MSM PROJECT ORIENTATION MANUAL

FOR THE MIDDLE EAST AND NORTH AFRICA REGION

Acknowledgements

The MENA programme's partner associations

- APCS (Association de Protection Contre le Sida) in Algeria
- SIDC (Soins Infirmiers et Développement Communautaire), OPV (Oui Pour la Vie) and Helem in Lebanon
- AMSED (Association Marocaine de Solidarité et de Développement), ASCS (Association Sud Contre le Sida) and OPALS-Fes (Organisation Panafricaine de Lutte Contre le Sida, section de Fes) in Morocco
- ATL (Association Tunisienne de lutte contre les MST/SIDA) in Tunisia

Contents

Abbreviations and acronyms

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
CCM	Country Coordinating Mechanism
CSO	Civil society organisation
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human immunodeficiency virus
ICT	Information and communication technology
HCV	Hepatitis C virus
IDLO	International Development Law Organization
LGBT	Lesbian, gay, bisexual, transgender
LGBTI	Lesbian, gay, bisexual, transgender, intersex
MENA	Middle East and North Africa
MSM	Men who have sex with men
NGO	Non-governmental organisation
PEP	Post-exposure prophylaxis
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PHDP	Positive Health, Dignity and Prevention
PrEP	Pre-exposure prophylaxis
STI	Sexually transmitted infection
TasP	Treatment as prevention
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNAIDS RST MENA	UNAIDS Regional Support Team for the Middle East & North Africa
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
WHO	World Health Organization

Introduction

Why this manual?

This orientation manual is the first of four volumes of a training toolkit that complement each other.

- The source document is the MENA regional UNAIDS handbook: *HIV and outreach programmes with men who have sex with men in the Middle East and North Africa: From a process of raising awareness to a process of commitment*.
- UNAIDS and the Alliance worked with local non-governmental organisations (NGOs) and civil society organisations (CSOs) across the region to develop a regional UNAIDS/Alliance MSM peer/outreach education training toolkit informed by global best practice.
- UNAIDS and the Alliance also developed this MSM project orientation manual together.

Who is it for?

The manual was developed to provide planners and managers working with HIV MSM programme prevention and support services with the necessary information to develop sympathetic, evidence-based and comprehensive HIV prevention and support services for MSM in the MENA region. The resource is useful to both experienced programme implementers as well as those who are beginning to plan new HIV prevention and care services for MSM.

How is it organised?

The manual is organised into three sections. The first two sections (Part A: Situational analysis and Part B: Conceptualisation) cover information related to the *awareness* part of the dynamic "from a process of awareness to a process of commitment". They provide essential scientific, factual and contextual information needed by programme planners and managers in order to develop effective and ethical HIV prevention and support services for MSM that are informed and guided by human rights and public health imperatives. They are a source document, and contains links and references to other documents for those planners and managers who want to further explore the issues raised in this part of the toolkit (see Annex 2).

The third section (Part C: Towards action) covers the *commitment* aspect. In this section, we describe the kinds of interventions and processes necessary to develop effective programme interventions in response to the prevention and care needs of MSM in the MENA region.

Terminology

As you will discover in this manual, how to describe men who have sex with other men is complex. For our purposes here, MSM refers to gay-identified and other men who have sex with men.

While transsexuals may also have male genitalia and have sex with other men, it should be noted that they will not necessarily relate to programme interventions aimed at MSM as they may identify with the biological sex they feel they were meant to be. Therefore, when working with transsexuals, appropriate adjustments to prevention and care interventions will need to be made, and these should be informed and guided by transsexuals themselves.

Limitations

Since this is an orientation manual, it does not provide detailed guidance about project cycle management, from analysis, conceptualisation and design to implementation, monitoring and evaluation. These are generic programming processes that apply to any programme, and greater detail about them can be found in standard project management cycle guidance. Rather, this manual provides those thinking of developing programmes for MSM, or those already engaged with MSM, with an overview of some of the key issues and considerations necessary to develop ethical, evidence-informed programmes that are guided by global best practice, and human rights and public health considerations.

How can you use it?

This manual can be used in two ways:

■ It can be used as an information reference and resource document.

■ It can be used by trainers to develop customised MSM orientation training programmes for local and national NGOs and CSOs, as well as those in charge of resource allocation and policy development.

A word of caution. The readers and users of this toolkit should be cautioned that they should pay particular attention to avoid unintentionally sharing any sensitive personal information about the individuals that will be involved as participants or facilitators in activities related to this toolkit. Inadvertently disclosing information relating to the sexual orientation, gender identity or HIV status of participants without consent to others may result in further distrust among the MSM community and will drive them further underground. Failing to protect confidentiality can jeopardise people's personal safety and can jeopardise the success of outreach programme activities among MSM.

Furthermore, the methodologies introduced in this toolkit should not be used as a means to identify, find, collect personal information and subsequently harass or denounce MSM. This toolkit aims to contribute to the redress of prevailing prejudice against MSM living in MENA, to provide health information and care to which all citizens are entitled, and to better understand MSM in order to increase their access to appropriate health services and public health services for everyone. It should not be used against this aim.

> This manual is for planners and managers working with MSM programming.

How to plan an orientation training for civil society and NGO leaders

It is essential that those who plan to use the content of this manual for training purposes have experience of working with MSM, have a positive regard and respect for MSM, are committed to human rights and the principles of public health, and are not afraid of discussing sensitive issues regarding sex and sexuality, and social norms. Ideally, experienced MSM programme staff should form part of the facilitation team.

Below and on page 7, we outline an example of a timetable that could be used to run orientation training based on the contents of this manual. This is not prescriptive, and experienced trainers should be able to adapt the timetable to reflect the needs of their participants. Trainers may also find some of the exercises in the accompanying peer-education modules useful for their purposes.

Always remember that any training should be based on an appreciation of the adult learning principles described in the introductory section of Module 1 of the *Training manual for MSM peer educators*, and be enjoyable as well as instructional.

ILLUSTRATIVE TRAINING OUTLINE		
DAY 1		
Session 1	Introduction and setting the scene	■ Introduction to workshop ■ Participants' introductions ■ Participants' expectations ■ Aims and objectives of the workshop ■ Short reflection on participants' own feelings about working with MSM
Session 2	Epidemiology of HIV in the MENA region; statistics	■ Global, regional and country statistics ■ Drivers of the epidemic ■ Types of epidemics ■ Regional responses to the epidemic ■ Introduction to MSM – what does MSM mean?
Session 3	MSM	■ Biology, sex and identity ■ What influences or can explain sexual orientation? ■ Questions and discussion
Session 4	Experiences of MSM	■ The range of sexual behaviour – the work of Kinsey and Fritz Klein ■ "Coming out" ■ MSM, family and society ■ Conclusions and discussion
DAY 2		
Session 1	Stigma and discrimination and MSM	■ What is stigma and its impact? ■ What is discrimination and its impact? ■ Discussion
Session 2	Risk, vulnerability and sexually transmitted infections (STIs)/HIV	■ What do we mean by risk and vulnerability? ■ Brief overview of STIs and HIV ■ STIs, HIV and MSM
Session 3	Prevention and treatment	■ HIV and STI prevention ■ HIV treatment
Session 4	Guiding approaches to inform HIV programmes	■ Public health, human rights, combination prevention

ILLUSTRATIVE TRAINING OUTLINE		
DAY 3		
Session 1	Guiding approaches continued	■ Positive Health, Dignity and Prevention, harm reduction, the prevention, treatment and care continuum
Session 2	Guiding approaches and principles continued	■ Participation, community mobilisation, holistic multi-sectoral, community mobilisation
Session 3	How change happens	■ Bringing in global experience – combination prevention, and comprehensive prevention and treatment ■ Introduction to multi-level responses
Session 4	Exploring responses at the individual and social normative levels	■ Individual level: behaviour change and increasing health-seeking behaviour ■ Social normative level: addressing stigma and discrimination; creating an enabling environment
DAY 4		
Session 1	Exploring responses at the services and structural levels	■ Services level: quality, user-friendly services – what they look like and improving access and quality ■ Structural level: addressing the policy and legal environment through advocacy and other forms of structural change
Session 2	Wrap up, next steps and training evaluation	

Training should be enjoyable as well as instructional!

PART A
SITUATIONAL ANALYSIS

In this section of the manual we provide important background information necessary to understand the HIV epidemic as it relates to MSM in the MENA region. Although HIV prevalence is concentrated among various groups who have a higher risk of exposure to HIV – sex workers, people who inject drugs, prisoners and MSM – the focus of this manual is to sensitise programme planners and managers to the unique issues related to men who are exposed to HIV primarily through sex with other men.

1. The scale, dynamic and focus of the HIV epidemic in the MENA region*

A global epidemic

According to the most recent information from the World Health Organization (WHO)/UNAIDS,[1] the number of people globally living with HIV at the end of 2013 reached 35 million (33.2–37.2), of whom 2.1 million were newly infected. Of these people, only 48% knew their HIV status.

By the end of 2013, 12.9 million people globally were receiving antiretroviral therapy (ART), and the percentage of people living with HIV who were not receiving ART had reduced from 90% (90–91%) in 2006 to 63% (61–65%) in 2013. However, 22 million, or three in five, people living with HIV were still not accessing ART.

The HIV epidemic in MENA[2]

Despite the number of people who are newly infected with HIV continuing to decline in most parts of the world, unfortunately this is not the case in the MENA region. It is estimated that around 230,000 (160,000–230,000) people are living with HIV in MENA, with an overall HIV prevalence of 0.1% among adults aged 15 to 49 – one of the lowest rates in any region of the world. However, in 2013 the estimated number of new HIV infections in adults and children had reached 25,000 (14,000–41,000), showing an increase compared to 2005 that was only second to Eastern Europe and Central Asia, while everywhere else the number of new infections had declined during the same period (see Figure 1).

FIGURE 1: PERCENTAGE CHANGE IN THE ANNUAL NUMBER OF NEW HIV INFECTIONS BY WORLD REGION, 2005–2013

Source: UNAIDS (2014), *The Gap Report. Annex: Epidemiology.*
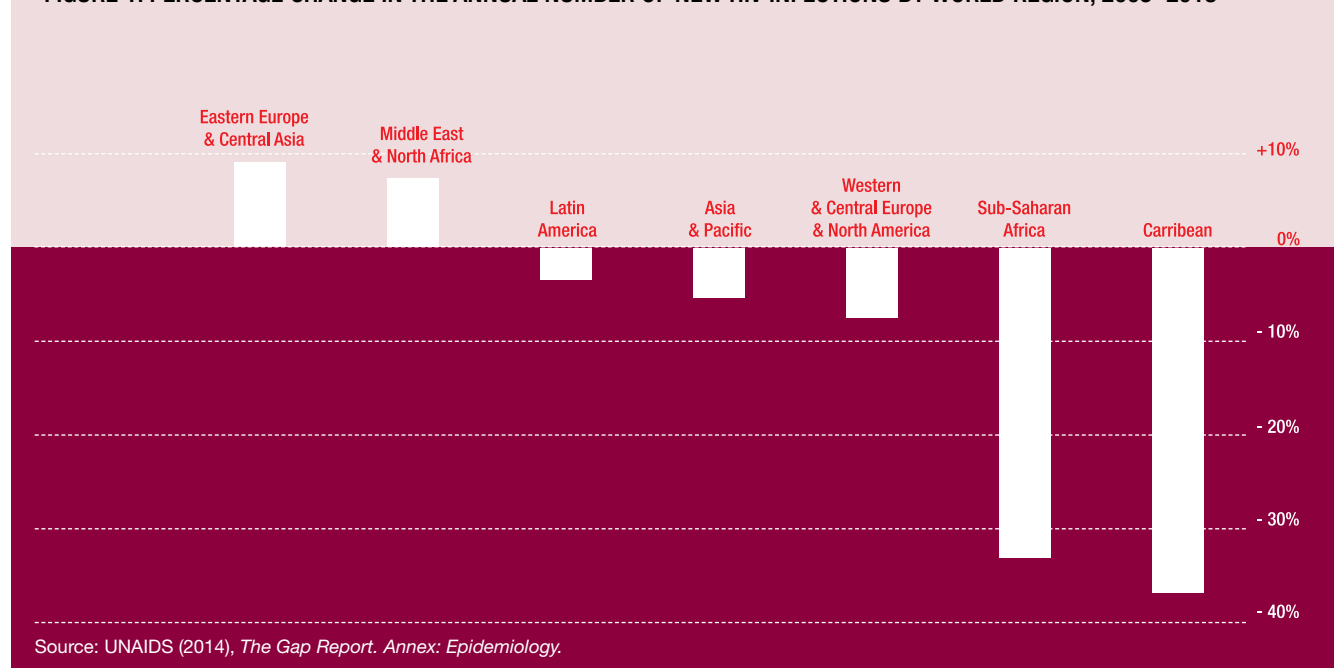
1. UNAIDS (2013), *Global report: UNAIDS report on the global AIDS epidemic 2013*.

2. This information is largely adapted from Setayesh H, Roudi-Fahimi F, Ashford L, *HIV in the Middle East: Low prevalence but not low risk* [online]. Available at: www.prb.org/Publications/Articles/2013/hiv-aids-in-middle-east.aspx The source of their statistics is UNAIDS (2014), *The gap report. Annex: Epidemiology.*

* The Middle East and North Africa region refers to the following 23 countries or territories: Afghanistan, Algeria, Bahrain, Djibouti, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, United Arab Emirates and Yemen. The regional data that is presented in this chapter does not include Afghanistan, Iran and Pakistan.

It is not just numbers of infections that are increasing. Between 2005 and 2013, the annual number of AIDS-related deaths in the region increased by 66% to 15,000 (10,000–21,000), while worldwide numbers are dropping.[3] The increasing numbers of AIDS-related deaths in MENA are due in large part to low levels of ART use – a combination of medicines that not only extends the lives of those infected with HIV but also reduces the likelihood of viral transmission. Across the MENA region, only one in five people in need of ART are getting the medicines they require – the lowest coverage rate across the world.[4] The lack of treatment is particularly acute when it comes to women and children. Less than 10% of pregnant women living with HIV receive antiretroviral medicines to prevent transmission of the infection to their baby – the lowest treatment rate in the world.[5]

Classification of the HIV epidemic in MENA

HIV prevalence and transmission dynamics vary from one location to another, from one population to another, and across populations and locations. Therefore, there is no single description that can encapsulate the epidemic dynamics in MENA and grasp the enmeshed networks of transmission. However, the available evidence from almost all MENA countries suggests that the epidemic dynamic is highly influenced by transmission linked to behaviours like injecting drug use and transactional sex, and to populations of MSM.

In fact, more than half of new adult HIV infections are coming from key populations: a proportion remaining almost stable for more than a decade. Notably, the number of new infections in the general population has followed the same trend, highlighting transmission to partners and beyond. In Morocco, for example, the majority (89%) of HIV infections among men are due to high-risk behaviours such as unprotected anal sex with other men and female and male sex workers, and sharing contaminated needles and injecting equipment.

However, about half of Morocco's new HIV infections are among women, with approximately three-quarters acquired from their husbands.[6] Although there is

FIGURE 2: RELATIVE SHARE OF KEY POPULATIONS IN NEW INFECTION

Legend: Injecting drug users — MSM — Sex workers
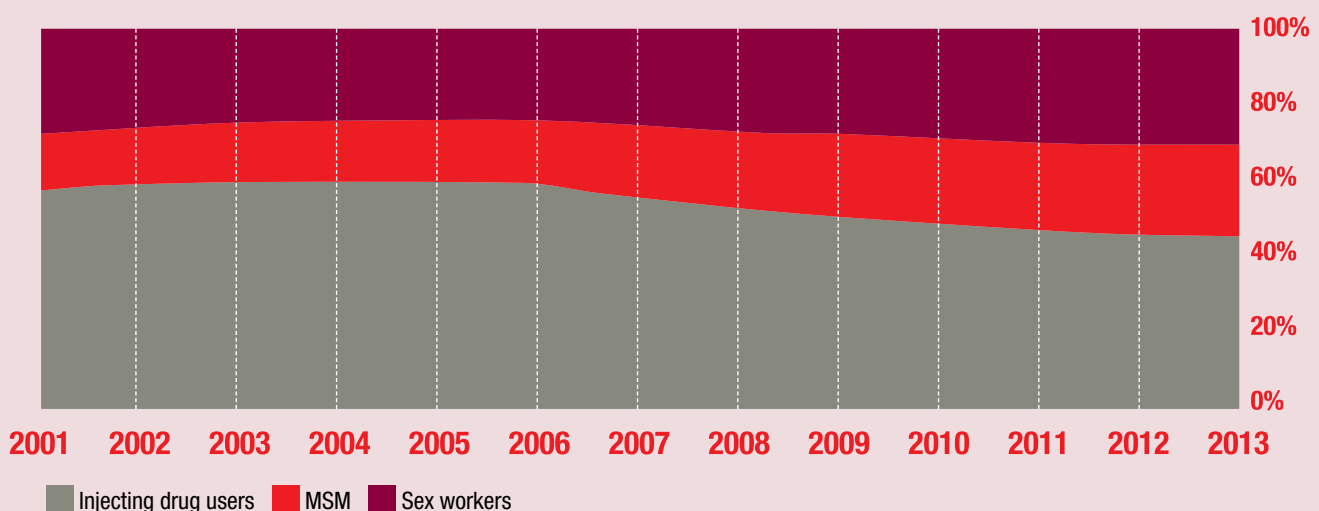
3. UNAIDS (2014), *The gap report*.

4. Ibid.

5. Ibid.

6. UNAIDS (2014), *The gap report*.

insufficient data to confirm what proportion of women become infected by a bisexual husband or partner, experience from countries with similar epidemics would suggest that that a proportion of heterosexually acquired HIV infection is as a consequence of the male sexual partner becoming infected through unprotected sex with another man. This infection dynamic in Morocco is similar to other countries in the region.

The table below contains the most recent HIV surveillance data about three key populations: MSM, people who inject drugs and female sex workers.

ESTIMATES OF HIV PREVALENCE AMONG KEY POPULATIONS IN SELECTED MENA COUNTRIES			
PREVALENCE	MSM	PEOPLE WHO INJECT DRUGS	FEMALE SEX WORKERS
<0.1%	Jordan, Syria	Syria	Egypt, Jordan, Yemen, Syria
1.0% to 4.9%	Egypt, Tunisia, Sudan	Algeria, Oman, Tunisia, Lebanon	Iran, Morocco, Sudan, Tunisia
5.0% to 9.9%	Morocco, Yemen	Egypt, Tunisia	Somalia
10.0% or higher	Algeria, Tunisia, Lebanon	Iran, Libya, Morocco	Algeria, Djibouti

Source: UNAIDS, *AIDSinfo* [online]. Available at: www.unaids.org/en/dataanalysis/datatools/aidsinfo

Example: the situation in Tunisia

"It emerges from the collected data, 14.9% of respondents are married or have been married. In the Tunisian context, the institution of marriage is the only legitimate form of relationship socially, both religiously and legally binding for a family foundation and procreation. A number of men who have sex with men opt for marriage because of their bisexuality, their refusal to accept the exclusive label of "homosexuality", their desire to have children, their willingness to convey an image that is socially accepted, and social pressures on people to marry regardless of their sexual orientation …

Bisexuality marks the course of a number of men who have sex with men. It concerns different groups: young singles, young adults, candidates for marriage, divorced (sometimes because of their sexual preference for men), married, and sex workers.

This experience can be explained by various reasons such as:

- The refutation of exclusive sex between men in the Tunisian context;
- The substitution of sex between men by some men because of the social control against the sexes mixing;
- Social pressure on individuals to marry regardless of their sexual orientation;
- The search for financial gain in exchange for sex with male partners ...

The survey also found that 55.1% of respondents reported having had at least one female partner during their lifetime. Sex between men, especially when there is unprotected anal intercourse, increases the vulnerability of female partners of men who have sex with men and their future children vis-à-vis HIV and AIDS."

Source: ATL, UNAIDS, Global Fund (2011), *Enquête sérocomportementale du VIH auprès des hommes ayant des rapports sexuels avec des hommes en Tunisie*.

> "There is a severe lack of general sexual health services in the Middle East and North Africa, let alone those which are equipped and sensitised to cater to the needs of young MSM, who do not have the social or financial support to consult a private care provider. Young MSM need access to information and services to keep themselves healthy."

YOUNG MSM ADVOCATE

> "One of the biggest barriers we face while accessing health services is that the doctors demand that we bring our parents, which is not possible for us."

YOUNG MSM

Young men who have sex with men

The MENA region today is home to approximately 90 million young people; i.e. 20% of its population. As a cohort, young people are a vulnerable population and contribute disproportionately to the priority populations in MENA.

Young MSM are often more vulnerable to homophobia than older men, experiencing discrimination, bullying, harassment, family disapproval, social isolation and violence, as well as criminalisation and self-stigma. These abuses can have serious repercussions not only for their physical health and their ability to access HIV testing, counselling and treatment, but also for their emotional, social, educational and economic wellbeing. Governments have a legal obligation to support the rights of these under-18 year-olds to life, health and development. Indeed, societies share an ethical duty to ensure this for all young people. However, in many cases young people from key populations are made more vulnerable by policies and laws that demean or criminalise them for their behaviours, and by education and health systems that ignore or reject them, and fail to provide the information and treatment they need to keep themselves safe.

