be the right setting to discuss their private life. Solidarity and mutual support would be further strengthened within the group of MSM when their members face the same problems or have the same concerns.

> *"Right now I feel very close to my community, I have learned a lot in discussing with friends who came to ATL and talked about their situation. In short, now I feel in good company […] I feel more self-confident and my self-esteem has grown exponentially.*"

The acceptance of homosexuality through an NGO setting such as the one found at ATL-Tunis would promote the adoption of preventive behaviors. Through continuous contact with peers who protect themselves, greater awareness gradually develops in newcomers and leads them to protect themselves and protect others.

3.2. Changes in access to relevant services

In the area of "access to services," 33 stories were collected among beneficiaries of support for MSM in the four countries. The issues raised by respondents are varied. Some of them were reported by several respondents, including: access to HIV and AIDS information, free access to condoms and lubricants, and free and anonymous access to HIV testing.

During the regional workshop held in June 2012, the MENA program partners selected three stories which reflect the most significant changes in beneficiaries' access to relevant services. The following table outlines the main themes raised by the respondents in the three selected stories.

Table 6: List of topics raised by the respondents of the 3 selected stories:

N°	Code	Respondent profile	Most significant changes in access to relevant services
1	LB1	Anis, 31, unemployed, single, defines himself as a bisexual (PLHIV)	• Access to psychosocial support • Access to counseling • Access to prevention information • Access to outreach services (mobile HIV testing) • Acceptance of oneself as a PLHIV • Risk awareness
2	TB1	Chaker, 31, manager, single, defines himself as a gay	• Access to free space for discussion to discuss sexual orientation and behaviors • Access to a range of services (free and anonymous HIV testing, psychological support, active listening, support groups) • Access to HIV and AIDS information • Peer support facilitating access to services
3	AB1	Mourad, 21, unemployed, single, defines himself as a MSM (PLHIV)	• Access to information on STIs, HIV and AIDS • Access to condoms and lubricants • Access to HIV testing and discovery of HIV positive status • Access to psychological support • Obtaining financial support

Story of Anis in Lebanon

The Lebanese team selected the story of Anis, 31, unemployed and single, who defines himself as bisexual, testifying to the investment of SIDC in the HIV response through the development of appropriate services for MSM. In the story of Anis, his meeting with SIDC also enabled him to discover his positive HIV status. This is what he declares:

> *"I have been in contact with SIDC for a year and half and during that time, I benefited from PLHIV support activities, since I discovered my positive status during the street work of the NGO's mobile unit. I was able to benefit from the psychological and social follow-up and also from scientific information about prevention."*

The absence or lack of discussion of AIDS is likely to increase the isolation of people living with HIV, who are often vulnerable for several reasons such as their learning about their HIV

infection, the burden of treatment, the degradation in their living conditions, professional inactivity, and disability. The support SIDC provided to Anis helped him to accept his positive status. He describes this evolution in the following terms:

> *"Concerning the changes that I experienced following this project, I felt I am not alone, I was able to live in peace and be reassured. I was too weak when I learned about my positive status. The support I received was more emotional than material […]. What I gained is the fact that I have accepted my situation as it is, and now I experience my positive status peacefully. I had dark thoughts about HIV, I thought my life was over but thanks to you, those ideas have changed and I told myself that I am still alive and that people around me are "good people" and that life goes on."*

Some people living with HIV experience their situation in loneliness and anguish. For them, self-esteem can hardly develop because of their fear of others' perception of them if their HIV status is discovered. Their uneasiness about their identity and lack of self-confidence leads them to withdraw into themselves. For Anis, SIDC provided him with the appropriate support in his search for identity after he discovered he was HIV-positive. He declares:

> *"I was more afraid of the future and didn't know how I would continue living. The association helped me a lot and gave me support and I was receptive. And notwithstanding the serious situation which I faced, I was able to overcome the problems with their help and thanks to my own beliefs."*

In his statement, Anis commits to protecting others from HIV. He doesn't wish to see the number of HIV-infected cases increase since it would undermine the opportunity of ensuring treatment to all the people living with HIV. He says:

> *"I caught the virus, it should not be transmitted to others because then the problem will worsen, since the number of PLHIV will increase and the Ministry of Health will not be able to provide drugs to a great number of patients."*

While MSM have difficulty accepting HIV testing, even those who engage in high risk behaviors, the reality is that a late discovery of HIV infection will reduce treatment effectiveness and facilitate the spread of HIV. The testimonies of various beneficiaries reveal that partner organizations emphasize the importance and need to practice HIV testing in their outreach to MSM. In this regard, both associations have continuously promoted this act of responsibility with key populations, ensuring that it is anonymous and free of charge.

Story of Chaker in Tunisia

For the Tunisian team, the story that was selected is that of Chaker, a 31-year-old beneficiary, presently a manager. The respondent highlights the importance of access to a space for free discussion about sexual orientation and behaviors. Through his contact with the counseling sessions, support groups or discussions made possible through the association, the respondent states that:

> *"The most important thing for me was to find people willing to listen to me, as I always needed to discuss my sexual orientation, my practices and the risks involved. I*

found in ATL a team that was also present. All the ATL team is always, at any time, at the service of beneficiaries. […] I am gay and I wish less and less to live underground. Because of my sexual orientation, there is no legal setting where I can discuss openly what I think and what I experience. With ATL, I found that space and I think it is very important for Tunisian gays, since there is no space or association where young people belonging to the LGBT community can meet to discuss and talk about their lives."

ATL-Tunis was able to position itself as a new source of information and thus respond to identified needs. In this regard, the respondent evokes the professional character of the organization:

"I want to congratulate them for their professional approach and the tools which they used which are very interesting, fun, educative and adapted to our specificities: we are very much at ease in a climate of trust and friendliness."

ATL-Tunis paid attention to provide a non-judgmental and unbiased space. Therefore, in developing projects specially designed for MSM, ATL-Tunis has introduced a space that did not exist before and that has filled a gap in NGO action. MSM who attend the association emphasize that they feel at ease in talking with their peers.

Story of Mourad in Algeria

The APCS team selected the story of Mourad, 21, unemployed and single, testifying to the efforts undertaken by this association in promoting free and anonymous HIV testing with key populations and supporting people living with HIV. Many MSM seem to ignore the existence of the HIV test or do not feel concerned about knowing their HIV status. In the story of Mourad, his contact with APCS enabled the beneficiary to know his HIV positive status. He reports the following:

"I must say that the most significant change which I had via this project is unfortunately the discovery of my positive status after my first visit to APCS VCT."

AIDS still frightens people despite progress in treatments that keep HIV inactive for increasingly longer periods. Learning about one's HIV positive status is often experienced in pain and loneliness. Having to face that frightening virus is an important moment in one's life, which is often difficult to cope with. Indeed, people living with HIV are led to redefine themselves, with varying degrees of difficulty. Diverse elements are linked to building a new identity for people living with HIV, such as self-image, how one relates to others, one's view of the world, and the vision of the future that might be at stake. Accepting to live with HIV is a long process depending not only on the person concerned, but also on the family, friends and health professionals. This respondent learned to live with HIV in giving it a male name, Abesse. Thus, he declares:

"It's now two years that I have been living with "Abesse," this is the name I gave this virus that invaded my body and my life without prior permission and which I must live with all my life. This change is important for me, since on the day when I confirmed my positive status, all my life has been turned upside down."

