REGIONAL SUMMARY OF FINDINGS OF AN ASSESSMENT OF HIV SERVICES PACKAGES FOR KEY POPULATIONS IN SELECTED COUNTRIES IN MIDDLE EAST AND NORTH AFRICA

April 2019
This report was produced by APMG Health, Inc. for the Global Fund to Fight AIDS, Tuberculosis and Malaria, under Purchase Order 20177290. The opinions presented here belong to the authors and do not represent the Global Fund’s official position.

This work may be cited as follows:


ACKNOWLEDGEMENTS

This regional report is drawn from the Key Population country reports and desk reviews for the Middle East and North Africa region. APMG Health would like to thank Nathalie Zorzi, Jinkou Zhao, Chinelo Ogbuanu and the other staff of the Monitoring and Evaluation and Country Assessment Team (MECA); Ed Ngoksin from the Community, Rights and Gender Department; and Susie McLean from the HIV program at the Global Fund, for their leadership and assistance in this project and in preparing this regional report. We also thank the international and local consultants who conducted the country-level assessments, the staff from global and regional organizations who provided feedback on the draft version of the report and the stakeholders/informants from the various services and key populations who participated in the process.
CONTENTS

Acknowledgements 2
Executive Summary 6
Design 6
Recommendations: Design of Service Packages for Key Populations 7
Implementation 8
Recommendations: Implementation of Service Packages for Key Populations 9
Monitoring 10
Recommendations: Monitoring of Service Packages for Key Populations 11
Financing 11
Background 15
Methodology 17
Country Assessment Process 17
Reporting Processes 18
Findings 19
Part I: Regional Profile and Key Populations Context 19
Analysis: Do we know what we need to know about key populations in the Middle East and North Africa? 26
Part II: Design and Documentation of Service Packages 27
Analysis: Are package designs meeting international standards? 36
Recommendations: Design of Service Packages for Key Populations 37
Part III: Implementation and Service Usage 39
Analysis: Are packages being implemented as designed? 55
Recommendations: Implementation of Service Packages for Key Populations 55
Part IV: Monitoring Systems 57
Analysis: Do we really have enough information to determine how well packages are implemented? 58
Recommendations: Monitoring of Service Packages for Key Populations 59
Part V: Financing 60
Analysis: Are countries prepared to adequately finance packages of services for key populations? 61

Limitations 61

References 63

Documents 63

IBBS & KP study references 64

Annex 1: Summary Table, WHO Consolidated Guidelines 66
**ACRONYMS**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Treatment</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-Based Organization</td>
</tr>
<tr>
<td>CCM</td>
<td>Country Coordinating Mechanism</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus group discussion</td>
</tr>
<tr>
<td>FSW</td>
<td>Female sex worker(s)</td>
</tr>
<tr>
<td>GAM</td>
<td>UNAIDS Global AIDS Monitoring reports</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender Based Violence</td>
</tr>
<tr>
<td>GF</td>
<td>Global Fund</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HTC</td>
<td>HIV Testing and Counseling</td>
</tr>
<tr>
<td>IBBS</td>
<td>Integrated Bio-Behavioral Surveillance</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, education and communication</td>
</tr>
<tr>
<td>LGBTI</td>
<td>Lesbian, Gay, Bisexual, Transgender, Intersex</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MENA</td>
<td>Middle East North Africa (UNAIDS regional definition)</td>
</tr>
<tr>
<td>MENAHRA</td>
<td>MENA Harm Reduction Association</td>
</tr>
<tr>
<td>MoU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>NSP</td>
<td>Needle-syringe program; National Strategic Plan (depending on context)</td>
</tr>
<tr>
<td>OST</td>
<td>Opioid Substitution Therapy</td>
</tr>
<tr>
<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
</tr>
<tr>
<td>PLHIV</td>
<td>Person (people) Living with HIV</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission of HIV</td>
</tr>
<tr>
<td>PR</td>
<td>Principal Recipient(s) of Global Fund funds</td>
</tr>
<tr>
<td>PrEP</td>
<td>Pre-exposure prophylaxis</td>
</tr>
<tr>
<td>PSE</td>
<td>Population size estimates</td>
</tr>
<tr>
<td>PWID</td>
<td>People who inject drugs</td>
</tr>
<tr>
<td>RDS</td>
<td>Respondent-driven sampling</td>
</tr>
<tr>
<td>SR</td>
<td>Sub-recipient(s) of Global Fund funds</td>
</tr>
<tr>
<td>SSR</td>
<td>Sub-sub-recipient(s) of Global Fund funds</td>
</tr>
<tr>
<td>SRH(R)</td>
<td>Sexual Reproductive Health (Rights)</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>SW</td>
<td>Sex Worker(s)</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TG</td>
<td>Transgender people</td>
</tr>
<tr>
<td>UIC</td>
<td>Unique Identifier Code</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Program on HIV/AIDS</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

The World Health Organization (WHO) has clearly outlined the comprehensive package of HIV services which should be available for men who have sex with men (MSM), people who inject drugs (PWID), sex workers (SW), transgender people (TG) and prisoners (WHO, 2016) to prevent new infections and to mitigate its impact. The Global Fund contracted APMG Health to review the design, implementation and monitoring of national HIV service packages for key populations in 65 countries, across six regions, in which the Global Fund has provided HIV grant funds.

These are the results of an assessment of the design, implementation and monitoring of a package of HIV prevention, treatment and care services for key populations (KP) in the Middle East and North Africa (MENA). This report is based on four country-specific desk reviews and three in-country assessment reports. Each of the country assessments consisted of an initial desk review and a field assessment. The Global Fund Country Team for each country provided data sources used for completing a desk review prior to the country visit. In three of the countries, a follow-up field assessment was carried out to verify and expand data collected during the initial desk review process. Each field assessment was conducted over the course of five days, with the exception of Morocco, which was conducted over the course of ten days. For each country, key populations and two sites were selected, with guidance from The Global Fund Country Teams and Country Coordinating Mechanism (CCM), with the exception of Morocco where three sites were selected.

Table ES1. Middle East and North Africa Key Population and Site Selection

<table>
<thead>
<tr>
<th>Country</th>
<th>Key Populations Selected</th>
<th>Sites Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morocco</td>
<td>FSW, MSM, PWID</td>
<td>Rabat, Casablanca, Marrakech, Tangiers, &amp; Tetouan</td>
</tr>
<tr>
<td>Sudan</td>
<td>MSM, FSW</td>
<td>Khartoum &amp; Wad Madani</td>
</tr>
<tr>
<td>Tunisia</td>
<td>MSM, PWID</td>
<td>Tunis &amp; Sfax</td>
</tr>
<tr>
<td>Desk Review Only: Egypt, Iran, Jordan and Lebanon</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DESIGN

For all countries assessed, consultants were able to review the current national strategic plans, action plans, outlines of state-provided HIV services, and national programs. While Lebanon is the only country that does not have a national strategic plan or framework in place, it is important to note that both Jordan and Sudan’s national strategic plans expired in 2016. It is unclear from this assessment whether these plans will be updated or extended in order to meet the current needs of their key populations in terms of service provision.
Six out of the seven countries assessed identify MSM as a key population and therefore outline specific services targeting this population. The exception is Iran, though the current HIV National Strategic Plan for Iran identifies ‘most vulnerable men’ as a key population group for the first time ever, and this is seen as a culturally-sensitive way to include MSM. Similarly, female sex workers (FSW) are referred to as ‘most vulnerable women’. Overall, lubricant is widely missing from the design of these services; however, most of the MSM HIV service packages described are in line with the WHO Consolidated Guidance for HIV Prevention, Diagnosis, Treatment and Care (WHO, 2016) as they are designed. Critically, all six countries include HIV testing and counseling (HTC) and treatment and care as part of their MSM service packages. Exceptions to alignment with WHO Guidance include sexual health interventions, where only four countries include STI prevention, diagnosis, or treatment as part of their package.

Six out of the seven countries assessed identify PWID as a key population and therefore outline specific services targeting this population, with the exception of Sudan. Lubricant is missing from all but two of the countries’ service packages for PWID. All six of the countries with PWID packages include provision of clean needles as part of their harm reduction package. Fifty percent (50%) of the assessed countries include opioid substitution therapy (OST). Morocco additionally includes overdose response in the form of naloxone and post-exposure prophylaxis (PEP) for PWID as part of their harm reduction package.

All seven of the countries assessed include FSW or SW as a key population and therefore have a defined package of service for this population. Packages for FSW are missing distribution of lubricants in all but Morocco. All of the countries outline HTC and HIV treatment and care in their packages, which is an important statement on rights to accessing comprehensive HIV care. Sudan includes testing for clients of SW as well.

Only two out of the seven countries (Egypt and Iran) included in this assessment identified prisoners as a key population in their national strategic plans or frameworks and outlined a separate package of HIV services for this population. Both countries with defined packages include both HTC and referral to antiretroviral treatment (ART) for prisoners. Of the two countries, Iran has the most comprehensive package of services for prisoners and it is largely in line with WHO guidelines.

Transgender people are not identified as a separate key population in any of the countries assessed and therefore there are no service packages that are designed around their needs. In Tunisia, a mapping of TG will be carried out later in 2018 supported by UNFPA.

**Recommendations: Design of Service Packages for Key Populations**

1. All countries in the MENA region should ensure that there is an endorsed national strategic plan that outlines the key populations at risk of HIV.
2. In addition to listing service elements, more detailed descriptions about service models, including how and where services will be delivered, would assist in guiding implementation. These could be included in the national strategic plan or in annual planning documents.

3. Recent developments in outreach and community testing models (in MENA and other regions) need to be incorporated into service package designs.

4. The development of minimum standards for behavioral interventions that are attuned to population needs would ensure that the intent of the design of this intervention carries over into appropriate resource mobilization and implementation.

5. Service packages for transgender people, prisoners and people in other closed settings need to be developed.

6. There is little information available about sub-populations of key populations and the specific service package elements that they require. Greater attention needs to be paid to sub-populations and different contexts of risk and vulnerability across geographical areas.

7. The recommendations of the MENA Harm Reduction Association (MENAHRA) operations research into PWID sub-populations (women who use/inject drugs; refugees and migrants) need to be considered at the country level and brought into service package design.

8. Across the region, HIV treatment packages should be enhanced to include more specific interventions for key populations.

9. Service packages must also include a description of packages that will be available in conflict and emergency settings, along with undertakings about prioritizing the re-introduction of service elements that cease during conflict or emergencies.

**IMPLEMENTATION**

Government and National AIDS Commissions, who also work with non-governmental organizations (NGOs) and various UN organizations, are the primary service providers for key populations in MENA. Overall, findings from countries assessed show that packages are implemented as designed, within the bounds of economic and human rights constraints. Limited data are available to provide coverage estimates for these programs. Coverage of key populations with service packages varies widely across the region, as do the definitions of coverage.

The major challenge in implementation of services for MSM is criminalization and prosecution, which discourages access to tailored services and reinforces their relative invisibility as an affected population. Stigma and discrimination towards key populations also result in barriers to services. In the three countries visited during this assessment, provision of HIV services by peer educators was observed. However, changes have been made recently, particularly in Sudan, in terms of the specific peer approach. Most of the data available for this assessment concerning coverage among MSM were obtained from surveys such as Integrated Bio-Behavioral Surveillance (IBBS). Programmatic coverage figures were not available with the exception of Morocco.

Very limited specific coverage data concerning PWID exist to confirm whether or not services are being implemented as designed. Services that are available to PWID vary from country to country.
throughout the region. The need to introduce scaled up overdose prevention was a recurrent theme in focus group discussions (FGD) during country visits - the provision of naloxone to PWID was stated as a priority among FGD participants.

Services provided to FSW throughout the region seem to be in line with the packages that each country has designed, though coverage achievements varied. In countries that were visited for this assessment, FGD participants expressed the need for a scale-up of reproductive health services, specifically abortion and post-abortion care, as well as access to pap smears. No data were found on the provision of services for male or transgender sex workers.

**RECOMMENDATIONS: IMPLEMENTATION OF SERVICE PACKAGES FOR KEY POPULATIONS**

1. There have been significant developments in key population outreach models in parts of the region and in other regions. These developments focus on community HIV testing, a sharper focus on increasing knowledge of status and linkage to HTC for people living with HIV (PLHIV) and onward community-level case management. These need to be adapted for use in MENA. E-outreach is also an expanding service provision area in many countries and needs to be adapted for use in this region.

2. Reach and coverage levels of harm reduction services for PWID, particularly needle/syringe and OST services, are dangerously low in most countries in the region. Particular attention to the expansion of services needs to be paid to sub-populations of PWID such as women, refugees, migrants and prisoners.