Despite data limitations, several studies have documented the nature of sexual behaviour among young people in MENA. The outcomes of behavioural surveys show substantial variability within the region. A study conducted in Egypt focused on high-risk behaviours of homeless MSM, and found that 65.8% of participants had had their first same-sex encounter before the age of 15. At the time of the study, nearly 80% of young participants had both single and multiple sex partners, and roughly 70% exclusively had had sex with men.[7] In Lebanon, 54% of MSM reported having had their first anal sex under the age of 18.[8] Another study focusing on MSM in Sudan revealed that more than half of participants (60.1%) were aged between 15 and 24 years, and 85.5% of them had had their first anal experience between the ages of 15 and 25.[9]

Risk factors that contribute to the spread of HIV and other sexually transmitted infections in MENA

As HIV is transmitted silently and the incubation period between infection and the first sign of symptoms is often many years, the HIV epidemic is sometimes described as "double blind". There are a number of factors that contribute to the increased risk of MSM to HIV and other infections across the region:

- Those who are at greatest risk of infection are sex workers and MSM. Both of these groups are condemned by dominant social and cultural norms in the region. These beliefs and norms are also often reflected in the law through criminalisation. Those most at risk of HIV are often not very visible in society, and therefore HIV prevention and support services for them are either not well developed or easily accessible.

- High levels of external and internalised (self) stigma often lead to low self-esteem among MSM, which is associated with increased risk-taking.

- Discrimination against MSM is reflected in the poor track record of countries in the region in recognising and upholding their human rights.

7. El-Sayyed N, Kabbash IA, El-Gueniedy M (2008), 'Risk behaviours for HIV/AIDS infection among men who have sex with men in Cairo, Egypt', *Eastern Mediterranean Health Journal*, 14(4): 907.

8. 'Mishwar: an Integrated Bio-Behavioral Surveillance Study among four vulnerable groups in Lebanon: men who have sex with men; prisoners; commercial sex workers and intravenous drug users', Report from the Lebanese AIDS Control Program (2008), funded by the World Bank.

9. 'Generating strategic information and assessing HIV/AIDS knowledge, attitudes and behaviour and practices as well as prevalence of HIV among MSM in Khartoum', Report submitted to Sudanese AIDS Control Program, Elrashied SM (2006).

- Poor provision of and access to health and social support services that are appropriate to MSM.
- Limited access to and use of condoms and condom-safe lubricants to reduce risk through penetrative sex.
- Challenges in reaching MSM for HIV prevention and support, particularly since many MSM are married and outwardly living a heterosexual life.
- In some areas, injecting drug use is also on the rise, and this often involves sharing drug-using equipment, which carries a high risk of HIV transmission.
- MSM recreational use of alcohol and psychoactive substances is also on the increase, and their use can lead to increased risk-taking or a lower ability to manage risk.
- There is a lack of educational materials customised to the sexual practices of MSM.

Other political, social and cultural factors, some of which have emerged or became more prominent with recent developments in the region, are described below:

- There are several MENA countries where adult consensual same-sex sexual conduct is illegal and punishable by death. These include the Islamic Republic of Iran, Saudi Arabia, Somalia (southern parts), Sudan and Yemen. Other countries either criminalise adult consensual same-sex sexual conduct or have criminally prosecuted lesbian, gay, bisexual and transgender people under other laws based on their sexual orientation and gender identity. These include Algeria, Egypt, Iraq, Kuwait, Lebanon, Libya, Morocco, Oman, Qatar, the Syrian Arab Republic, Tunisia, and the United Arab Emirates.
- These discriminatory legal measures make it less likely for MSM to be able to access HIV prevention services, including regular voluntary testing or access to prevention commodities such as condoms and water-based lubricants. They are also less likely to organise and participate meaningfully in the design of programmes to provide HIV services, peer outreach or other community-level initiatives, thereby limiting public health outcomes for the country.
- Further, the criminalisation of sex work and same-sex relationships in many MENA countries means that the issue is treated largely as a criminal law concern rather than a public health issue. Over-reliance on criminal law and its enforcement undermines public health programmes that have demonstrated effectiveness in improving the health of key affected populations and reducing the spread of HIV.
- The overall policy environment continues to challenge the HIV response due to ongoing or escalating conflicts in many countries. The development landscape in the region has been adversely affected by conflicts, and the humanitarian response is often prioritised over development programmes, whether in countries directly affected by the conflict or in neighbouring host countries. An example is the impact of the Syrian crisis on the economy, demographics, political instability and security in Lebanon and Jordan, as well as Iraq and Egypt. Furthermore, Syrian refugees, like the host local communities most affected by the influx, are becoming increasingly vulnerable despite the large-scale inter-agency response to date. Humanitarian needs show little signs of abating. As their displacement extends and their savings deplete, refugees' socio-economic vulnerability increases.
- Stigma against MSM in many countries, especially those affected by the Arab Spring, is buttressed by religious conservatism that further constrains the much-needed HIV response among gay and MSM communities.

> "As I remember, since my childhood it was very difficult for me to discuss issues related to sexuality, specifically homosexuality, with others [friends or parents]. There was no awareness and receptiveness, as it is the case today. For me, gays nowadays are 'privileged'."

BISEXUAL MARRIED MAN, 45 YEARS OLD
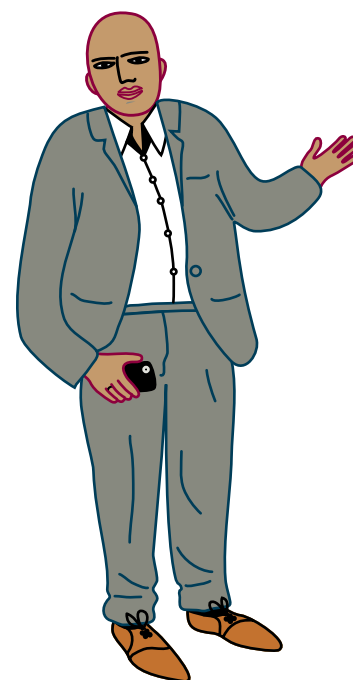
Responses to the HIV epidemic in MENA

Despite the challenges, there have been a number of important responses so far to HIV in the region. Among the most significant, and considered to be a turning point in the political commitment to the HIV response, is the **Arab AIDS Strategy 2014–2020**, which was endorsed by the Council of Arab Ministers of Health on 13 March 2014 during its 41st Ordinary Session held at the League of Arab States. The strategy is intended to guide the development of a multi-sectoral, coordinated and consensus-driven regional response to HIV.

It is based on ten goals that are aligned to the targets set in the 2011 United Nations General Assembly Political Declaration on HIV and AIDS, while maintaining a broader vision for an AIDS-free generation beyond 2015. Targets key to the HIV response among MSM include to:

- reduce HIV incidence among key populations at higher risk of infection by more than 50%
- increase HIV treatment coverage to 80% (which is also scaled up among key populations
- address stigma and discrimination.

The strategy as a major regional commitment to advancing the HIV response can act as a catalyst for increased action and accountability at country level. This guiding document was the result of a rigorous consultative process with all partners and actors, including civil society and affected populations.

Another milestone is the **Arab Convention on the Prevention of HIV/AIDS and the Protection of the Rights of People Living with HIV** that was passed by the Arab Parliament in 2012. Ongoing efforts with United Nations (UN) agencies, League of Arab States and civil society are in place towards ratifying it in countries of the region. The purpose of this convention is to protect the community by promoting, protecting and ensuring that all people living with HIV enjoy, in full and on an equal basis with other people, all human rights and fundamental freedoms. It is also to promote respect for their dignity, and to enable them to participate fully and effectively in their societies on equal footing with other people, within the framework of the national identity of the Arab countries. The term "people living with HIV" covers every person to whom the virus has been transmitted, regardless of the method of its transmission, and is referred to in this convention as "the person living with HIV".

The region has also recently witnessed a strong surge by civil society at the regional level, yielding strong thematic regional networks such as the Regional Arab Network Against AIDS (RANAA), MENAROSA and M-Coalition focusing on work with key populations, particularly MSM and sex workers, as well as the meaningful involvement of people living with HIV. Another relevant actor is the Arab Foundation for Freedom and Equality, whose mission is to "*encourage and support body, gender and sexual rights activists in the MENA region in their work by building their capacities, funding the activists to organise and providing emergency support to activists when needed*". Another important programmatic achievement is the USAID-funded MENA programme, implemented by the Alliance and CSOs from Algeria, Lebanon, Morocco and Tunisia, which has richly impacted the HIV response among MSM over the past decade. Finally, the newly established M-Coalition is the first regional network of MSM in MENA to voice the needs, challenges and also possibilities for stronger involvement of this important and catalytic key group in the HIV response.

Among the important efforts paving the way for an enabling environment has been the strong voices of religious leaders within the CHAHAMA (Network of Arab

> "CHAHAMA means 'able to give' in Arabic, and we need the support of all leaders in Islam and Christianity in all countries in the region. Through our work, I have learned to look at people affected by HIV from a humanitarian perspective and to talk about love for everyone in our community. In the future, we need to go beyond HIV to talk about other important issues, such as gender-based violence, poverty reduction and comprehensive development. We have only just begun to tackle the issues that matter."
>
> **SHEIKH AHMED TURKI, AL AZHAR, EGYPT**

Example: Helem

Helem (Lebanese Protection for Lesbians, Gays, Bisexuals and Transgenders) is a non-profit NGO that presented its notification of association to the Lebanese Ministry of Interior on 4 September 2004.

Although it focuses on sexual orientation and gender identity issues, Helem's membership is open to anyone who shares its values based on the Universal Declaration of Human Rights. Helem is also strongly opposed to any kind of segregation, whether in the services it offers or in the struggle it leads.

Helem's primary goal is the annulment of Article 534 of the Lebanese Penal Code, which punishes "unnatural sexual intercourse". This law is used primarily to target people with non-conforming sexuality or gender identity, through the violation of their privacy and by denial of their basic human rights. Abolishing this law, along with other laws that criminalise non-conforming sexuality or gender identity, will help to reduce state and societal persecution, and pave the way to achieving equality for the lesbian, gay, bisexual and transgender (LGBT) community in Lebanon. The presence of Helem in Lebanon is very important to this long-term work.

Example: M-Coalition – the first Arab coalition on MSM and HIV

Hosted by the Arab Foundation for Freedoms and Equality (AFE), the M-Coalition is an advocacy platform that coordinates at local, regional and international levels in order to facilitate the access of MSM to prevention, care and treatment services, and to quality support. It achieves this through advocacy, creation of a favorable environment, capacity-building and follow-up, research, exchange of good practices, and by collaborating with other structures of health and human rights, as well as relevant key policymakers.

The M-Coalition was created during a gathering in Lebanon in January 2014 to discuss the future of the HIV response among MSM in the region. The meeting, supported technically by the Global Forum on MSM & HIV (MSMGF), united 13 civil society advocates and service providers from five MENA countries (Algeria, Lebanon, Mauritania, Morocco and Tunisia) who decided to stay connected. In this way, under the name of M-Coalition, they created the first regional coalition of advocates and service providers working on HIV among MSM in the MENA region. In July 2014, the M-Coalition was officially presented during the International AIDS Conference in Melbourne, Australia.

M-Coalition members commit to increase their efforts and to unite with key stakeholders from national governments, international institutions, CSOs and the MSM community to improve the coverage and quality of HIV prevention, treatment, care and support interventions targeting MSM in Arab countries.

religious leaders responding to AIDS) regional network of faith-based organisations that brings together Muslim and Christian leaders across the Arab countries. This initiative, initiated and supported by the United Nations Development Programme (UNDP)/Regional HIV/AIDS in the Arab States (HARPAS), has mobilised 250 Christian, Muslim, male and female religious leaders in the region, who are now initiating their own outreach work, anti-stigma campaigns, and care and support programmes for people living with and affected by HIV.

Example: the MENA programme of the Alliance – responding to the needs of MSM in MENA

The MENA programme is a community-based outreach programme for MSM funded by USAID between 2005 and 2015. For many years it has been the only continuous MSM-focused service delivery programme in the region. It is implemented in four countries – Algeria, Lebanon, Morocco and Tunisia – by six HIV-thematic organisations, one development organisation and one LGBT organisation.[10] These partners are among the few CSOs working openly with MSM and having MSM staff.

The project established community-based outreach programmes in various sites, where partner CSOs implement a package of combination prevention services aimed at MSM. CSOs inform programme development by carrying out participatory situation assessments of the various MSM communities and identifying their needs. They train and support teams of volunteer MSM peer educators, who implement prevention, HIV test promotion and referral activities. They offer HIV testing (rapid), pre- and post-test counselling, and psychosocial and legal support. They also try to challenge stigma and discrimination through stigma reduction workshops targeting health service providers and other audiences.

In the last two years of the programme (between August 2013 and September 2015, under LMG Project):

- An estimated **47,900 MSM were reached** through outreach interpersonal communication activities (one-to-one peer support, small group discus¬sions, educational sessions, and counselling) conducted by teams of volunteers MSM peer educators mainly in nine cities across Algeria, Lebanon, Morocco and Tunisia.

- Approximately **660,000 condoms, 237,000 lubricant sachets* and 250,000 informative materials** on HIV or SRH were distributed to MSM

- **8,205 MSM received voluntary counselling and testing services** for HIV provided by the NGOs at the NGOs' reception centres, sexual health clinics and mobile units, and several HIV testing promotion campaigns were conducted. **3,492 MSM were tested, diagnosed or treated for STIs** (the referrals made to public VCT and STIs services are not included in this figure).

- **2,106 MSM benefited from psychological support** and 385 from legal support.

- **3,020 individuals (health providers, religious leaders, police officers, journalists etc.) were reached** through stigma reduction activities, and 608 decisions makers were reached through advocacy efforts.

The programme has had a significant impact on MSM lives, including their personal development (life skills, self-esteem), access to relevant prevention, care and support services, and development of prevention-seeking behaviours. The partner CSOs have become central actors in the response in their respective countries, and are regularly solicited on MSM programming by their national AIDS programmes and other strategic stakeholders. At the same time, their advocacy efforts have raised awareness on the specific vulnerabilities and needs of MSM among health authorities and service providers, and contributed to the reduction of stigma in healthcare settings.

Finally, the programme has significantly contributed to the empowerment of the LGBTI community by providing continuous support to the only legal LGBT organisation working specifically with the transsexual community and, through its continuous training and support, to teams of MSM peer educators. In this respect, it serves as a "school" for LGBT activists.

> I've been trained as a volunteer peer educator. We do a lot of work around stigma reduction as well as prevention.
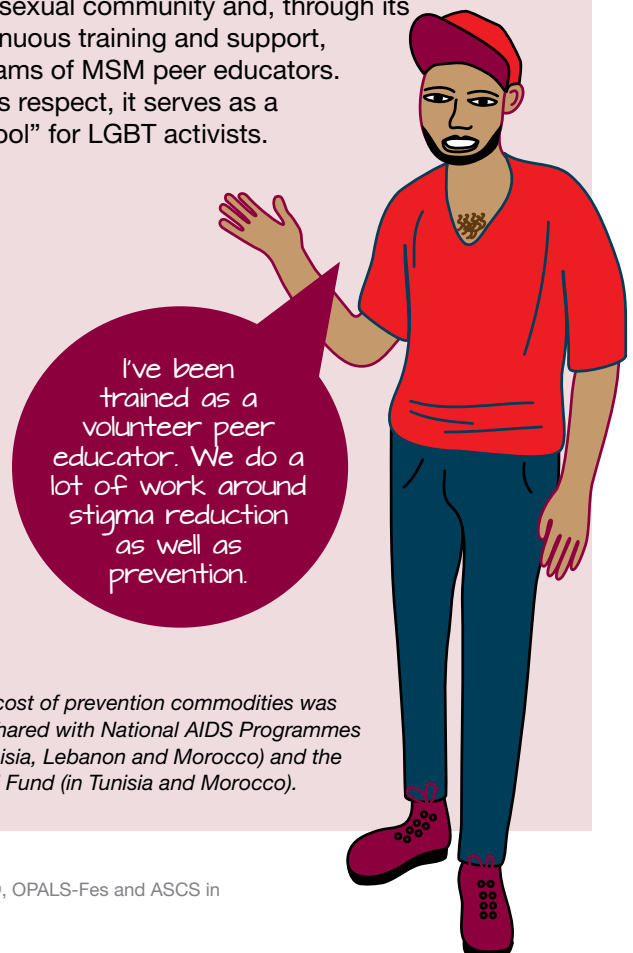
* The cost of prevention commodities was cost shared with National AIDS Programmes (in Tunisia, Lebanon and Morocco) and the Global Fund (in Tunisia and Morocco).

10. APCS in Algeria, SIDC, Helem and Oui Pour la Vie in Lebanon, ATL in Tunisia, AMSED, OPALS-Fes and ASCS in Morocco.

These initiatives, coupled with a growing number of studies on key populations, are strong indicators of an increasing willingness of national governments in the region to acknowledge HIV as a national challenge that requires intervention. Yet this commitment towards HIV prevention, treatment, care and support services at the national level varies from one country to the other within the list of their national priorities. Also, in most cases it is not coordinated or uniform across all decision-makers, such as law enforcement agents, religious leaders and the media, who are important in influencing an enabling environment for supporting responses at the regional, country and local levels, especially for interventions targeting key populations.

The region also receives leadership support from UN agencies to help to build local and regional capacities, strengthen the role of CSOs, share country and regional experiences, and develop and support programmes that are firmly based on human rights, public health and global best practice. This is done through coordinating, funding and technically supporting applications for global funding in eligible countries (and through continuous advocacy in non-eligible ones) for domestic resources on HIV and AIDS, especially on prevention efforts.

2. Men who have sex with men

Why "men who have sex with men"?

"Men who have sex with men" (MSM) is a concept developed in public health to describe sexual behaviour between men. It is a label used to describe behaviour and not identity. While some men who have sex with men will define themselves as homosexual/gay or bisexual, many will not because it does not reflect their perception of their own identity. For instance, sex between men can take place between men in single-sex only environments such as prisons and the military, and those men who have sex with other men in that context will do so because their preferred sexual partner, a woman, is unavailable. Likewise, some married men may have sex with other men while still enjoying active and satisfying sexual relations with their wives. Other married men may prefer to have sex with men but for family and societal reasons will live in a traditional heterosexual marriage. Another increasing trend in MENA countries such as Egypt and Tunisia is men having sex with men within the context of sex work.

What is sex?

It is important to understand what kind of sexual behaviour is covered by the term "sex". Some people think that only penetrative sex (anal or vaginal) constitutes "sex", whereas others define sex as a catch-all term for any activity that results in sexual pleasure and orgasm; for example, mutual masturbation, oral sex and sensual massage. Not all men who have sex with other men have or enjoy penetrative sex.

Among those who do have anal sex, some are only active (the person who penetrates), some are only passive (the person who is receptive/is penetrated), and some men are versatile (sometimes they are receptive and sometimes they are the active partner).

When it comes to developing HIV prevention guidance and support, it is important for programmers to know how local MSM define sex and what are common sexual practices.

This distinction between behaviour and identity is particularly important in the MENA region, where sexual identity is differently understood from many European and Western-based countries. For instance, scholars[11] have argued that there is no historical concept of homosexuality within Arab history, despite many descriptions of sexual expression between men, and between older and younger men/boys, in poetry and literature. While there are a number of countries within the region who have a recognised homosexual (gay) community, in other countries sexual behaviour between men will be much more hidden and secret.

The reality is that despite protestation and denial by some, historical and contemporary evidence shows that sex between men has existed throughout history and in all civilisations. Within the MENA region it is referred to in Arab stories, novels, poems and songs, and exists among all age groups, social classes, educational backgrounds, marital statuses, races, colours, nationalities and ethnicities.[12]

Biological sex, gender identity and sexual orientation

To deepen our understanding of human sexual behaviour and its association with HIV risk, it is important to understand how biology, gender and identity interact as they refer to MSM. Definitions are not always straightforward, and yet understanding them is vital to inform the basis and development of meaningful HIV prevention and care services.

THE SPECTRUM OF HUMAN BIOLOGY AND ANATOMY

Male   Intersex   Female
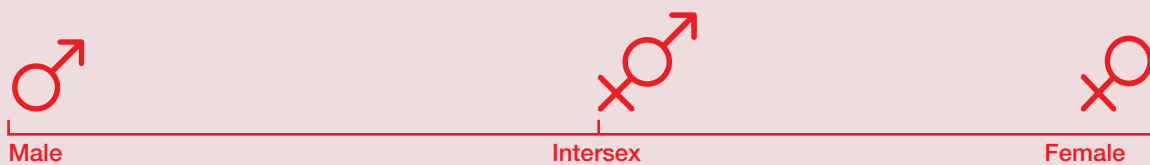
Intersex

Historically, people who are intersex were known as hermaphrodite. Most people who are intersex were assigned a gender identity (male/female) by doctors and/or family, and sometimes underwent surgery to make their genitalia match their assigned gender identity. Empirical evidence has shown that children born intersex often suffered greatly from being assigned an identity that did not necessarily match how they felt about themselves. Over recent years, many people who are intersex have come to define themselves as a third sex and do not want to be assigned to a male or female identity. They do not feel that they need to be changed in any way from how they were born.

