HIV AND OUTREACH PROGRAMMES WITH MEN WHO HAVE SEX WITH MEN IN THE MIDDLE EAST AND NORTH AFRICA

FROM A PROCESS OF RAISING AWARENESS TO A PROCESS OF COMMITMENT

Contents

Abbreviations and acronyms

AIDS	acquired immunodeficiency syndrome
ALCS	Association de Lutte Contre le sida
ANIS	Association de lutte contre les IST/sida et de Promotion de la Santé
GPS	global positioning system
HIV	human immunodeficiency virus
ICASO	International Council of AIDS Service Organizations
M&E	monitoring and evaluation
MENA	Middle East and North Africa
MSM	men who have sex with men
NGO	nongovernmental organization
OPALS	Pan African AIDS Organization
UNAIDS	Joint United Nations Programme on HIV/AIDS
STI	sexually transmitted infection

Introduction

"*HIV and outreach programmes with men who have sex with men in the Middle East and North Africa: from a process of raising aware-ness to a process of commitment*" describes in four modules the whole cycle of a national outreach programme aimed at engaging men who have sex with men (MSM) .

- **MODULE 1:** Situation analysis
- **MODULE 2:** Outreach programme: from reflection to conception
- **MODULE 3:** The outreach approach
- **MODULE 4:** Monitoring the outreach programme

The objective of this handbook is to provide countries that are currently implementing MSM programmes with additional tools to improve these programmes. It also provides other countries willing to initiate MSM programmes with sufficient elements to design them.

Although similar documents have been designed for Europe, sub-Saharan Africa, Canada and Asia, a MENA-specific document was needed, because this region's different cultures and traditions require the imple-mentation of new approaches.

This handbook on outreach programmes complements the recently published WHO Guidelines that focus on good practice recommendations in the area of prevention and treatment of HIV and other STIs among MSM and transgender people.

The practical handbook is timely for the MENA region, where sexuality and sexually transmitted infections (STIs) are sensitive issues that are rarely discussed, and homo-sexuality and transsexuality remain taboo subjects. This applies to both the public sphere, which sometimes severely punishes such sexual orientation, and also to the private sphere, where the weight of family and traditional images of female and male gender prevail.

Such a situation makes the access of MSM to social and health services virtually impossible despite the pressing need to act for these key populations who are at higher risk of HIV infection. Indeed, the increasing number of bio-behavioural surveys in the MENA region shows that the AIDS epidemic is concentrated within key populations at higher risk – notably MSM. The same surveys reveal that MSM regularly change sexual partners, and may be drug users or sex workers while their knowledge of STIs remains limited.

This handbook has been designed specifically for the MENA region where MSM program-ming in many countries is in its nascent stages. Initiatives that could work within this region may have some applications in similar environments. The handbook focuses on get-ting crucial services to individual men who have sex with men who currently do not have access. As programmes with MSM grow in the region, more elements that work within the environment can be added such as com-munity empowerment, advocacy and specific approaches for subpopulations of MSM.

The handbook is the result of extensive expe-rience in several MENA countries over the last decade. It provides readers with useful tips that help effectively reach these key populations, starting with a good knowledge of MSM communities and their sexual

practices, and gradually building up relationships of trust through continuous dialogue.

Although programmes vary according to key populations and subpopulations, the handbook emphasizes the importance of their integration into national strategic AIDS plans. Programmes should also be coordinated by a multisectoral or interdisciplinary body, to ensure the country's existing response strategies are adhered to and that monitoring and adjustments are adequate.

The handbook also puts emphasis on the good knowledge of the environment of MSM communities. Indeed, an essential prerequisite in designing effective programmes to engage MSM populations is to carry out a comprehensive analysis of the political, legal, cultural, social and health contexts in a given country. This analysis includes on-going mapping of areas that are frequented by MSM populations and estimating population size to best determine the areas of programme activities.

Different outreach models in the MENA region provide a wide range of services (information, education and communication; delivery of prevention kits; medical, legal and psychological consultations; HIV testing and counselling, etc). Each has advantages and disadvantages that are detailed in this handbook.

Throughout this handbook, two fictional characters, Adel and Fadel, are presented to illustrate the necessary steps to develop an outreach programme. Adel and Fadel are outreach workers for an MSM HIV prevention programme. Fadel, whose life story is presented after the introduction, has more

experience which he is trying to share with Adel through the various tips provided throughout the document.

The handbook is for all people involved in the design, implementation, monitoring and evaluation of programmes for MSM in the MENA region:

- The National AIDS Programme
- Partners of the National AIDS Programme (donors, UN system, Non-governmental organizations)
- Programme coordinators
- Outreach workers

Modules 1 and 2 were designed for National AIDS Programmes and partners, while Modules 3 and 4 were designed for programme coordinators and outreach workers.