Silence, whether chosen or imposed, can be a burden for many people living with HIV. Their suffering may be heavy because it is not shared with their people. Mourad acknowledges the role of APCS in his acceptance of his positive status:

> *"Thanks to the follow-up, the support and perseverance of the association psychologist, I was able to overcome all those difficulties, I regained my self-confidence, I accepted my positive status and got free from all the dark thoughts that had haunted me. With the benefit of hindsight, I thank God and the people involved in this project who enabled me to discover my positive status before I got more ill and who enabled me to receive early care and treatment against the virus […]. APCS helped me and supported me a lot morally and financially, because without their support I would really have been lost in the wilderness and especially in our Algerian context, it is even doubly more difficult to say that I am a homosexual living with AIDS."*

3.3. Changes in peer educator experiences

A total of 23 stories were collected among peer educators involved in the support of MSM in Algeria, Lebanon, Morocco and Tunisia. During the regional workshop held in June 2012, the Mena program partners selected four stories which reflect the most significant changes in peer educators' experiences. The following table outlines the main themes raised by the respondents in the four selected stories:

Table 7. List of topics raised by the respondents of the four selected stories

N°	Code	Respondent profile	Most significant changes in peer educators' experiences
1	MEP2	Jamel, 21, single, defines himself as gay	• Adoption of preventive behavior (regular condom use, testing) • Involvement, engagement in outreach work and association work • Self-assertion
2	TEP7	Bassem, 32, single, defines himself as gay	• Individual capacity-building • Feeling of belonging to a group • Improved self-confidence • Acceptance of sexual orientation • Investment/activism in the MSM community cause • Visible impact of prevention
3	AEP5	Rachid, 30, single, interpreter, defines himself as gay	• Access to services • Participation in training sessions • Access to a friendly space • Fulfillment in volunteer service and servitude • Development of links with PLHIVs • Opening up to MSM and more respect for "effeminate" MSM • Reduced feeling of fear and guilt • Development of self-confidence • Improved relations with the family • Improved communication and listening skills

			• Development of a feeling of being useful
4	LEP1	Walid, 31, student, single, defines himself as MSM	• Individual capacity building through training (peer education, field work planning, communication…) • Opening up to other MSM populations • Identification of MSM needs and better knowledge of MSM behaviors • Adaptation of the approach based on population sub-groups • Improved self-confidence as a peer educator • Improved relationships with beneficiaries

Story of Jamel in Morocco

The Moroccan team selected the story of Jamel, 21, single, who defines himself as gay. This testimony concerns the development of self-confidence thanks to OPALS work.

In the story of Jamel, the development of self-esteem led to the adoption of preventive behaviors. Before his encounter with OPALS, Jamel recognizes that he did not accept his sexual orientation, did not like his body and experienced a feeling of rejection by his family and guilt towards religion.

> *"In the past, I was so much concerned with my life, it made me so thoughtful that I couldn't sleep. I suffered a lot from stigma [...]. I didn't have the courage to face this situation. Today, I feel ready to defend myself: "a lion." I was underestimated because of ignorance […]. Now I feel that I have dignity and personality and that I have the right to live my femininity as I wish, provided that I respect the social environment (to avoid stigma and discrimination). Now, I am supported by the NGO."*

Now, through his contact and involvement with OPALS, Jamel is convinced that he must respect his sexual orientation while protecting himself.

> *"At the beginning, I was a friend's peer. During that period, I was 50% convinced of STI/HIV risk. After entering OPALS and after benefiting from several activities including training and services from the anonymous testing center, the way I see things has changed. For me, the NGO gave me a lot. There are multiple changes: I was in great doubt. Now, I have a great responsibility and commitment to my peers. After the trainings I attended, I wanted to put everything in practice and share the information I got. The project provided many things: prevention methods, materials, health services, the positive environment for meetings and different activities."*

Story of Bassem in Tunisia

The Tunisian team selected the story of the peer educator Bassem, 32, student. It is to be noted that this story reflects the experience of other peer educators as reported in other interviews. The change outlined in his story brings out the sense of responsibility that emerged in the respondent thanks to his involvement in the activities of ATL-Tunis and the trainings he received. With the important knowledge acquired in HIV and AIDS and prevention, Bassem not only benefited from those inputs for himself, as he became aware of

the importance of prevention, but he is also able now to sensitize his peers on the ground. Equipped with field techniques and HIV and AIDS knowledge, the respondent underlines his commitment to MSM:

> *"Today, I feel responsible for [my] sexual behaviors; 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."*

The feeling of belonging to a group or a community shows how Bassem became committed to his peers. Now, he acknowledges himself as a man who has sex with men and claims the rights of the group. He stated:

> *"I now feel that with the group that I joined, we are stronger. There is this feeling of belonging that I have and which is very important, now that we are a strong and solid group and we can stand for our rights."*

In this regard, fighting stigma and discrimination against MSM appears as an important step of his personal investment.

> *"This prevention and mobilization work with the community and key actors in the HIV response has led to deep changes. Now if, for example, an effeminate gay man presents himself to any service, he won't be turned down; there is still a lot of work to do, however I believe that we have made great strides."*

The tasks of a peer educator include information, education, communication, awareness-raising, counseling, orientation, providing non-medical services to his peers. The peer educator must be unobtrusive, for confidentiality reasons, committed and motivated. Moreover, the peer educator should never be judgmental or moralizing with his peers.

The MENA program partners in the four countries committed to providing training sessions to peer educators to disseminate basic information about sexual and reproductive health to their allies to enable the latter to provide this information in turn to their peers. The peer educator principle is to facilitate information uptake and dissemination with individuals who are reluctant to receive this information from health professionals for various reasons (lack of time, refusal to go to health facilities, or other reasons).

Story of Rachid in Algeria

The APCS team selected the story of Rachid, 30, an interpreter who is single, to illustrate the most significant change in the "peer educators" area. His testimony reflects the story of several educators collaborating with APCS. Not only has Rachid accessed diverse services provided by APCS (HIV and AIDS information, psychosocial support, space for exchange), but he has also participated in various APCS-organized training sessions for peer educators. For this respondent, his status as a peer educator brought him personal fulfillment in helping him to engage in the HIV response. He declares:

> *"I must say that this project brought me so many changes, starting with my fulfillment in volunteer work, solidarity. I managed to overcome the fear I had of*

sexually transmitted diseases and AIDS; better still, I had the opportunity to know and make friends with people living with HIV in the association, which strengthened even more my convictions about prevention."

Moreover, Rachid's view of MSM, in particular the effeminate ones, has evolved. This change required working on himself, thanks to this respondent's uptake of the APCS program for MSM. The opening up of this respondent to the outside world enabled him to know himself better, to know his peers better and to engage in their support. In his story, he describes his evolution in terms of self-acceptance and the acceptance of his peers:

"The most significant change for me is that I overcame the problem I had with homosexuals, in particular the effeminate ones. Though I was effeminate myself, I avoided them and could not stand them even: on the one hand I was afraid of them. I found them coarse and violent […]. Thanks to this project that allowed me to get in touch with other homosexuals, including peer educators and beneficiaries and also thanks to the different trainings which I received and the workshops addressing self-esteem, discrimination, I overcame my shyness, I now feel more self-confident, I have succeeded in dealing with my parents and convincing them of accepting my work as a peer educator."

Rachid's commitment to peer education made him proud. In his approach, he became aware of the risks which MSM are exposed to. This is why he invests in peer protection:

"I am proud of my work as a peer educator and I accept my community without any fear or prejudice. Also, I make myself and feel useful in preserving the health of my peers with more openness to others without having to hide, or judging others, I feel more self-assured and more at ease, I regain my balance because, in essence, I like to help my fellow people."

Story of Walid in Lebanon

The Lebanese team selected the story of Walid, 31, a student who is single, and who defines himself as MSM. It reflects the story of several educators collaborating with the three associations involved in support to MSM in Lebanon. These associations have committed to ensuring training sessions for peer educators with an objective of disseminating basic information about sexual health. Walid has participated in several training sessions organized by SIDC. He is aware of the importance of conciliation between the theoretical and practical aspects in terms of population support. He says:

"I am a peer educator in the project and I benefited from all the trainings in terms of information, approaches for conducting peer education, planning my field work and, overall, I benefited from the field work and the practical aspects. I was able to put in practice the theoretical information I learned."