Our **biological sex** refers to our physical biology at birth defined by our genitalia. Predominantly, the human race is born either female or male, with a small percentage (between 0.1% and 1.6%) who have ambiguous genitalia or both. These people are normally described as "intersex".

There are also a number of people who from the earliest age feel that their genitalia do not reflect how they feel; i.e. someone with female genitalia may feel that they are a man and vice versa. People who feel this way are known as transsexual.

Our **gender identity** refers to the way that we outwardly express ourselves in how we dress, behave and identify. Normally this is heavily informed and framed by cultural and social norms. Feminine identity is associated with being a women and masculine identity is associated with being a man. In reality, this is not so defined

11. El-Rouayheb K (2009), *Before homosexuality in the Arab–Islamic world, 1500–1800*, University of Chicago Press.
12. Ibid.

and there are woman who may display characteristics that would be commonly described as masculine and vice versa.

However, if a man expresses traits traditionally associated with femininity, this does not necessarily mean that they are homosexual, and a woman who expresses traits traditionally associated with masculinity is not necessarily a lesbian. In fact, gender norms are changing and evolving, and this is demonstrated by what is acceptable now for men and women regarding clothes, hairstyles, professions and so on, compared to what was acceptable in the past.

THE SPECTRUM OF GENDER PERFORMANCE

Feminine   Androgynous   Masculine
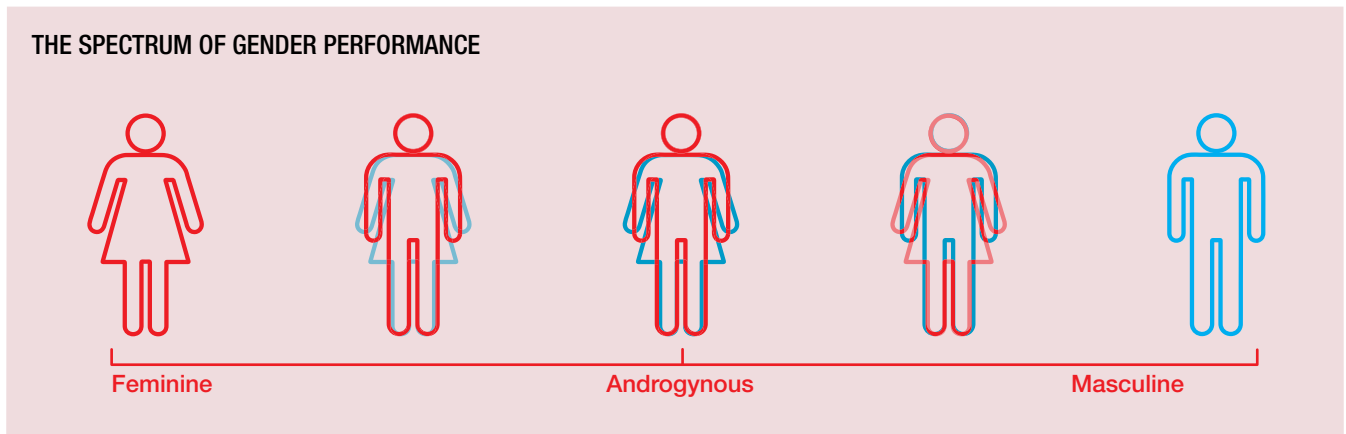
The term **transgender** describes someone who dresses, acts as, and wishes to be (or is) recognised as a member of the opposite sex from which they were born. It includes those people who identify as transsexual and transvestite.

THE SPECTRUM OF GENDER IDENTITY

Female/   Trans woman   Genderqueer/   Trans man   Male/Man
Woman   Agender
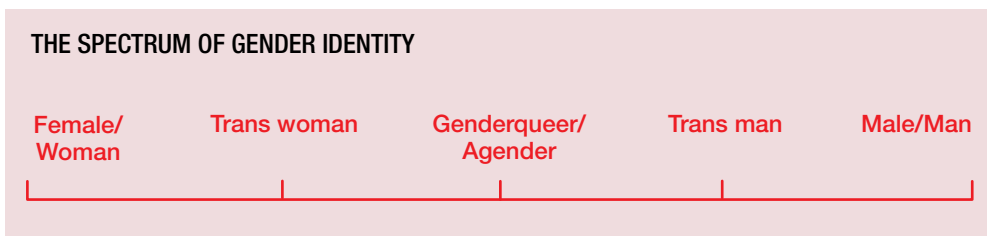
A **transsexual** is someone who feels they are in the wrong biological body and wants to change it – or has changed it through hormone treatment and sometimes surgery. This is known as gender reassignment. Once a person has gone through gender reassignment, they often identify as the other sex from the one they were born as. However, changing their body does not mean that they necessarily change their sexual orientation. Therefore, someone who was a biological man who loves women prior to reassignment will continue to love women post reassignment, and vice versa.

A **transvestite** is someone who dresses and makes themselves appear outwardly as the opposite gender. It does not mean that a man who dresses as a woman wants to have sex with men, or vice versa. There can be many reasons why people dress as the opposite sex, including for enjoyment, relaxation, sexual pleasure, sex work, entertainment work (dancer, singer) or sometimes for ritual purposes.

Sexual orientation refers to sexual attraction; i.e. who arouses our sexual feelings and who we want to express our sexual feelings with through sexual and other forms of intimacy.

Over a lifetime, people may not feel they are so clearly defined by these labels. Who they primarily have sex with when they are young may be different from who they have sex with as they get older.

THE SPECTRUM OF SEXUAL ORIENTATION

Heterosexual   Bisexual   Homosexual
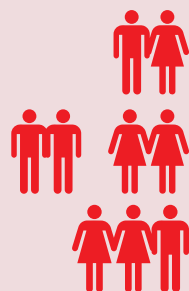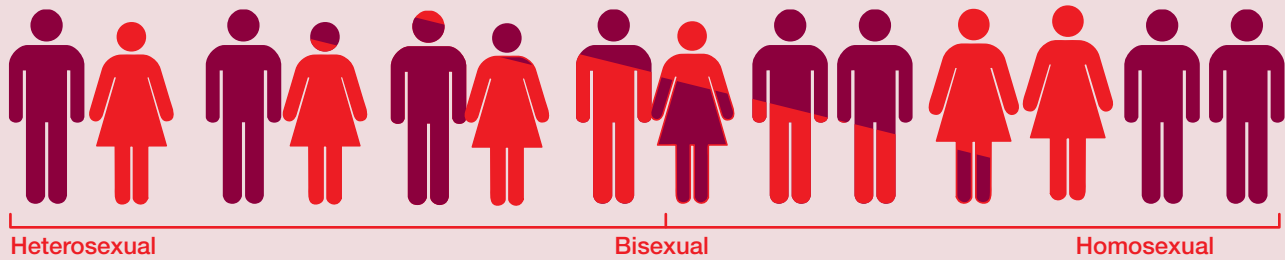
Someone who is **heterosexual** seeks sexual intimacy with someone of the opposite sex.

Someone who is **homosexual** seeks intimacy with someone of the same sex.

Someone who is **bisexual** seeks intimacy with both men and women.

What influences or helps to explain sexual orientation?

People often ask what influences or explains sexual orientation; i.e. why some people are heterosexual and others homosexual.

Scientists and researchers have explored many different areas of investigation. These have included the study of:

- **genes** – possible genetic differences between homosexuals and heterosexuals, and evolutionary genetics (the idea that sexual orientation has occurred to adapt to context).

  Exploring the hypothesis that genes have a determining effect on sexual orientation has also included the study of identical and non-identical twins. These studies have shown mixed results, with some finding a strong link between being a twin and having the same sexual orientation, whereas other have not found a significant link

- **hormones** – the influence of male and female sex hormones (testosterone and oestrogen) on foetal development

- **the brain** – the structure of the brain; i.e. whether there are any differences in the brain structure of people who are heterosexual or homosexual

- **psychology** – psychological theories, including the influence of family dynamics and relationships

- **family history** – transgenerational factors; i.e. is there a pattern of people being homosexual in particular family lines, and therefore might homosexuality be more common in one family line than another. This area of investigation is also linked to the study of genes

- **societal norms** – exploring sociological/contextual factors; e.g. the influence of social norms on sexual expression and identity; the history of same-sex relationships within a given culture.

The reality is that none of these areas of study have proven conclusive, although interesting differences have been observed. While it might appear from reading the results of one study that there is evidence that genetics has a strong influence on sexual orientation, other studies exploring the same area of investigation have not found the same results.

Historically, some psychiatrists and religious groups have tried various approaches to change people who are homosexual into people who are heterosexual through what is known as "conversion therapy". Often the measures used have been extreme, including electric shock therapy and intense psychological reorientation. Independent assessment of the results of conversion therapy have shown that it has little or no success, but that the psychological harm of undergoing the therapy can leave a negative legacy.

WHO, in its International Classification of Diseases (ICD-10), reviews all global evidence to define what is and is not a disease. After reviewing the entire body of research, it concluded that "sexual orientation by itself is not to be regarded as a disorder",[13] and therefore any non-consensual attempt to change someone's sexual orientation would be seen as a violation, as being homosexual is not a disorder.

The range of same-sex behaviour and expression

While there is no conclusive explanation about the factors that influence whether someone is heterosexual or homosexual, researchers have tried to understand the range of same-sex experience and, based on their research, develop frameworks that help to capture the range of human sexual experience.

The Kinsey scale

In 1948 the American scientist Alfred Kinsey developed a scale system to help to classify the spectrum of human sexual orientation. He developed this because his research had suggested that sexual orientation is more subtle than is indicated by the heterosexual–bisexual–homosexual continuum. For instance, some men may be predominantly heterosexual but have occasional sexual contact with other men and not define themselves as bisexual. He developed a six-point scale that people can use to position themselves along the spectrum from heterosexual to homosexual. The rating is what the person themselves thinks best reflects their experience.

THE KINSEY SCALE	
RATING	**DESCRIPTION**
0	Exclusively heterosexual
1	Predominantly heterosexual, only incidentally homosexual
2	Predominantly heterosexual, but more than incidentally homosexual
3	Equally heterosexual and homosexual
4	Predominantly homosexual, but more than incidentally heterosexual
5	Predominantly homosexual, only incidentally heterosexual
6	Exclusively homosexual
X	No socio-sexual contacts or reactions

You can read more about the Kinsey scale at: http://en.wikipedia.org/wiki/Kinsey_scale

13. WHO (2011), *International statistical classification of diseases and related health problems. ICD-10* (10th edition).

The Klein Sexual Orientation Grid

Researchers, while fully acknowledging Kinsey's pioneering work, have observed that his scale does not take into consideration issues such as how orientation can change throughout a person's lifetime, and also how a person expresses their sexual orientation emotionally and socially rather than just sexually. In 1978, Fritz Klein developed a more refined tool called the Klein Sexual Orientation Grid (KSOG), which takes into consideration other factors that may relate to sexual orientation, such as a person's fantasy life, emotional attraction and their own self-identification.

The KSOG uses a seven-point scale to assess seven different dimensions of sexuality at three different points in an individual's life: past (from early adolescence up to one year ago), present (within the last 12 months), and ideal (what would you choose if it were completely your choice). To complete the grid, the person uses the scoring guidance that is given after the grid.

Scale to measure variables Starting with the past, individuals choose a number that most corresponds to their situation based on the guidance scale below. The process is then repeated for the "present" and "ideal" boxes, bearing in mind that there is no right or wrong number.

These tools are presented here to give some insight into the kinds of research and tools used to measure sexual orientation.

THE KLEIN SEXUAL ORIENTATION GRID				
	VARIABLE	PAST (UP TO LAST YEAR)	PRESENT (LAST 12 MONTHS)	IDEAL (IF YOU HAD A CHOICE)
A	Sexual attraction. To whom are you sexually attracted?			
B	Sexual behaviour. With whom have you had sex?			
C	Sexual fantasies. About whom are your sexual fantasies?			
D	Emotional preference. Who do you feel more drawn to or close to emotionally?			
E	Social preference. Which gender do you socialise with?			
F	Lifestyle preference. In which community do you like to spend your time? In which do you feel most comfortable?			
G	Self-identification. How do you label or identify yourself?			

Scale to measure variables A, B, C, D and E of the KSOG

1	2	3	4	5	6	7
other sex only	other sex mostly	other sex somewhat more	both sexes equally	same sex somewhat more	same sex mostly	same sex only

Scale to measure variables F and G of the KSOG

1	2	3	4	5	6	7
heterosexual only	heterosexual mostly	heterosexual somewhat more	heterosexual/ homosexual equally	homosexual somewhat more	homosexual mostly	homosexual only

Conclusion

It is not the purpose of this orientation manual to explain the full history of research around sexual orientation. However, there are a number of conclusions that can be confidently asserted from the available evidence:

- There are people who are heterosexual and homosexual in all countries and cultures, including in the Arab world and in MENA.
- Sexual orientation (who we are sexually attracted to) is rarely a matter of choice. Most people become aware of their sexual orientation early in their teens, if not before, even if they are not able to put a name to what they are feeling.
- Homosexuality is not a disease or sickness but rather a part of the rich diversity of human experience.
- There is a wide variety of experience in our sexual fantasies, and what we fantasise about does not necessarily translate into how we behave sexually.
- Non-biased research has shown that it is not possible to "convert" someone who is primarily homosexual into someone who is primarily heterosexual. In fact, research has shown that the methods used to try to convert people's sexual orientation can be very damaging to the individual's wellbeing. Homosexuality is not a disease or a disorder, and it does not need to be changed.
- There is a myth that people who are homosexual are also paedophiles. This is not true. Tragically, both girls and boys experience sexual abuse, and paedophiles are just as likely to be heterosexuals. In fact, evidence has shown that most child sexual abuse occurs within families by family members.
- Sometimes parents feel that they are in some way responsible for their child being sexually attracted to people of the same sex. In fact, there is no evidence that same-sex attraction is the result of parental nurturing. There are people who are homosexual in all societies in the world. Homosexuality is not a disorder, although historically it has often been treated as such, and in some cultures and societies continues to be so.

> " Being MSM is a big challenge, especially when you live with your parents. They do not stop nagging about marriage. I am looking for a woman and I want her to be lesbian so we can 'cover up' our sexual orientation with a fake marriage and please society."
>
> **MARRIED MSM, 32 YEARS OLD**

STORIES OF MSM LIVING IN MENA

Khalid, a 37-year-old married MSM

Khalid started to have sex with men when he was a young man. He knew that he was gay and was comfortable liking men, although he was worried that his family would find out. Other MSM friends had been "discovered" by their parents and their lives had become miserable. When he became 30, his parents started to pressure him to get married. He agreed, hoping they would leave him in peace, but he continued to have occasional male partners.

Soon after getting married, he found out that one of his previous male partners had tested HIV positive. So he started to worry about his own status. What would people think if he was HIV positive? Would they find out that he was MSM? How would he be treated? He went to a public health centre to take a HIV test, but the healthcare worker made him feel very uncomfortable. He asked lots of questions about Khalid's sex life. When Khalid mentioned having had sex with men the counsellor said, "No, you are not one of those! You seem different!"

Khalid left the clinic without taking the test and promised himself he would never go back. He started to worry about infecting his wife, so insisted on using condoms with her. However, she got angry saying that she wanted to have children. Khalid became very depressed and worried about what to do next.

"I do not know yet if I am really homosexual. I have been doing it for a long period of time because I was seduced by others to hang out and have fun. Now I am not sure if I can get an erection whether by a woman or a man. I am so confused."

MSM LIVING WITH HIV, 37 YEARS OLD

Badiane, a 42-year-old MSM who has always wanted children

Three years ago Badiane met a woman with whom he had two children. She does not know that he used to have sexual relations with men. Last year he started getting sick, and since then has become progressively more ill. He doesn't know his HIV status, worries about his health and is aware that he should go for an HIV test. But his biggest fear, if he tests HIV-positive, is for his children's future and what will happen to them. So he keeps postponing the HIV test.

Mehdi, 30-year-old policeman

Men in the community make fun of Mehdi because of his walk, and this makes him less confident in his job. He has a male lover but also a girlfriend in order to keep up the appearance that he is not MSM. He has joined other policemen in arresting male sex workers. He is struggling with leading this double life and wishes he could be more comfortable with himself as an MSM.

MARRIED MSM

Feedback from peer educators and MSM consultation meetings show that one of the major challenges in the HIV response among MSM in the region is that many MSM are married and/or also in a relationship with a woman. Although this situation is not unique to MENA, experience suggests that the prevalence of married MSM is greater than in other parts of the world. This presents significant challenges to HIV prevalence among partners of MSM, as well as to prevention, treatment and care in the MENA region. The reasons for this are complex and relate to the religious, political and socio-cultural context. These influences have an impact on the responses of parents and families to their children who are MSM.

" I am homosexual and I consider myself different, thus out of the ordinary. This could be positive and does not always have to be negative."

GAY MAN, 20 YEARS OLD

"During my teenage years I noticed that I was different. I wasn't like my friends, and I began to notice that I liked men. I knew it wasn't the norm in my circle of friends and family. I felt inferior. I became very withdrawn and alone most of the time to protect myself.

"As I am thinking I realise that I'm there like an island in the plain ocean ... anywhere I look, and as far as I can remember, I only see my own reflection. Loneliness weighs on me ... I miss my family."

3. Stigma, discrimination and their impact

In this chapter we begin to encounter some of the complexities involved in responding to the HIV epidemic among MSM in the MENA region. We will do this by looking at part of the root cause, which is stigma towards MSM and how it is manifested in discrimination and denial of human rights.

What is stigma and how does it relate to MSM?

Stigma is a set of negative beliefs and attitudes that people in a group or society have about something, and most often relates to attitudes towards individuals. It sometimes relates to particular behaviours, but more often to some fundamental characteristic of another person that they cannot change, such as the way they look, mental illness, disability or being a member of a particular nationality or tribe. What is powerful and often so damaging about stigma is that the negative beliefs and attitudes are usually held by the majority whereas those who are stigmatised are from a minority in a society.

The impact of stigma is far-reaching and pervasive. Stigma can lead to discrimination and persecution. It can also result in the person, or even group, who is being stigmatised internalising the negative attitudes and behaviour, and therefore suffering from both outward and internalised stigma.

Historically, MSM, including men who are gay and people who are transgender, have been the focus of stigma by majority populations, including in the MENA region. As opposed to discrimination, which is much easier to identify, stigma is often expressed in subtle but powerful ways. Stigma has its origins in dominant cultural, religious and societal beliefs, and therefore is not always easily recognisable or even seen as a problem by the majority – it is just the way it is. Heterosexuality is seen as the norm, and any variation from it is considered to be deviation; something abnormal and wrong that should be punished.

Homophobia

Stigma can be expressed in the way that someone speaks to another person, in the way they look at them, the way they interact with them on a daily basis, or the way that they speak about them to others. What is characteristic is that the person who is stigmatised – the person who is gay, transgender or MSM – is seen as "other": someone who is different and undesirable, someone who is not even worthy of respect. This is known as **homophobia**. Stigma and homophobia can cause deep and lasting harm to people who are MSM.

Young people absorb the dominant attitudes and beliefs of the society in which they live. As they grow up and realise that they may be sexually attracted to people of the same sex, they often experience deep shame and fear as they learn that this is not perceived as acceptable in society. This can lead to isolation and self-hatred, and is often described as **internalised homophobia.**

The impact of stigma is pervasive and its consequences far reaching. Research has shown that men and women who are sexually attracted to people of the same sex experience much higher levels of depression than the majority, and suicide levels are several times higher than in the general population. It is not only the general public who can demonstrate overt discrimination. Healthcare workers can too, together with those in charge of allocating health and social care resources, the judiciary, religious leaders, the police, the media – all of them people who have

> "Stigma remains the single most important barrier to public action. It is a main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world."[14]
>
> **BAN KI-MOON, UNITED NATIONS SECRETARY GENERAL**

14. 'The stigma factor', *Washington Times*, 6 August 2008 [online]. Available at: www.washingtontimes.com/news/2008/aug/06/the-stigma-factor/

"Because you are homosexual, you deserve to have HIV: this is what my best friend told me last time. This hurts."
MSM LIVING WITH HIV, 22 YEARS OLD

power and influence. The result of this is that MSM do not get the health and social support care they need, the spiritual support they may seek from religious leaders, or the protection from the police or the law that is the right of every citizen. Stigma can also lead to a society's tolerance of abuse and violence towards MSM.

Recent crackdowns and arbitrary arrests of MSM groups in Lebanon and Egypt are evidence enough of violent discrimination. However, a positive note to consider has been the powerful response of civil society that led to the release of the MSM in Lebanon. Similar support was provided in Egypt through vigorous efforts from CSOs and the International Development Law Organization (IDLO).

Self-acceptance and "coming out"

Many men whose sexual orientation is homosexual/gay live a hidden life in fear of being found out by family and others who they feel may not accept them as they are.

Despite this, many men around the world, including in the MENA region, have decided to be open about their sexual orientation. For many, this means "coming out" as gay. For some people, coming out is the end point of a struggle towards self-acceptance, and has meant overcoming their fear of persecution and violence, rejection and isolation. For others, the experience is more straightforward and self-acceptance has been easier to achieve.