In view of the topic's complexity and the need to tailor responses to the constantly evolving situation, this handbook will be updated on a regular basis based on new experiences generated from fieldwork in the MENA region.

The Story of Fadel

This story highlights the path of an outreach worker, Fadel. The story is presented in the form of a comic strip.

VIII

During the training the interactions went well.
I observed a lot and I also learned at the same time!
And I saw that this programme could be helpful for me,
as well as for my community.

The training was about the HIV epidemiological
situation of our country and the existing
programme.

I learned about the transmission of the virus,
prevention, HIV testing, treatment, care and
support.

And these training sessions were very
interactive, which made them really interesting!

The outreach workers informed
us that several additional trainings
were being organized, and
that we were free to attend.

I decided to attend, because
the first training had really
convinced me.

During the third training, they asked me
if I wanted to be an outreach worker.
I needed to think, because this role will be a big
commitment. I needed to think about what such a
work opportunity would bring me.

But first of all, I had to think about what
this commitment would mean in my life.

By committing, I had to apply the
message to my own life before I could
communicate it to others.

And this was not easy at the beginning!

HIV AND OUTREACH PROGRAMMES WITH MEN WHO HAVE SEX WITH MEN IN THE MIDDLE EAST AND NORTH AFRICA

MODULE 1/4
SITUATION ANALYSIS

1 – Situation analysis

This module covers the first step needed to design an outreach programme for men who have sex with men (MSM). This is the situation analysis which includes:

- Policy analysis (health, social, cultural, religious and legal contexts);
- Population analysis, especially subpopulations of MSM.

This module has been designed for National AIDS Programmes and partners of National AIDS Programmes (donors, UN system, Non-governmental organizations).

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1.1 Policy analysis

HEALTH CONTEXT

Assessing the health context requires developing detailed maps of the existing health structures. Then, the services that health structures offer should be identified, as well as the cost (if any) of accessing these services, their resources and geographical distribution. The ability of MSM to access these services should also be specified.

The analysis of the health context should be detailed, comprehensive, and integrated into the process of national AIDS strategic planning. However, it is possible to perform a rapid assessment, which will provide preliminary answers that are necessary to strengthen the programmes.

SOCIAL, CULTURAL AND RELIGIOUS CONTEXTS

In the MENA region, sexual relations between men are prohibited. MSM are often victims of psychological pressure, physical punishment and violations of human rights. The question of sexual identity struggles with taboo, desire, punishment, and the freedom to choose sexual practices and partners.

In MENA, this phenomenon is partly linked to the importance of the family and the wider community as opposed to the individual. Whether institutionalized or implicit, the laws and norms that govern the population can be influenced by the Holy Books. Marriage, procreation and filiation are fundamental elements that give status to the

individual and ensure the maintenance of a social cell. Consequently, sex between men may not be tolerated by society. Because they are forced to meet these standards, some MSM may not reveal or admit their true sexual identity. Many MSM thus marry, which sometimes puts their wives at risk of being infected with HIV or another STI.

The issue of sexual identity has been highlighted through various studies. The quest for identity remains painful for some MSM. Opening a debate on this issue is unavoidable. However, in this approach, one should focus on the importance of sexual behaviour in the context of the HIV epidemic.

Are all MSM homosexual?

Good question! It is not so easy to answer. Sexual behaviour does not define sexual identity.

In MENA countries, some men have sexual relations with men as well as with women. They do not consider themselves homosexual or bisexual, but heterosexual. Men who identify themselves in this way are found most often among insertive partners in sexual relationships.

LEGAL CONTEXT

It is necessary to analyze the legal context within which MSM live, since programme feasibility always depends on a country's politico-legal framework. Understanding this framework is an important part of the situation analysis. Thorough comprehension of

the legal framework allows an organization to prepare relevant arguments for advocacy.

It is also important to obtain feedback from MSM communities about law enforcement and police behaviour. This is a crucial step in the process to better understand how laws are being implemented.

Creating new laws in favour of a population in an environment that is not ready for the implementation of these laws may not be sufficient. However, reviewing existing laws can help identify the gaps related to vagueness and misinterpretation of some laws that lead to discrimination in their enforcement against MSM.

Legal contexts for MSM in MENA countries [1]

ALGERIA	**Penal Code (Ordinance N°66-156 of 8 June 1966)** **Article 338:** "Anyone guilty of a homosexual act is punishable with imprisonment of between 2 months and two years, and with a fine of 500 to 2000 Algerian Dinars."