In his story, Walid realized the diversity in the population of MSM which led him to understand the need to adapt his action to his audience. He relates his experience:

"In my position as a PE, 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."

The peer educator makes his utmost effort to share pertinent health information with individuals who are reluctant to receive that information for various reasons. Walid's involvement in supporting MSM has helped him to develop a keen sense of observation and the capacity of adapting to situations. He proudly describes this evolution:

"It is during my work on the street that I could feel the difference between the populations I meet with, and I started using two different methods or approaches. This was very important because it makes my interventions more useful and increases my self-confidence and my 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."

3.4. Changes in partner organizations

A total of 15 stories were collected from association staff and managers in the four countries. During the regional workshop held in June 2012, the MENA program partners selected four interviews which reflect the most significant changes in partner organizations. Table 8 on the following page outlines the main themes raised by the respondents in the four selected stories.

Table 8. List of topics raised by the respondents of the four selected stories:

N°	Code	Respondent profile	Most significant changes in partner organizations
1	TA3	Bilel Mahjoubi Executive Coordinator ATL MST/SIDA – section de Tunis	• MSM mobilization in HIV response • Involvement of the community as key actors in the response to HIV • Know-how sharing at the regional level
2	AA1	Aziz Tadjeddine, APCS President	• Acceptance of the presence of MSM by the association staff • Development of a user-friendly space for MSM • Ownership by the association team of the issue of sex between men • Capacity-building of the association team in diverse areas • Development of a legal service • Development of partnership with religious leaders • Development of MSM's responsibility and empowerment • MSM involvement in decision making within the association • Project ownership by MSM • Development of actions more adapted to MSM and targeting them in a concentrated epidemic context • Involvement of many MSM in HIV response to the benefit of the general population
3	LA4	Mahdy Sharafeddine, member of the Steering Committee Helem	• Development of the association partnership with other associations in Lebanon and at the regional level • Capacity building of associations' members and educators • Development of services for MSM and their families • Publication of documents about beneficiary rights • Development under the Alliance program of an advocacy strategy with the collaboration of various actors • Integration of the association network working in social and health areas • Partnership between the association and the national AIDS program
4	MA2	Dr. Boutaina Drissi Alami OPALS Rabat	• Increased visibility of MSM in advocacy for promoting access to services (care and other) to key populations

Testimony in Tunisia

The Tunisian team selected the story of the Executive Coordinator of ATL-Tunis, Bilel Mahjoubi. This story describes the development of a pioneer project for MSM and testifies to the courage that was needed to start such a project in a context that was hostile to the latter. Indeed, with a socio-cultural and legal context criminalizing sex between men in Tunisia, there was no appropriate prevention program for this population.

Besides, in Tunisia, just in a few years, a critical change occurred: there was a shift from the general HIV response to a targeted response with the most vulnerable populations who had remained a taboo subject until then. Also, ATL-Tunis put in place a prevention program

targeting MSM: the association succeeded in integrating and basing its action on people from the target community in opening their doors to the very members of that community while professionalizing them.

In adopting a participatory community approach, ATL-Tunis was able to develop the required conditions for successful actions targeting MSM. As stated by the respondent:

> *"The greatest success of this program according to me is the fact that MSM who were mobilized on the ground have become peer educators, trainers, activists, have founded NGOs working for MSM rights and, above all, skilled program managers."*

Some MSM, members of ATL-Tunis, have developed and implemented appropriate projects for this population. This aspect is one of the major strengths of the association. Members of the community are represented at different levels of the organization: the mobilization of community members appears both as evidence to make projects operational, but also as a necessary condition.

Moreover, the association ensured that beneficiaries become key actors of the program. This evolution process is supported by trainings, field experience and the space of confidence provided by ATL-Tunis to its members. This direct involvement of the target population appears as a major lesson of the association.

Building on all those advantages, the association, a pioneer in the region, now provides technical assistance to other NGOs in the MENA region. This sharing of a professional know-how has been outlined as follows by the respondent according to whom ATL-Tunis is:

> *"A professional, credible organization with expertise in working with key populations that has become an association for technical support and capacity building of NGOs in the MENA region."*

ATL-Tunis turned its attention to MSM. Several actions were then conducted to provide this population with more appropriate support. The experience of the organization has strengthened over time, making it a resource in this area.

Testimony in Algeria

The Algerian team selected the story of APCS President Aziz Tadjeddine. In his testimony, he recounts the history of the integration of the issue of sex between men in the NGO activities, notwithstanding the weaknesses and initial institutional reluctance in addressing this question. APCS became involved in providing support to MSM gradually. The work of this association thus presents itself as a long range process that consists not only in identifying the needs of MSM in sexual and reproductive health, but also in adapting the most relevant actions to this population. He said:

> *"At the beginning, we accepted that the project be carried out at our level without any prejudice nor bias; let me state that we had no qualification, nor the skills required for this issue and we did not understand the internal and external obstacles (reluctance of some association members…). During the first training workshop with*

MSM, we realized that young people critically needed information, prevention methods and support, so we decided to engage in this project with more conviction."

President Tadjeddine thinks that ATL-Tunis underwent a number of changes thanks to the MENA program, such as the acceptance by the association staff of the presence of MSM, the development of a friendly space for this population, the ownership by the association team of the issue of sex between men, the capacity-building of the association team in diverse areas, the development of a legal service, the development of partnership with religious leaders… But the most significant change he perceives is the increased responsibility and empowerment of MSM. Indeed, APCS was led to revise the ways of thinking of target populations, often regarded as an object of intervention:

"But the most important change that we witnessed in our organization, thanks to this project, is the empowerment and responsibility of MSM who become more and more the architects of their lives. MSM now assume better their role as educators, ensure their work with beneficiaries with more confidence and conviction, without fearing being stigmatized by society. They are involved in decision-making, governance and facilitation of the organization's life."

Moreover, he acknowledges the greater involvement of MSM in the health response, not only with their peers but also with the general population. Thus, the involvement of some volunteer MSM results from their awareness: they are led to first-person involvement in HIV response and sexual health promotion. In this context, he declares:

"Some MSM, in addition to their work with their community, have decided to get involved in the sensitization of the general population. In other words, they get more involved in the welfare of those youth, which adds value to their actions and gives them the feeling of living in society, as according to them, remaining in their community is a kind of exclusion! This change is important for the association, as it fully meets our need of relevant and targeted AIDS action in our region, knowing that we are facing a concentrated epidemic."

APCS has worked to identify MSM and accompany them as actors and partners. Through their familiarization with associative life, many MSM don't want to be further set aside from the actions, measures and programs concerning them. Thus APCS has undertaken to associate MSM in the identification, the implementation and the development of most actions to their benefit.

Testimony in Lebanon

The Lebanese team selected the story of Mahdy Sharafeddine, member of Helem's Board, as illustrating the most significant change regarding the "Association" area. In his testimony, Helem representative recognizes the role of the program in the opening of the association up to their environment. He declares:

"The contributions of the MENA project are very important, especially as this project is one of the first projects on which the association has worked. It contributed to their

expansion and spread through their partnership with other local and regional associations."

Today, Helem is known for its commitment to the defense of human rights, expertise in the context of key populations, including the needs of MSM, and for opening up to national and international associative experiences. Helem has gained increased experience in providing support to MSM and recognizes the MENA program played an important role in this:

"When Helem was selected to participate in the MENA project on the basis of their work with MSM, this enabled Helem to become a partner of the national AIDS program in Lebanon. This helped integrate them in the networking system with associations working on human rights and sexual health within and outside Lebanon. This expansion would not have been so fast without this project."

Moreover, Helem developed several services to both meet the needs of MSM and to defend the rights of this population. According to the Helem representative, this commitment was supported by the MENA program:

"This project also integrated the psychosocial support service in the intervention. The project also launched the hotline and the reception service, work with parents, the publication of documents regarding beneficiary rights. This project also developed advocacy strategies in collaboration with lawyers, media, religious leaders, the police and key stakeholders in the region."