The experience of the majority of people who have come out is ultimately a positive one in that they no longer have to hide who they are, and they have been often surprised by their experience of acceptance by close friends and family. They no longer feel that they have to hide who they are to themselves or others, and they can also seek the support that they need. Few who have come out regret doing it. However, the process is not always straightforward or easy. There are many gay men who have come out and have experienced rejection by friends and family, and this can be hugely challenging and hurtful to deal with. Support from friends and others within the gay community can help enormously if the person is able to access it.

For families who have found it very difficult to accept that their son or daughter is gay, getting support from other parents and families who have been through a similar process of acceptance can help them with their own experience and enable parents to continue having a meaningful, open and honest relationship with their gay child. This is sadly not the case for all families, and there are parents who reject their children because they are gay and cut off communication with them. This can be very painful for the child and leave them ostracised and estranged from those they thought had loved them most.

The family's understanding and acceptance

" My father beat me and put me in chains so I would not go outside. My mother and sister took my side and said to my father that God created me this way."

Parents, siblings and immediate family often go through a difficult process of coming to terms with their child's sexual orientation. They may go through a period of denial and disbelief. For those who find it difficult to accept their child as gay or homosexual, their reaction is often fuelled by fear, guilt and shame. They may want to try to understand and find explanations for why their child is gay, and some blame themselves. Given the prevalent attitudes and laws around same-sex love in the MENA countries where they live, they may experience conflicting emotions around wanting to love and support their child while also not wanting to disregard the values expressed by their societies. Finding an opportunity to talk to other parents of gay children can be helpful, although where there is little public discussion about homosexuality it can be difficult to find parents who are willing to support others openly. Some parents find it too difficult to accept their child as homosexual and simply reject them.

> ⚠️ ***I LOVE THEM .... BUT*: SIDC's and Helem's booklet for parents of MSM**
>
> *I LOVE THEM .... BUT* is a parents' guide that was developed in 2009 within the framework of the MENA programme by SIDC, in partnership with Helem. The booklet addresses parents' issues around the homosexuality of their children and how best to deal with their gay/lesbian children. The booklet was developed through a participatory approach involving focus groups with MSM and interviews with parents and family members of homosexuals (men and women). There was a desk review, and documentation of resources on homosexuality and misconceptions. A series of questions were also developed on the issues and concerns of parents, and advice on how to deal with these with their children. The content was developed, tested and finalised, then revised by psychologists and psychosocial counsellors. The booklet includes a definition of homosexuality, a series of questions and answers that parents ask themselves when they discover or suspect that their children are homosexuals, misconceptions about homosexuality, stages of acceptance, and references.

What is discrimination?

Discrimination is the manifestations of stigma, negative beliefs and attitudes. Discrimination is often much more easily recognisable than stigma as it can be objectively observed and assessed.

For MSM and people who identify as gay and transgender, discrimination can come in many forms. It can mean that:

- the way they express their love and affection towards someone of the same sex through intimacy and sex is criminalised
- they are not considered for employment, even though they may be more qualified for the position than someone who is not seen to be MSM
- the police do not deal with people who are violent or hateful towards MSM in the same way as they treat other people who are violent, abusive or disruptive
- the police do not investigate or take an interest in crimes against MSM
- MSM are not treated equally under the law, and as a result MSM do not feel they have any protection in the society where they live
- MSM are denied appropriate healthcare and support services, and that even when they do receive healthcare, the way they are treated by healthcare workers makes them feel reluctant to discuss their specific needs, be open about their sexual orientation and return for further services
- MSM do not have access to the services and commodities they need in order to protect their health and the health of their sexual partners
- they have no right to inherit if their partner dies, and may not receive their family inheritance either if they have been rejected by their families (some may even be threatened with death).

Why is it important to address stigma and discrimination?

MSM – be they gay, transgender or intersex – deserve to be treated with respect, live free from violence and fear, and have their human rights fully upheld by the law. Without this, they will be marginalised, and unable to demand or access the support and services they need. MSM are not second or third class citizens. They are equal citizens.

> " At work, nobody knows about my sexual orientation. I make sure that my look is 'straight'. Only one colleague knows: she is my best friend. My boss is homophobic: he does not stop talking in a bad manner about the community in front of me."
>
> **GAY MAN, 23 YEARS OLD**

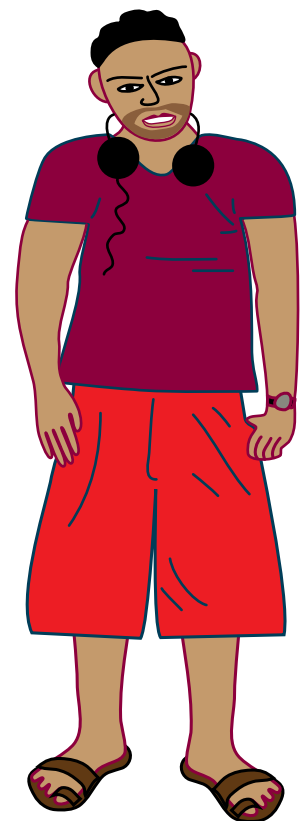MSM in the MENA region have a much higher burden of HIV and STIs than the general population, and part of the reason for this is the stigma and discrimination that they experience. MSM need access to comprehensive prevention and care services that are non-judgemental and tailored to their specific health (physical and psychological) needs.

Given the prevailing stigma and discrimination in the region, MSM are less able to get the prevention support they need, and as a consequence, the prevalence of HIV infection will continue to increase.

From a public health and human rights point of view, it is essential that MSM are able to access the full continuum of prevention, care, treatment and support as defined by WHO/UNAIDS to prevent new HIV infections, reduce the suffering of people living with HIV, and enable people living with HIV to access life-saving ART.

"It is difficult to have high self-esteem when everyone laughs at you and when your parents do not want you."
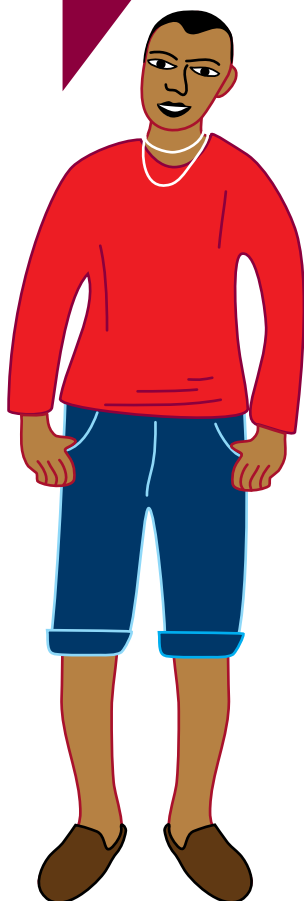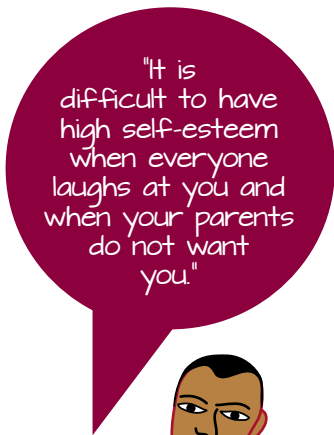
Common misconceptions about homosexuality in MENA societies

- Homosexuality is a disease that can be treated
- Homosexuality is a new phenomenon
- Homosexuals are all drug users and sex workers
- Homosexual males are not real men, they cannot perform sex like other men
- Homosexuals are looking for multiple sexual partners
- Homosexuals brought HIV to our region
- Homosexuals are obsessed with sex
- Homosexuals are non-believers

Ahmed, a 22-year-old single man who is unemployed

"When I discovered I was homosexual, I discovered homophobia. I experienced my sexuality in isolation, loneliness, 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.

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.

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."

" I'm forced to leave the country because it is difficult to live my homosexuality in the open. There are friendly places for hanging out, but I can never express myself freely." **GAY MAN, 27 YEARS OLD**

Zaheer, a 25-year-old fruit seller who lives with his family in Marrakesh

Zaheer has three sisters and is very close to his mother. One day Zaheer was at home with his friend Bashir when his mother came back unexpectedly early from the market. She saw them kissing. Zaheer's mother was shocked and no longer speaks to him. She told his father, who now refuses to acknowledge him. Zaheer's parents did not wish to tell anyone in the community, and also insisted that his sisters must never know. In fact, Zaheer had already told his oldest sister but did not let his mother know this. The atmosphere at home is very tense and Zaheer has decided to leave as soon as he can afford to.

Mahfuz, a 26 year-old who lives with his family in Algiers

Mahfuz is from a well-respected, religious family and is well known in the neighborhood. Each day he went to the mosque to say his prayers. One day his parents caught him in a compromising position with his friend's uncle. Mahfuz was evicted from the family house and the following Friday he was denied access to the mosque.

Nabih, a 35-year-old businessman

Nabih is unmarried and living with his family. He has a girlfriend, Saba, and a male friend, Raashid, an MSM. Both are very supportive to him, and he does not mix with the gay community. One day Nabih went to the hospital for a consultation. After the doctor asked Nabih some questions he concluded that he was MSM. Then the doctor's attitude changed: he looked at Nabih as if he was no longer a human being. Nabih had trusted this doctor, believing he was tolerant and understanding. Now he felt insulted and ashamed. He vowed he would never go to a clinic again.

> "I feel lonely, freaked out, rejected and scared. I am not able to identify myself. I suffer."
> **QUEER, 20 YEARS OLD**

> "I get hurt because of my surroundings; the way they look at me and whisper behind my back. I am in constant conflict with myself."
> **GAY MAN, 21 YEARS OLD**

Gay man, 25, fled the country to seek asylum

"My mum complained to the police because I am gay and she does not like that. My uncle is searching for me; he wants to kill me because I give a 'bad' image about the family. My uncle is a renowned person in the country. He sent people after me to my workplace to disclose my orientation to my boss, and they threatened me many times. Where can I go now? I do not have the right to live. What am I accused of? What is wrong with being gay? I did not choose to be so. I am simply like that."

> "Since early childhood I know myself and my tendencies, but society led me to review myself more than once. I'm not comfortable with my own self. I feel that I cannot act according to my nature."
> **TRANS, 28 YEARS OLD**

Problem Tree: Examples from MENA stigma training workshop

Causes: judgments; blaming; lack of confidence in own sexuality; conservative religious beliefs; fear of infection; ignorance; poverty; belief in myths; moral judgments.

Forms: Being chased from home; not welcomed at the clinic; rejected by family; finger-pointing; name-calling; being attacked; violence; losing your job; mistreated by police; blackmail; loss of inheritance; devalued.

Effects: isolation; loss of dignity; viewed as an object; suicide; depression; loneliness; going into hiding; increased HIV infections; increased risk-taking; breakdown of family relations; low self-esteem; loss of family honour.

EFFECTS

FORMS

CAUSES

"I live in a society that does not accept me. It is frustrating for me to live in this situation. This led me to be in conflict with myself."

LEBANESE GAY MAN
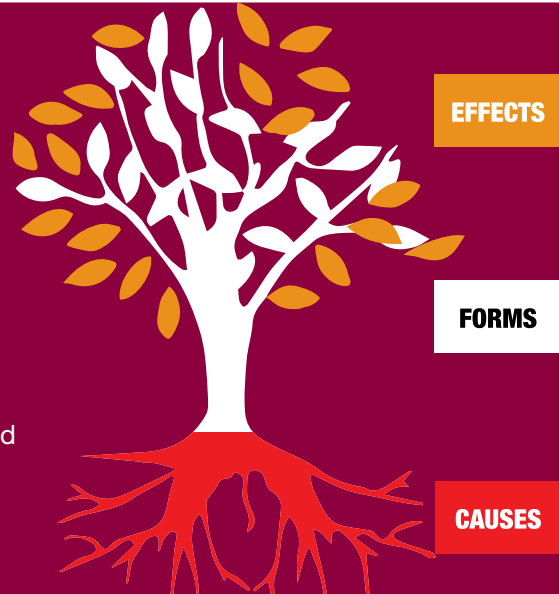
"They say by our behaviour we violate the law, but we say you are violating humanity. MSM are the community with risky behaviours that is left behind. It's time for us to be treated equally in the eyes of the law and in the eyes of the society. Every human has the right to live in peace."

YOUNG MSM ADVOCATE
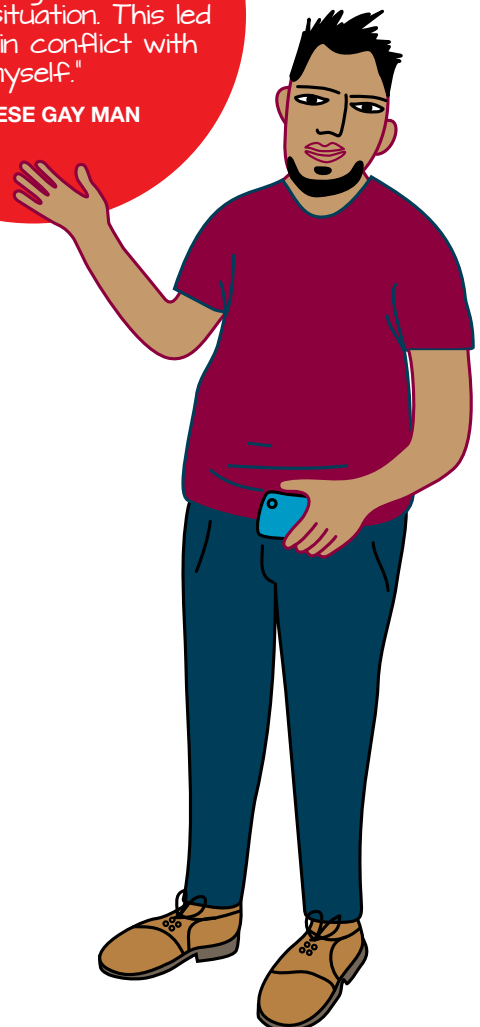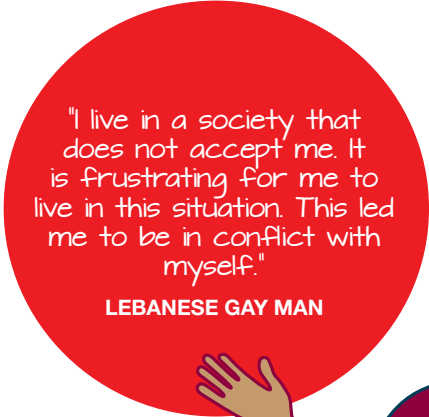
4. Risk, vulnerability, sexually transmitted infections and HIV

Introduction

Previous chapters explored issues relating to sexuality, sexual orientation, and stigma and discrimination. In this chapter we begin to look at the vulnerabilities of MSM and their risk of contracting STIs and HIV.

Two important concepts are often used to understand HIV and STI transmission: risk and vulnerability.

Risk refers to the probability or likelihood that a person will become infected with an STI/HIV. Particular behaviours increase risk, such as sharing injecting equipment and unprotected penetrative sex. The degree of risk depends on many factors, such as the HIV status of the sexual partner and whether injecting equipment contains traces of blood from an HIV-infected person.

Vulnerability refers to the range of factors outside of the control of an individual that reduce their ability to avoid risk. These may be lack of access to appropriate and accurate information about HIV/STIs; lack of access to services or commodities, such as peer education, condoms and lubricants or new injecting equipment; and the impact of stigma, discrimination and other human rights violations, as they increase MSM's vulnerability to HIV.

Sexually transmitted infections

STIs are viruses and bacteria that are transmitted during sexual intimacy with another human being. Some have very obvious symptoms but others do not.

Bacterial STIs, such as gonorrhoea, chlamydia, syphilis and chancroid, are normally treated with antibiotics. Both sexual partners need to be treated to avoid reinfection. Unfortunately, some bacterial STIs are becoming resistant to the drugs used to treat them, and therefore there is a global rise; for instance, in multi-drug resistant gonorrhoea.

Viral STIs, such as herpes simplex types 1 and 2 (HSV) and human papilloma virus/ genital warts (HPV), cannot be treated with antibiotics but can often be managed/ suppressed by the use of medication and lifestyle changes. Once infected, HSV and HPV remain in the body, and post acute infection the virus often remains dormant. Various factors can lead to reoccurrence of the symptoms, such as low immunity and poor health, stress and, in the case of genital herpes, direct exposure to sunlight of the area that was originally infected.

Viral STIs are sometimes associated with mental health concerns, such as depression and anxiety. Reasons for this can include a fear of passing on the virus (herpes, genital warts or HIV) to a sexual partner; the symptoms are often uncomfortable, in particular those of genital herpes; having a herpes outbreak is often accompanied by an acute but short-lived depression; and the stress of coping with a chronic illness.

HIV, AIDS and antiretroviral treatment

HIV (human immunodeficiency virus) is the virus that causes **AIDS (acquired immune deficiency syndrome)**. HIV is passed from one person to another through blood-to-blood and sexual contact involving the exchange of sexual fluid. In addition, infected pregnant women can pass HIV to their baby during pregnancy or delivery, as well as through breastfeeding. HIV is found in all body fluids but only in sufficient quantity for transmission in blood, semen, vaginal fluids and breast milk.

Over time, HIV slowly damages a person's immune system until it is unable to fight infection or prevent the development of certain forms of cancer. Without appropriate therapy, most people with HIV will develop AIDS and die.

Antiretrovirals (ARVs) are medicines that are used to suppress HIV and thereby prevent the virus from damaging the immune system. The aim of treatment is to reach a position where the level of HIV is undetectable in the blood. This does not mean that HIV is no longer present. It is just that the level of virus in the blood is below the lower cut-off point of the test. Before the introduction of ART in the mid-1990s, people with HIV could progress to AIDS in just a few years. People successfully treated with ARVs are now able to live a long and healthy life. In fact, with good treatment adherence, it is possible for someone living with HIV to have a relatively normal life span.

The risk of transmitting HIV to another person through sex increases with the amount of HIV circulating in the body. The risk of a person transmitting HIV when they have an undetectable viral load as a result of successful ART is dramatically reduced, although not eliminated. In fact, successful suppression of the virus through treatment with ART is increasingly seen as a key component of HIV prevention globally.[15]

Given that, the prevention impact of ART in the MENA region is compromised by the reality that only 20% of those eligible for ART in MENA are receiving it.[16] Even for those who are receiving it, there is very limited access to viral load screening. This is problematic if people taking ART assume, rather than know, that their viral load is undetectable and therefore stop using condoms. Advice from WHO/UNAIDS strongly recommends the use of condoms for penetrative sex even when someone is taking ART. This becomes all the more important when STIs exist and are untreated, since they increase HIV viral shedding in the genital tract, resulting in significant increases in HIV infectiousness. Hence it is recommended that aggressive strategies for detecting and treating STIs in people receiving ART are necessary to achieve the desired protective benefits.[17]

Factors that influence a person's vulnerability to HIV and sexually transmitted infections

STIs and HIV do not discriminate between heterosexual and homosexual people, and there is no mystery about how they are transmitted. If someone is exposed to the virus during unprotected sexual intercourse with someone who is infected with HIV, there is a risk that HIV will be transmitted to the uninfected partner.

⊙ Antiretroviral therapy

Antiretroviral therapy (ART) involves taking a combination of HIV medicines consistently every day to maintain viral suppression. If treatment is not taken every day as prescribed, the body develops resistance to treatment, which means they will not work. The WHO *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection* launched in 2013 provides ample information on this issue.

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15. More information can be found in WHO (2013), *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection*. Available at: http://www.who.int/hiv/pub/guidelines/arv2013/download/en/

16. UNAIDS (2013), *Global report: UNAIDS report on the global AIDS epidemic 2013*.

17. Kalichman S, Cherry C, White D, Jones M, Kalichman M (2011), 'The Achilles' heel of HIV treatment for prevention', *Journal of the International Association of Physicians in AIDS Care*, 10(6): 365-72.

There are a number of factors that increase a person's risk of being exposed to STIs, including HIV.

- **The number of sexual partners**: the more people someone has sex with, the greater is their chance of being exposed to the virus through sexual contact with a person who is infected with an STI or HIV.
- **The prevalence of STIs and HIV in a community**: if the levels of STIs and/or HIV are high in the community where a person chooses their sexual partner, then there is a higher risk that they will be exposed to infection. Moreover, as is the case in MENA, there are sections of the population among whom HIV prevalence is much higher than among the general population; for instance, among MSM. This means that the risk of exposure for a man who has sex with another man from that community will be far greater than for a man who has sex with a woman from the same community.
- **The kind of sex**: some sexual practices are most risky than others. For instance, the risk of HIV transmission from being the receptive partner during anal sex is 17 times greater than being the receptive female partner during vaginal sex,[18] or being the active male partner during vaginal or anal sex.
- **Not knowing their HIV status**.

Ways of reducing the risk of STIs and HIV

A person can reduce their risk of infection through practising safer sex. Safer sexual practices include:

- the use of condoms and condom-safe lubricants for penetrative sex (anal and vaginal)
- reducing the number of sexual partners
- avoiding higher risk practices such as anal sex
- taking ART correctly as this can reduce the amount of virus in the body and therefore reduces the risk of transmitting the virus to a sexual partner, although it is still necessary to use condoms for penetrative sex.