3. Attention to STI prevention, diagnosis and treatment seems to be lacking, despite high rates of unprotected sex. More attention to innovative models for STI prevention and care service provision (including HIV testing and onward referral for people with HIV) needs to be explored and implemented.

4. Differentiated care models have also been developed in other regions, making best use of available resources to ensure that those most in need of support are prioritized. These need to be considered.

5. In other regions, NGOs are playing a more significant role in providing harder to reach sub-populations with prevention and care services such as community HIV testing, ART provisions, STI services and adherence support. These models need to be explored and adapted to countries in the region.

6. There are significant access barriers to services for key populations in this region. The recent Baseline Assessment on human rights-related barriers carried out by Global Fund in Tunisia, and the upcoming development of a five-year strategy to reduce these barriers, provide a good model for assessments in other countries in the region.

7. Greater attention to issues of gender needs to guide service development – the impact of HIV on women in the region and the particular barriers they experience to accessing health services are poorly understood. Strategies to improve men’s health-protecting and health-seeking behaviors,
and work that targets the control that men exert over women’s health, need to be developed and implemented.

8. Service access for young people also needs particular attention, especially for street or out-of-school children. This includes attention to policies about age of consent for minors and the development of youth-friendly services.

**MONITORING**

Monitoring of service packages for key populations in countries in the region needs urgent attention. Whilst countries receiving donor funds for projects are generally reporting program data to these donors, there are weaknesses in national monitoring and evaluation and strategic information systems in many countries that make it difficult to track service use and quality and health outcomes for key populations.

Where Unique Identifier Code (UIC) systems are in place, they do not extend to tracking service use by key populations living with HIV, making it difficult to track health outcomes in this area. Many countries have carried out IBBS studies, but key informants report that some of these have not been in line with global guidance or are outdated.

There is little evidence of data synthesis and analysis at the national level, feedback of data to service level, or the use of data to drive service modification and improvement.

**Table ES2. UIC System Scores by Country in Middle East and North Africa**

0: No data/evidence of UIC found;
1: Monitoring contacts, which disallow de-duplicated reporting;
2: Partially using UIC, which disallows de-duplicated reporting. This includes scenarios where UICs are used in some regions of the country or different UICs are used in the country but not harmonized;
3: Nationally using UIC, which allows de-duplicated reporting. This includes the scenario where different UICs are used but harmonized.

<table>
<thead>
<tr>
<th>Country</th>
<th>Score</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morocco</td>
<td>3</td>
<td>The UIC in place is limited to prevention services.</td>
</tr>
<tr>
<td>Sudan</td>
<td>0</td>
<td>In-country assessment confirmed that there is no UIC in place for any of the key populations.</td>
</tr>
<tr>
<td>Tunisia</td>
<td>2</td>
<td>The same UIC is used among all NGOs, which has been set up by the PR of Global Fund funding; however, the UIC is not used in the case of clients who go directly to HTC centers; the UIC is not used in care and treatment sites.</td>
</tr>
</tbody>
</table>

*For countries that only received a desk review, there was not enough information available to adequately and reliably assess the existence and use of a UIC. Therefore, details are not included here.*
RECOMMENDATIONS: MONITORING OF SERVICE PACKAGES FOR KEY POPULATIONS

1. Most countries in the region would benefit from having more accurate and up-to-date key population size estimates to assist them in determining reach and coverage levels and to track progress against 90-90-90 targets for key populations.

2. There is an urgent need for more reliable data on coverage of services amongst all key populations. This can be achieved by establishing consistent national UIC systems that extend to HIV treatment and care services and by examining the successful national HIV data system reforms taking place in countries like Georgia, Pakistan, the Philippines and Papua New Guinea. Whilst each of these has its limitations, there are valuable lessons here for MENA countries.

3. The quality of IBBS studies needs to be improved in accordance with WHO guidance (WHO, 2017).

4. Prison systems in most of the countries assessed not only need to design and implement services for their prisoners, but they also need to set up monitoring and evaluation (M&E) systems to be able to determine how well the interventions are being implemented in the prison systems.

5. Feedback loops, recommended in the Implementation section, should be extended throughout the reporting system so that quality problems are quickly reported to the level at which action can be taken to remedy the situation. In the case of products such as syringes and condoms that are usually procured nationally, this may mean that rapid communication is enabled from the affected clients to the Principal Recipient(s) of Global Fund funds (PR) or the Ministry of Health entity responsible for procurement.

FINANCING

It was beyond the scope of this assessment process to conduct an in-depth financial analysis of costing, allocation and expenditure related to packages of services for key populations in MENA. Throughout the MENA region, many countries are phasing out of eligibility for HIV funding from Global Fund. As a result, there is a focus on transition and sustainability of responses, particularly on mobilizing increased funds from national and local government sources, in order to maintain current funding levels. Continuation of funding from international donors is of concern to some countries in the MENA region. The different stakeholders will need to work to ensure political support and greater mobilization of funds at the national level and to gradually increase the health insurance coverage of PLHIV under the health insurance system.
### Table ES3. Summary of Key Findings in MENA

Survey/IBBS (S); GAM (G); Programmatic Data (P); Other (O); Desk Review Only (*)

*Note: Details of dates and references contained in footnotes in the tables in the body of this report.*

<table>
<thead>
<tr>
<th>Service</th>
<th>Population</th>
<th>Egypt*</th>
<th>Iran*</th>
<th>Jordan*</th>
<th>Lebanon*</th>
<th>Morocco</th>
<th>Sudan</th>
<th>Tunisia</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSM</td>
<td></td>
<td>61,348 (0.07%)</td>
<td>360,000 (0.46%)</td>
<td>N/A</td>
<td>4,220 (0.07%)</td>
<td>45,000 (0.13%)</td>
<td>140,847 (0.32%)</td>
<td>29,888 (0.27%)</td>
</tr>
<tr>
<td>PWID</td>
<td></td>
<td>93,314 (0.1%)</td>
<td>200,000 (0.25%)</td>
<td>N/A</td>
<td>3,114 (0.05%)</td>
<td>1,500 (0.004%)</td>
<td>N/A</td>
<td>13,000 (0.12%)</td>
</tr>
<tr>
<td>Prisoners</td>
<td></td>
<td>106,000 (0.1%)</td>
<td>230,000 (0.61%)</td>
<td>15,700 (0.2%)</td>
<td>6330 (0.11%)</td>
<td>82,512 (0.23%)</td>
<td>21,000 (0.05%)</td>
<td>20,745 (0.23%)</td>
</tr>
<tr>
<td>SW</td>
<td></td>
<td>22,986 (0.03%)</td>
<td>395,183 (0.50%)</td>
<td>N/A</td>
<td>N/A</td>
<td>75,000 (0.22%)</td>
<td>258,736 (0.37%)</td>
<td>23,500 (0.2%)</td>
</tr>
<tr>
<td>TG</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

1. Where programmatic data are used, coverage values have been calculated using available programmatic coverage data as numerators and nationally accepted PSEs as denominators.
### Assessment of HIV Service Packages for Key Populations
#### Middle East & North Africa

<table>
<thead>
<tr>
<th>Service</th>
<th>Population</th>
<th>Egypt*</th>
<th>Iran*</th>
<th>Jordan*</th>
<th>Lebanon*</th>
<th>Morocco</th>
<th>Sudan</th>
<th>Tunisia</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Prevention Programming&lt;sup&gt;2&lt;/sup&gt;</td>
<td>MSM</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>4% (P)</td>
<td>61% (S)</td>
<td>33.2% (P)</td>
<td>35.9% (P)</td>
</tr>
<tr>
<td></td>
<td>PWID</td>
<td>N/A</td>
<td>16.1% (S)</td>
<td>N/A</td>
<td>4% (P)</td>
<td>33% (S)</td>
<td>N/A</td>
<td>29.3% (P)</td>
</tr>
<tr>
<td></td>
<td>Prisoners</td>
<td>N/A</td>
<td>7% (S)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>SW</td>
<td>N/A</td>
<td>12% (P)</td>
<td>N/A</td>
<td>45% (S)</td>
<td>12.4% (S)</td>
<td>35.8% (P)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TG</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Knowledge of HIV status&lt;sup&gt;3&lt;/sup&gt;</td>
<td>MSM</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>66% (S)</td>
<td>50% (S)</td>
<td>11.9% (S)</td>
<td>20% (S)</td>
</tr>
<tr>
<td></td>
<td>PWID</td>
<td>N/A</td>
<td>6.2% (P)</td>
<td>N/A</td>
<td>82.3% (S)</td>
<td>23.2% (S)</td>
<td>N/A</td>
<td>18.2% (S)</td>
</tr>
<tr>
<td></td>
<td>Prisoners</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>SW</td>
<td>N/A (S)</td>
<td>7.5% (P)</td>
<td>N/A</td>
<td>40.1% (S)</td>
<td>23.1% (P)</td>
<td>23.2% (P)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TG</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Antiretroviral therapy&lt;sup&gt;4&lt;/sup&gt;</td>
<td>MSM</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>83.8% (S)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>PWID</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<sup>2</sup> Coverage with prevention package as defined in national design documents

<sup>3</sup> Percentage of the key population that have received an HIV test in the past 12 months and know their results

<sup>4</sup> Antiretroviral therapy coverage among the key population living with HIV
## Assessment of HIV Service Packages for Key Populations

### Middle East & North Africa

<table>
<thead>
<tr>
<th>Service</th>
<th>Population</th>
<th>Egypt*</th>
<th>Iran*</th>
<th>Jordan*</th>
<th>Lebanon*</th>
<th>Morocco</th>
<th>Sudan</th>
<th>Tunisia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prisoners</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>SW</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>TG</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
BACKGROUND

In 2015, it was estimated that key populations and their sexual partners accounted for 80% of new HIV infections outside of sub-Saharan Africa; even in sub-Saharan Africa it is estimated that key populations account for 25% of new HIV infections (UNAIDS, 2017). A range of policy and legal barriers and harmful social factors increase the HIV vulnerability of key populations and undermine their access to HIV and other services. The criminalization of sex between men, sex work, drug use and HIV transmission, as well as high rates of incarceration, homophobia, transphobia, violence and social marginalization, all serve to influence risk practices and undermine access to services. People from key populations often migrate to cities in search of safer and more secure communities (UNAIDS, UN Habitat, 2015). Women in key populations face specific challenges and barriers, including gender-based violence and poorly-tailored services. These factors further intensify their vulnerability to HIV.

While the WHO has clearly outlined the comprehensive package of services that should be available for MSM, PWID, SW, TG and prisoners, these populations rarely have access to the full range of recommended services (WHO, 2016).

The Global Fund contracted APMG Health to review the design, implementation and monitoring of national HIV service packages for key populations in 65 countries in which the Global Fund has provided HIV grant funds across six regions. Out of the 65 countries assessed, 55 countries were selected based on the Global Fund KPI2 (2014-2016) results, where key population size estimations were classified as ‘nationally adequate’ by 2016. The additional ten countries were selected based on discussions with the Global Fund regional teams and consultation with global partners. The specific objectives of this assessment were:

1. To determine whether HIV service packages as designed in the national guidelines or supported by Global Fund programs are in line with international standards and guidelines (e.g. WHO Consolidated Guidelines for Key Populations, Key Populations Implementation Tools, amongst others), and are appropriate to epidemiological context, available, accessible and utilized by relevant key population groups;
2. To examine the implementation of HIV service packages in reaching intended target groups, taking into account specific needs and vulnerabilities within sub-groups of key populations (e.g. age, sex), along with the coverage and reported quality of these programs;
3. To assess whether the monitoring framework, tools and other mechanisms set up by implementation partners are appropriate to local contexts and are used effectively to regularly report on programmatic coverage;
4. To examine the enabling environment and other factors facilitating and inhibiting the availability, accessibility and utility of intervention services; and,
5. To determine the degree to which financial resources are made available and used accountably for funding the implementation of service packages for key populations.
These objectives were completed through a mix of desk review and in-country visits, as further described below. This report is one of six regional reports produced to summarize the assessment findings.
Methodology

Country Assessment Process

Each of the country assessments consisted of an initial desk review of documents provided by the GF Country Teams. The main data sources provided for desk reviews in MENA were:

- Global Fund Performance Framework
- IBBS Reports
- National Strategic Plans
- Monitoring and Evaluation Plans
- Global Fund Funding Request Reports & Concept Notes
- Global AIDS Monitoring Reports (GAM)
- Global Fund Program Update data
- Programmatic Spot Checks
- Cross checking of findings at a debrief with PR and other stakeholders

For four of the seven countries covered in this assessment, data collection was restricted to desk review. For the remaining three countries, a follow-up field assessment was carried out to verify and expand on data collected during the initial desk review process.