Testimony in Morocco

The Moroccan team selected the story of a manager from OPALS-Rabat, Dr. Boutaina Drissi Alami. The most significant change outlines here how individual capacity building enabled peer educators to discuss their rights as MSM with the National Human Rights Center.

Her testimony also shows how OPALS, with the technical support from AMSED, was able to open up in Rabat and Fes and adapt to peer educators who were gradually involved in the organization. Through OPALS' work and the provision of various tools, such as trainings, workshops, and discussion sessions, peer educators slowly became more self-confident and they now feel at ease to express themselves within the association. Their assertion of their sexual orientation was a gradual process:

"Our first monitoring meetings would compulsorily be conducted on Fridays after the departure of the organization staff, because peer educators did not feel at ease in the presence of about ten people, which I recognize was right because of a very stigmatizing look at them. But overtime, they became more confident. [...] In terms of changes, their way of dressing changed, they do not hide their swaying walk any longer."

Those first changes led to greater self-confidence and trust in the community. Several peer educators have engaged in the defense of human rights. This is how the National Human Rights Center received MSM, who introduced themselves as OPALS partners.

"If I must mention one "most significant" change, it is the visit of our peer educators to the National Human Right Center in April [2012]. For me, it is more than a change, it is a victory. The peer educators were received as MSM and benefited from a session in which human rights were defined as being common to all, whatever group we belong to. This is a success. And I think that the most important thing for our MSM group is that this visit is the beginning of a work on the self-stigma in which they live and they are aware that their rights are not different from those of other Moroccans."

Through greater self-confidence, increasing self-awareness of their role, and speaking out on the issue of MSM and their rights, the peer educators of OPALS in Rabat and Fez are claiming a space for discussion and exchange. On this point, Dr. Boutaina Drissi Alami states:

"For our association, what has changed is more visibility in terms of advocacy to facilitate access to services (care and other) for higher risk populations."

The commitment of peer educators aims at defending their rights, meeting the needs and facing the challenges of MSM on a daily basis. In order to illustrate this change in the work of peer educators, the respondent refers to another intervention:

"I cannot end without mentioning that our peer educators are part of the OPALS Youth Committee. They have integrated the organization and they do not work in their own context of the project only, this Youth Committee talked for 45 minutes on April 04 with UNAIDS Executive Director, Michel Sidibé, on the premises of OPALS, MSM took the floor and expressed their views as young MSM."

With the technical support from AMSED, OPALS-Rabat but also OPALS-Fes succeeded in developing the necessary conditions to enable MSM to defend their rights by themselves and raise their voices.

3.5. Changes in the environment

The field work enabled the MENA partners to collect 23 stories related to the environment area. They were collected among 15 association representatives, five key stakeholders, and three peer educators. During the regional workshop, the partners selected four interviews which reflect the most significant changes in the environment. Table 9 on the following page outlines the main themes raised by the respondents in the four selected stories:

Table 9. List of topics raised by the respondents of the four selected stories:

N°	Code	Respondent profile	Most significant change in the environment
1	LAC1	Dr Mustafa El Nakib, Director of the Lebanese National AIDS Program (NAP)	• Development of the project over time • Association institutional capacity building • Increased visibility of associations • Development of association partnership in Lebanon and at the regional level • Better knowledge of MSM and homosexuality • Reduced stigma and discrimination against MSM in society • Increased visibility of MSM • Defense of their rights by MSM • Development of the feeling of safety/protection in MSM
2	TAC2	Dr Myriam Ben Mamou UNAIDS Program Officer	• Greater knowledge of HIV epidemic among MSM • Better analysis/knowledge of MSM situation • Greater visibility of MSM • Acceptance of the issue of sex between men by HIV response actors • Integration of the MSM vulnerability question in the strategic planning • Good use of results in advocacy research
3	MA2	Rachida Akerbib Coordinator of the AMSED Health Department	• Visibility/recognition of MSM • Acknowledgement of the need to work with MSM as a public health priority
4	AA1	Aziz Tadjeddine, APCS President	• Greater freedom of speech and action around the theme of sex between men • Media reporting on the issue of sex between men without censorship • Involvement of religious leaders in HIV response and MSM support • Involvement of religious leaders in the development of recommendations for MSM • Acknowledgement of the organization's work for MSM by the Ministry of Health

Testimony in Lebanon

The Lebanese team selected the story of Dr. Mustafa El Nakib, the Director of the Lebanese NAP. In his testimony, the he recognizes the dynamism of the MENA program for MSM and the development of their activities. However, notwithstanding the efforts undertaken, HIV prevalence has not decreased among MSM. This population is highly vulnerable. The lack of financial resources often is a hindrance to the support to MSM:

> *"I think this project is very active at the level of its services and its interventions. It really developed those last years […]. Results are below expectations. On the contrary, I find that there are more AIDS affected people at the level of the target population."*

Regarding stigma and discrimination as an obstacle to HIV and AIDS prevention, the associations involved in the program for MSM have engaged in fighting homophobia, especially as sex between men is subject to legal repression in Lebanon. According to the NAP Director, Lebanese society is beginning to be more open-minded about the issue of sex between men, thanks to the activities conducted in health promotion. He says:

> *"Information, communication and prevention activities have enabled society to understand better the questions linked with STDs, as well as homosexuality. Those gains have led society to be less discriminating."*

Also, MSM are becoming more visible. This is a very important step in HIV response and in the inclusion of this population in society. For NAP Director:

> *"The MSM population has become more visible. They are now able to conduct public activities peacefully, to claim their rights and stand for them. They are less afraid of coming out […] and they have three NGOs taking care of the MSM population. This is the result of the Alliance support to those organizations. This support enabled beneficiaries to feel more protected and more understood, especially as they are criminalized by the law; this is why they always feel the need to be protected from these laws."*

Through their familiarization with NGO w, many MSM are less indifferent to the public sphere in Lebanon. Now, they are increasingly aware that their involvement in public affairs is a means that can help in their opportunities, choices and decisions. The involvement of MSM contributes to strengthening the HIV response though the sharing of their experiences.

Through the efforts of SIDC, Helem and Oui Pour la Vie, many MSM have become aware that their involvement in fighting STIs and AIDS is critical to ensure that their rights and health needs are considered. In paraphrasing the saying, "if you want something done right, do it yourself," young MSM have begun engaging in associative work and volunteer service to defend their interests and ensure support and counseling to their peers. They are also investing in outreach work with other types of populations affected by those infections, including youth in the general population.

Testimony in Tunisia

The Tunisian team selected the testimony of Dr. Myriam Ben Mamou, Program Officer at the UNAIDS Secretariat in Tunisia, for its wealth in information and for Dr. Ben Mamou's deep knowledge of the evolution of the situation of MSM in Tunisia. She highlighted the role that ATL-Tunis has played to break the silence around the question of sex between men and to reduce the invisibility of MSM:

> *"We have moved from a time when discussing MSM was very difficult and almost impossible in public with governmental partners, to a situation where this issue has been accepted with gradual maturation. […] One can see more and more in technical meetings the MSM representative saying: "I represent MSM", this is something new and particularly courageous in the present context, since this behavior is still criminalized. This is something that has really changed. […] Through this program, the*

involvement of people from this community has given a human face to the issue, in particular for technicians for whom it was something abstract in the past. So it has humanized the issue and this is very important."

Dr. Ben Mamou also stressed the importance of research not only in the increased knowledge of this population, but also in the improved targeting of the interventions designed for them:

"The first study that was conducted with key populations was a behavioral study with MSM. […] I think that was an important point in starting the objectivation of the epidemiological situation in Tunisia with key groups. For me, this is really the first important contribution of the project. For we moved from a time when discussing MSM was very difficult and almost impossible in public with governmental partners, to a situation where this issue has been accepted with gradual maturation."