The reality is that sexually active people do not always understand or know about these facts. This is particularly the case if the prevalence of STIs and HIV is not generally known in a community where there is little information available about the risk of transmission through particular sexual practices – a situation that is common in the MENA region. Also, knowledge of how to reduce risk is not enough. For example, despite common knowledge about using condom as a means of prevention, more than 50% of the 1,225 MSM targeted in an intervention programme in Lebanon from 2007 to 2011 did not use them. Common reasons given were that condoms reduce sexual pleasure and sexual pleasure has a higher value than reducing the risk of being infected with HIV and other STIs through unprotected sex.[19]

Throughout history, STIs have been transmitted to a wife or a husband because their spouse became infected through having sex with a partner outside the marriage. Many married women have become infected with an STI through their husbands becoming infected from a sex worker or other sexual partner. In the MENA region, it has been suggested that approximately three-quarters of married women living with HIV became infected from their husbands. As they usually have only one sexual partner, unless they suspect their husband of having sex with other people, they would not consider themselves to be at risk of HIV or STIs and therefore would not expect to be tested.

> "I am transsexual. I was kicked out of school at the age of 12, I was not able to face all the whispering around me. I started to hang out with a friend who was very well known by the community, and he introduced me to sex work. That's how I make my life since then. I tried to get over it and look for a decent life, but do you really believe that a trans can have a 'regular' life, a decent life like any another person? If you do, well I don't."

TRANSSEXUAL, 25 YEARS OLD

18. Aidsmap, HIV transmission risk during anal sex 18 times higher than during vaginal sex [online]. Available at: www.aidsmap.com/HIV-transmission-risk-during-anal-sex-18-times-higher-than-during-vaginal-sex/page/1446187/

19. SIDC (2012), *Focus: a panorama of key affected populations in Lebanon from 2007 to 2011.*

5. Global and regional responses

Introduction

Since the beginning of the HIV and AIDS pandemic in the early 1980s, the global response has been characterised by action at all levels:

- indigenous grassroots responses by affected communities
- CSOs acting in the absence of government interventions and/or complementing the government response
- health and social care professionals in the areas of prevention, care and treatment
- national governments domestically through their national AIDS plans and strategies
- overseas assistance from bilateral agencies and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)
- international leadership and guidance by such bodies as the UN.

From a global leadership perspective, there are three main vehicles that are driving the international response: UNAIDS, the Global Fund and the United States President's Emergency Plan for AIDS Relief (PEPFAR), with the Global Fund and PEPFAR providing the largest amounts of funding to support national responses. These three bodies have systematically examined the evidence of what works and have reached a good degree of consensus about where global resources should be directed to have the greatest impact. They all work closely together to help to guide resource investment and international cooperation. However, only 12 countries and territories from this country are eligible for Global Fund monies. PEPFAR countries do not include any focus countries in the MENA region while funding is potentially available for key populations.

There are other national governments and donors for the MENA region, such as the Drosos Foundation, the Ford Foundation, OFID (the OPEC Fund for International Development), GIZ (Deutsche Gesellschaft für Internationale Zusammenarbeit) and some embassies, that support CSOs and governments to mount an effective response to the HIV pandemic. However, the Global Fund remains the largest donor by far.

For organisations, leaders and managers who are beginning, or want to begin, working in the area of HIV, it is useful to have some background about the two relevant global bodies for MENA.

UNAIDS: getting to zero. Fast tracking the response to end AIDS by 2030

UNAIDS works to prevent the transmission of HIV, provide treatment and care for people living with the disease, reduce the vulnerability of individuals and communities to HIV, and alleviate the epidemic's impact worldwide.

UNAIDS is guided by a programme coordinating board made up of representatives of 22 governments from around the world and the 11 UNAIDS cosponsors. Five more seats, without voting rights, are reserved for a balanced mix of NGOs, including those representing people living with HIV/AIDS. This makes UNAIDS the only UN institution to have NGO participation on its governing board.

The programme brings together the efforts and resources of the cosponsors towards fast-tracking the AIDS response and setting ambitious targets that are considered critical to ending the AIDS epidemic. Fast tracking requires transforming the UNAIDS'

The fast track targets

- Achieving 90–90–90:
    - ➔ 90% of people living with HIV knowing their HIV status.
    - ➔ 90% of people who know their status on treatment.
    - ➔ 90% of people on treatment with suppressed viral loads.
- Other targets include reducing the annual number of new HIV infections to 500,000 in 2020, to 200,000 in 2030, and achieving zero discrimination. The targets are firmly based on an approach to leaving no one behind, which is rooted in human rights and will significantly improve global health outcomes. Hence, UNAIDS is leading the global HIV community towards an increased acceleration period over the next five years, along with focused investments for the countries, cities and communities most affected by HIV.

vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths into concrete milestones and endpoints.

UNAIDS' efforts in the region are coordinated by the regional support team located in Egypt, which supports 22 MENA countries.[20] The MENA regional office backstops nine country offices in Algeria, Djibouti, Egypt, Iran, Morocco, Sudan, Somalia, Tunisia and Yemen. In these countries, as well as in Lebanon, the HIV response is coordinated by joint UN programmes and teams on AIDS. These are demand-driven leveraging tools to "make the money work" using the UNAIDS Technical Support Division of Labour, with the main aim of uniting UN action to supporting the national response in scaling up towards universal access for prevention, treatment, care and support.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund was created in 2002 to increase resources dramatically for the fight against the three pandemics. It spurs partnerships between government, civil society, the private sector and communities living with the diseases, as the most effective way to fight these deadly infections. The Global Fund does not manage or implement programmes on the ground, relying instead on local experts/implementers. It works with partners to ensure that funding serves the men, women and children affected by these diseases in the most effective way.

Central to the Global Fund's commitment to local ownership and participatory decision-making is the structure of **Country Coordinating Mechanisms** (CCM). The CCM is a country-level multi-stakeholder partnership that develops and submits grant proposals to the Global Fund based on priority needs at the national level. After grant approval, the partnership oversees progress during implementation.

CCMs include representatives from both the public and private sectors, including governments, multilateral or bilateral agencies, NGOs, academic institutions, private businesses and people living with the diseases. For each grant, the CCM nominates one or more public or private organisation to serve as Principal Recipients.

CCM core functions

- Coordinate the development and submission of national proposals.
- Nominate the Principal Recipient.
- Oversee implementation of the approved grant and submit requests for continued funding.
- Approve any reprogramming and submit requests for continued funding.
- Ensure linkages and consistency between Global Fund grants and other national health and development programmes.

20. UNAIDS: www.unaidsmena.org

The Global Fund Strategy 2012–2016: Investing for impact

The Global Fund Strategy 2012–2016 defines the organisation's aspirations and strategic actions for contributing to the collective fight against HIV/AIDS, tuberculosis and malaria. It defines how the Global Fund aims to accelerate progress, build on past successes and investments, and evolve to address challenges and seize opportunities – how it will "invest for impact".

The strategy sets ambitious goals: to save 10 million lives and prevent 140–180 million new infections over 2012–2016. The goals are complemented by partner-aligned disease-specific targets. It includes five strategic objectives and their associated strategic actions to achieve the goals and targets.

PEPFAR blueprint: Creating an AIDS-free generation

The United States President's Emergency Plan for AIDS Relief (PEPFAR) is the US Government initiative to respond to the HIV pandemic and is the largest commitment by any nation to combat a single disease internationally. In late 2011, PEPFAR outlined its strategic approach, or blueprint, to creating an AIDS-free generation, which is based on the following principles:

- Make strategic, scientifically sound investments to rapidly scale-up core HIV prevention, treatment and care interventions and maximise impact.
- Work with partner countries, donor nations, civil society, people living with HIV, faith-based organisations, the private sector, foundations and multilateral institutions to effectively mobilise and efficiently utilise resources to expand high-impact strategies, saving more lives sooner.
- Focus on women and girls to increase gender equality in HIV services.
- End stigma and discrimination against people living with HIV and key populations, improving their access to, and uptake of, comprehensive HIV services.
- Set benchmarks for outcomes and programmatic efficiencies through regularly assessed planning and reporting processes to ensure goals are being met.

PEPFAR also has a number of road maps that complement each other and are all essential in the goal of creating an AIDS-free generation. These road maps are: the Road Map for Saving Lives; the Road Map for Smart Investments; the Road Map for Shared Responsibility; and the Road Map for Driving Results with Science. Each road map contains specific goals and comprehensive action and implementation steps.

PART B
CONCEPTUALISATION

In this section we introduce some of the key guiding approaches and principles that have proven to be the most important when implementing HIV and STI prevention, care and treatment programmes for MSM worldwide and in MENA.

6. Guiding approaches and principles

Introduction

This chapter introduces some of the key guiding approaches and principles that have been proven to be the most important when implementing HIV and STI prevention, care and treatment.

A. Human rights

In 2006, UNAIDS published a consolidated version of the *International Guidelines on HIV and Human Rights*. The purpose of the international guidance was to provide a framework for a rights-based response to the HIV/AIDS epidemic by outlining how human rights standards apply in the context of HIV/AIDS and translating them into practical measures that should be undertaken at the national level. These were to be based on three broad approaches:

- Improvement of government capacity for multi-sectoral coordination and accountability.
- Reform of laws and legal support services, with a focus on anti- discrimination, protection of public health, and improvement of the status of women, children and marginalised groups.
- Support and increased private sector and community participation to respond ethically and effectively to HIV/AIDS.

The principle of human rights

The concept of "human rights" refers to the universal and fundamental rights that every human being is entitled to, without distinction.[22] Mary Robinson, a former United Nations High Commissioner for Human Rights, asserted that the human rights approach is based on involvement, freedom and accountability. It is a developmental, non-discriminatory and inalienable model based on individual and global freedoms.

The primary audience for the *International Guidelines on HIV/AIDS and Human Rights* is national governments, who are the primary duty-bearers for upholding and ensuring that human rights are embedded in national policy and laws, and ensuring they are implemented and enforced. Some core principles form the basis of the guidelines:

- **Universal and inalienable:** every human being is entitled to these rights with no exception.
- **Without distinction:** all human rights are of equal value.
- **Interdependence:** all rights are closely interlinked. When talking about the right to health, one cannot overlook the right to privacy. There is a link between sexual violence and HIV/AIDS to the right to liberty and security, freedom from cruelty and inhuman and degrading treatment.
- **Equality and non-discrimination:** equal rights to all, with the priority given to the vulnerable and most at risk.
- **Participation and inclusion:** everyone has the right to free, active and effective participation in and enjoyment of social, economic, political and cultural development, where the principles of human rights are respected.
- **Accountability and the rule of law:** nations and officials are accountable for the promotion and observance of human rights.

21. Remarks at the launch of the Report of the Commission on AIDS in Asia, UN Headquarters (New York), 26 March 2008.
22. Article 2 of the Universal Declaration of Human Rights: www.un.org/en/documents/udhr

> " There will be no equitable progress in HIV prevention so long as some parts of the population are marginalised and denied basic health and human rights – people living with HIV, sex workers, men who have sex with men, and injecting drug users."[21]
>
> **BAN KI-MOON, UNITED NATIONS SECRETARY GENERAL**

Another principle of the human rights approach is to provide support to human rights defenders and develop their capacities to carry out their responsibilities.
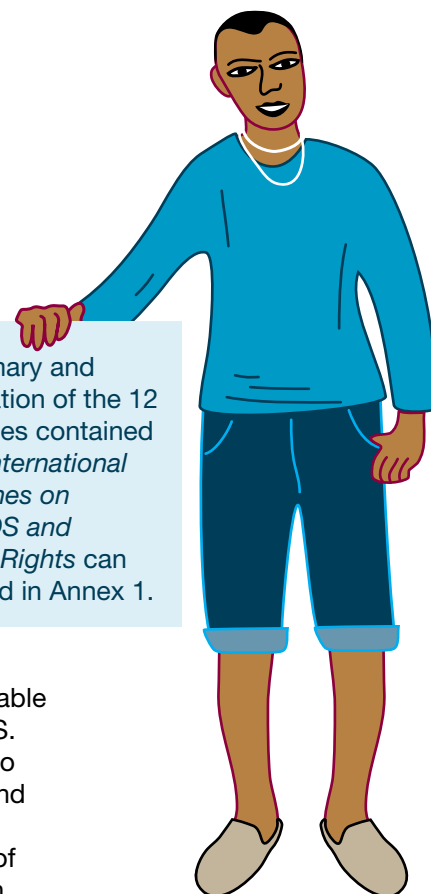
Human rights and HIV

Among its fast track targets, UNAIDS has adopted zero discrimination targets by 2020 and 2030:

- By 2020, everyone everywhere lives a life free from HIV-related discrimination.

- By 2030, all people living with HIV, key populations and other affected populations fully enjoy their HIV-related rights, including protection within their communities and equal access to health, employment, justice, education and social services.

> A summary and explanation of the 12 guidelines contained in the *International Guidelines on HIV/AIDS and Human Rights* can be found in Annex 1.

The emergence of HIV and AIDS in the mid-to-late 1980s presented the world with a challenge like no other in its history. HIV was found to be transmitted primarily through sexual intercourse. There were few recognisable symptoms of infection until major immune damage had occurred heralding AIDS. The highest prevalence of HIV was found among MSM, sex workers, people who inject drugs, and men and women in sub-Saharan Africa. These groups were, and continue to be, among the most vulnerable and least powerful in society. From the earliest days of the HIV epidemic, it was clear that unless the human rights of those most affected and at risk were protected, there was a risk of gross human rights violations occurring as a result of fear and prejudice. Moreover, there could not be an effective response to the epidemic as people living with the virus would be hidden. It was also clear from the outset that in order to respond to the HIV epidemic it was necessary to work in partnership with those most affected to come up with solutions and responses that were realistic, achievable and reflective of the contextual realities of their lives.

Human rights and men who have sex with men

In many countries, particularly in those where sex between men is illegal (which includes most countries in MENA), talking about the rights of MSM is not acceptable. The general public and decision-makers consider MSM behaviour "undesirable" and often "offensive". Therefore asserting that MSM also have human rights may seem contrary to beliefs and social norms. When MSM are also HIV positive, the situation becomes even worse due to double discrimination. This situation demonstrates clearly why the principle of human rights was developed: that minorities and vulnerable populations need to be protected from discrimination by the majority, be they migrants, small ethnic groups, people with disabilities, people with a different skin colour, or those whose sexual orientation and way of living does not conform with the majority. Everyone has the right to health and to the means to protect their health and that of others. This is **enshrined within international human rights legislation**.

Some of the basic human rights related to HIV and AIDS include:

- the right to non-discrimination
- the right to privacy
- equal access to quality and appropriate health services free from discrimination
- the right to education and a discrimination-free workplace environment
- the right to have a family.

Although almost all governments in the MENA region have signed human rights conventions, and also played a part in their development, their application in practice is not always evident. Likewise, all governments in the region have national AIDS programmes that include the importance of addressing the needs of most-at-

risk populations, which includes MSM. Unfortunately, translating that ambition into supporting effective and contextually relevant programmes is not always evident. In MENA and many other parts of the world, criminalising laws continue despite evidence that criminalisation has a high cost for MSM in denial of health services, and in discrimination in healthcare, communities, employment, education and access to justice. Few people living with HIV or affected by HIV seek redress when their rights are violated, and homophobia remains widespread.

Global experience has shown that effectively embedding human rights within their own HIV and AIDS programmes can be best achieved through the active participation of those most affected in the decision-making process. Any programme developed for this purpose – from design to evaluation – should consider:

- adopting a participatory approach through active and meaningful involvement of MSM in planning and implementation
- strengthening existing capacities and identifying development needs through participatory assessment
- facilitating the inclusion of MSM in decision-making processes to ensure they are actively engage in decisions regarding resource allocation and programming priorities that reflect reality
- ensuring prevention advice is tailored to meet the needs of different audiences, including the diversity of experience of all MSM, and includes access to quality and affordable condoms and lubricants
- establishing MSM-friendly and discrimination-free services that respect confidentiality and meet the specific needs of MSM and their partners.

"The key to ending HIV in MENA is preventing new infections and making sure that those living with HIV are well taken care of. The former would imply spreading sexuality education among youth, breaking taboos about sex and using a relevant language in awareness campaigns, while the latter would mean that we need to fight ferociously against stigma and discrimination to break social and legal barriers to health. The will to take care of one's self needs to come from the individual. We just need to open the doors widely for them to cross."

**JOHNNY TOHME,
REGIONAL COORDINATOR,
M-COALITION**

Example: Association Tunisienne de Lutte contre les MST/Sida legal clinic for key populations

Association Tunisienne de Lutte contre les MST/Sida (ATL) legal clinic is a decentralised project implemented in partnership with IDLO that targets key populations and people living with HIV. Its mission is to:

- ensure the continuity of legal services based on a dynamic and efficient approach
- ensure the participation of field workers in promoting a legal clinic for people living with HIV and key populations
- provide legal help for MSM, sex workers, people living with HIV and people who inject drugs
- contribute to the development of an adequate legal environment for the fight against the spread of HIV
- overcome barriers to treatment using an approach based on human rights
- create a legal research centre for students.

Available legal services include listening and orientation sessions, written legal advice, and complaint (in cases of stigma and discrimination related to HIV).

Advocacy work has included:

- coordination with legal authorities and stakeholders from the public health sector
- a training session for judges, lawyers, police officers and prison staff, with the participation of human rights defenders and representatives of key populations
- a training session for medical staff
- a workshop for representatives of people living with HIV and key populations, with leaders from the health and justice sectors.

More generally, MENA has seen some advancement in the area of human rights for minorities, particularly with the establishment of AFEMENA (Arab Foundation for Freedoms and Equality) but also with best practice models in some countries. These include the launch in May 2014 of a national strategy on human rights and HIV in Morocco in collaboration with the Ministry of Health and the National Council of Human Rights. Iran succeeded in adopting an inclusive approach to all people living with HIV, key populations and CSOs in its Global Fund concept note development stage and also in the national strategic plan development process. Also Tunisia has established a human rights observatory to document all human right violations at the national level.

B. Public health

WHO defines public health as all organised measures used to prevent disease, promote health and prolong life among the general population. It aims to address the determinants of ill health and disease, and create conditions in which people can be healthy and thrive, not just be free of disease. Public health efforts are focused on entire populations and communities, and not on individual patients. They recognise that we are all interdependent, and that the health or lack of health of one person can affect the health of another.

The three main public health functions are:

- **assessment and monitoring** of the health of communities and populations at risk to identify health problems and priorities
- **formulating public policies** designed to solve identified local and national health problems and priorities
- **ensuring access** by all populations to appropriate and cost-effective care, including health promotion and disease prevention services.

Since STIs and HIV are communicable diseases, they require a public health response to manage them effectively. In the MENA region, those most at risk of HIV and other STIs are sex workers, people who inject drugs, MSM and their sexual partners – all of them are often marginalised and therefore experience greater isolation and discrimination. As a result, key populations are often reluctant to seek medical support and services as they fear being discriminated against. For these same reasons they can also be difficult to reach.

In this context, if medical and social services focused only on each individual living with HIV or an STI alone, it would be impossible to address some of the underlying factors that make MSM and other key populations particularly vulnerable to STIs and HIV.

Therefore, while a human rights approach is essential to protect the rights of every individual MSM, the public health approach complements it by trying to address the key factors that render a community vulnerable to infection and disease. In the response to HIV, human rights and public health intertwine to ensure that effective measures are taken to reduce the burden of HIV infection in communities through:

- MSM-friendly STI and HIV counselling and testing services
- providing access to quality and tailored education and information, particularly oriented towards young people at risk
- ensuring access to quality condoms and lubricants
- monitoring the dynamics of HIV infection through surveillance and analysis of data to inform planning (The kinds of questions this work seeks to answer are: Who is infected? How many? Where? How? What are the factors that contribute to vulnerability and risk?)

ensuring that there are public policies in place to provide an enabling environment for responding to the public health threat of HIV. This includes ensuring that the human rights of those at risk of infection and those living with HIV are fully respected and upheld, and that discrimination is confronted and managed

key population user-friendly services and effective outreach prevention, care and support services, with particular access to young people at risk.

C. Prevention and treatment

UNAIDS global prevention targets for 2020 and 2030

By 2020, reduce the number of new HIV infections by 75% to under 500,000 per year, towards a reduction by 90% to under 200,000 new infections per year in 2030.