Each field assessment was conducted over the course of five days, with the exception of Morocco, which was conducted over the course of ten days. For each country, key populations and two sites were selected, with guidance from The Global Fund Country Teams and CCM, with the exception of Morocco where five sites were visited.

Table 1. Middle East and North Africa Key Population and Site Selection

<table>
<thead>
<tr>
<th>Country</th>
<th>Key Populations Selected</th>
<th>Sites Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morocco</td>
<td>FSW, MSM, PWID</td>
<td>Rabat, Casablanca, Marrakech, Tangiers &amp; Tetouan</td>
</tr>
<tr>
<td>Sudan</td>
<td>MSM, FSW</td>
<td>Khartoum &amp; Wad Madani</td>
</tr>
<tr>
<td>Tunisia</td>
<td>MSM, PWID</td>
<td>Tunis &amp; Sfax</td>
</tr>
</tbody>
</table>

One international consultant and one local consultant carried out each country assessment, with the exception of Tunisia where, due to the experience and nationality of the international consultant, a local consultant was not needed. The majority of the data collected during each country assessment was collected through:
An initial meeting with representatives of CCM, PR, Sub-recipients of Global Fund funds (SR) working with key populations and other key informants to discuss design and enabling environment issues.

- Visits to at least two sites for observation of package delivery.
- Visits to SR/SSR to discuss implementation issues and to examine M&E forms and systems.
- Additional key informant interviews.
- FGD with individuals from key populations: in each country, focus groups were held with representatives of each of the two selected key populations in each site visited.

**REPORTING PROCESSES**

For each of the three countries visited, a report was produced with detailed findings and recommendations for that country. For each region, a summary report has been produced providing analysis of trends and recommendations for consideration for decision-makers and programmers working across the region. This report provides summary and analysis of the seven countries assessed in the MENA region, as displayed in Table 2.

**Table 2. MENA Countries Assessed**

<table>
<thead>
<tr>
<th>Middle East and North Africa</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Desk Review and Country Assessment</td>
<td>Morocco</td>
</tr>
<tr>
<td></td>
<td>Sudan</td>
</tr>
<tr>
<td></td>
<td>Tunisia</td>
</tr>
<tr>
<td>Desk Review Only</td>
<td>Egypt</td>
</tr>
<tr>
<td></td>
<td>Iran</td>
</tr>
<tr>
<td></td>
<td>Jordan</td>
</tr>
<tr>
<td></td>
<td>Lebanon</td>
</tr>
</tbody>
</table>

As the countries selected for this region were not selected on the basis of being a regionally representative sample, extrapolation of these results to other countries in the region should be done with caution. The findings of this assessment may be instructive for development of policy or practice across the region, but any country-level decisions should always be grounded in the reality of the specific country context.
**FINDINGS**

**PART I: REGIONAL PROFILE AND KEY POPULATIONS CONTEXT**

There were an estimated 18,000 new HIV infections in Middle East North Africa in 2017 – up 12% from the new infections estimate for 2010. Almost two-thirds of new HIV infections in 2017 were in Egypt, the Islamic Republic of Iran and Sudan (UNAIDS, 2018). Figure 1 presents the distribution of new infections by country and Figure 2 by population.

*Figure 1. Distribution of New HIV Infections and AIDS-Related Deaths by Country, Middle East and North Africa 2017 (UNAIDS Estimates 2018)*
Thirty-eight percent (38%) of new infections are attributed to PWID and 30% to clients of SW and sexual partners of other key populations.

Figure 3 presents the HIV testing and treatment cascade, indicating that, out of the estimated 222,000 PLHIV in the region at the end of 2017, only around 50% know their HIV status. Only around 29% of PLHIV in the region are on treatment, representing a gap of around 112,000 to achieving the 90% target. Algeria is the exception in the region, with a reported HIV treatment coverage rate of 80%. The proportion of PLHIV who reached viral suppression increased from around 17% in 2016 to 22% in 2017. Of the around 5,200 women with living HIV who gave birth in the region in 2017, only around 1,100 received ART to prevent HIV transmission. This has a direct link to key population focus, given the high number of MSM and male PWID who have regular female sexual partners and sex with other women (UNAIDS, 2018).

In many countries in the region, the ratio of men to women identified as living with HIV is very high – this is partly due to high levels of sex between men, but also a result of barriers that women experience in access to health services, the underservicing of women who use and inject drugs, and the fact that many men who have sex with men have regular sex with women who do not have an understanding of the risk that their male partners pose, nor the power to take action to minimize that risk.
Figure 3. HIV Testing and Treatment Cascade, Middle East and North Africa 2017 (UNAIDS Special Analysis 2018)
### Table 3. Population Size Estimation (PSE)\(^5\) and HIV Prevalence\(^6\) by Key Population\(^7\)

<table>
<thead>
<tr>
<th>Country</th>
<th>Egypt*</th>
<th>Iran*</th>
<th>Jordan*</th>
<th>Lebanon*</th>
<th>Morocco</th>
<th>Sudan</th>
<th>Tunisia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population (WPP 2015)</td>
<td>91,508,000</td>
<td>79,109,000</td>
<td>7,594,000</td>
<td>5,851,000</td>
<td>34,378,000</td>
<td>40,235,000</td>
<td>11,254,000</td>
</tr>
<tr>
<td>MSM PSE (% of total population)</td>
<td>64,318 [2014] (0.07%)</td>
<td>360,000 [2015] (0.46%)</td>
<td>N/A</td>
<td>4,220 [2,243-8,304] [2015] (0.07%)</td>
<td>45,000 (0.13%) [2016]</td>
<td>129,872 (0.32%) [2015]</td>
<td>29,888 (0.27%) [2014]</td>
</tr>
<tr>
<td>MSM HIV Prevalence</td>
<td>5.7% (Cairo); 5.9% (Alexandria) [2010]</td>
<td>14.8% [2007]</td>
<td>0.2% [2013]</td>
<td>12.6% [2015]</td>
<td>5.7% [2015]</td>
<td>1.4% [2015]</td>
<td>9.1% [2014]</td>
</tr>
<tr>
<td>PWID PSE (% of total population)</td>
<td>93,314 [2014] (0.10%)</td>
<td>200,000 [2015] (0.25%)</td>
<td>N/A</td>
<td>3,114 [703-7,507] [2015] (0.05%)</td>
<td>1,500 (0.004%)</td>
<td>N/A</td>
<td>13,000 (0.12%) [2014]</td>
</tr>
<tr>
<td>PWID HIV Prevalence</td>
<td>6.5% [2010]</td>
<td>15.0% [2010]</td>
<td>0.0% [2013]</td>
<td>0.3% [2015]</td>
<td>7.9% [2015]</td>
<td>N/A</td>
<td>3.9% [2014]</td>
</tr>
<tr>
<td>FSW PSE (% of total population)</td>
<td>22,986 [2014] (0.03%)</td>
<td>395,183 [2015] (0.50%)</td>
<td>N/A</td>
<td>N/A</td>
<td>75,000 (0.22%) [2016]</td>
<td>148,083 (0.37%) [2015]</td>
<td>23,500 (0.20%) [2014]</td>
</tr>
<tr>
<td>FSW HIV Prevalence</td>
<td>0.9% FSW Cairo; 3.4% MSW Cairo [2010]</td>
<td>4.5% [2010]</td>
<td>0.5% [2013]</td>
<td>N/A</td>
<td>2.0% [2016]</td>
<td>1.3% [2015]</td>
<td>0.9% [2014]</td>
</tr>
</tbody>
</table>

---

\(^5\) Population size estimates are from IBBS, GARPR, programmatic mapping, the Global State of Harm Reduction, or UNODC (prisoners only)

\(^6\) HIV prevalence rates are from IBBS or GARPR/GAM

\(^7\) None of the countries in the Middle East North Africa region included in this assessment have PSE or HIV prevalence rate data for TG and so TG are not included in this table
### Assessment of HIV Service Packages for Key Populations
#### Middle East & North Africa

<table>
<thead>
<tr>
<th>Country</th>
<th>Egypt*</th>
<th>Iran*</th>
<th>Jordan*</th>
<th>Lebanon*</th>
<th>Morocco</th>
<th>Sudan</th>
<th>Tunisia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prisoner PSE (% of total population)</td>
<td>106,000 (0.1%)</td>
<td>230,000 (0.61%)</td>
<td>15,700 (0.2%)</td>
<td>6330 (0.11%)</td>
<td>82,512 (0.23%)</td>
<td>21,000 (0.05%)</td>
<td>20,745 (0.23%)</td>
</tr>
<tr>
<td>Prisoner Prevalence</td>
<td>N/A</td>
<td>1.6% [2009]</td>
<td>N/A</td>
<td>N/A</td>
<td>0.5% [2016]</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>TG PSE (% of total population)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>TG Prevalence</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

---

8 World Prison Brief 2016
**Men who have Sex with Men**

Around 17% of new infections in MENA were attributed to MSM (UNAIDS, 2018). This is likely to be an underestimate, given that IBBS from countries in the region show a consistently high proportion of MSM who also have regular sex with women. Extreme levels of violence, stigma discrimination experienced by MSM in many countries in the region would act as a strong barrier to men disclosing their sexual activity at the time of diagnosis with HIV.

Prevalence of HIV in MSM populations varies across the countries included in this assessment, from 0.2% in Jordan to 12.6% in Lebanon.

Levels of condom use, knowledge of HIV status coverage of MSM populations with a package of prevention services vary widely between countries and within countries. Some countries, notably Morocco and Lebanon, have MSM community-based organizations (CBOs) that are a recognized part of the national HIV response.

Country-level IBBS studies in the region also show that a high proportion of MSM also have frequent and regular sex with women.

The environment that MSM live in is fraught with risk and violence. The Laws and Policies Scorecard in the UNAIDS Global Report 2018 indicates that eight out of the 20 countries in the region have the death penalty in place for men convicted of sex with another man and a further six impose lengthy jail sentences – from 14 years to life imprisonment. Due to intervention of UN agencies, key governmental stakeholders and civil society organizations, HIV services for MSM are still able to be implemented in most settings – and in Tunisia, LGBTI rights associations have even been legalized. However, this does not diminish the risk to an individual of publicly identifying as gay, bisexual, or MSM. Therefore, MSM are considered ‘invisible’ in many of the countries in the region; they may be reticent to present for services targeted towards MSM or engage in surveys of MSM behavior for fear of legal or societal retribution if they are diagnosed with HIV, they may be unlikely to accurately disclose their risk factors. This explains why official PSE show a population size well below the internationally accepted average of 2% to 5% of the general population in low- and middle-income countries (Cáceres, 2008). This has important implications for appropriate service design and implementation, as further discussed below.

**People Who Inject Drugs**

Transmission of HIV through needle sharing is a significant issue in MENA, with around 38% of new HIV infections in 2017 attributed to PWID (UNAIDS, 2018). Prevalence of HIV across the countries included in this assessment ranges from zero in Jordan to 15% in Iran. Libya is estimated to have an 87% HIV prevalence among PWID. The estimated 2017 HIV incidence rates among PWID in MENA range from 0.7% per person year (ppy) in Tunisia to 4.4% in Iran – with Libya as an outlier at 24.8% ppy (Mumtaz et al, 2018).
Information in the region on the context of injecting drug use and underserviced sub-populations (particularly women who inject and women partners of male injectors) is improving. The regional MENAHRA Project has conducted several mapping exercises and studies that can begin to assist countries to respond more effectively, including: Women with HIV Who Use or Inject Drugs: MENAHRA, 2013 & 2017; and, Refugees and migrants: MENAHRA, 2015 – internal document only). Although these studies are sub-population specific, they provide extremely detailed and useful information on the context of drug use in several MENA countries (Egypt, Jordan, Lebanon, Tunisia and Morocco).

**Sex Workers**

In 2017, FSW account for approximately 30% of new HIV infections throughout the region (UNAIDS, 2018). HIV prevalence rates among FSW are available for five out of the seven countries in this assessment and range between 0.5% in Jordan and 4.5% in Iran. Female sex workers are also heavily stigmatized and discriminated against in MENA. During the in-country assessment in Sudan, participants of the FSW FGD detail experiencing stigma from the general population as well as within their own community and report fears of seeking medical care due to stigma and discrimination from medical care providers. For instance, participants provide several anecdotes of doctors, including dentists, maternity ward doctors and other specialists refusing care, surgery and other invasive interventions upon disclosing their HIV status. As with MSM and PWID, this stigma may contribute to the invisibility of FSW, making them reluctant to participate in surveys or to present for care when it is needed.