This testimony shows that ATL-Tunis has used research and analysis to help develop the evidence base related to MSM, identify the needs of MSM and better target activities for this population. As an illustration, the results of the participatory community diagnosis[11] conducted in great part by MSM among their peers were used to develop and implement several activities (information, communication, training, support, and others). The 2009 and 2011 bio-behavioral surveys with MSM conducted by ATL-Tunis enabled this organization to better capture the extent of the epidemic in MSM and to grasp the experience lived by this under-researched population. Dr. Ben Mamou of UNAIDS says:

"I believe that from the moment when we had figures about behavior and later on in 2009 about prevalence, that were confirmed in 2011, this is when we really irrefutably proved that the epidemic was concentrated in particular in the MSM population and that we all have the duty to strive to provide an efficient response."

Disseminating the results of these studies provides evidence that can be used by governmental and non-governmental agencies to break the silence around the issue of sex between men and to address the vulnerability of this population in strategic planning.

Dr. Ben Mamou also insisted on the progress achieved in integrating this issue of sex between men in the strategic planning regarding HIV response in Tunisia, which started in 2004. The AIDS and STI response national strategic plan (2012-2016) focused particularly on key populations, including MSM. Many respondents in Tunisia referred to the strategic focus of this plan regarding "the reform of the legal framework and the promotion of human rights to ensure human dignity and reduce stigma and discrimination in all the contexts of HIV response:"

"In the NAP, we have an important focus, which is human rights, the reform of the legal framework and human rights watch, I think it is important because the community gets involved even if the context is not favorable."

[11] International HIV/AIDS Alliance, ATL MST/SIDA - section de Tunis, *Diagnostic communautaire participatif, Répondre aux besoins en santé sexuelle des Hommes ayant des relations Sexuelles avec des Hommes à Tunis*, Tunis, International HIV/AIDS Alliance, ATL/SIDA - section de Tunis, 2006.

In her testimony, Dr. Ben Mamou also raised the issue of the involvement of MSM: through their familiarization with associative life, many MSM engage in the public sphere. Indeed, they no longer want to be set aside from actions, measures, and/or programs that affect them. Thus, ATL-Tunis has engaged this population in the identification and implementation of actions to their benefit:

> *"At the national level, in 2006 when those studies started being implemented, apart from ATL, there was no organization or stakeholder who had easy access to the population; yes very clearly, ATL through their MSM program has played an important role in operational research with key populations. ATL was a pioneer in this area. […] I think that the great strength of the MSM program is to work with people from the community, this is obvious and it is also true that we have witnessed some maturation. […] it also seems very important to me that ATL activism and watch role should not be diluted in service provision only."*

The commitment of ATL-Tunis to MSM continues to grow. This investment constitutes a valuable legacy in terms of analysis and support to a plural key population. Many signs demonstrating institutional dynamics, based on the development of a know-how focused on the will of promoting health and the respect of human rights with MSM.

Testimony in Morocco

The Moroccan team selected the story of Rachida Akerbib, Coordinator of the AMSED Health Department. This testimony recalls the context of the need to work with MSM and sex workers. The most important change remains this acknowledgement that MSM are a public health issue:

> *"At the beginning, the project raised a lot of debate, especially regarding homosexuality and male sex work. Each time, the debate was very interesting and also challenging, due to the sensitivity of the questions raised especially at the religious and moral levels. Homosexuality is said to be unnatural…"*

It is clear that developing a project for and with MSM in this context appeared as an approach both innovative and courageous. As the respondent explains, an emergency in terms of public health arose and working with MSM appeared crucial:

> *"There is a reality: [the] epidemiological situation in Morocco. One must acknowledge that it is a very high risk population and our role as development agents is to facilitate the access of higher risk populations to services whatever their sexual identity and their behaviors and sexual practices."*

In initiating the MENA Project for and with MSM, AMSED and their partners (ALCS then OPALS – see footnote on page 17) were able to publicly raise the need to improve MSM's access to prevention and care. Rachida Akerbib also noted that now, different actors recognize the existence of a concentrated epidemic in MSM:

"The question gradually becomes a health issue overall. We must facilitate access to prevention services in a respectful and non-stigmatizing setting. Thus, several actions were taken to this effect by the national AIDS program in which I participated as AMSED: Acknowledgement of MSM as a population at higher risk of HIV infection in the National AIDS Strategic Plan; Organization of a workshop to reflect about HIV integration in national safety; Organization of training workshops on stigma for physicians; Review of the Right and Gender component in the NAP 2007-2011."

Testimony in Algeria

The APCS team selected the story of its president, Aziz Tadjeddine. He spoke of how APCS contributed to providing visibility for MSM while also attempting to meet their needs, noting that this is a very important step in the HIV response and in the inclusion of this population in society:

"This change is important for me, as in a difficult, hostile, aggressive context, the association, taking its time, was able to successfully develop such issue in a country where it was impossible to discuss homosexuality without being insulted or verbally abused! We have succeeded in freeing speech."

Religious leaders in Algeria became aware of the vulnerability of some invisible groups including MSM. Now, some of them have taken into account the specificity of the issue of sex between men, and, in some cases, they refer people asking for advice about HIV and AIDS and sex between men to APCS. This partnership with religious leaders enabled APCS to develop recommendations likely to guide the actions of the association in the future. In this regard, the respondent said:

"But the most significant change is the involvement of Imams in this project, while homosexuality is criminalized and forbidden by Islam […]. We were able to gather 18 Imams in September 2011 for a roundtable conducted under this project, where we discussed the care and support to vulnerable populations, especially MSM […]. Imams made a series of recommendations in which they share an important part."

The efforts undertaken by APCS have contributed to break the silence around the issue of sex between men. MSM, who were for a long time left aside, even marginalized by most social actors and stakeholders, including health professionals, have now started being taken into account by many actors. In this context, the civil society appears to be a link between some population groups and the governmental and non-governmental agencies that are involved in their welfare.

Conclusion: The impact of the MENA Program

In the context of the HIV response, sharing information around this global epidemic requires addressing various sensitive issues such as sexuality outside marriage, sex between men, sex work and drug use. However, addressing those questions in the socio-cultural and un-enabling environment of the MENA Region is challenging.

The "invisibility" of MSM and the great stigma against sex between men often result in shortcomings in prevention, care and support actions. It is in this context that the partner organizations of the USAID-funded MENA Program focus on providing combined prevention information and services to the MSM population.

The most significant change approach was chosen in order to document the changes brought about by the actions of partner organizations for the benefit of MSM. This exercise revealed that MSM involved in the program now have access to improved sexual health services and are beginning to see increased respect for their human rights, thanks to the commitment of the MENA program partner organizations. There is still a lot to do for MSM to enjoy their full rights and be socially recognized without stigma and discrimination, however, this report has helped to highlight some progress in this.

A space of openness and tolerance

The MENA partner organizations are committed to MSM and defending their health needs and human rights. In a context where sex between men is criminalized and where MSM are overlooked by HIV policies and programs, these organizations have, over time, gained expertise in supporting this key population in enabling them to access services.

The various testimonies collected through the MSC approach have emphasized the "human/ friendly" character of the intervention of the partner organizations, reflected in the development of user-friendly spaces where supporting MSM gives priority to self-esteem: whether the populations they serve are HIV-positive bisexuals, gays, transgender people, sex workers or homosexuals or not, the MENA partners' guiding principle to defend their rights to dignity.

As underscored many times in this report, many MSM, due to their fear of stigma and discrimination, often withdraw into themselves and have difficulty accepting themselves. The MENA partner organizations have created places of tolerance where their rights and dignity are preserved and respected. This is why for many MSM, the associative space is a haven where they are free to express themselves: they feel confident there, thanks to the professionalism and the ethical conduct of the members of those associations.