With the following two sub-targets:

By 2020 new infections in key populations will be reduced by 75%

By 2020 new infections in young women and girls will be reduced by 75%
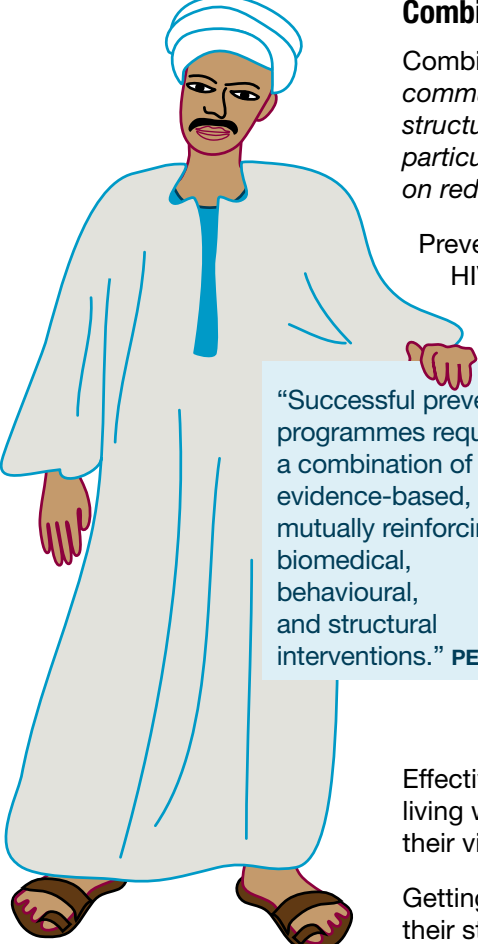
Combination prevention

Combination prevention programmes are "*rights-based, evidence-informed, and community-owned programmes that use a mix of biomedical, behavioural, and structural interventions, prioritized to meet the current HIV prevention needs of particular individuals and communities, so as to have the greatest sustained impact on reducing new infections*".[23]

Preventing HIV transmission is complex. People need to have knowledge about HIV and how it is transmitted. They need to have an accurate perception of their own risk, want to reduce that risk and know how they can do it: for example, by using condoms for safer sex. They also need to feel that they are able to do it: that is, possess self-efficacy. However, human behaviour is often contextual and influenced by the community and society in which we live. MSM in the MENA region may have little access to information and services, and because of discrimination and prejudice, may not be in a position to practice safer sexual behaviour without raising suspicion and fear of being "found out". Therefore, for MSM to be able to adopt safer behaviours freely, it is necessary to address structural factors, such as the lack of services (especially for young people at risk), stigma and discrimination, and repressive laws against MSM that contribute to their vulnerability, and improve their human rights environment.

"Successful prevention programmes require a combination of evidence-based, mutually reinforcing biomedical, behavioural, and structural interventions." **PEPFAR**

Effective prevention also means reducing the level of HIV (the viral load) of people living with HIV, since they are less likely to pass on HIV to their sexual partners if their viral load is low. Reducing viral load is achieved through ART.

Getting people on to treatment can only happen once they test for HIV and know their status. Unless sympathetic and user-friendly services for MSM are available, the chances of MSM testing and retesting for HIV are low.

23. UNAIDS (2010), *Combination HIV prevention: tailoring and coordinating biomedical, behavioural and structural strategies to reduce new HIV infections. A UNAIDS Discussion Paper.*

Combination prevention recognises all of these factors and acknowledges the need to intervene at multiple levels: at the individual level (behaviour), by ensuring access to quality HIV testing, commodities, care and treatment services (biomedical), as well as at the systems level, as interventions to address negative social norms and discriminatory laws. This approach is supported and championed by UNAIDS, the Global Fund and PEPFAR because it is evidence-based and reflects global learning.

When developing a HIV prevention programme, it is essential that a combination prevention approach guides programme interventions. Addressing only one aspect of prevention (for example, increasing access to condoms and lubricants) is insufficient to effect positive change or sustain behaviour change.

In order to fast track combination prevention, actors need to consider:

- **Renewing a national commitment to prevention**
  - Commitment to a national prevention strategy needs to be cascaded to leaders at all levels (policymakers, other leaders, financing institutions and implementers). They need to be presented with clear and simple packages of investment for prevention. This has to happen at both national and at local levels, with key players from health and non-health sectors working together.
  - A financial commitment to prevention now saves money in the future. A recent UNAIDS modelling exercise[24] showed that about 25% of all HIV investments should go into effective combination prevention interventions.
  - A personal commitment must be made by leaders from all spheres to become role models and advocates, and speak out in support of HIV prevention, its cost-effectiveness and the importance of different prevention options and choices.

- **Focusing on the right locations and methods to maximise impact**
  - Prevention resources should focus more intensely on geographic and administrative areas at elevated risk.
  - Focusing combinations of prevention approaches with high coverage and intensity on people at greatest risk and locations where risk takes place can increase prevention benefits without increasing expenditures.
  - Since cities tend to be home to large numbers of people belonging to key populations, a strong focus on service availability for key populations in urban areas is essential, and can be the starting point for developing national programmes that gradually reach out to smaller towns and rural areas.

- **Synergies – defining effective programme packages**
  - Although there are now a number of options for HIV prevention that have proven effective if used consistently (pre-exposure prophylaxis (PrEP), condoms as a triple protection tool, voluntary medical male circumcision, specific communications and social change approaches, harm reduction interventions), different settings and populations will require different combinations of programmes.
  - The best prevention impact comes from the careful selection of prevention interventions and approaches, tailored to the epidemic setting and offered as a package with consistency over time.
  - Packages for all populations will have a strong component of biomedical prevention tools, including ARV-based strategies and condoms; a behavioral and community component for ensuring that community norms are supportive and uptake of prevention options is high; a strong community empowerment element; and be integrated into a wider system of structural health and development synergies.

24. UNAIDS (2013), *Global report: UNAIDS report on the global AIDS epidemic 2013*.

> " I know that I am homosexual, but still I'd like to have a family and children. Can I do that today given my new positive status?"

MSM LIVING WITH HIV, 35 YEARS OLD
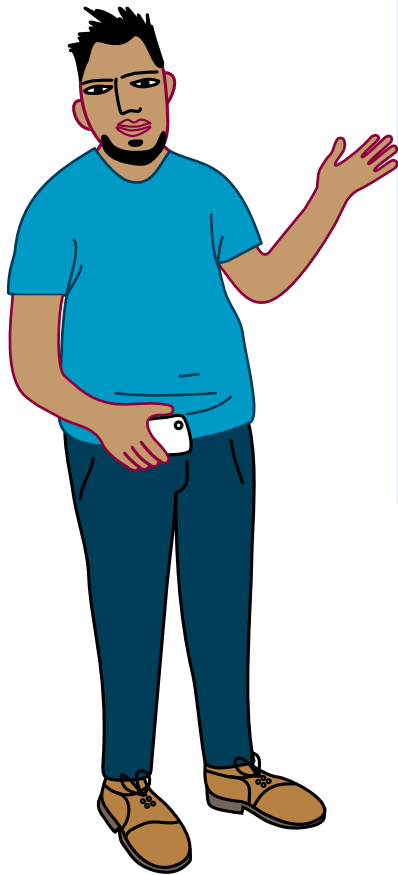
Early initiation of antiretroviral therapy for health and prevention benefits

Antiretroviral therapy (ART) reduces the amount of virus in the body of a person living with HIV and therefore preserves the functions of the immune system preventing illnesses that would otherwise take place. By lowering the amount of the HIV virus in blood and body secretions, ART also dramatically reduces the risk of onward HIV transmission. Early initiation of ART for prevention purposes is referred to as "treatment as prevention" (TasP) and has been shown to be very effective in preventing further transmission of HIV.

What is "treatment as prevention"?

The role of HIV treatment as a method for preventing HIV infection is known as "treatment as prevention" (TasP) and refers to the fact that the risk of HIV transmission between HIV positive people taking HIV treatment with suppressed or undetectable HIV viral loads and HIV negative people is dramatically reduced.

A pivotal study, in 2011, conducted to measure the effect of ART in preventing HIV transmission among heterosexual sero-discordant couples (couples in stable sexual relationship where one partner is living with HIV and the other is not), showed that people on treatment were 96% less likely to transmit HIV to their partners than untreated people. In other words, the study suggested that if a sufficiently large percentage of the HIV positive population could be provided with ART and their viral loads decreased to an undetectable level, HIV transmission could significantly decrease.

This study set the foundations for the idea that HIV treatment should be offered to people living with HIV as soon as they are diagnosed and irrespective of CD4 count. This strategy is known as the "test and start" approach and it focuses on offering ART to people living with HIV straight after a positive HIV diagnosis.

The Guide on *Implementing comprehensive HIV and STI programmes with MSM* developed in 2015 by UNFPA, MSMGF, UNDP, WHO, USAID and the World Bank (*see* Annex 2) explains that there is mounting evidence to support the multiple health advantages of early initiation of ART.

In 2015 a large study showed that there are benefits to starting treatment as soon as possible, with high CD4 cell counts. The study demonstrated that starting HIV treatment earlier decreases the risk of illnesses, AIDS and death. Furthermore, the study also described how people who began HIV treatment earlier had a better quality of life than people who waited.

Because viral suppression has important prevention benefits on the individual level, it is fair to think that it may have benefits also on the population level. Viral suppression in this sense can be a public health goal, not only to improve the health of people living with HIV, but also to decrease new infections in communities with high HIV incidence. For instance, HIV positive MSM in sero-discordant relationships or who engage in sex work should be initiated on ART irrespective of CD4 cell count or clinical stage of infection to achieve viral suppression and decrease the risk of onward transmission. In other words, increasing the number HIV-positive MSM on treatment has the potential to reduce the total amount of virus circulating in a community (also known as community viral load) and lead to a reduction in the number of new HIV infections.

Derived from TasP, the strategy referred to as "test and start" involves screening MSM for HIV and immediately offering ART to those who are HIV positive, irrespective of CD4 cell count or clinical stage. This can be an effective strategy for improving health among HIV positive MSM and interrupting transmission of HIV, particularly in concentrated epidemic areas. However, it should be always implemented ensuring the autonomy of the individuals in their choices of care and respecting their human rights.

Using antiretroviral drugs to prevent HIV

Applying a combination prevention approach means that prevention services should include the use of ARVs by people who are uninfected to prevent them from acquiring HIV.

Pre-exposure prophylaxis (PrEP)

Pre-exposure prophylaxis (PrEP) is a strategy to prevent HIV and it consists of a daily medication that people who do not have HIV take to prevent getting infected with HIV. The concept of PrEP is similar to anti-malarial tablets, taken before travelling to malaria endemic countries to prevent becoming sick with the disease. Similarly PrEP for HIV, is an anti-HIV drug taken by HIV negative people, so that if they are exposed to HIV, the drug can prevent the HIV virus to enter cells and replicate.

Scientific evidence demonstrated that PrEP is highly effective in preventing the sexual transmission of HIV, as long as the drugs are taken as prescribed. It works for men and women, heterosexual and homosexual, but while PrEP can prevent HIV, it does not prevent other STIs or pregnancy.

If taken correctly, PrEP has the potential to greatly reduce HIV transmission, but, as with any prevention methods, it should always be made available in an environment of combination prevention, meaning that different prevention methods are combined and made available to match the prevention needs and preferences of individuals in different contexts and circumstances.

PrEP works best if taken every day and those who use it should have regular monitoring for side effects, adherence, and HIV testing and regular sexual health check-ups.

PrEP is not yet available in MENA countries, however Morocco has succeeded in adopting the protocol of a PrEP feasibility study for MSM and female sex workers by the National Treatment Committee, allowing the feasibility study to be conducted from October 2016 onwards in four Moroccan cities.

PrEP is a new tool for HIV prevention that could expand the range of prevention options available for people and communities to prevent HIV. Everyone should be given the possibility to choose from a range of prevention options. In the MENA region, access to PrEP is currently extremely limited. Civil society can play an important role in understanding the benefits of PrEP to those most at risk of HIV. Opportunities to explore advocating for PrEP should be created and lessons learnt from other regions.

Post-exposure prophylaxis (PEP)

Post-exposure prophylaxis (PEP) is short-term ART to reduce the likelihood of acquiring HIV infection after potential exposure, either occupationally or through sexual intercourse.

> " It took me time to accept my new status as PLHIV, and this was with help and support of the NGOs. However, accepting my homosexuality maybe I will never reach."

MSM LIVING WITH HIV, 22 YEARS OLD

> " Mum knows about me being homosexual, but I cannot tell her that I am HIV positive, she will blame me."

MSM LIVING WITH HIV, 25 YEARS OLD

> "It took me three months after discovering my new status to accept to do sex with my partner. It was difficult for me to regain my self-confidence and to reconcile with my new status."

MSM LIVING WITH HIV, 24 YEARS OLD

STORIES FROM MSM LIVING WITH HIV

Anis, a 31-year-old single man who defines himself as bisexual. He is unemployed and lives in Lebanon

"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.

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.

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.

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."

Mourad, a 21-year-old single man who is unemployed and lives in Algeria

"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 voluntary testing and counselling.

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.

Thanks to 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."

> "I went with my father to open a medical record at the ministry. The employee addressed me in front of my father with this comment, 'Your father worked here and had a very good reputation. Why are you a bad guy? This hurts."

TRANSSEXUAL, 35 YEARS OLD

> "I walked out crying from my dentist clinic. I told him that I am positive to be aware and take more precautions. He asked me to leave and he said cannot treat me without giving me any excuses."

MSM LIVING WITH HIV, 25 YEARS OLD

Positive Health, Dignity and Prevention

Many of the early prevention responses to HIV prevention efforts were focused on primary prevention: prevention messages and campaigns that were aimed at preventing the uninfected from becoming infected. Generally, there was little support or attention given to prevention issues for people already living with the virus. Where attention was given or raised, it was frequently in the context of heavy condemnation of people living with HIV as being the vectors of disease. This was compounded by condemnation of people living with HIV who were also MSM.

As a response, people living with HIV, under the leadership of the Global Network of People Living with HIV (GNP+), developed an approach called Positive Health, Dignity and Prevention (PHDP). PHDP highlights the importance of placing the person living with HIV at the centre of managing their health and wellbeing and at the centre of the response.

PHDP stresses the importance of addressing prevention and treatment simultaneously and holistically. It also emphasises the leadership roles of people living with HIV in responding to policy and legal barriers within the socio-cultural and legal contexts in which they live, and in driving the agenda forward towards better health and dignity. In considering the ongoing challenge of HIV prevention, people living with HIV should be recognised as a part of the solution, not a part of the "problem". As people living with HIV who are also MSM are doubly discriminated against, it is essential that they should not be further marginalised in decisions regarding their prevention, treatment and care.

The public health and human rights goal of preventing new HIV infections can only be achieved when the human, sexual, and reproductive rights of people living with HIV are protected and supported; when the broader health and dignity needs of people living with HIV are met; and when access to timely and uninterrupted treatment and care encourages greater uptake of confidential voluntary counselling and testing.

The primary goals of PHDP are to improve the dignity, quality and length of life of people living with HIV. If achieved, this will in turn have a beneficial impact on their partners, families and communities, including reducing the likelihood of new infections. These important goals can only be achieved with broad stakeholder commitment. PHDP should shape how governments, policymakers, programmers and international agencies work with people living with HIV, moving away from treating them as passive targets of prevention messages towards recognising them as active participants in the global HIV response.

PHDP encompasses the full range of health and social justice issues for people living with HIV. It espouses the fundamental principles that responsibility for HIV prevention should be shared, and that policies and programmes for people living with HIV should be designed and implemented with the meaningful involvement of people living with HIV.

Attaining the goal of PHDP specifically requires promoting and affirming the empowerment of people living with HIV through the following objectives:

- Increasing access to, and understanding of, evidence-informed human rights-based policies and programmes that support individuals living with HIV to make choices that address their needs and allow them to live healthy lives free from stigma and discrimination.

> " While receiving my HIV diagnosis in a renowned hospital in my country, the nurse handed me a sealed results and commented, 'Did you hang around with women to get it?'"
>
> **NEWLY DIAGNOSED MAN, 28 YEARS OLD**

- Scaling up and supporting existing HIV counselling, testing, care, support, treatment and prevention programmes that are community owned and led, and increasing access to rights-based health services, including sexual and reproductive health.

- Scaling up and supporting literacy programmes in health, treatment, prevention, human rights and the law, and ensuring that human rights are promoted and implemented through relevant programmes and protections.

- Ensuring that undiagnosed and diagnosed people, along with their partners and communities, are included in HIV prevention programmes that highlight shared responsibilities regardless of known or perceived HIV status, and have opportunities for, rather than barriers to, empowering themselves and their sexual partner(s).

- Scaling up and supporting social capital programmes that focus on community-driven, sustainable responses to HIV by investing in community development, networking, capacity-building, and resources for organisations and networks of people living with HIV.

Operationalising PHDP is not about creating new programmes, except where basic programmes do not exist. Rather, it is about using the principles of PHDP to create linkages among existing programmes and taking them to scale, so that they are more efficient and responsive to the needs of people living with HIV.

D. Harm reduction

Harm reduction is an evidenced-based approach that aims to reduce the harms associated with drug use and HIV. It is a pragmatic approach to health comprised of interventions that address harms like HIV transmission, hepatitis C (HCV) transmission, overdose and unsafe injecting. Harm reduction is shaped by both public health and human rights principles.

In the MENA region, there is evidence of an increasing epidemic of drug use. Some MSM use injectable drugs and some use recreational drugs. While the principle risk associated with HIV infection is the sharing of injecting equipment, increased risk of HIV transmission is also associated with non-injectable recreational drug use, as this could lead to behavioural disinhibition – people taking sexual risks while taking drugs that they would not take otherwise.

WHO defines harm reduction as: *"Interventions that reduce the adverse health, social and economic consequences of psychoactive substance use for individual drug users, their families and their communities. Comprehensive harm reduction programmes can reduce new HIV infections among people who inject drugs."* [25]

The harm reduction approach does not set out to stop people taking drugs but rather acknowledges that those who are currently unwilling or unable to become abstinent remain at risk of HIV and other preventable harms. Harm reduction, based on public health principles, is a client-driven approach that aims for improved health at a speed that is acceptable and realistic for the client.

Harm reduction focuses on short-term, achievable goals because it is driven by the urgent need to prevent HIV and HCV transmission, and to get services to people with HIV and/or HCV who inject drugs. While many argue that the best approach to managing drug use is abstinence and zero drug tolerance, the reality is that there is little or no global evidence to show that this has been done successfully, even in countries with the tightest drug laws. Also it does not take into account that

25. WHO South-East Asia and Western Pacific Regions (2008), *HIV/AIDS care and treatment for people who inject drugs in Asia and the Pacific: an essential practice guide.*

even if the ambition of a person who injects drugs is abstinence, to avert the harm associated with injecting drug use (HIV and HCV transmission), the person would need to limit their exposure by using harm reduction measures, such as not sharing injecting equipment, while trying to achieve that goal.

Many would argue that a drug-free world is a long-term or even unattainable goal. In the meantime, HIV needs to be prevented and people need health services, education, care and support.

Harm reduction programmes that are shaped by development principles take the approach beyond its public health and human rights roots to include a focus on family and partner support, income support and improved livelihoods.

Harm reduction is the only proven successful approach to HIV programming for people who inject drugs, offering interventions that can reduce the risk of HIV transmission and build a culture of care and support for HIV-positive people who use drugs.

A harm reduction approach uses the concept of a **hierarchy of risk** to categorise HIV infection risk related to injecting drug use.

Hierarchy of risk

Never use drugs or stop using drugs.
This is the most effective way to avoid HIV infection related to drug use.

⬇

If you use drugs, do not inject them.
This is a very effective way to avoid HIV infection related to drug use.

⬇

If you inject drugs, always use sterile injecting equipment.
This is the only effective way to avoid HIV infection related to drug use.

⬇

If you cannot always use sterile injecting equipment, re-use your own injecting equipment.

HIV infection related to drug use can be avoided if you re-use your own injecting equipment (so long as no one else has used the equipment).

When developing HIV prevention and care programmes for people who use drugs, it is essential that implementers take into consideration any national laws as they relate to the use of psychoactive substances. The goal of organisations working to prevent HIV and HCV transmission, as well as the care and support of people who use drugs, is to minimise the harm to the person themselves, their families and society as a whole. Global evidence has shown that the most effective way of achieving this is through the implementation of harm reduction programmes informed by human rights. As there can be a lack of understanding of harm reduction at government levels, HIV programme planners often have to invest in engaging ministries of health through education and advocacy to enable harm reduction programmes to be implemented, and thereby limit the potential harms of injecting drug use.

E. The prevention and treatment continuum

With the advent of combination prevention, the former distinction that was often made between prevention on the one hand and care and treatment on the other seems increasingly problematic. This is because HIV treatment is also part of HIV prevention as it lowers viral load, and HIV testing is essential to both treatment and prevention.

It is more common now to talk about the continuum of prevention and care, which incorporates:

■ **primary prevention** – preventing people who are uninfected from getting infected

■ **secondary prevention** through PHDP, and testing, treatment and care services.

The HIV treatment component of the continuum relates to **testing and offering treatment**, and ensures retention through:

■ quality HIV testing so people can learn of their HIV status

■ getting people living with HIV referred and linked to a healthcare provider or services for the specific kind of care they need, such as HIV treatment, mental health support/counselling, HIV prevention advice support

■ ensuring people living with HIV have access to CD4 testing to clinically assess their eligibility for ART, and getting people living with HIV on ARV combination therapy to reduce their viral load in order to limit the risk of developing opportunistic infections and minimise the risk of transmitting infection

■ ensuring that people living with HIV do not wait to receive treatment in cases where access to CD4 count machines is unavailable

■ maintaining viral load reduction and avoidance of ART resistance through adherence support throughout their lives.