**Prisoners**

There are very limited data available regarding prisoners in the MENA region. Population size estimates and HIV prevalence rates are only available for three out of the seven countries assessed prison population sizes range from 26,000 people in Tunisia and 76,000 in Morocco (0.2% of the general population in each) to 480,000 (0.6% of general population) in Iran. HIV prevalence rates range between 0.5% in Morocco and 1.6% in Iran; notably, with a large number of incarcerated individuals, Iran’s prevalence rate translates to approximately 7,680 PLHIV in closed settings in that country alone.

In countries visited during this assessment, findings confirm that prisons are associated with risk-taking behaviors including injection drug use and unprotected sex.

**Transgender People**

Transgender people are not identified as a key population in any of the countries included in this assessment. Therefore, no data are available about this population, including population size estimates or HIV prevalence rates. Until recently, most countries had grouped TG data together with MSM. Even indicators for MSM and TG interventions were combined previously and this is how countries were reporting to UNAIDS and to the Global Fund. With the new funding requests for the
Global Fund, the indicators are now disaggregated and countries are just beginning to strengthen their reporting mechanisms to capture the two groups separately. There is an urgent need for more reliable information about the relative risk and intervention needs of this population in the MENA context.

**Analysis: Do we know what we need to know about key populations in the Middle East and North Africa?**

Most of the countries in the MENA region now acknowledge key populations. Countries are also using language that is more palatable to national leadership and in line with religious values in order to collect information on populations that they previously did not acknowledge. There is, however, a general lack of data to assist countries in designing services and interventions based on the real context of risk and vulnerability in these populations. Some countries (notably Morocco, Lebanon and to some extent, Tunisia) have stable and capable NGOs working with key populations therefore, the ability to generate useful data to assist in tailoring programs for maximum effectiveness. The existence of the Global Fund regional project has assisted in providing essential data, operations research and implementation of services that might have been politically difficult at the country level.

Significant data gaps for key populations in MENA remain. There is very little information available about sub-populations. Men who have sex with men, SW and to some extent PWID, are described in the available data as homogeneous groups. There is little information on the specific needs of sub-populations within these key populations.

There are also gaps and inaccuracies in population size estimates for key populations in many of the countries in the region, making it impossible to accurately track progress against 90-90-90 targets. A critical approach to addressing this consistent underestimation of population size is necessary in order to meaningfully engage key populations in the design and implementation of surveys. Failure to do so is a self-reinforcing problem, which keeps the hardest-to-reach and most-at-risk segments of populations hidden.

There are also very little data on how countries can adapt effective key population interventions from other countries and regions to the MENA context or how they can build on the intervention successes in the region. Most countries have the right values and service elements set out in their national HIV strategic plans but do not have practical information about how to deliver these interventions and service in their local context. Some countries are making significant changes to key population outreach models in an attempt to increase knowledge of HIV status and connection to onward services; however, there were concerns expressed in key informant interviews that these may not be based on clear data about what will work in the region based on previous experience and evaluation of existing or previous programs.
PART II: DESIGN AND DOCUMENTATION OF SERVICE PACKAGES

For all countries assessed, consultants were able to evaluate the current national strategic plans, action plans, outlines of state-provided HIV services national programs. Package design is shown in Table 4, based on key national reference documents. While Lebanon is the only country that does not have a national strategic plan or framework in place, it is important to note that both Jordan and Sudan’s national strategic plans ended in 2016. It is unclear from this assessment whether these plans will be updated or extended to meet the current needs of their key populations in terms of service provision.

It should also be noted that the presence of key populations programming in national strategic plans and frameworks for the majority of the countries is a sign of success in itself; most countries in the region had no defined packages of services for key populations five years ago. Some countries, like Lebanon, offer harm reduction services without drawing attention to their existence in national documents. With most countries moving to include such packages in key national documents, rather than including them only in Global Fund funding requests, it is likely that these services will be seen as key activities to be continued as countries approach transition from external donor support. All assessment findings for each country are based on the package of services described in its latest HIV program review.

Table 4. Key Populations Identified in Countries Assessed

*Desk-review only country

<table>
<thead>
<tr>
<th>Country</th>
<th>Key Populations Identified in Nationally Endorsed HIV Strategies/Plans</th>
<th>Document(s) Defining Service Packages for Key Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Egypt*</td>
<td>MSM, PWID, FSW, prisoners⁹</td>
<td>National Strategic Framework 2015-2020</td>
</tr>
<tr>
<td>Iran*</td>
<td>PWID, FSW, prisoners¹⁰</td>
<td>National Strategic Plan 2015-2019</td>
</tr>
<tr>
<td>Jordan*</td>
<td>MSM, PWID, FSW, prisoners¹¹</td>
<td>National Strategic Plan 2012-2016</td>
</tr>
<tr>
<td>Lebanon*</td>
<td>MSM, PWID, FSW¹²</td>
<td>Not Available</td>
</tr>
</tbody>
</table>

⁹ Other vulnerable populations identified: street children, labor migrants, and refugees
¹⁰ Other vulnerable populations identified: children and women
¹¹ Prisoners identified as a vulnerable population; other vulnerable populations identified: migrants, orphans, young women, and prisoners
¹² Identified only in the Country Progress Report 2014
Several countries in the region set out design elements that seek to address some of the critical enablers – mostly expressed as relevant for all key populations, rather than any particular key population. Many national strategic plans contain a reference to supportive policies or to removing barriers to access, but few set out specific interventions.

Under law and policy, Sudan seeks to establish a legal environment that shows zero tolerance for gender-based violence. Iran undertakes to amend the law in relation to expulsion of PLHIV or prevention of their entrance to the country. Jordan undertakes to review and revise legislation regarding impact of PLHIV in the workplace and mandatory HIV testing by employers.

Most countries include statements relating to stigma and discrimination. Strategies include information campaigns and training in health workplaces. Morocco plans the establishment of an observatory to document stigma and discrimination against PLHIV and key populations. Egypt plans campaigns in mass media and among college students and training for health care personnel to reduce stigma and discrimination. Sudan seeks to establish an enabling legal environment that protects the health, education, labor and social rights of PLHIV and supports effective prevention among key populations by ensuring their right to information and access to health services.

Community empowerment is rarely specifically mentioned, though the Morocco National Strategic Plan refers to the mobilization of health actors, civil society, human rights institutions and opinion leaders to reduce barriers to services.

Violence is rarely specifically referred to, but some national strategic plans outline actions to train police in their dealings with people from key populations.

---

13 Prisoners identified as a population who will benefit from targeted intervention with a limited geographical coverage

14 Prisoners identified as a priority group but not a key population
Men Who Have Sex with Men

Six out of the seven countries identify MSM as a key population and outline specific services targeting this population. The exception is Iran, which describes high-risk men as a key population and it is assumed that this includes MSM. Table 5 below presents details for the six countries that include MSM as a specific key population. Iran does however provide a population size estimate for MSM (359,000) in its 2015 estimates and an HIV prevalence of 14.85 (though in a 2007 IBBS).

Most of the WHO-recommended HIV service package elements for MSM are present in the national strategic plan designs, though lubricant is generally not included specifically (only two countries mention lubricant). All countries include HTC and HIV treatment and care as part of their MSM service packages. At the time of these reviews, no pre-exposure prophylaxis (PrEP) programs were in operation in the countries reviewed.

Exceptions to alignment with WHO guidance include sexual health interventions, where only four countries include STI prevention, diagnosis and/or treatment as part of their package. This is particularly significant for Jordan, which in addition to not including STI services also has no specific behavioral interventions for MSM. This indicates that key knowledge and behavior change needed to prevent and identify STIs may be missing. In addition, Egypt identifies MSM as a key population but does not include any STI services. It also does not provide any other co-infection management provisions, indicating that the nature of its services for MSM are strictly limited to HIV and a broader conception of the package of services may be needed.

Table 5. Comparison of national packages of HIV Services for MSM with the WHO Consolidated Guidelines for Key Populations

<table>
<thead>
<tr>
<th>WHO Guidance</th>
<th>Summary of Findings for Six Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comprehensive condom and lubricant programming</td>
<td>All six countries included distribution of condoms to MSM; however, only two countries (Morocco and Lebanon) specifically include the distribution of lubricants in their package of services.</td>
</tr>
<tr>
<td>2. Behavioral interventions</td>
<td>Five of the six countries included behavioral interventions, including counseling, IEC, BCC and health education. Jordan does not include any behavioral interventions in their packages of services for MSM.</td>
</tr>
<tr>
<td>3. HIV testing and counseling (HTC)</td>
<td>All six countries included the provision of HTC. Lebanon is the only country that specifically outlined the provision of community-based testing and counseling.</td>
</tr>
<tr>
<td>4. HIV treatment and care</td>
<td>All six countries include referral to HIV treatment and care in their packages of services. Tunisia is the only country that include the provision of CD4 testing and viral load testing if needed in their outlined</td>
</tr>
</tbody>
</table>
Assessment of HIV Service Packages for Key Populations
Middle East & North Africa

<table>
<thead>
<tr>
<th>Package of services for MSM</th>
<th>Overall, Tunisia’s treatment and care interventions are the most comprehensive.</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions</td>
<td>Five of the six countries, with the exception of Egypt, included provision of preventative and management services for other co-infections, including hepatitis B and C, TB and syphilis. In the case of organizations not specifically providing these services, it is outlined that referrals to these services would be made. Tunisia and Morocco also include nutritional services within their MSM packages of services, and Morocco includes psychosocial support within their package.</td>
</tr>
<tr>
<td>6. Sexual health interventions</td>
<td>Four of the six countries include STI interventions in their packages (exceptions being Egypt and Jordan). The services include prevention and treatment of STIs as well as linkage to treatment, if was not available on site, and linkage to other STI-related services.</td>
</tr>
<tr>
<td>7. Supportive law and policy</td>
<td>No design elements for specific key populations – general elements set out in section above.</td>
</tr>
<tr>
<td>8. Addressing stigma and discrimination</td>
<td>No design elements for specific key populations – general elements set out in section above.</td>
</tr>
<tr>
<td>9. Community empowerment</td>
<td>No design elements for specific key populations – general elements set out in section above.</td>
</tr>
<tr>
<td>10. Addressing violence</td>
<td>No design elements for specific key populations – general elements set out in section above.</td>
</tr>
</tbody>
</table>

People Who Inject Drugs

Six out of the seven countries identify PWID as a key population and therefore outline specific services targeting this population, with the exception of Sudan. Table 6 presents details for the countries that include PWID as a key population.

As with MSM, lubricant is missing from all but two of the countries’ service packages for PWID. All six of the countries with PWID packages include provision of clean needles as part of their harm reduction package. Only half of the assessed countries include OST. Morocco additionally includes overdose response in the form of naloxone and PEP for PWID as part of their harm reduction package.

Most countries include behavioral interventions, though the design of those interventions varies. Morocco notably includes family-based intervention, while Lebanon is the only country that explicitly mentions internet-based outreach for behavioral interventions, including information about safe injection practices.
As is the case with MSM, all six countries include HTC and HIV treatment and care as part of their PWID service packages. In an environment where PWID may experience extreme stigma and discrimination, this explicit statement of their right to access these services is important and should be commended.

Services for co-infection and other related health services are more sparsely addressed in service packages. Hepatitis and TB co-infection are addressed in only four countries and STI prevention and treatment in only Morocco and Tunisia.

Morocco has developed a separate National Harm Reduction Plan, which outlines several services provided to this population, including the provision of needles and syringes, HTC, OST, psychosocial support, and stigma and discrimination interventions.

Table 6. Comparison of national packages of HIV Services for PWID with the WHO Consolidated Guidelines for Key Populations

<table>
<thead>
<tr>
<th>WHO Guidance</th>
<th>Summary of Findings for Six Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comprehensive condom and lubricant programming</td>
<td>All six countries include condom provision as part of their package. Only two countries, Lebanon and Morocco, include the distribution of lubricant.</td>
</tr>
<tr>
<td>2. Harm reduction interventions for substance use (in particular, NSP and OST)</td>
<td>All six countries have some kind of harm reduction package specifically for PWID. At the very least, all six countries include needle and syringe programs. Three out of the six countries include OST for PWID. Morocco has the most comprehensive harm reduction programming for PWID, which include not only NSP and OST, but also PEP and overdose prevention and response.</td>
</tr>
<tr>
<td>3. Behavioral interventions</td>
<td>Five of the countries (with the exception of Jordan) outline behavioral interventions, which include counseling, IEC and BCC. Some also include working with drug users’ families (Morocco), and Lebanon outlined specifically peer education and even internet-based outreach to PWID for the provision of behavioral interventions.</td>
</tr>
<tr>
<td>4. HIV testing and counseling</td>
<td>All six countries include HTC in their package for PWID. Lebanon is the only country to specify including community-based testing and counseling as well as mobile outreach and testing for sexual partners of PWID.</td>
</tr>
<tr>
<td>5. HIV treatment and care</td>
<td>All six countries outline referral to HIV treatment and care for PWID who test positive for HIV. Two countries - Tunisia and Egypt - specifically outline CD4 and viral load testing as part of their package. Overall, Tunisia’s treatment and care interventions are the most comprehensive.</td>
</tr>
</tbody>
</table>
6. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions

Four countries (Tunisia, Morocco, Iran and Jordan) outline services related to co-infection, including hepatitis B and C and TB. Morocco has the most comprehensive package for this intervention, which includes group therapy and addition counseling.