Active involvement of MSM

Thanks to the involvement of the partners in the field, links were developed between the active members of the associations and MSM: this enabled the latter to move from a status of objects of intervention to actors involved in the most relevant responses to the needs of that population. The partner organizations work to involve MSM in the development, implementation and monitoring of STIs, HIV and AIDS prevention efforts. In this perspective, using the peer educator approach has favored outreach work with diverse groups of MSM.

Many collected testimonies emphasize solidarity between the association beneficiaries and members. In a context that is hostile to sex between men, the links among this population appear to be a shield against stigma and discrimination. In this perspective, associations work to promote psychosocial support to MSM, and make them more self-confident. This is how the latter have become aware of their key role in HIV response and are now fighting to prevent the number of HIV-infected cases from increasing and also to enable PLHIV to benefit from anti-retroviral treatment, and wider care and support services.

Creating an open and enabling environment for better care and support of MSM
In supporting MSM, the MENA partners have also strived to form a network between the different institutions working on the HIV response in order to develop more favorable conditions to address this population's needs in a society where sex between men is repressed or criminalized. The idea of developing networks between those associations and other key actors, for example, is one way of integrating this population in the national policies and programs. Effective networking can lead to better referrals between and within services, widens the support available to individuals and helps to ensure a better understanding of MSM needs and challenges.

Prevention of high risk sexual behaviors and awareness-raising in MSM to safe sex
In the development and implementation of programs and activities that benefit MSM, it is critical to address their specificities and not only focus on their marginalization. To this effect, the MENA partners engaged in adopting programs and actions that integrated the harm reduction approach without any stigmatizing connotations in order to avoid marginalizing MSM.

It must also be noted that the MENA partners have worked to improve the conditions of men who sell sexual services, in promoting self-esteem, solidarity and mutual support (peer education) and ensuring greater access of MSM in general to prevention, care and support services for sexually transmitted infections including HIV and AIDS, while encouraging them to get free and anonymous counseling and testing.

Better access to services and higher self-esteem among the MSM population contribute to the national HIV response. Much progress remains to be made, such as the systematic use of condoms, promoting testing, improving the continuum of prevention, testing and care or continuing the fight against stigma and discrimination against MSM.

In the MENA region, sex between men continues to be condemned socially and carries legal punishment; there are few programs specifically tailored for MSM. The taboo on the issue of sex between men reinforces the vulnerability of an invisible and under-analyzed population. However, better support for MSM through specific prevention campaigns and appropriate and non-stigmatizing health services would reduce the spread of HIV and AIDS both within this group and the population in general. The HIV response would be more effective if it broke the silence surrounding the issue of sex between men.

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Annexes

Annex 1. Implementing the 'demonstrating results' project – April-June 2012

The participatory approach increases the quality, effectiveness and relevance of policies and programs, in particular through community system strengthening. In the different phases of the technical support of this project, we built upon a participatory approach that ensured the involvement of diverse actors, including men who have sex with men. Thus, in the four countries MSM were involved in the main steps of this project, including:

- Participation in the 1st regional workshop of training of investigators and design of data collection tools;
- Data collection;
- Focus groups: – selection of the most significant changes;
- Participation in the 2nd regional workshop for result validation and communication/dissemination.

A) Regional Workshop to present the MSC methodology and design tools (April 2012)

The first regional workshop, held in Tunisia in April 2012, aimed to make a detailed presentation of the method used for this project, namely the most significant change approach, finalize interview guides for each respondent type, and agree the budget required to gather and monitor data collection.

B) Data collection (May 2012)

As part of this work, interviews were conducted with the following people: beneficiaries, peer educators involved in supporting MSM, organization representatives, and key players in the HIV response (in Lebanon and Tunisia). A total of 84 interviews were conducted. We interviewed 41 beneficiaries of partner organizations involved in the MENA program and 23

peer educators involved in supporting MSM. The number of interviews by country and type of respondent is as follows.

Number of interviews conducted by country and by type of respondents:

	Algeria	Lebanon	Morocco	Tunisia	Total
Beneficiaries	9	12	8	12	**41**
Peer educators	5	6	5	7	**23**
Representatives of associations	3	6	2	4	**15**
Other key actors	-	2	-	3	**5**
Total	**17**	**26**	**15**	**26**	**84**

C) Participatory data analysis and selection of stories (May 2012)

In the present study, focus groups were held in each country during the month of May 2012, to discuss and select key stories. Focus group participants were representatives from partner organizations, beneficiaries, peer educators, investigators, and in some cases key external actors.

Discussion groups helped reduce the number of stories collected, focusing on: the importance and validity of a story; the integration of evidence to support the change; links to the areas of change selected for the evaluation.

For each area, the group selected a story to represent the most significant change through a vote or consensus.

D) Regional Workshop on story validation and lessons learned (June 2012)

There was a second workshop two months later on 21-22 June 2012 in Rabat on data validation and communicating results. The meeting's objectives were:

- Present and validate the results of national reports
- Select stories for the regional report
- Identify lessons learned from the process

Eleven people attended the second regional workshop, representing six partner organizations from the MENA program.

Annex 2. Profile of the respondents

Profile of the beneficiaries interviewed (41 respondents):

- 5 were under 20, 21 were between 20 and 30, 15 were over 30.
- 5 had reached primary education only, 6 had reached the first cycle of basic education, 13 had reached the second cycle of basic education (secondary) and 15 higher education level.
- 1 is unemployed and has never worked, 14 are unemployed but have worked before, 17 are workers, 6 are students and 1 Moroccan is an annuitant.
- Most of them (19) reside with their family, 8 with relatives, 5 in their own houses, 5 live with or at friends and 1 interviewee in Lebanon has no fixed abode.
- 5 interviewees were married and 3 of them have children, the 36 others are single.
- Regarding their perception of their sexual identity, 15 reported feeling bisexual, 9 perceive themselves as homosexuals, 5 as MSM, 10 as gays and 1 as a transgender.
- About half reported having experienced verbal and/or physical violence in the last 12 months preceding the survey, due to their sexual orientation.
- The most frequently reported places and settings of contact with male sexual partners are: internet, the street, cafés/tea rooms, bars/restaurants and, to a lesser extent, parks or gardens, discothèques, Moorish baths.
- Among the interviewees, 17 wished they could leave the country, 7 reported not thinking about the future, 4 wished they could leave the parental home, 2 wished to move to another region and 8 wished to remain in the same situation.

Profile of the peer educators interviewed (23 respondents):

- 1 respondent was under 20, 16 are between 20 and 30 and 6 are 30 and over.
- Most interviewees (21) attended school: 2 reached the 1st cycle of basic education, 4 reached the secondary cycle, 14 had pursued higher education.
- 2 were unemployed and have never worked, 4 were unemployed but have worked before, 7 were workers and 9 were students.
- Most peer educators live with their family (17 of them), 5 reported living in their own house, 1 with relatives and 2 at or with friends.
- 14 were single, 1 is divorced and 3 are living with a male sexual partner.
- As to their perception of their sexual identity, 3 reported feeling bisexual, 1 perceives himself as a homosexual, 4 as MSM and 15 as gays.
- Concerning the violence experienced from peer educators, 12 among them report having experienced verbal and/or physical violence in the last 12 months preceding the survey, due to their sexual orientation.
- Also, the places of contact with male sexual partners most frequently reported by peer educators include: internet, cafés/tea rooms, bars/restaurants and, to a lesser extent, the street, discothèques, public gardens and Moorish baths.
- 8 wished they could leave the country, 3 reported not thinking about the future, 1 wished to leave the parental home and 5 wished to remain in the same situation.

Annex 3. Data collection tools

These were developed during the regional workshop in April 2012:

1) Interview Guides

1. Introduction

Good morning/afternoon, my name is (*insert your first name*), I am a member of the association (*insert association name*).

Since 2004, this association has been implementing a MENA regional program to meet the sexual health needs of men who have sex with men (MSM) and has been working on the improvement of MSM conditions of life, inter alia, in *(insert country name)*. For this purpose, we conduct activities such as: (*insert main activities conducted by the organization. Ex: distribution of condoms/lubricants, legal support, online, orientation, VCT, etc.*).