The new treatment recommendation

In 2015, WHO released new recommendations on the use of ARVs for treatment and prevention of HIV. WHO now recommends that all people living with HIV should be offered treatment of ARVs regardless of WHO clinical stage or CD4 cell count. During the scale up and regardless of the type of epidemic and disease burden, people with symptomatic HIV disease or with a CD4 count at or below 350 cells/mm^3 and those who are at high risk of mortality and most likely to benefit from ART in the short term, should be prioritised. These include people at highest risk for co-infections, as well as all pregnant and breastfeeding women.

These recommendations are a major step forward in the global response to HIV. The recommendation that ART should be offered to everyone living with HIV, at any CD4 cell count, reinforces the fast-track assessment that earlier provision of HIV treatment is key to bringing the HIV epidemic under control and that accelerated scale up of treatment access is a critical priority today. Earlier treatment can mean better health outcomes for people living with HIV, simplification of treatment services and decreased HIV transmission. Availability of earlier treatment can also encourage more people to learn their HIV status, offering opportunities for expanded access to HIV prevention services along with treatment. The recommendation that the daily use of oral PrEP be offered as an additional prevention choice for people at substantial risk of HIV infection as part of combination prevention can bring previously marginalised populations to HIV services.

F. Commonly agreed approaches to HIV programming

Participation

Central to effective HIV prevention, care and support services for MSM is the principle of participation. Often, people most at risk of HIV and those in need of services are marginalised and little understood by traditional health and social support services.

By actively engaging with people most affected by HIV and those most at risk of HIV infection, programmes can be developed in partnership that can meet the specific needs of that group, rather than developing generic programmes that may miss the realities of their lives.

By actively engaging with potential programme beneficiaries, trust and confidence can be developed, together with more active engagement and commitment to the programme. Top-down approaches, where programme planners develop programmes for beneficiaries, often miss critical components that can only be known through active engagement.

By contrast, programmes where beneficiaries have been active participants in developing them are likely to have greater impact and reach. They will be developed to match the needs of MSM, and MSM will be mobilised to take action through the process of participation.

Bassem, a 32-year-old student and peer educator with ATL in Tunisia

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

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 up for our rights.

This prevention and mobilisation work with the community and key actors in the HIV response has led to deep changes. Now, for example, if 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."

Peer education

Peer education is an approach that is often used to reach marginalised populations such as MSM. Part of the rationale is the assumption that those who share similar experiences and come from a similar background can be a more effective and credible source of information. Someone who shares characteristics in common with the person being reached is often more trusted by the community they serve, and may be able to access people who are hard to reach using traditional approaches.

Research into the impact of peer education has shown that certain conditions need to be met in order for peer educators to be effective. Unless peer educators are rigorously trained, supervised, supported and receive ongoing information, the impact of their intervention may be negligible. Therefore, peer education approaches are not a cheap or easy means of accessing hard-to-reach populations such as MSM. However, with the right management, leadership, training and support, peer education approaches can be extremely successful and contribute to lasting change for those being reached, as well as for the peer educators themselves.

STORIES FROM MSM PEER EDUCATORS

Jamel, a 21-year-old student who defines himself as gay. He is a peer educator with OPALS in Fes, Morocco

"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.

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 centre, 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, a positive environment for meetings and different activities."
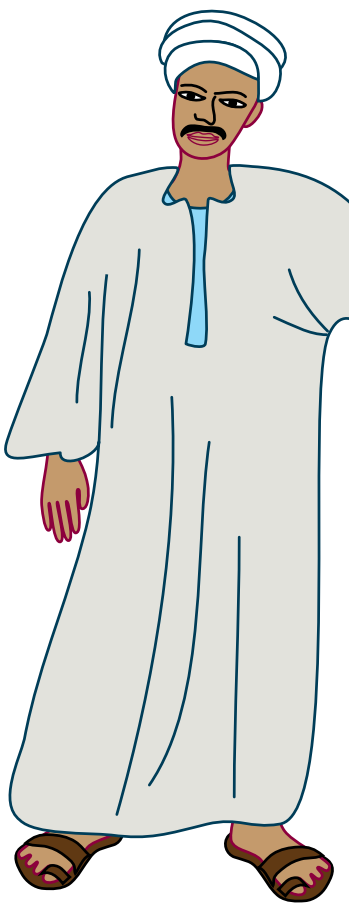
Walid, a 31-year-old student who is single and defines himself as MSM. He is a peer educator with SIDC and Helem in Lebanon

"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 into practice the theoretical information I learned.

In my position as a PE [peer educator], what has changed is that I met other groups and communities who are different from the people I knew, and I have learned how to work with approaches adapted to each of those groups. The way of working, of speaking, the content of the information destined to street youth are different from those used with young people in bars and nightclubs. I am no longer limited in using one single method or approach.

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

Chaker, a 31-year-old beneficiary and manager in Tunisia

"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.

I want to congratulate them for their professional approach and the tools that 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."

For a comprehensive approach to the training of peer educators for HIV and MSM, please see the three-module toolkit that accompanies this orientation manual.

Peer navigation[26]

Patient navigators are people who guide patients through and around barriers in healthcare systems to facilitate their access to services that they otherwise may not be able to access. Patient navigators assist patients in navigating the healthcare system to help them meet their basic and specialised healthcare needs, and within the HIV continuum of care, peer navigators can have a critical role in supporting new patients in overcoming the anxiety of being newly diagnosed with HIV. They can work in clinics, hospitals, HIV testing and ART distribution centers, and social service agencies, among other sites. Through activities such as community outreach, regular phone calls, appointment reminders and accompanied referrals, peer navigators support people living with HIV in being linked to and retained in HIV care. People who often experience challenges when accessing healthcare, such as MSM, can benefit greatly from such services. Patient navigation is very important in the context of a chronic infection like HIV in countries where HIV is highly stigmatised, and affecting communities such as MSM who often do not seek HIV services because they have experienced stigma and discrimination in healthcare settings or know someone who has.

> **Rachid, a 30-year-old interpreter and peer educator with APCS in Algeria**
>
> "I must say that this project brought me so many changes, starting with my fulfillment in volunteer work and 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.
>
> … 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 and 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.
>
> I am proud of my work as a peer educator and I accept my community without any fear or prejudice. Also, I 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, and I regain my balance because, in essence, I like to help my fellow people."

Existing peer educator programmes provide an optimal opportunity for training patient navigators. The training of peer educators can also include a component on peer navigation in their curriculum. The trained peer educators/navigators can then educate MSM individuals about how to prevent HIV infection and help individuals diagnosed with HIV learn about health systems, so they can access and remain in care. This new navigation strategy should be a part of any prevention programme targeting people living with HIV.

In the context of MENA, adding a patient navigator role to the MSM peer educator's role should be approached with caution, given the high level of internal stigma towards HIV-positive MSM within the MSM community. The most experienced and mature peer educators would be best placed to take up this important role.

26. Reference: amfAR GMT Initiative Factsheet on Patient Navigation. Available at: www.amfar.org/gmt-initiative-fact-sheets-patient-navigation-and-country-ownership/

Patient educators in HIV programmes implemented by key population-friendly organisations are usually peer educators living with HIV themselves, and are often experienced and trustworthy former peer educators. They are familiar with the healthcare facilities in their communities and know which health providers are MSM and people living with HIV friendly, and they assist newly diagnosed MSM and MSM who have previously avoided health settings in finding the care that meets their needs.

The role of the peer educator in helping clients access services and directing them to sympathetic treatment and care providers and supporting them through the process is critical. However, in context of the MENA region where access to ART is so limited and prescribed and HIV so stigmatised, the "navigator" component of the MSM peer educator's role should be holistic (sexual health, testing, psycho-social support and mental health, and treatment and adherence support).

Community mobilisation

UNAIDS defines a community as a group of people who have something in common and will act together in their own interests. From the earliest days of the epidemic, mobilising communities to respond to the threat and impact of HIV has been a key component of the response. Driving this has been the premise that communities themselves, with the necessary information and resources, are most likely to come up with meaningful and realistic solutions.

Community mobilisation is a process whereby individuals, groups or organisations analyse, plan, carry out and evaluate activities and responses in a participatory and sustained way to improve their health and wellbeing. By mobilising the MSM population in a given country, there is the potential for them to act together to develop contextually relevant interventions and programmes that may not have been possible using a more traditional top-down planning process.

Multi-sectoral

Managing HIV, and the discrimination, isolation and fear experienced by so many MSM, as well as the economic and social impact of HIV, demands responses across multiple sectors. These include health, psychology, social welfare, the police and law enforcement, the judiciary, the media, and spiritual and religious leaders, as well as government agencies, and the private and civil society sectors. HIV and AIDS is not just a health issue. People have complex human needs, and they all interact with each other. It is not possible to concentrate on one while ignoring others without this having consequences on someone's health and wellbeing. HIV also has a social and economic impact on individuals, households, communities and countries.

An effective response to HIV and AIDS, and the challenge of meeting the needs of MSM in the MENA region, demands committed, urgent and sustained action. Healthcare workers cannot provide services if MSM are discriminated against and fear interacting with them. Experiences by MSM of physical violence and sexual assault cannot be addressed if MSM fear reporting it because the police and/or the judiciary will not treat them fairly. Issues of self-esteem and mental health are further compounded by negative and hostile social and religious norms towards MSM. Discrimination experienced by MSM at work has an impact on their ability to do their jobs and provide economic security for themselves and their families.

Those interested in developing programmes with and for MSM need to fully acknowledge the necessity, as well as the challenge, of working with other sectors to mount a comprehensive multi-sectoral response. In situations where people living with HIV and MSM are discriminated against, as is the case for many in the MENA region, learning from the experience of others and finding like-minded

Holistic

To develop effective responses to HIV and to treat people with dignity and respect, it is essential to approach work around HIV and STI prevention by considering the person as a whole. This means not reducing a person to being only an MSM who is living with HIV or who is at risk of HIV infection, but rather taking their emotional, physical, social and spiritual needs into consideration as well as their health. This is essential not only for wellbeing and respect, but also can help someone who is MSM in a hostile environment to feel more connected, respected and whole.

individuals and organisations to partner with (in particular, UNAIDS) is essential to be able to advocate and nurture effective and sustainable programmes.

> **❝** 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 behaviour is still criminalised. This is something that has really changed … Through this programme, 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 humanised the issue and this is very important."
>
> The first study that was conducted with key populations was a behavioral study with MSM … I think that was an important point in starting being objective about 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.
>
> 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."
>
> **DR MYRIAM BEN MAMOU, FORMER UNAIDS COUNTRY OFFICER IN TUNISIA**

G. Using communication technology for HIV programming for MSM populations*

Information and communication technology (ICT) can be used across the HIV continuum of prevention, testing, treatment, care and retention, including supporting an enabling environment. ICT refers to computers, mobile phones and other Internet-enabled communication devices. Examples of ICT platforms include social media, websites, chat rooms, applications (apps) for feature phones and smartphones, text messaging and short message service (SMS). ICT is an umbrella term that can include other terms like eHealth (electronic health applications, i.e. electronic medical records) and mHealth (mobile health applications, i.e. mobile phone apps for health purposes).

MSM worldwide may use ICT to access online ("virtual") safe spaces for social and sexual encounters, or to arrange such encounters in the "offline" (physical) world, often in private locations. Consequently, in many countries there has been a decline in the number and significance of public locations where men who have sex with men meet one another. This may be more so in countries where same sex relationships are criminalised and highly stigmatised and where meeting face to face would be highly risky. The use of ICT is therefore increasingly important to reach the full range of men who have sex with men. ICT offers a variety of ways for service-providers to connect with men, including anonymously. These tools and methods can be instrumental in scaling up HIV services for MSM, especially those most hard to reach.

The increasing significance and reach of ICT make it applicable to various areas of men's sexual health including HIV programming: peer outreach prevention, community empowerment, addressing violence, stigma and discrimination, condom and lubricant programming, services and service delivery. When programming with ICT, it is crucial to link online outreach (for example, through social media and apps) to physical services (such as HIV and STI testing and counselling). The safety, security and privacy of MSM must always be a key component of any ICT intervention.

* This section is citing UNFPA 2015 *Guide on comprehensive HIV and STI programmes with MSM*. See full reference in Annex 2.

Similarly to other regions, MSM living in MENA, especially young people, largely use social media networks to exchange information safely, socialise, support each other or meet sexual partners. However, ICT is not routinely used yet to share HIV prevention messages or promote access to care and treatment services. ICT should increasingly be used for outreach, support and advocacy for MSM in the coming years. Several pilot interventions conducted recently in the region confirm the high potential of ICT to further reach and support MSM:

Example: A mobile app and web widget to promote HIV testing in MENA

In order to address the first 90 in the fast track targets, UNAIDS MENA has developed a HIV testing center locating widget and a mobile app to provide easier ways to find information on nearest HIV and STI testing site. The database currently has information about testing centres in Algeria and Egypt.

The mobile app is a testing centre locating tool that allows anyone to search for testing services and other service providers near their current location. This will be maintained through a database which will hold the details regarding the centres and will be made available for country NAP managers to update and modify details for testing centres accordingly.

A web widget is a small application that is embedded in a social network, blog, or website (www.testingcentresmena.com). The widget is developed to allow users to find the nearest center either by zip/city/country, or within a specific distance from their current location. An Android application is developed to provide the same functionalities of the web widget, in addition to the option to start a navigation route to the selected test centre.

Example: A pilot online peer outreach project to reach more MSM in the MENA region

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

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

Based on these findings, the partners designed a pilot ICT-based intervention for HIV prevention in MENA. Experienced peer educators from the partner associations created avatars representing different profiles of beneficiaries, designed collectively an online peer outreach intervention and developed the corresponding standard operating procedures and M&E framework. This specific intervention was identified as the most feasible output based on existing resources and ICT experience. Building capacity of community groups for this intervention would result in more effective use of popular social

media platforms for MSM-peer outreach activities. Local trainings of "online peer educators"* were organised to strengthen: digital security, content creation systems, online outreach procedures, conduct of peer educators online, and M&E framework to measure the success and outcomes towards the HIV continuum of care.

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

This test phase lasted from July to September 2015 in Agadir, Beirut, Tunis and Sousse. The results were promising. By way of example during the month of September 2015, the six online peer educators of ASCS in Agadir reached 546 MSM via chat rooms, websites, apps and instant messaging. They referred 148 MSM for an HIV test and 86 MSM for an STI consultation. During this period ASCS noticed an increase of number of MSM passing by the association to take condoms and lubricant; ASCS peer educators appreciated this new type of outreach work compared to street outreach, the latter being uneasy due to growing harassment of

police. Some challenges that peer educators faced online were similar to "traditional" (face-to-face) outreach work: high interest in sexual health, initially reluctance to visit association or uptake services, or to change risk behaviour.

Some of the lessons learned of this pilot project:

- **Overall high acceptability**: many MSM are eager to engage in an online conversation about HIV prevention, STIs, rights, and associations providing services; virtual spaces are perceived as a safe space to talk freely about sexual practices (no face-to-face bias); however not all: a significant proportion of MSM contacted online refused any discussion.

- **Strong operational procedures and human resource capacity** are required to maintain a high quality ICT tool which maintains privacy and confidentiality; consequently, organisational ICT capacity needs to be assessed and strengthened before initiating an online prevention project.

- **M&E challenges**: it is not easy to measure uptake of services or user engagement online or to clearly show the link between use of ICT and uptake of services; M&E between outreach CSOs and friendly service providers need to be aligned to track referral from virtual spaces to services.

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

How to use ICT appropriately, safely, ethically and efficiently for HIV prevention, support and referral purposes for MSM is not covered in this version of the Training Manual for MSM peer educators.

The small pilot project and other ICT pilot interventions (notably of ALCS in Marrakech) have demonstrated the high potential of ICT for reaching MSM in MENA and increasing their access to HIV prevention, testing and care services.

Various types of interventions could be piloted in MENA, for instance social media-based campaigns to promote access to accurate and appropriate information about men's sexual health, HIV prevention, and HIV testing. Technology could support, remote clinical consultations and referral via video conferencing, web-based sexual health consultation and advice, mapping human rights abuses or provision of psychosocial support. Internet-based programmes and mobile phone-based programmes (SMS/Whatsapp platforms) could play a role in motivating and sustaining behaviour change, supporting and referring MSM to healthcare and psychosocial services, networking, and data collection. As a result of these interventions, more uptake of services, more HIV awareness, more support and guidance and more empowerment and resilience among MSM communities could be achieved.

PART C
TOWARDS ACTION

In this section we begin to explore what is needed to mount an effective response to the HIV epidemic among MSM in the MENA region.

7. Understanding how change happens

Individuals do not live in isolation from their context, and people's behaviour and health is deeply affected by social norms, their access or lack of access to quality health and social support services, and the legal and policy environment in which they live. This is particularly true for people who are marginalised in society. Therefore, in order to ensure that MSM can be healthy and thrive, any programmatic response needs to intervene at different levels: individual, community/social norms, service delivery and structural levels.

Programmatic responses are needed at the following levels:

- **Individual:** behaviour change; building self-esteem; psychological health and wellbeing.
- **Community:** building social capital within the gay community to support each other and fight prejudice and isolation.
- **Services:** access to quality HIV prevention, care and treatment services; condoms and lubricants; HIV testing; STI screening and treatment; ART; psychological and social support.
- **Structural** (enabling environment): advocacy; policy development; ensuring laws, statutes and societal norms are conducive to effective HIV prevention, care and support programmes for MSM.

Behaviour is influenced by:

- our beliefs and world view
- our psychology
- our experience, education and learning
- our stage of life and age
- observing others
- our domestic situation
- our sense of agency and power (self-efficacy) and whether we feel any sense of threat or fear that we may be at risk of HIV
- our socio-economic status and position in society
- the context in which we live – prevalent social and religious norms, national laws and policies, political governance.

In order for change to happen, we need to intervene at multiple levels (change theory) with multiple interventions (dose effect) and with sufficient coverage (scale). What we do, how we intervene, needs to be based on a hypothesis about how we think the intervention will effect/produce the change we want to observe. Our hypothesis of change needs to be based on evidence and not guesswork.

Evidence is informed by:

- past programme learning from our country or regional projects, or from global learning (this kind of learning is often derived from programme monitoring and learning, evaluations and operational research)
- good and emerging practice (tools, resources and case studies)
- quantitative and qualitative research.

It is always helpful when designing programmes to have a framework to structure interventions based on a logic model. This is important because it:

- ensures that you have systematically thought through what you want to achieve and how you might get there
- provides a structure to help organise thinking about why you are doing what you are doing

- is transparent and democratic; i.e. it helps everyone involved to understand the rationale for what you are doing
- recognises that change needs to happen at multiple levels
- helps to identify the most appropriate intervention at the right level to achieve your objective.

When working with MSM, or any marginalised population, it is essential that programme design is based on a participatory situational/needs analysis that is triangulated with other sources of information/data, such as epidemiological surveys. Potential unintended consequences of interventions must have been thought through, and you must be clear about how they will be identified and mitigated. Realistically, it also needs to take into account what donors are willing to fund where local funding is not available.

8. Understanding your context

In order to develop effective programmes that will have impact, it is essential that programme implementers have a good knowledge and understanding of the population they are working with. This can be achieved in part through informal outreach, but that cannot take the place of more formal approaches.

Mapping

> Mapping is a thorough and valuable step towards identifying key groups

Mapping is an approach that has proven successful in helping programme implementers to get to know their programme beneficiaries better. It is an approach to gain knowledge and understanding of:

- the particular characteristics and dynamics of MSM in the programme area – those that are more open to having contact with a peer education programme, as well as those men who are hidden and would not want to be identified in any way
- where MSM meet in that specific geographic area – this could be places where MSM socialise and also areas where MSM may cruise[27] for sex (sometimes a cruising site may be a park, a beach or another place where they feel they are unlikely to be discovered)
- the specific HIV risk behaviours of MSM in that area; for example, what their knowledge is of their risks of HIV and STIs, how many people are using condoms and whether they are using them regularly, whether they treat a regular sexual partner differently to a more casual encounter
- what time of day people meet and how often
- issues related to safety and security in the areas where they meet, such as their relationship with venue owners, the police and the local community.

There can be a tendency to treat sexual behaviours that may be risky for HIV transmission in a negative way. It is important to remember that people normally have sex because it is pleasurable, and it is the work of the peer educator to let them know how they can reduce the risk by modifying behaviour, not necessarily stopping the practice.

When undertaking mapping, it is also important to recognise that some MSM will be much easier to reach than others. Using a peer-informant[28] approach sensitively

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27. "Cruise" in this instance means someone who is hanging around a certain place trying to identify if there are people who may be interested in meeting for a casual sexual encounter.