7. Sexual and reproductive health interventions

Only two countries (Tunisia and Morocco) include STI prevention and treatment services.

8. Supportive laws and policies

No design elements for specific key populations – general elements set out in section above.

9. Addressing stigma and discrimination

No design elements for specific key populations – general elements set out in section above. Exception is Iran, where “at least 45% of the PWID receive standard training on HIV prevention method and correct attitude toward HIV focusing on stigma reduction, harm reduction and correct use of condom every year”

10. Community empowerment

No design elements for specific key populations – general elements set out in section above. Exception is Morocco, where psycho-social support, reintegration and self-support actions for PWID are to be implemented in partnership with associations with advocacy to remove barriers to sustainable access to services.

11. Addressing violence

No design elements for specific key populations – general elements set out in section above.

**Sex Workers**

All seven of the countries assessed include FSW or SW as a key population and have a defined package of service for this population. Similar to other service packages in this region, packages for FSW are missing distribution of lubricant in all but the Morocco package. Sudan is unique in including the provision of female condoms.

Most countries, with the exception of Jordan and Iran, include some sort of behavioral intervention. Tunisia, Sudan and Morocco outline the most comprehensive approaches, as described in Table 7. As with the populations previously discussed, all of the countries outline HTC and HIV treatment and care in their packages, which is an important statement on rights to accessing comprehensive HIV care. Sudan includes testing for clients of SW as well.

Support for other complementary health services are more consistent for SW than for other populations. Five countries outline some form of co-infection support, though approaches vary
considerably. Notably, five countries explicitly include STI services for SW, and Sudan includes referral to a wider range of reproductive health services. The latter, paired with the provision of female condoms, indicate that Sudan’s package has a higher sensitivity to the specific needs of FSW than other countries in the region.

Table 7. Comparison of national packages of HIV Services for sex workers with elements in the WHO Consolidated Guidelines for Key Populations

<table>
<thead>
<tr>
<th>WHO Guidance</th>
<th>Summary of Findings for Seven Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Comprehensive condom and lubricant programming</strong></td>
<td>All seven countries include condom distribution to FSW as part of their package. Morocco is the only country to specifically include lubricant in their package. Sudan includes the provision of both male and female condoms, while Lebanon outlines the provision of condoms accompanied by training on how to use them.</td>
</tr>
<tr>
<td><strong>2. Behavioral interventions</strong></td>
<td>Five countries, with the exception of Jordan and Iran, include some kind of behavioral intervention for FSW. While Tunisia, Sudan and Morocco outline more comprehensive interventions (such as counseling, IEC, BCC and health education), Egypt and Lebanon only outline education during outreach.</td>
</tr>
<tr>
<td><strong>3. HIV testing and counseling</strong></td>
<td>All seven countries include HTC in their packages for FSW. Sudan specifically outlines testing for clients of FSW, and Lebanon outlines community-based HTC.</td>
</tr>
<tr>
<td><strong>4. HIV treatment and care</strong></td>
<td>All seven countries include provision of (or referral to) HIV treatment and care as part of their package for FSW. Only Tunisia and Egypt specifically mention provision of or referral for CD4 and viral load testing, while Sudan also mentions adherence training and monitoring throughout treatment. Overall, Tunisia’s treatment and care interventions are the most comprehensively described.</td>
</tr>
<tr>
<td><strong>5. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions</strong></td>
<td>Five countries, with the exception of Lebanon and Jordan, outline some kind of prevention and management of co-infections for FSW. Tunisia, Sudan and Morocco include hepatitis B and C, syphilis and TB screening and treatment, as well as psychological support. Egypt and Iran only include psychological support.</td>
</tr>
<tr>
<td><strong>6. Sexual and reproductive health interventions</strong></td>
<td>Five countries with the exception of Egypt and Jordan, include prevention and treatment, or referral to prevention and treatment, of STIs for FSW.</td>
</tr>
</tbody>
</table>
Sudan also specifically mentioned linking FSW to reproductive health services as part of their package.

7. Supportive laws and policies

No design elements for specific key populations – general elements set out in section above.

8. Addressing stigma and discrimination

No design elements for specific key populations – general elements set out in section above.

9. Community empowerment

No design elements for specific key populations – general elements set out in section above.

10. Addressing violence

No design elements for specific key populations – general elements set out in section above.

**Prisoners**

Only three out of the seven countries (Egypt, Iran and Tunisia) included in this assessment identify prisoners as a key population in their national strategic plans or frameworks and outline a separate package of HIV services for this population. Table 8 presents details for the three countries that include prisoners as a key population.

All three countries with defined packages include both HTC and referral to ART for prisoners. This is important, since prisoners do not have the opportunity to access services intended for the general population, and the large volume of estimated prisoners living with HIV (recall Findings Part I, above) necessitates these services. All three countries also include some sort of behavioral intervention.

Out of the three countries, Iran has the most comprehensive package of services for prisoners and it is largely in-line with WHO guidelines. Notably, the provision of clean needles and syringes is not present in any of the packages of services for prisoners, and the only harm reduction intervention mentioned is within Iran’s package (OST). Tunisia outlines non-OST drug treatment services as part of their co-morbidities interventions.

Morocco’s National Strategic Plan identifies prisoners as a population who will benefit from targeted interventions with a limited geographical coverage, since this population is only located in prison settings; however, there are no details provided in the plan regarding a separate package of services for prisoners, or further information regarding what the targeted interventions are. In Jordan, prisoners are identified as a vulnerable population; however, there is no designed package of services available.

**Table 8. Comparison of national packages of HIV Services for prisoners with the WHO Consolidated Guidelines for Key Populations**
<table>
<thead>
<tr>
<th>WHO Guidance</th>
<th>Summary of Findings for Three Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comprehensive condom and lubricant programming</td>
<td>Only Iran includes the distribution of condoms, and only in the conjugal rooms.</td>
</tr>
<tr>
<td>2. Harm reduction interventions for substance use (in particular, needle and syringe programs and opioid substitution therapy)</td>
<td>Only Iran outlines any harm reduction activities for prisoners who are injecting drugs, and the only intervention that is outlined is OST.</td>
</tr>
<tr>
<td>3. Behavioral interventions</td>
<td>All three countries outline education for prisoners. Iran includes peer education, while Tunisia includes access to IEC and BCC.</td>
</tr>
<tr>
<td>4. HIV testing and counseling</td>
<td>All three countries include access to HIV testing and counseling in prison.</td>
</tr>
<tr>
<td>5. HIV treatment and care</td>
<td>All three countries include referral to ART for prisoners who are HIV positive.</td>
</tr>
<tr>
<td>6. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions</td>
<td>Only Tunisia includes referral to TB and drug treatment services.</td>
</tr>
<tr>
<td>7. Sexual and reproductive health interventions</td>
<td>None of the countries include any specific interventions related to prevention, screening, or treatment of STIs for prisoners.</td>
</tr>
<tr>
<td>8. Supportive laws and policies</td>
<td>No specific reference to this for prisoners in the designs set out in national strategic plans.</td>
</tr>
</tbody>
</table>
| 9. Addressing stigma and discrimination                                      | No specific reference to this for prisoners in the designs set out in national strategic plans. The exception is Iran: "At least 60% of the prisoners with more than 10 days stay in prison, receive standard training on prevention methods and correct attitude toward HIV focusing on stigma reduction [...] At least 20% of the prisoners’ spouse receive standard training on prevention methods and correct attitude toward HIV focusing on stigma reduction."
| 10. Community empowerment                                                    | No specific reference to this for prisoners in the designs set out in National Strategic Plans.                                                                                                                                                                                                                                                                                               |
Transgender People

Transgender people are not identified as a separate key population in any of the countries assessed, and there are no service packages that have been designed around their needs. Therefore, this report does not further assess the design of TG packages of services. This situation is likely to improve in the next implementation period, as countries are now required by donors to include TG as a population separate to MSM.

Analysis: Are Package Designs Meeting International Standards?

It is promising that all of the countries assessed have developed national strategic plans, with the exception of Lebanon, and in those plans, have recognized all key populations in some way. However, there are some notable deviations from the WHO Consolidated Guidelines for HIV Prevention, Diagnosis, Treatment and Care (2014) that need to be addressed in order to assure that packages are epidemiologically responsive.

The lack of universal inclusion of lubricant for all key populations, except in Morocco, displays a need for greater consideration of the above-mentioned WHO Consolidated Guidelines around condom programming and the science underlying it.

The absence of biomedical prevention interventions is also clear: PEP is included in only one package across all assessed countries (PWID in Morocco) and PrEP (currently recommended for MSM only in designed packages, though is being made available for other key populations in Morocco) is not included in the packages for any population in any of the seven countries. While these technologies have to be considered alongside population context and need and balanced with financial constraints, it is important that they be considered for use as evidence-based interventions when they meet specific key population needs.

While behavioral interventions are universally included in packages in some form, there is a notable lack of detailed standards for what these interventions include, how they are delivered, and what is considered sufficient coverage. Currently, Lebanon is the only country that specifically outlines community-based testing for key populations.

Out of the countries assessed, Tunisia’s treatment and care section of their packages for key populations is the most comprehensive. The country’s package (for all key populations with the exception of prisoners) most notably includes: referral to ART; follow up with PLHIV concerning adherence and opportunistic infection treatment; pre-treatment counseling; CD4 and viral load testing; and, transportation costs for clients who are on ART. It is important to note that only two out
of the seven countries mention anything specific about CD4 or viral load testing as part of their treatment package or key populations, indicating a potential lack of clinical monitoring, which has implications for treatment success and achievement of 90-90-90 targets.

Other complementary services, such as those addressing co-morbidities and related health needs, need more careful consideration in most countries. While services for TB, hepatitis C, STIs and other reproductive health issues may be available in the country in general, and some key populations may be able to access these services in the same manner as the general population, in environments of stigma, discrimination and violence, it is often necessary to tailor these services to be more accessible to key populations and to state explicitly that key populations have the right to access them. Additionally, in settings where these services are under-resourced for the general population, careful consideration of real need relative to population size is critical to allow accurate resource planning.

There is little information in HIV national strategic plans from the region about how access to essential HIV services (ART for PLHIV; PMTCT) will continued in conflict and emergency settings, or be prioritized for re-introduction after conflict or emergency. The International Committee of the Red Cross (ICRC) HIV Field Guide provides information that could be adapted at country level to guide this (ICRC, 2009).

RECOMMENDATIONS: DESIGN OF SERVICE PACKAGES FOR KEY POPULATIONS

1. All countries in the MENA region should ensure that there is an endorsed national strategic plan that outlines the key populations at risk of HIV.
2. In addition to listing service elements, more detailed descriptions about service models, including how and where services will be delivered, would assist in guiding implementation. These could be included in the national strategic plan or in annual planning documents.
3. Recent developments in outreach and community testing models (in MENA and other regions) need to be incorporated into service package designs.
4. The development of minimum standards for behavioral interventions, which are attuned to population needs, would ensure that the intent of the design of this intervention carries over into appropriate resource mobilization and implementation.
5. Service packages for TG and for prisoners and people in other closed settings need to be developed.
6. There is little information available about sub-populations of key populations and the specific service package elements they require. Greater attention needs to be paid to sub-populations and different contexts of risk and vulnerability across geographical areas.
7. The recommendations of the MENAHRA operations research into PWID sub-populations (women who use/inject drugs; refugees and migrants) need to be considered at the country level and brought into service package design.
8. HIV treatment packages across the region should be enhanced to include more specific interventions for key populations using the example of Tunisia as a model.
9. Service packages need also to include a description of packages that will be available in conflict and emergency settings, along with undertakings about prioritizing the re-introduction of service elements that cease during conflict or emergencies.
Government and National AIDS Commissions, who also work with NGOs and various UN organizations, are the primary service providers for key populations in MENA. Overall, findings from countries assessed show that packages are implemented as designed, within the bounds of economic and human rights constraints. Limited data are available to provide coverage estimates for these programs.