We are conducting this interview with our beneficiaries to improve our services and facilitate your access and use of them.

The goal of our study is to give an overview of the impact of the MENA Region programs in collecting their feedback on the **most significant changes** that may have occurred.

2. Confidentiality

Please tell the respondent explicitly: "We can use your story to better understand the results of the project and to help our association review our activities"

Do you agree (the respondent):

That your story be published anonymously (check as appropriate) Yes No

That our interview be recorded Yes No

(The recording will only help transcribe your answers and will be destroyed later. Nobody outside the organization will have access to the recording)

3. Details

Name of investigator:
Collection method (face to face, by telephone, self-administered, etc.):
Date of the interview:
Duration of the interview:
Code:

4. Questions

4.1 Questions for the beneficiaries

Change at your level

1. Since when have you been in contact with our organization?
2. During that period, how did you benefit from this project/were you affected by this project?
3. In this regard, what has changed in your situation? What did it bring to you?
4. In those changes, which one was the most important?
5. *Probing questions:*

a. Can you give details about this change (how, why, thanks to what, thanks to whom, for whom, when?) and
b. Can you give examples of what happened?

6. Why was it important for you?

Comments of the investigator (summarize the most significant change identified and say why it is important for that person):

Change(s) in relation to the services received (if not addressed in the first part)

Thank you for those answers.

1. This project worked on specific services, like HIV testing, STI diagnosis and treatment, online, legal support, etc. *to be customized according to the association*): did you benefit from those services?
2. In this regard, what has changed in your situation? What did it bring to you?
3. In those changes, which one was the most important?
4. *Probing questions:*
    a. Can you give details about this change (how, why, thanks to what, thanks to whom, for whom, when?) and
    b. Can you give examples of what happened?
5. Why was it important for you?

Comments of the investigator (summarize the most significant change identified and say why it is important for that person):

4.2 Questions for the peer educators

Change at your level as a peer educator

1. Since when have you been working with our organization as a peer educator?
2. During that period, how did you benefit from this project?
3. In this regard, what has changed in your situation as a peer educator? What did it bring to you?
4. *Probing questions*:
    a. Can you give details about this change (how, why, thanks to what, thanks to whom, for whom, when?) and
    b. Can you give examples of what happened?
5. Why was it important for you?

Comments of the investigator (summarize the most significant change identified and say why it is important for that person):

Choose a second theme: 1) change at the MSM population level OR 2) change at the environment level. This choice is to be determined according to the expected contribution of the respondents. You must choose respondents who would be able to answer according to their possible contribution to the first or second question.

Option 1: Change at the MSM population level

1. Now, we are going to discuss the MSM with whom your work. Have you seen any change at the level of the population?
2. In this regard, what has changed in their situation? What did it bring to them?
3. In those changes, which one was the most important?
4. *Probing questions*:
    a. Can you give details about this change (how, why, thanks to what, thanks to whom, for whom, when?) and
    b. Can you give examples of what happened?
5. Why was it important for the population?

Comments of the investigator (summarize the most significant change identified and say why it is important for that person):

Option 2: Change at the environment level

1. Now we are going to discuss environment. Have you seen any change at the level of environment? This may concern the environment of the MSM population, the environment of the association or HIV/AIDS response in our country.
2. *Give examples, as necessary. For example, by environment, one can understand the MSM community, sub-groups in the population, people in MSM environment who may have positive or negative influences (service providers, law enforcement agents, anti-gays), the key actors around this association, the actors and decision- makers in AIDS action (associations, public sector).*
3. Following this project, what has changed in the environment?
4. In those changes, which one was the most important?
5. *Probing questions:*
    a. Can you give details about this change (how, why, thanks to what, thanks to whom, for whom, when?) and
    b. Can you give examples of what happened?
6. Why was it important?

Comments of the investigator (summarize the most significant change identified and say why it is important for that person):

4.3 Questions for the organization staff

Change at the association level

1. Since when have you been working with our organization or are you a member of our association?
2. During that period, how did the association benefit from this project/how was it affected by this project?
3. In this regard, what has changed in the association? What did it bring to the association?
4. In those changes, which one was the most important?
5. *Probing questions:*
    a. Can you give details about this change (how, why, thanks to what, thanks to whom, for whom, when?) and
    b. Can you give examples of what happened?
6. Why was it important for the association?

Comments of the investigator (summarize the most significant change identified and say why it is important for that person):

Change at the environment level

1. During this period when you were involved, did you notice any change at the level of environment. This may concern the environment of the MSM population, the environment of the association or HIV/AIDS response in our country.
2. *Give examples, as necessary. For example, by environment, one can understand the MSM community, sub-groups in the population, people in MSM environment who may have positive or negative influences (service providers, law enforcement agents, anti-gays), the key actors around this association, the actors and decision makers in AIDS action (associations, public sector).*
3. Following this project, what has changed in the environment?
4. In those changes, which one was the most important?
5. *Probing questions:*
    a. Can you give details about this change (how, why, thanks to what, thanks to whom, for whom, when?) and
    b. Can you give examples of what happened?
6. Why was it important?

Comments of the investigator (summarize the most significant change identified and say why it is important for that person):

4.4 Questions for stakeholders representatives

1. Since when have you been working in collaboration with our organization?
2. According to you, did this project contribute to AIDS response? If yes, how?
3. What changes did you perceive following our prevention efforts with the MSM population?
4. In those changes, which one was the most important?
5. *Probing questions*:
    a. Can you give details about this change (how, why, thanks to what, thanks to whom, for whom, when?) and
    b. Can you give examples of what happened?
6. Why was it important?

Comments of the investigator (summarize the most significant change identified and say why it is important for that person):

5. Ending the interview

Thank the respondent for their availability and their time. Specify that in part thanks to their participation, the effectiveness of HIV/AIDS projects targeting MSM should be better known. On this basis, new projects still more relevant should be developed.

Include, according to the wish of countries, one word on the restitution and/or sharing of results with the project beneficiaries. Give maximum details on the process that you have identified to achieve this.

2) Questionnaire about respondents' profile

Country	**Algeria**	**1**	**APCS**	
	Lebanon	**2**	**SIDC**	[__]
			Oui pour la Vie	[__]
			Helem	[__]
	Morocco	**3**	**AMSED**	[__]
			OPALS – Fez	[__]
			OPALS – Rabat	[__]
	Tunisia	**4**	**ATL MST/SIDA – Tunis**	
Code of questionnaire	**……**			
Investigator	**……**			
Date of interview	**……**			
Status of respondent	**Beneficiary**		[__]	
	Peer educator		[__]	

N°	Questions	Coded answers		Go to
Q1	How old are you?	Age in years [__|__]		
Q2	Did you attend school?	Yes	1	
		No	2	➔Q4
Q3	What level did you reach in your education?	Primary	1	
		First cycle of basic education	2	
		Secondary/2nd cycle of basic education	3	
		Higher education	4	
		Vocational training	5	
		Adult education	6	
Q4	What is your occupation (the activity that takes most of your time presently)?	Worker. Specify……..	1	
		Unemployed and has already worked	2	
		Unemployed and has never worked	3	
		Pupil/student	4	
		Annuitant	5	
		Unable to work for health reasons	6	
		Other……..	7	
Q5	Where do you live now?	Own house	1	
		With family	2	
		With relatives	3	
		At/with friends	4	
		No fixed abode	5	
		Other……..	6	
Q6	Present marital status?	Single	1	
		Engaged	2	
		Married	3	
		Divorced	4	
		Widow	5	
		Living with a male sexual partner	6	
		Living with a female sexual partner	7	
		Separated	8	
Q7	If you have children, how many?	Number of children	[__|__]	
Q8	How do you define yourself?	Gay	1	
		Homosexual	2	
		MSM	3	
		Bisexual	4	
		Heterosexual	5	
		Transgender	6	
		Other……..	7	
Q9	In the last 12 months, did you experience a verbal or physical abuse because of your sexual orientation?	Yes	1	
		No	2	
Q10	In the last 12 months, where did you meet your male sexual partners most often?	Street	1	
		Cafés / tea room	2	
		Bars / restaurants	3	
		Discothèques	4	
		Parks / public gardens	5	