28. A peer informant approach is where a person is interviewed and asked about the what, when and who they have had sex with, and about their opinion on the best way to reach a sexual partner who might not be willing to have contact with a peer educator.
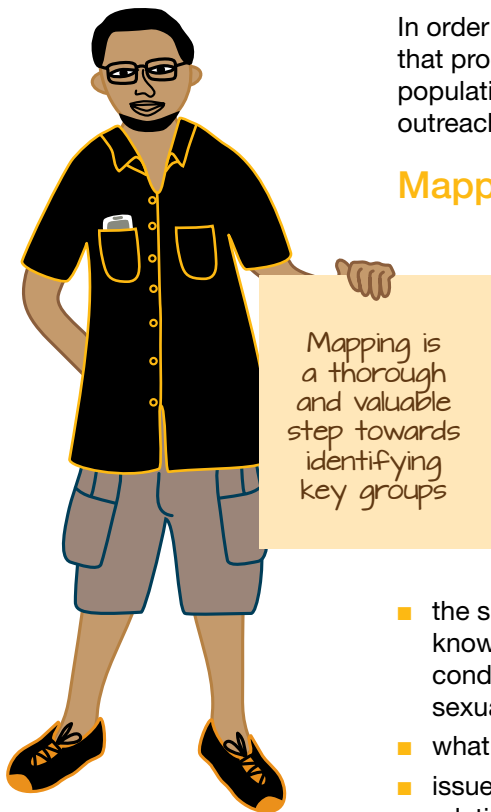
and confidentially can help a project to identify people who may need services and support but who would not be accessed by venue or street-based outreach. To do this, peers need to be trained and orientated towards the methodology, as well as grounded in the professional ethics demanded of them to undertake such sensitive work. Module 3 of the tookit has a number of exercises related to preparing peer educators for mapping.

> ⚠ From a planning point of view, it should also be noted that there are risks associated with mapping and that it has to be undertaken with great sensitivity and caution. Mapping can actually draw attention to areas and raise suspicion where there was none before. It can open up areas of enquiry that mean that the MSM who use and visit the particular meeting point begin to avoid it because they fear exposure.
>
> Therefore sound ethical principles for mapping must be used to ensure safety and security. Mapping should only be done when the confidentiality of participants and programme sites can be respected. NGOs must balance the need for data and the need to do no harm in potentially hostile environments. They should pay particular attention with mapped data, because maps containing information about locations where MSM meet may be used to locate and harm them. These maps should be considered confidential and stored securely. In addition, they should avoid using labels or titles, and they should use general language (for example, "participants") that is not associated directly with same-sex sexual behaviour.

Since mapping is a thorough and valuable step towards identifying key groups, it is important to ensure sustainable funding for the next phase to avoid losing identified clients, their trust and the credibility of the programme.

Synthesising local knowledge – quantitative and qualitative

Other sources of information can be gathered from:

- epidemiological and local HIV and STI prevalence surveys
- population size estimates of MSM where they exist (these can be difficult to undertake because of political and social realities, and therefore proxy data is sometimes used from other sources)
- qualitative surveys and research
- interviews with local healthcare providers, social workers and psychologists
- reports and research from the region that may have been published locally or in international journals and publications (for example, SIDC (2012), *Focus: a panorama of key affected populations in Lebanon 2007–2011*).

Programme implementers working with MSM often operate with little information about the local MSM population, and it can be tempting to rely overly on the information already available. It is essential that available information is triangulated and all the information is reviewed together to check for what is consistent and what is not, and then to verify it with people from the local area.

Where insufficient information is available, it can be helpful to undertake some information-gathering though focus group discussions or one-to-one interviews.

Ethical principles for mapping must be used to ensure safety and security.
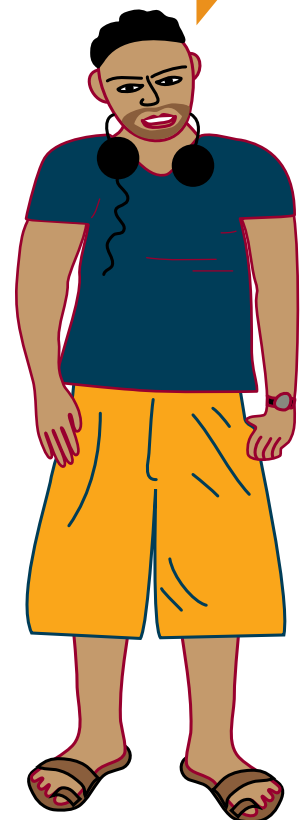
> **Example: a peer educator from APCS talks about starting an MSM project**
>
> "At the beginning, we accepted that the project be carried out at our level without any prejudice or bias. Let me state that we had no qualifications nor the skills required for this issue, and we did not understand the internal and external obstacles [reluctance of some association members]. During the first training workshop with MSM, we realised that young people critically needed information, prevention methods and support, so we decided to engage in this project with more conviction.
>
> But the most important change that we witnessed in our organisation, thanks to this project, is the empowerment and responsibility of MSM, who became 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 stigmatised by society. They are involved in decision-making, governance and facilitation of the organisation's life.
>
> Some MSM, in addition to their work with their community, have decided to get involved in the sensitisation 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."

9. Change framework

As previously discussed, developing an effective programme to meet the HIV and sexual and reproductive health needs of MSM in the MENA region demands that interventions are developed at multiple levels. In this chapter, we provide some examples of the types of interventions that evidence suggests are important to ensure an effective response to the HIV epidemic among MSM.

Individual level

> "Now that I got it [HIV], I care more about the young and adolescents."
>
> **MSM LIVING WITH HIV, 22 YEARS OLD**

At the individual level, the kinds of changes that the programme should try to make include:

- helping MSM to have an accurate perception of their risk of infection
- guidance about how to reduce risk and how MSM can access quality information and commodities such as condoms and lubricants
- approaches aimed at helping MSM to increase their self-esteem and sense of wellbeing
- increasing health and legal literacy so that MSM can become informed service users
- ensuring MSM know how to access HIV testing, and STI and HIV treatment services
- adherence support for people living with HIV.

Approaches include:

- community outreach
  - peer–peer promotion and condom distribution
  - services at venues and hotspots
- improving access and referral to user-friendly, quality health and social care services, including HIV testing
- supportive, well-organised self-help groups.

Social normative/community level

At the social normative/community level, interventions include assessing societal factors that inhibit and limit the self-determination of MSM by trying to create an enabling environment and addressing:

- stigma and ignorance
- discriminatory practices and behaviours
- homophobia
- harmful gender norms
- violence against MSM.

Approaches include:

- participatory reflection by communities and MSM
- local advocacy and knowledge-sharing
- sensitisation and training of influential figures/gatekeepers, such as religious and civic leaders, and the police
- discussions about these issues on community radio, social educational dramas in the community and sensitising the media.

Services level

At the services level, interventions are aimed at:

- increasing MSM's access to commodities (condoms and lubricants) and quality services
- ensuring that services (HIV testing, STI and HIV prevention and treatment, mental health/psychological support) are user friendly, and that all staff are trained in how to work without discrimination against MSM.

Approaches include:

- procurement of essential commodities such as water-based lubricants and condoms, often achieved through a partnership between public providers such as ministries of health, national AIDS councils and NGOs
- ensuring that there are effective and geographical distribution channels to reach remote and rural areas
- training healthcare and other service providers (e.g. police), and involving MSM in this training where it is possible and safe to do so
- developing MSM-friendly services by scaling up testing facilities at NGO sites via the government
- developing effective referral processes between peer educators and service providers
- providing patient advocates where MSM are fearful of using services.

"The training I received the last period empowered me to be able to discuss HIV/AIDS prevention with peers without disclosing serology. Now I considering living positively my HIV positive status."

MSM LIVING WITH HIV, 24 YEARS OLD

Addressing structural barriers through advocacy

Advocacy is a continuous process with the aim of bringing about change in policies, legislation and practices. It is usually a set of actions by individuals, groups or institutions seeking to make these changes through negotiation and sensitisation of decision-makers and those in positions of power and authority. This is in order to improve the lives of people such as MSM, who are unfairly discriminated against, and/or do not benefit from the same level of attention, resource allocation and protection as other members of the society where they live.

Advocacy is a key component of a combination HIV prevention approach and treatment and care continuum. In the context of MSM programming in the MENA region, advocacy is an important means of trying to address and change some of the structural barriers that MSM encounter when attempting to protect their health and wellbeing, including marginalisation, stigma, discrimination, human rights violations, and lack of access to appropriate healthcare services.

Advocacy initiatives can be targeted at:

- service providers
- politicians and government ministries
- religious leaders
- donors.

There are a number of publications that can be used as effective sources for developing work around advocacy objectives, and these can be found in the resource list of publications at the back of this manual.

Structural level

At the structural level, interventions are aimed at:

- identifying and trying to change laws and policies that discriminate against and limit the self-determination of, MSM
- promoting public health and the human rights of MSM, particularly to health and dignity
- promoting and monitoring the rational allocation of resources to meet the needs of MSM.

Approaches will be largely informed by advocacy approaches, and include:

- media monitoring and journalist training
- commission reports on the impact of abuses of MSM and successful responses to abuses, including best practices
- improving the participation of civil society in decision-making bodies
- monitoring resource allocation and ensuring that there is adequate funding for MSM-friendly and appropriate services, including legal-friendly services.

10. Partnership development

Through the process of analysing the challenges involved in ensuring that MSM have access to quality HIV and sexual health services, it will soon become evident that responding to their needs can only be achieved by working with multiple actors. These include healthcare workers, entertainment and social venue owners, the police and law enforcement agencies, religious leaders, and health and social care planners, as well as other community-based organisations working in the areas of HIV and sexual health, human rights, the private sector, international NGOs, UN entities and donors.

Without investing in developing meaningful relationships and partnerships at the outset of a programme, implementation can become challenging. Implementing any HIV/sexual health programme for MSM in a country where gay and other MSM do not have the full protection of the law can be difficult, and it is incumbent on the implementers to make life better for MSM and not risk their safety or wellbeing. Therefore, careful consideration should be given to the kinds of sensitisation and training the programme may need to undertake with critical programme partners and ensure that this is negotiated at the programme outset.

By maintaining a focus on the human rights and public health imperatives of any programmes working with MSM, a great deal of resistance to providing support to MSM can be overcome. Through education and sensitisation, using human rights language, and in particular by drawing attention to human rights considerations (especially in accessing health services), effective programmers can make an abstract and feared challenge – working with a marginalised and ostracised group such as MSM – less daunting and open the door to developing meaningful and effective partnerships. Experience has shown that when MSM have themselves been involved in developing those relationships, a richer and more effective partnership has been created.

Example: the Network of Associations for Harm Reduction in Egypt

FHI 360/Egypt in collaboration with the National AIDS Programme, the Drosos Foundation and the Ford Foundation, established the Network of Associations for Harm Reduction (NAHR) in 2013. NAHR is a coalition of CSOs and stakeholders dedicated to harm reduction who share the common goal of reducing stigma, promoting behaviour change and expanding harm reduction services to key populations, mainly MSM, people who inject drugs, female sex workers, people living with HIV and their related communities. Connecting comprehensive care with street-based outreach through using a combined approach of safer sex and safer injecting has proved to be successful in facilitating early detection and care for key populations.

The package of services offered by NAHR include HIV prevention and care; street-based outreach; peer education; VCT; clinical care; distribution of syringes, condoms and strategic behavioral communication materials; support groups for people living with HIV; addiction and psychological support counselling sessions; referral of MSM and other key populations to required services; and linking HIV positive detected clients to the treatment programmes provided by the Ministry of Health and Population. All services are voluntary, anonymous, confidential and free of charge.

NAHR advocacy efforts aimed at reducing stigma and discrimination include conducting annual meetings for key populations to assess their needs, and HIV/AIDS orientation sessions and focus groups to selected members from the general population. To ensure that the rights of key populations are not breached, FHI 360 developed a code of ethics that highlights the ethical principles and behaviours that govern the relations of all members. Advocacy efforts also include training service providers from harm reduction projects on the human rights of key populations, and Muslim and Christian religious leaders on how to communicate with young people.

11. Documentation, monitoring, reflective learning and evaluation

As for any project or programme, there are core components that are essential for effective project management and operations. These include:

■ accurate **documentation and reporting** of the implementation of the project for knowledge sharing and donor reporting

■ ongoing **monitoring**, which involves developing appropriate indicators and metrics that will be used to monitor progress and assess whether the project is achieving what it set out to achieve

■ **reflective learning**, which is a modus operandi established by the leadership of the project to ensure that all staff, volunteers and partners continually reflect on the programme, critically analyse what the monitoring data are telling them at least once per quarter, and depending on what comes out of the reflection and learning, make project adjustments when new information emerges

■ **evaluation** – the process of trying to assess the impact of the project and whether it has achieved its purpose.

As much of the project work for MSM in the MENA region will be conducted by peer educators, ensuring that these educators are actively engaged in core components of the project is not only good practice but essential. These include planning, training, monitoring and documentation. Marginalised communities in hostile situations can often feel understandably fearful and apprehensive about how any information collected might be used. By ensuring the active engagement of the peer educators and the community from the outset, it is possible to help them to understand the value and importance of documentation and monitoring, and how the information can be used to help to ensure that MSM have not only quality services but also appropriate levels of resource allocation to meet needs. No information should ever be kept regarding the identity of individuals, and MSM may need reassurance that the integrity and safety of all data collected will be maintained at all times.

The reality in the MENA region is that there are a number of different organisations and actors working with MSM. To avoid project overlap and to ensure accurate reporting, it is also good practice to work closely with other projects to ensure that the information they collect is the same as that collected by your own project. This enables accurate comparisons to be undertaken to help national AIDS programmes and UNAIDS (as the local coordinator through its joint teams) get a more accurate picture of the needs and experiences of MSM, as well as an indication of who, how and where MSM are being reached and where gaps exist.

Ensuring confidentiality and keeping data secure

Designing and managing a programme with MSM requires information on locations where they gather and the size of the community as well as risk behaviour and personal characteristics. Data that identifies locations or individuals, as well as unique identifiers or phone numbers if used, must be handled with strict confidentiality and protected from access by individuals, groups or organisations that might cause harm to MSM. NGOs should have a written code of conduct that sets out clear practices to strictly ensure security, safety and privacy of data about programme beneficiaries and implementers, and this code of conduct should be regularly discussed and agreed by all staff and volunteers of the organisation. It is essential that guidelines for confidentiality be strictly and consistently followed. Wherever possible, data should use unique identifier codes rather than real names.

MSM who are reached for interpersonal communication activities, or who receive HIV testing, treatment or support services, should not be put at risk of discrimination, arrest or prosecution. Staff and peer educators' training should insist on the importance of maintaining confidentiality and on the potentially harmful consequences of disclosing an individual's sexual orientation or HIV status or otherwise violating confidentiality. The procedures set up to ensure data protection should clear address the challenges and risks of using real names and contact details and keeping paper records.

Data must be handled with strict confidentiality and protected from access by individuals, groups or organisations that might cause harm to men who have sex with men.
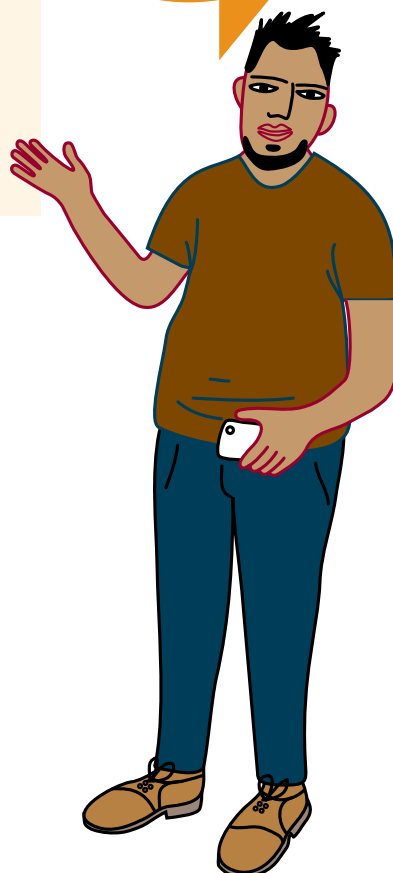
Annex 1: Summary International Guidelines on HIV/AIDS and Human Rights

2006 Consolidated version. UNAIDS/OHCHR, Geneva

GUIDELINE 1: States should establish an effective national framework for their response to HIV which ensures a coordinated, participatory, transparent and accountable approach, integrating HIV policy and programme responsibilities across all branches of government.

GUIDELINE 2: States should ensure, through political and financial support, that community consultation occurs in all phases of HIV policy design, programme implementation and evaluation and that community organizations are enabled to carry out their activities, including in the field of ethics, law and human rights, effectively.

GUIDELINE 3: States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV and that they are consistent with international human rights obligations.

GUIDELINE 4: States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted against vulnerable groups.

GUIDELINE 5: States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation, and provide for speedy and effective administrative and civil remedies.

GUIDELINE 6 (as revised in 2002): States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price.

States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions.

States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.

GUIDELINE 7: States should implement and support legal support services that will educate people affected by HIV about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units and human rights commissions.

GUIDELINE 8: States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

GUIDELINE 9: States should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatization associated with HIV to understanding and acceptance.

GUIDELINE 10: States should ensure that Government and the private sector develop codes of conduct regarding HIV issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.

GUIDELINE 11: States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV, their families and communities.

GUIDELINE 12: States should cooperate through all relevant programmes and agencies of the United Nations system, including UNAIDS, to share knowledge and experience concerning HIV-related human rights issues and should ensure effective mechanisms to protect human rights in the context of HIV at international level.

Annex 2: Resources for HIV and health programming with and for MSM

The following list provides key references on topics relevant to rights-based, effective and integrated community-led and public health responses to men having sex with men. They are primarily intended for civil society organisations and MSM community-led organisations supporting programmes with and for MSM.

- **Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations** (WHO, 2014).
  www.who.int/hiv/pub/guidelines/keypopulations/en/

- **Fast-tracking combination prevention: towards reducing new HIV infections to fewer than 500 000 by 2020** (UNAIDS, 2015).
  www.unaids.org/en/resources/documents/2015/20151019_JC2766_Fast_tracking_combination_prevention

- **Good Practice Guide: HIV and human rights** (International HIV/AIDS Alliance, 2013).
  www.aidsalliance.org/resources/400-good-practice-guide-hiv-and-human-rights

- **Implementing comprehensive HIV and STI programmes with men who have sex with men: practical guide for collaboration interventions** (UNFPA, 2015).
  www.unfpa.org/publications/implementing-comprehensive-hiv-and-sti-programmes-men-who-have-sex-men

- **My life, my power: a training curriculum for peer educators on HIV prevention and risk reduction among MSM in Kenya** (NASCOP, 2013).
  www.jsi.com/JSIInternet/Resources/publication/display.cfm?txtGeoArea=INTL&id=14409&thisSection=Resources

- **Pehchan training curriculum: MSM, transgender and hijra community systems strengthening** (India HIV/AIDS Alliance, 2014).
  www.allianceindia.org/ourwork/pehchan-training-curriculum-msm-transgender-hijra-community-systems-strengthening-curriculum-guide-pdf-1-1-mb/

- **Resources for action for HIV and health programming with and for men who have sex with men (MSM)** (International HIV/AIDS Alliance, 2015).
  www.aidsalliance.org/resources/653-resources-for-action-for-hiv-and-health-programming-with-and-for-msm

- **Sustaining the human rights response to HIV: funding landscape and community voices** (UNAIDS, 2015).
  www.unaids.org/en/resources/documents/2015/JC2769_humanrights

In MENA

- **Aali soutak/Speaking out: toolkit for MSM-led HIV/AIDS advocacy in MENA** (MSMGF, 2012) French and Arabic.
  http://msmgf.org/wp-content/uploads/2015/11/speakingout_arabic_adaption2015.pdf

- **Analysons nous-mêmes nos besoins. Guide pratique pour réaliser des Diagnostics Communautaires Participatifs pour répondre aux besoins en santé sexuelle des HSH dans la région MENA** (International HIV/AIDS Alliance, 2015) French.
  www.aidsalliance.org/resources/680-mena-analysons-nousmemes-nos-besoins

- **Demonstrating results of the 'Responding to MARPs in the MENA region' project using the Most Significant Change methodology**: regional report April – June 2012 (International HIV/AIDS Alliance, USAID, PEPFAR, AIDSTAR-Two, 2013).
  www.msh.org/sites/msh.org/files/msc_regional_report_final_july_8_2013.pdf

- **Health assessment of men who have sex with men in the Arab world** (M-Coalition, 2015) English.
  www.m-coalition.org/#!resources/c1o4h

- **HIV and outreach programmes with men who have sex with men in the Middle East and North Africa: from a process of raising awareness to a process of commitment** (UNAIDS, 2012) English and French.
  www.unaids.org/sites/default/files/media_asset/20120920_MSM_MENA_en_0.pdf

- **Mental health of men who have sex with men in the Arab world** (M-Coalition, 2015) English.
  http://media.wix.com/ugd/c2ad70_a8cbe35e78214b0190faa398f3dd205c.pdf

- **Understanding and challenging HIV stigma in the MENA region: toolkit for action** (Alliance, 2013) English, French and Arabic.
  www.aidsalliance.org/resources/305-toolkit-understanding-and-challenging-hiv-stigma-in-the-mena-region

About the International HIV/AIDS Alliance

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

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

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

www.aidsalliance.org

About UNAIDS

UNAIDS, the Joint United Nations Programme on HIV/AIDS, is an innovative joint venture of the United Nations family, bringing together the efforts and resources of ten UN system organisations in the AIDS response to help the world prevent new HIV infections, care for people living with HIV, and mitigate the impact of the epidemic. UNAIDS helps mount and support an expanded response to AIDS – one that engages the efforts of many sectors and partners from government and civil society. Cosponsors include UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, UNWOMEN, WHO and the World Bank.

TIME TO SHIFT FROM AWARENESS TO COMMITMENT