Based on the data available, coverage of key populations with service packages varies widely across the region, as do the definitions of coverage. As noted in Table 1, the key indicator should be coverage of a key population with the defined package of services. However, this is impossible to track in most countries because the service package often includes ART, for which coverage figures can usually not be disaggregated by key population (this is discussed in further detail in the Monitoring section of this report). In addition, some countries use different definitions of coverage in the GAM versus other reports: as shown in the tables below, some coverage estimates come from research reports and others from IBBS surveys, where programmatic data are not available. Even in cities or locations where coverage levels are relatively high, it is beyond the scope of this study to assess the quality of the services being provided.

Stigma and discrimination in health settings is raised as a key barrier to health services by MSM, PWID and SW participants in FGD for this assessment. Men report an extreme reluctance to disclose MSM activity in healthcare settings, while PWID report judgment and abuse in some settings. While there have been sporadic efforts in some countries to train a cadre of health workers to sensitively treat people from key populations, this workforce development is rarely long-term and benefits are not enduring. There are few examples cited of quality assurance practices in health care services that key populations utilize.

Obviously, these challenges are magnified in countries in the region in which the sexual or drug-using behavior of key populations results in extreme forms of state- or community-sanctioned harassment, rejection, violence and even death.

There are also significant barriers to service use described for particular populations: in some countries, key population service packages are only available for people over 16 years of age and there is little attention to the needs of street children or children living outside the family home. Women living in families and communities where their movement outside the home or community is tightly controlled by men or other senior family members face particular problems in service access. Despite some statements in HIV national strategic plans about attention to these issues, there is little evidence of services or programs to address them.

A more detailed assessment of the implementation of packages by key population is presented below.
Men who have sex with men

Findings, especially from the countries with an assessment visit, overwhelmingly show that the major challenge in implementation of services for MSM is criminalization and prosecution, which discourages access to tailored services and reinforces their relative invisibility as an affected population.

In the three countries visited during this assessment, provision of HIV services by peer educators is observed. However, changes have been made recently, particularly in Sudan, in terms of the specific peer approach. Sudan has changed from an NGO peer educator model to a governmental peer driven intervention (PDI). This new approach rests on the idea that peers, such as MSM in the community, are more effective at reaching their networks than more traditional, salaried peer educators. In Morocco, a peer educator team interviewed for this assessment report pioneering an outreach program via the mobile platform Grindr, and offered community-based testing and counseling that took place at the homes of several members of the local LGBTI community.

Most of the data available for this assessment concerning coverage among MSM are obtained from surveys such as IBBS. Programmatic coverage figures are not available. One exception is in the data from Morocco, which reports that 300 MSM are enrolled in their pilot PrEP program (which is outside the designed package of services as it is still in the pilot phase). Morocco is the only country for which any information regarding PEP (only for PWID) or PrEP is available and seems to be the only country offering PrEP as an HIV intervention to the MSM population in any capacity. Among the three countries visited, surveyed coverage of HIV prevention programs among MSM ranges from 61% in Morocco to 20% in Sudan.

Use of condoms varies between countries: the percentage of MSM who used a condom during last anal sex in Amman, Jordan was 15%; but levels of condom during last anal sex in both cities included in the survey in Egypt were 83.5% in Cairo and 89.2% in Alexandria.

Coverage of testing services also varies greatly for countries where data are available (four out of the seven countries). In Lebanon, HTC coverage among MSM is surveyed at 66% and in Morocco at 50%; but is as low as 11.9% in Sudan. The field visit in Tunisia notes stock outs of HIV test kits at HTC centers, and when test kits are available, the testing yield is disturbingly low - well below 1%, in comparison to an estimated prevalence over 9%. Key informants in Tunisia indicate that current outreach methods may have hit a plateau in reaching new clients, and that new methods may be needed to increase testing yield. Morocco also reports problematically low yields for testing overall, which may be due in part to the fact that only 3% of all tests were administered to MSM in 2016. Geographic coverage is also a significant issue for Morocco, with not enough resources allocated to HTC centers to reach all areas of the country.
Assessment of HIV Service Packages for Key Populations
Middle East & North Africa

Comprehensive MSM services in Marrakesh - Association de Lutte Contre le SIDA (ALCS)

In Morocco, homosexuality is illegal, leading to social exclusion and limited access to public services. In partnership with implementing NGOs, a large effort has been made to extend program coverage and reach MSM in the areas where they gather. High quality mapping has allowed for effective targeting of peer educators’ interventions.

In addition to outreach services, ALCS hosts a sexual health clinic within its premises offering increased access to a range of health services and a stigma free service to key populations. In addition to condoms and lubricants, the clinic has started delivering PrEP in a pilot study to more than 100 MSM and offers participants the hepatitis B vaccine as well. The program also provides anonymous and confidential counseling and testing for HIV and syphilis and treats STIs through a syndromic approach, free of charge.

The peer educator team is pioneering an outreach program via the mobile platform Grindr and offers community-based testing and counseling that takes place at the homes of several members of the local LGBTI community. During the field visit, an efficient system of linkage and enrollment in care was observed for youth under 18, who benefitted from their services even though the current package is offered to those over 18.

The operation of health clinics by NGOs focused on and sometimes led by key populations is one way to attract key populations to needed services and to ensure that KPs experience no stigma or discrimination when accessing these services.

MSM-specific ART coverage data only exist for one country, Lebanon, which reports 83.8% coverage in a Crossroads survey in 2015. It is important to note here that it is often the case that if a monitoring system exists, different UIC are used in prevention programs versus treatment and care programs, and treatment UIC do not track population characteristics such as risk behaviors or identities associated with key populations. Therefore, countries are not able to track when an individual from a key population is enrolled in ART.

During in-country assessments, MSM interviewed were able to outline the services that they receive and also the services that they feel their community needs. The need for PrEP was explicitly stated in Tunisia and Morocco. In Sudan, MSM are also very aware of changes in the movement of MSM (around the country and from city to city) due to the criminalization of same-sex relationships.

There are a number of interventions for which no data are available for this assessment, including:

- PEP
- Behavioral interventions
- Community-based testing and counseling
- Linkage and enrollment in care
- ART drug interactions
● Hepatitis prevention and management of co-infections
● TB prevention and management of co-infection
● Mental health services and management of co-morbidities
● Nutrition services
● STI prevention, screening and treatment
● Anal cancer treatment

It is important to note that some of the above listed interventions are designed and have been confirmed as being implemented in many of the countries assessed, namely STI prevention, screening and treatment, linkage and enrollment in care, hepatitis and TB prevention, and behavioral interventions such as access to health education and information, education and communication (IEC) materials. However, data on the coverage of these interventions among MSM are not available. This is addressed further in the monitoring section of this report.
### Table 9. Summary of Service Coverage for MSM

Survey/IBBS (S); GAM (G); Programmatic Data (P)\(^{15}\); Other (O), (*) Indicates Desk Review Only

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Egypt*</th>
<th>Iran*</th>
<th>Jordan*</th>
<th>Lebanon*</th>
<th>Morocco</th>
<th>Sudan</th>
<th>Tunisia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive condom and lubricant programming(^{16})</td>
<td>N/A(^{17}) (S)(^{18})</td>
<td>N/A</td>
<td>N/A(^{19})</td>
<td>35(^{20}) (S)</td>
<td>50(^{21}) (S)</td>
<td>23.8(^{22}) (S)</td>
<td>50(^{23}) (S)</td>
</tr>
</tbody>
</table>

\(^{15}\) Where programmatic data are used, coverage values have been calculated using available programmatic coverage data as numerators, and nationally accepted PSEs as denominators

\(^{16}\) Percentage of men reporting using a condom the last time they had anal sex with a male partner

\(^{17}\) No national coverage figure. IBBS 2010 found 83.7% (Cairo) and 89.2% (Alexandria)

\(^{18}\) No national coverage estimate. IBBS 2010 found 83.7% (Cairo) and 89.2% (Alexandria)

\(^{19}\) No national coverage figure. IBBS 2013 found 15% in Amman and 92% in Irbid

\(^{20}\) IBBS 2015

\(^{21}\) IBBS 2015

\(^{22}\) IBBS 2015

\(^{23}\) IBBS 2014
## Assessment of HIV Service Packages for Key Populations

### Middle East & North Africa

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Egypt*</th>
<th>Iran*</th>
<th>Jordan*</th>
<th>Lebanon*</th>
<th>Morocco</th>
<th>Sudan</th>
<th>Tunisia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage of HIV prevention programs among MSM(^{24})</td>
<td>N/A(^{25,26})</td>
<td>N/A</td>
<td>N/A(^{27})</td>
<td>4%(^{28}) (P)</td>
<td>61%(^{29}) (S)</td>
<td>33.2%(^{30}) (P)</td>
<td>35.9%(^{31}) (P)</td>
</tr>
<tr>
<td>Knowledge of HIV status(^{32})</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>66%(^{33}) (S)</td>
<td>50%(^{34}) (S)</td>
<td>11.9%(^{35}) (S)</td>
<td>20%(^{36}) (S)</td>
</tr>
<tr>
<td>ART coverage</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>83.8%(^{37}) (S)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

---

\(^{24}\) Coverage with prevention package as defined in national design documents

\(^{25}\) No national coverage figure. IBBS 2010 found 80.3% (Cairo) and 50.6% (Alexandria)

\(^{26}\) No national coverage estimate. IBBS 2010 found 80.3% (Cairo) and 50.6% (Alexandria)

\(^{27}\) No national coverage figure. GF programmatic data 2016: Amman: 76% Irbid: 94%

\(^{28}\) GF PUDR 2016

\(^{29}\) IBBS 2015

\(^{30}\) GF PUDR 2014

\(^{31}\) GF PUDR 2014

\(^{32}\) Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results

\(^{33}\) IBBS 2015

\(^{34}\) IBBS 2015

\(^{35}\) IBBS 2015

\(^{36}\) IBBS 2014

\(^{37}\) IBBS 2015
**People who inject drugs**

Six out of the seven countries assessed included PWID as a key population in their national strategies and have designed specific services for this population; but very limited specific coverage data exist to confirm whether or not services are being implemented as designed. The Islamic Republic of Iran and Morocco are the only countries in the region with nationwide harm reduction strategies. Both needle–syringe programs and OST are in place in Lebanon, and needle-syringe programs also exist in Egypt, Jordan and Tunisia (UNAIDS, 2018).

Services that are available to PWID vary from country to country throughout the region. In Morocco, the National Harm Reduction Plan is being implemented as designed. There are several positive developments that have come from this focused approach to harm reduction, including 900 OST clients being served across five cities and multiple prisons at the end of 2015. Needle-syringe and OST programs are complemented by comprehensive services at addiction treatment centers, which include counseling and other psychosocial support from trained professionals. At the same time, the need for services outpaces supply, and Morocco is struggling to cover the PWID population. Waiting lists for OST and other services of addiction centers reach into the thousands.

The need to introduce scaled-up overdose prevention is a recurrent theme in FGD during country visits - the provision of naloxone to PWID is stated as a priority among FGD participants. Focus group discussion participants in Tunisia report that due to increasing heroin use, especially for PWID in prison, they fear more people will die due to overdose. It should be noted that despite the frequency with which this issue was raised during country visits, hard data on overdose are very scarce to nonexistent, highlighting a need for strengthened monitoring in this area.

Some countries report the need for services specifically targeting women PWID. During the in-country assessment for Morocco, female PWID FGD participants report that the current services being offered to PWID do not accommodate women’s specific needs, namely: childcare while receiving methadone; shelters for single mothers using drugs; pap smears; childbirth delivery; and, contraceptive services.

Geographic coverage of prevention services is also a significant issue in Tunisia. Focus group participants in Sfax confirm that they have never received any of the services designed in the package, such as free syringes, condoms, or any psychosocial support.

As is the case for MSM, population-specific data on ART coverage are not available for PWID. In Tunisia, it is noted that health care providers are often reluctant to offer ART to people who are actively using drugs out of concerns about adherence.