		Moorish Baths	6	
		Internet	7	
		Other……..	8	
Q11	What are your future plans?	Maintain the same situation	1	
		Leave parental home	2	
		Move to another city or region	3	
		Leave the country	4	
		Not think about the future	5	
		Other…….	6	

Annex 4. Lessons learned from the 'demonstrating results' project

Using the most significant change approach to document their interventions' results was a first experience for the partner organizations. They found the approach easy to implement and said they would use the CPS approach again to document their work with other key populations. The project fostered exchange:

- Within the associations involved in each country;
- Between the associations of the four countries, on the one hand, and the representatives of those organizations and IHAA, on the other hand, during two regional workshops;
- Between the concerned associations and key stakeholders of the HIV response (in Lebanon and Tunisia).

A review of organizations' activities

This participatory documentation project of the results of the MENA program was an opportunity for organizations involved to review their contribution to the HIV response and their support to a diverse and hidden population group, often left to its own devices. In some cases, the experience helped organizations identify areas of weakness. This documentation and learning exercise was seen as an opportunity to look back at interventions, which is often not possible due to a lack of time and the burden of daily work. According to some stakeholders, the adoption of this approach has contributed to the development of a partnership between their organization and its beneficiaries.
Regarding the involvement of peer educators, it appears that this year has not only contributed to the development of their skills but also enabled them to take a step back from their work in the field with the target group.

The importance of monitoring

For many participants involved in implementing this project, planning and ongoing monitoring are crucial steps. However, continuous monitoring could not always be assured because of the field work supervisor's workload, the lack of communication between team members and the lack of experience in handling the qualitative data collected.

A relevant and easy to implement approach

The representatives of associations in Algeria, Lebanon, Morocco and Tunisia easily developed ownership of the most significant change approach. According to those actors, this participatory and transparent approach, that gives priority to the qualitative method, is relevant and quite easy to implement and could be regularly used.
The discussion groups organized in the four countries to select the stories reflecting the most significant changes among the collected testimonies were regarded by some representatives as important moments in the implementation of the documentation project.

Short time-frame

The investigator teams did not face any major challenges in using the investigation tools developed. However, a three-week period to collect, transcribe and translate the interviews was proved to be short, in particular to ensure the monitoring of the quality of stories and

provide a feedback to investigators. The field work supervisors found in particular difficult to check all the stories, yet interview checking remains a significant step.

The short time for the field work prevented the Algerian and Moroccan teams from collecting the statements of some partners. Yet the point of view of external stakeholders about the most significant changes generated by the project is essential to reinforce the credibility of the study and provide additional information on the actions conducted.

Difficulties in selecting the MSC

Despite the clarity of questions in the interview guides, the respondents often found difficult to select the most significant change among those that they reported: a difficulty in prioritizing and "ranking" changes in a clear and articulate way.

Under-prepared investigators

All the investigators did not master fully the data interview skills, in particular the probing technique. In some cases, this problem had a negative impact on the quality of the stories collected, which were not always rich in information. A lack of diversity in the collected stories was also observed: some stories were redundant regarding some significant changes identified such as access to the condom and HIV testing, improved HIV/AIDS knowledge.

Extending this experience to other populations

The methodology overall proved to be valuable: it demonstrated in a powerful way, using beneficiaries own words, the impact to them in combating stigma, better understanding and prioritization of their own health etc. Satisfied with this first experience, the associations see the added value of such qualitative evaluation and expressed their intention to use the most significant change approach further with other populations targeted by those organizations.

Lessons learned in Algeria

The implementation process for the most significant change approach encouraged APCS to discuss their MSM interventions. This experience was perceived as an opportunity to review APCS' contribution to the HIV response and the support provided to a specific and diverse population. The APCS team did not have any problems taking ownership of the most significant change approach or using the research tools. However, some weaknesses were identified at the end of this process, namely: interview skills; transcribing data; timelines: the short timeframe devoted to fieldwork prevented APCS from collecting the stories from some of their partners, such as religious leaders. After this experience, the APCS team said they wanted to use this approach with other vulnerable populations they work with.

Lessons learned in Lebanon

The implementation process for the most significant change approach encouraged discussions within SIDC, Helem and OPV. It enabled the organizations to look back at their contribution to the HIV response and their support to MSM.

It was easy for the three teams to take ownership of the most significant change approach. The interviewers did not encounter any difficulties in using the research tools, but despite their positive experience, some negative points emerged:

- The work was delayed because some actors were unavailable;

- The period for the collection, transcription and translation of the interviews was too short, especially in terms of monitoring story quality;
- Respondents appear to have struggled to select the most significant change, despite the clarity of the questions in the interview guides;
- Translation from Lebanese into French added more time to the schedule, but this means two versions of the stories are available.

In spite of these difficulties, it is important to highlight the success of this experience regarding the development of self-esteem within this population group: many respondents expressed their willingness to testify by giving their name. It was their way of supporting the MSM cause in their country. The three organizations said they wanted to use this approach with other populations they work with.

Lessons learned in Morocco

The most significant change approach has provided stories that contain quite a lot of information on changes that have taken place since AMSED and OPALS have started to implement their activities. However, it is worth noting that a number of weak points relating to the adoption of this approach came to light during the field work:

- Despite the questions in the interview guides being clear, some investigators did not fully grasp interview techniques, and this had a negative impact on the quality of the interviews which were sometimes lacking in information
- The short time devoted to field work prevented t AMSED and OPALS from collecting information from some of their partners, including representatives from the Ministry of Health or UNAIDS.

Information was collected from investigators and from the coordinator to identify lessons learned. It appeared that the time to collect, transcribe and translate interviews was too short to monitor the quality of the stories and provide feedback to investigators. In addition, when the investigators had not been trained in the regional workshop, the stories collected were not of good quality, short and sometimes incomplete.

Despite these shortcomings, this exercise allowed these organizations to strengthen their skills. OPALS plans to reuse this method in the near future for other projects with migrants.

Lessons learned in Tunisia

The most significant change approach has provided stories rich in information regarding the changes that have taken place since ATL-Tunis started implementing its activities. However, it should be noted that this experience has highlighted some weaknesses in adopting this approach, particularly with regard to the collection, transcription, translation and verification of interviews, especially as some stories were incomplete.

It should be noted that ATL-Tunis did highlight the positive aspects of this approach that allowed it to review its strengths and weaknesses. The organization wants to follow this method in the near future for other projects. This method is not expensive and is easy to set up and plan and has therefore captured the attention of the organization’s members.

Annex 5. List of investigating teams

In Algeria:

Omar Ouhaddad (Country Coordinator), APCS

Mohamed El Amine Ain Kouir
Abdelouafi Ouali
Djamila Ouabdsselam
Fatiha Razik

In Lebanon:

Nadia Badran (Country Coordinator), SIDC
Rony N. Abou Daher, (Supervisor, Translator), SIDC

Joseph Azzi, OPV
Ibrahim Diahb, Helem
Elie Elkik, OPV
Roy Fadel, OPV
Mario Hayek, OPV
Rabih Maher, Helem

In Morocco:

Said Kharouiche (Country Coordinator), AMSED

Rachida Akerbib, AMSED
Boutaina Drissi Alami, OPALS
Rachid Krissou, OPALS

In Tunisia:

Bilel Mahjoubi (Country Coordinator), ATL MST/SIDA – section de Tunis

Badr Baabou
Skander Gajim
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Hassen Hnini
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