Co-morbidities including hepatitis, TB and STIs are well addressed in Morocco through addiction treatment centers, as outlined in the National Harm Reduction Program. There is some optimism in Tunisia that treatment for hepatitis C may soon be available. Elsewhere, there is no specific confirmation of interventions available for co-morbidities.
There are a number of interventions for which no data are available for this assessment, including:

- PrEP
- PEP
- Other harm reduction: Naloxone, overdose treatment and prevention
- Harm reduction for PWID: other drug dependence treatment
- ART-related prevention
- Behavioral interventions
- Community-based testing and counseling
- Linkage and enrollment in care
- ART drug interactions
- Hepatitis prevention and management of co-infections
- TB prevention and management of co-infections
- Mental health and management of co-morbidities
- Nutrition services
- STI prevention, screening and treatment

It is important to note that some of the above listed interventions are designed and were confirmed as being implemented in the countries assessed, namely STI prevention, screening and treatment, linkage and enrolment in care, hepatitis and TB prevention, and behavioral interventions such as access to health education and IEC materials. However, data on the coverage of these interventions among PWID are not available. This is addressed further in the Monitoring section of this report.
### Table 10. Summary of Service Coverage for PWID

Survey/IBBS (S); GAM (G); Programmatic Data (P)\(^{38}\); Other (O), (*) Indicates Desk Review Only

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Egypt*</th>
<th>Iran*</th>
<th>Jordan*</th>
<th>Lebanon*</th>
<th>Morocco</th>
<th>Sudan</th>
<th>Tunisia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive condom and lubricant programming(^{39})</td>
<td>N/A(^{40}) (Alexandria)(^{41})</td>
<td>41.8(^{42}) (S)</td>
<td>N/A</td>
<td>34.8(^{43})</td>
<td>28%(^{46}) (S)</td>
<td>N/A</td>
<td>78%(^{47}) (S)</td>
</tr>
</tbody>
</table>

---

\(^{38}\) Where programmatic data are used, coverage values have been calculated using available programmatic coverage data as numerators, and nationally accepted PSEs as denominators

\(^{39}\) Percentage of PWID using a condom during last sex

\(^{40}\) No national coverage figure. IBBS 2010 found 3.2% condom use with last non-commercial sex partner and 12.2% with commercial partners in Cairo; 2.6% condom use with last non-commercial sex partner and 25% with commercial partners in Alexandria

\(^{41}\) Use of condom during last sex with non-regular, non-commercial sexual partners

\(^{42}\) IBBS 2010

\(^{43}\) Condom use during last sex with female partner

\(^{44}\) Condom use during last sex with male partner

\(^{45}\) IBBS 2015

\(^{46}\) IBBS 2015

\(^{47}\) IBBS 2014
## Assessment of HIV Service Packages for Key Populations
### Middle East & North Africa

<table>
<thead>
<tr>
<th>Service Package</th>
<th>Middle East</th>
<th>North Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coverage of HIV prevention programs among PWID</strong></td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>16.1% (S)48</td>
<td>4%59 (P)</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>33%10 (S)</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>29.3%51 (P)</td>
<td></td>
</tr>
<tr>
<td><strong>Harm reduction - NSP</strong></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>63 per person per year 52 (P)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>80 per PWID per year54 (G)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Harm reduction - Safe injection practices55</strong></td>
<td>75%56 (S)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>81.6%57 (G)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>80%58 (S)</td>
<td></td>
</tr>
</tbody>
</table>

---

48 BSS 2010  
49 GF PUDR 2016  
50 IBBS 2015  
51 GF PUDR 2016  
52 GF Performance Framework 2014  
53 GARPR 2013 states that 71,527 syringes were distributed in a 2-year period, but there is no PSE for PWID in Jordan  
54 GARPR 2015  
55 Percentage of PWID who reported using sterile injecting equipment the last time they injected  
56 IBBS 2010  
57 GARPR 2014  
58 IBBS 2015  
59 IBBS 2015  
60 IBBS 2014
<table>
<thead>
<tr>
<th>Harm reduction - OST&lt;sup&gt;61&lt;/sup&gt;</th>
<th>N/A</th>
<th>37%&lt;sup&gt;62&lt;/sup&gt; (O)</th>
<th>N/A</th>
<th>N/A</th>
<th>28.8%&lt;sup&gt;63&lt;/sup&gt; (O)</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of HIV status&lt;sup&gt;64&lt;/sup&gt;</td>
<td>N/A&lt;sup&gt;65&lt;/sup&gt;</td>
<td>6.2%&lt;sup&gt;66&lt;/sup&gt; (P)</td>
<td>N/A</td>
<td>82.3%&lt;sup&gt;67&lt;/sup&gt; (S)</td>
<td>23.2%&lt;sup&gt;68&lt;/sup&gt; (S)</td>
<td>N/A</td>
<td>18.2%&lt;sup&gt;69&lt;/sup&gt; (S)</td>
</tr>
<tr>
<td>ART coverage</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Sex Workers

Services provided to FSW throughout the region seem to be in line with the packages that each country has designed, though coverage achievements vary. Coverage with HIV prevention services is high in Jordan, which reports 76% in Amman and 94% in Irbid, but lower elsewhere, with only 12.0% of surveyed FSW in Iran and 12.4% in Sudan report coverage with prevention programming. The percentage of FSW reporting using a condom during their last sex with their most recent client also ranges from 98% (with non-regular clients) in Lebanon to as low as 28.2% in Sudan.

HIV testing and counseling is reported to be available and included in the package of HIV services that this population receives, ranging from 12% coverage in Iran to 94% in Irbid, Jordan. Neither of these countries is included in in-country assessments, so it is not possible to gain more information about what might be the cause of the extreme range in coverage of HTC services. In Morocco, FGD participants report that community-based testing is conducted in partnership with public primary healthcare units, where FSW are invited by peer educators to take an HIV test. According to survey data, the percentage of FSW who were tested for HIV in the past 12 months and knew their result was 40.1%. It is also reported that HIV testing is also accompanied by STI testing for FSW in Morocco.

In countries that were visited for this assessment, FGD participants express the need for a scale-up of reproductive services, specifically abortion and post-abortion care, as well as pap smears. In Morocco, for example, they also describe difficulties in obtaining STI tests, treatment and care. Similarly, organizations in Tunisia that target sex workers only offer STI screening free of charge, while a full package of reproductive health services is available for a fee.

In one promising practice in Morocco, organizations that serve FSW are also working to connect clients with related services, such as legal advice, psychosocial support, protection against violence, and literacy programs. These services are seen as complementary to the prescribed package and may also provide additional incentive for FSW to access HIV services. As is the case for populations previously discussed, population-specific data on ART coverage are not available for SW.

No data are available on the provision of services for male or transgender sex workers.

There are a number of interventions for which no data are available for this assessment, including:

- PrEP
- PEP
- ART-related prevention
- Behavioral interventions
- Community-based testing and counseling
- Linkage and enrollment in care
- ART drug interactions
- Hepatitis prevention and management of co-infections
Assessment of HIV Service Packages for Key Populations
Middle East & North Africa

- TB prevention and management of co-infections
- Mental health and management of co-morbidities
- Nutrition services
- STI prevention, screening and treatment
- Contraceptive services
- Safe abortion and post-abortion care
- ART coverage
- PMTCT
- Cervical cancer screening and treatment

It is important to note that some of the above listed interventions are designed and confirmed as being implemented in many of the countries assessed, namely STI prevention, screening and treatment, linkage and enrollment in care, hepatitis and TB prevention, and behavioral interventions such as access to health education and IEC materials. However, data on the coverage of these interventions among FSW are not available. This is addressed further in the Monitoring section of this report.
### Table 11. Summary of Service Coverage for SW
Survey/IBBS (S); GAM (G); Programmatic Data (P)\(^70\); Other (O); (*) Indicates Desk Review Only

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Egypt*</th>
<th>Iran*</th>
<th>Jordan*</th>
<th>Lebanon*</th>
<th>Morocco</th>
<th>Sudan</th>
<th>Tunisia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive condom and lubricant programming(^71)</td>
<td>N/A(^72)</td>
<td>59.1(^{73}) (S)</td>
<td>N/A(^74)</td>
<td>N/A</td>
<td>62.7(^{75}) (S)</td>
<td>28.2(^{76}) (S)</td>
<td>57.5(^{77}) (S)</td>
</tr>
<tr>
<td>Coverage of HIV prevention</td>
<td>N/A</td>
<td>12(^{79}) (P)</td>
<td>N/A(^80)</td>
<td>N/A</td>
<td>45(^{81}) (S)</td>
<td>12.4(^{82}) (S)</td>
<td>35.8(^{83}) (P)</td>
</tr>
</tbody>
</table>

---

70 Where programmatic data are used, coverage values have been calculated using available programmatic coverage data as numerators, and nationally accepted PSE as denominators

71 Percentage of sex workers reporting the use of a condom with their most recent client

72 No national coverage figure. IBBS 2014 found 33.3% condom use at last transactional sex among female SW in Cairo, and 92.4% among male SW in Cairo

73 BSS 2015

74 No national coverage figure. GARPR 2013 reported 80% Amman and 67% Irbid

75 IBBS 2016

76 IBBS 2015

77 IBBS 2014

78 Performance Framework 2015

79 No national coverage figure. GARPR 2013 reported 76% Amman and 94% Irbid

80 IBBS 2016

81 IBBS 2015

82 GF PUDR 2016
<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
<th>Egypt*</th>
<th>Iran*</th>
<th>Jordan*</th>
<th>Lebanon*</th>
<th>Morocco</th>
<th>Sudan</th>
<th>Tunisia</th>
</tr>
</thead>
<tbody>
<tr>
<td>programs among FSW(^{78})</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge of HIV status(^{84})</td>
<td>N/A</td>
<td>7.5(^{85}) (P)</td>
<td>N/A (^{86})</td>
<td>N/A</td>
<td>40.1(^{87}) (S)</td>
<td>23.1(^{88}) (P)</td>
<td>23.2(^{89}) (P)</td>
</tr>
<tr>
<td>ART coverage</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

\(^{78}\) Coverage with prevention package as defined in national design documents
\(^{84}\) Percentage of FSW that have received an HIV test in the past 12 months and know their results
\(^{85}\) Performance Framework 2015
\(^{86}\) No national coverage figure. GARPR 2013 reported 672 FSW were tested for HIV that year
\(^{87}\) IBBS 2016
\(^{88}\) IBBS 2015
\(^{89}\) IBBS 2014
**Prisoners**

The only data available among the assessed countries are for Iran, where IBBS data reports 50% of prisoners using a condom during last sex, 6.7% coverage with HIV prevention services, and 6.7% coverage of prisoners with HTC. It is concerning that even in a country from which data are available, service coverage is below 10%, and reported risk behaviors are so high.

In Tunisia, while coverage data are not available, information about the HIV services that are provided in prison was obtained during the field visit. It was confirmed that there are no HIV prevention services provided in prisons; however, prisoners who are living with HIV are sent to one specific prison in Tunisia, where they can be connected with an infectious disease physician and receive ART and other support. Further, PLHIV are provided with TB diagnosis and treatment while in prison.

**Transgender People**

There are no program access data available for transgender people.
**Analysis: Are packages being implemented as designed?**

In general, there is evidence that elements of the service packages set out in the country designs are being implemented, but in most countries this is only in a limited number of settings and not at a scale that will ensure good progress against 90-90-90 targets.

Though many interventions are not captured in regular reporting data, in-country assessments confirm that services are available at some level. Again, this should be seen as a success. Further, it is promising that newer interventions, such as PrEP for MSM (in Morocco), are making their way into service provision despite not being included in the designed package. What is not clear in most cases is the percentage of the key population that actually receives these services or any details on the quality of services. In the three countries assessed with field visits, data are only available regarding coverage of condom and lubricant programming, coverage of overall HIV service packages and coverage of HTC. Focus group discussions with selected key populations in each country show that while overall satisfaction with services is expressed, there are wide geographic disparities in the services that are available as well as significant barriers (e.g. enabling environment, economic) to key populations obtaining the services that are available.

Quality of services is also a multi-faceted issue that is not captured in most systematic data. The use of outcome indicators for proxy, such as condom use at last sex or use of a clean needle and syringe at last injection, may give some indication of service quality; however, these data rely on self-reported behaviors in surveys (which may have serious sampling problems, as discussed in the next section) and may not accurately reflect real outcomes.

The lack of information about data regarding coverage of HIV services for both prisoners and TG in the countries selected for assessment in the MENA region indicates that there is significant room for growth in addressing the specific needs of these populations and in implementing services to target these populations. The lack of ability to analyze coverage of services among prisoners and TG should not be interpreted as a lack of importance of service provision for this population; it should be an urgent call to improve the design, delivery and monitoring of services for this population at risk.

Similarly, the lack of data about service provision for male sex workers and women who inject drugs raises the question of whether any services are available for these populations.

**Recommendations: Implementation of Service Packages for Key Populations**

1. There have been significant developments in key population outreach models in parts of the region and in other regions: these are centered on community HIV testing, a sharper focus on increasing knowledge of status and linkage to treatment and care for PLHIV, and onward community-level case management. These need to be adapted for use in MENA. E-outreach is also an expanding service provision area in many countries and needs to be adapted for use in this region.
2. Reach and coverage levels of harm reduction services for PWID, particularly needle/syringe and OST services, are dangerously low in most countries in the region. Particular attention to the expansion of services needs to be paid to sub-populations of PWID (such as women, refugees, migrants and prisoners).

3. Attention to STI prevention, diagnosis and treatment seems to be lacking despite high rates of unprotected sex. Innovative models for STI prevention and care service provision (including HIV testing and onward referral for PLHIV) need to be explored and implemented.

4. Differentiated care models have also been developed in other regions, which make best use of available resources to ensure that those most in need of support are prioritized. These need to be considered in MENA.

5. NGOs in other regions are playing a more significant role in reaching harder-to-reach sub-populations with prevention and care services such as community HIV testing, ART provision, STI services and adherence support. These models need to be explored and adapted to countries in the region.

6. There are significant access barriers to services for key populations in this region. The recent Baseline Assessment on human rights-related barriers carried out by Global Fund in Tunisia and the upcoming development of a five-year strategy to reduce these barriers provide a good model for assessments in other countries in the region.

7. Greater attention to issues of gender needs to guide service development is needed – the impact of HIV on women in the region and the particular barriers they experience to accessing health services are poorly understood. Strategies to improve men’s health-protecting and health-seeking behaviors and work on the control that men exert over women’s health both need to be developed and implemented.

8. Service access for young people also needs particular attention, especially for street or out-of-school children. This includes attention to policies about age of consent for minors and the development of youth-friendly services.
**PART IV: MONITORING SYSTEMS**

The process of monitoring the implementation of packages of services against their design is multi-faceted.

There are significant problems related to population size estimations for most key populations in most countries in the region. While most countries are able now to report programmatic data on coverage with a defined set of prevention services for the services funded by Global Fund, the defined packages vary from country to country. There also appears to be limited data synthesis and analysis in many countries, as data going from service to donors is not always reported to national health departments or national AIDS programs and data from range of services is rarely brought together to assist in future planning and service modification.

There is also a scarcity of data on service quality or on health outcomes for key populations.

There appears to be significant problems with the design and/or implementation of IBBS studies in the region. The differences between IBBS results and programmatic data findings can be very large (see Tables 10-12). Given what has been reported below on monitoring systems, some of these problems may be attributable to challenges in program reporting, but it seems likely that many IBBS studies continue to have sampling problems that over-represent the behavior or experiences of people who are regular clients of HIV prevention agencies while failing to capture the behavior or experiences of those who are not reached by services.

As part of this assessment process, there was a requirement to rate the systems used to monitor key population service packages. This was only possible in the three countries where field visits were conducted. Ratings in these countries show that Morocco has a national UIC, which allows for de-duplication, with some limitations, Tunisia is building a system and Sudan has no UIC in place.

**Table 12. UIC System Scores by Country**

<table>
<thead>
<tr>
<th>Country</th>
<th>Score</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morocco</td>
<td>3</td>
<td>The UIC in place is limited to prevention services.</td>
</tr>
</tbody>
</table>

---

90 Score has been assigned based on available information from country assessments.
Sudan & Tunisia

<table>
<thead>
<tr>
<th>Country</th>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudan</td>
<td>0</td>
<td>In-country assessment confirmed that there is no UIC in place for any of the key populations.</td>
</tr>
<tr>
<td>Tunisia</td>
<td>2</td>
<td>The same UIC is used among all NGOs, which has been set up by the PR of Global Fund funding; however, the UIC is not used in the case of clients who go directly to HTC centers, and the UIC is not used in care and treatment sites.</td>
</tr>
</tbody>
</table>

*For countries that only received a desk review, there is not enough information available to adequately and reliably assess the existence and use of a UIC. Therefore, details are not included here.*

The implementation of a national UIC has assisted greatly to track use of services by individuals and to assess reach and coverage in countries with concentrated epidemics and high levels of stigma and discrimination. Just as the PSE is the important denominator, the UIC leads to the construction of the national coverage numerator. Countries can have excellent programs but, without a way to accurately report de-duplicated client numbers, no statements about coverage of the programs can be made with any certainty. It should be noted that the UIC also allows programs to distinguish between unique individuals (clients) and visits (occasions of service), a confusion that has plagued key population programs for many years. While Morocco and Tunisia are receiving at least partial benefits from this system, Sudan has been unable to formulate an accurate numerator for coverage without a UIC in place. In this region, as in many other regions, the UIC is only in place for prevention services and does not provide information on HIV treatment and care service access and health outcomes for key populations. This makes it difficult to accurately track key populations across the prevention to treatment cascade.

Morocco appears to have the strongest monitoring and evaluation system of the countries that included an in-country assessment. The monitoring system consists of several levels. The first (operational) level is characterized by its main role of developing and documenting the activities carried out in the field. It is made up of health centers, NGO local offices, field workers, and prevention or specific care centers such as risk reduction centers. The service provider carries out the collection of technical and programmatic data and any other relevant information. The second level consists of the provincial administrative units and the regional health units. The provincial delegation consolidates information from the province for all operational structures and communicates the provincial data to the governmental regional health unit. At the regional level, the information is centralized and provided to the National AIDS Program M&E Unit. As part of the decentralization of the national HIV response, local health units work in close collaboration with Ministries’ regional representatives and NGOs involved in the response in the regions.

**Analysis: Do we really have enough information to determine how well packages are implemented?**

Among the three countries that included an in-country assessment, the state of M&E systems for HIV services targeting key populations varies greatly. In Morocco and Tunisia, it is more realistic that we would be able to determine how well packages are being implemented because of their use of a UIC. However, it is important to note that, like the other regions included in this assessment, none of the
current monitoring systems in place in MENA countries allow them to track service use and health outcomes for key populations across the prevention to care continuum.

Of note, information on the implementation of service packages for prisoners and TG is largely missing, due to the fact that countries are not including these populations in their packages of services and are not disaggregating their data according to these populations.

**RECOMMENDATIONS: MONITORING OF SERVICE PACKAGES FOR KEY POPULATIONS**

1. Most countries in the region would benefit from having more accurate and up-to-date key population size estimates to assist them in determining reach and coverage levels and to track progress against 90-90-90 targets for key populations.
2. There is an urgent need for more reliable data on coverage of services amongst all key populations. This can be achieved by establishing consistent national UIC systems that extend to HIV treatment and care services and by examining the successful national HIV data system reforms taking place in countries like Georgia, Pakistan, the Philippines and Papua New Guinea. Whilst each of these has its limitations, there are valuable lessons here for MENA countries.
3. The quality of IBBS studies needs to be improved in line with WHO Guidance (WHO, 2017).
4. Prison systems in most of the countries assessed not only need to design and implement services for their prisoners, but they also need to set up M&E systems to be able to determine how well the interventions are being implemented.
5. Feedback loops, recommended in the Implementation section, should be extended throughout the reporting system so that quality problems are quickly reported to the level at which action can be taken to remedy the situation. In the case of products such as syringes and condoms that are usually procured nationally, this may mean that rapid communication is enabled from the affected clients to the PR or the Ministry of Health entity responsible for procurement.
PART V: FINANCING

Throughout the MENA region, many countries are phasing out of eligibility for HIV funding from Global Fund. As a result, there is a focus on transition and sustainability of responses, particularly on mobilizing increased funds from national and local government sources in order to maintain current funding levels. The bars in Figure 4 below present 2017 data from UNAIDS on the share of domestic funding versus external donor support for HIV responses in the region. At the time, red dots in this figure indicate the level of funding needed to reach UNAIDS Fast-Track targets; without dramatic changes, resource mobilization in the region is far off-track to achieve targets.

Figure 4. HIV Resource Availability in Middle East and North Africa (UNAIDS 2017)

![Graph showing HIV resource availability by source, 2006-2016, and projected resource needs by 2020, Middle East and North Africa.](image)

While the picture presented above is bleak, there is an even more concerning situation for key populations: in many countries, the share of domestic funds that are allocated to key populations are dwarfed by spending on other budget lines including ART and laboratory services as well as medical personnel. While these items are necessary for key populations, they are not sufficient without targeted funding for prevention, testing and linkage to care.

As a promising example, Tunisia has specific budget allocations in its most recent National Strategic Plan (2015-2018) for activities for ‘vulnerable populations’ and also specifically for PWID and SW.

Continuation of funding from international donors is of concern to some countries in the MENA region. For example, Morocco’s National Strategic Plan 2017-2021 mentions that the sustainability of the national response requires a constant commitment from the state and a continuous integration of the expenditure of essential services in the national budget. The different stakeholders will need to work
to ensure political support and greater mobilization of funds at the national level and to gradually increase the health insurance coverage of PLHIV under the health insurance system.

**Analysis: Are countries prepared to adequately finance packages of services for key populations?**

It was beyond the scope of this assessment process to conduct an in-depth financial analysis of costing, allocation and expenditure related to packages of services for key populations in MENA. However, what is found is a heavy reliance on Global Fund to support key population programming in all countries. Cost information is a particularly critical input into the process of setting priorities and efficient allocation of resources, and given the urgency of scale-up to meet Fast-Track targets, countries must urgently fortify their expenditure analysis and budget development processes to be sure that sufficient resources are available to implement the designed packages of services as intended.

**Limitations**

There were several limitations in conducting this assessment process, including during the initial desk review portion of country assessments. It is important to note that four of the seven countries within the MENA region were limited to ‘desk review only’, meaning that APMG Health did not conduct an in-country assessment to collect data and information that could disprove or verify that information found in the initial desk review. Desk review data from these four countries has been included throughout this review.

The desk review process was limited by contractual time allowed (an average of two consultant days was allotted to each review) and by the scope of the review: sources reviewed were limited to those provided by Global Fund Country Teams in the last quarter of 2017.

The list of documents used for conducting these assessments has been considerably expanded for those countries selected for an in-country assessment. To the degree possible, data were expanded upon and verified by follow-up country visits; however, this process was also subject to time restrictions. As such, only two sites and two populations were selected for focus in each country. It is important to note that because of this, country assessments may not have been representative of the national situation and reports only speak to the data available in the regions, districts and cities that were visited or within other reports reviewed. This has therefore limited the amount of data and information about the other key populations that were not selected for in-country data collection. Within the regional report for the MENA region, this presents a particular limitation for the TG and prisoner key populations, which were not selected as key populations of focus in any of the three country visits.
Data was collected in-country by only one international and one local consultant, which limited the amount of site visits, key informant interviews and FGD consultants were able to conduct while in-country.

During the in-country data collection, FGD participants were identified by programs that were being visited. Therefore, respondents may not have been representatives of key populations more broadly. Focus group participants could have experienced peer pressure or pressure from program staff to give biased answers to the moderator’s questions. Focus group discussions also seemed to be made up of program participants who sought services fairly regularly or were even peer educators themselves. Therefore, the viewpoints of those individuals from key populations who do not receive services or face more barriers in receiving services are not represented. Focus group discussions were often conducted in local languages, and therefore, at times, were translated for the international consultant. One limitation of this is that only some of the information that participants were giving was actually recorded and presented in the country report.

Because only seven countries were selected for assessment from the MENA region, and only three of those countries had an in-country assessment, this report cannot be considered a regional assessment, and rather, an assessment of a limited selection of countries within the region.
REFERENCES

DOCUMENTS


**IBBS & KP STUDY REFERENCES**


## Annex 1: Summary Table, WHO Consolidated Guidelines

<table>
<thead>
<tr>
<th>Health Sector Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HIV prevention (condoms, lubricant, PrEP, PEP, VMMC)</td>
</tr>
<tr>
<td>2. Harm reduction interventions for substance use, in particular NSP, OST and naloxone for overdose management</td>
</tr>
<tr>
<td>3. HIV testing and counselling</td>
</tr>
<tr>
<td>4. HIV treatment and care</td>
</tr>
<tr>
<td>5. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, TB and mental health conditions</td>
</tr>
<tr>
<td>6. Sexual and reproductive health interventions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Critical enablers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Supportive legislation, policy and financial commitment, including decriminalization of behaviors of key populations</td>
</tr>
<tr>
<td>2. Addressing stigma and discrimination</td>
</tr>
<tr>
<td>3. Accessible, available and acceptable health services</td>
</tr>
<tr>
<td>4. Community empowerment</td>
</tr>
<tr>
<td>5. Addressing violence against people from key populations</td>
</tr>
</tbody>
</table>