AFGHANISTAN	**Penal Code, 1976**
	 CHAPTER EIGHT: Adultery, Pederasty, and Violations of Honour
	 Article 427:
	 "(1) A person who commits adultery or pederasty shall be sentenced to long imprisonment.
	 (2) In one of the following cases commitment of the acts, specified above, is considered to be aggravating conditions:
	     a. In the case where the person against whom the crime has been committed is not yet eighteen years old.
	     b. …"

BAHRAIN [2]	The legal status of homosexual acts are unclear in Bahrain. Sodomy was illegal in Bahrain between 1955 and 1976. The new Penal Code of March 1976 technically permitted private, non-commercial acts of sodomy between consenting adults over 21 years of age. However, the legal system is influenced by traditional Islamic morality that gives law enforcement agents and judges broad discretionary powers to issue fines, jail time and, for visitors, deportation for engaging in activities deemed to be immoral. The offender can be sentenced to up to ten years in prison, if the victim is at least 16 years old. When the victim is under 16 years of age, death is the punishment (Article 345 of Bahrain Penal Code).
DJIBOUTI	**Articles 347 to 352 of the 1995 Penal Code:** Criminalization of "impudent acts" under the criminal section of "public immorality".
EGYPT	The Egyptian law does not criminalize sex between men. However, the laws below are used to arrest men who have sex with men. **Law N°10 of 1961 on "Combating prostitution, incitement and its encouragement":** **Article 9:** "Anyone who habitually engages in debauchery or prostitution is liable to a penalty of three months to three years imprisonment and/or a fine of LE 25–300."

[1] **Itaborahy, L.** *State-sponsored homophobia: a world survey of laws prohibiting same sex activity between consenting adults.* International Lesbian, Gay Bisexual Trans and Intersex Association, 2012. *http://old.ilga.org/Statehomophobia/ILGA_State_Sponsored_Homophobia_2012.pdf*

[2] The source of information is Wikipedia, the free encyclopedia. *http://en.wikipedia.org/wiki/LGBT_rights_in_Bahrain*

IRAN	**Islamic Penal Code of Iran of 1991, Articles 108 until 138 (which detail homosexuality and the associated penalties):** Homosexual relations taking place between two consenting adults in private is considered a crime. The maximum penalty for this crime is death.
JORDAN	No law exists; homosexuality is not illegal as such, but homosexuals are victims of violence.
KUWAIT	**Penal Code, Law N°. 16 of June 2, 1960, as amended in 1976** **Article 193:** "Consensual intercourse between men of full age (from the age of 21) shall be punishable with a term of imprisonment of up to seven years." Such relations with a man under 21 years of age are criminalised by article 192.
LEBANON	**Penal Code 1943, modified in 2003** **Article 534:** "Sexual intercourse against nature is punishable by imprisonment for a period of 1 month to 1 year and a fine ranging from 200 000 to 1 million Lebanese pounds."
LIBYA	**Penal Code of 1953 – "Offense against freedom, honour and morality"** **Article 408: Lewd acts** (1) Any individual who commits lewd acts with a person in accordance with one of the methods specified in the preceding article (*article 407 on sexual assault and rape*) shall be punished with a period of imprisonment of five years at most. (2) This punishment shall also be imposed if the act has been committed in agreement with a person who was not yet 14 years of age or with a person who did not resist on account of a mental or physical disability. If the victim was between the ages of 14 and 18, the term of imprisonment shall be at least one year. (3) If the offender belongs to one of the groups of offenders specified in paragraphs (2) and (3) of Article 407, a term of imprisonment of at least seven years shall be imposed. (4) If an individual commits a lewd act with another person with their agreement (outside marriage), both parties shall be punished with a term of imprisonment.
MOROCCO	**Penal Code of November 26, 1962** **Article 489:** "Any person who commits lewd or unnatural acts with an individual of the same sex shall be punished with a term of imprisonment of between six months and three years, and an additional fine of 120 to 1000 Dirhams, unless the facts of the case constitute aggravating circumstances."
OCCUPIED PALESTINIAN TERRITORY	**The British Mandate Criminal Code Ordinance, No. 74 of 1936 is in force in Gaza.** Section 152(2) of the Code criminalizes sexual acts between men with a penalty of up to 10 years. In the West Bank, including East Jerusalem, the Jordanian Penal Code of 1951, largely modified in 1960 is in force, having no prohibition on sexual acts between persons of the same sex.
OMAN	**Penal Code of 1963** **Article 223:** "Anyone who commits erotic acts with a person of the same sex shall be sentenced to imprisonment from six months to three years. The suspects of homosexual intercourse shall be prosecuted without a prior complaint, if the act results in a public scandal."
PAKISTAN	**Penal Code of 1860, Section 377 "Unnatural offences":** "Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with imprisonment for life, or with imprisonment of either description for a term which shall not be less than two years nor more than ten years, and shall also be liable to a fine."

QATAR	**Penal Code currently in effect, Act N°11 of 2004:** Sexual acts with a male are prohibited by article 284. The penalty is up to seven years imprisonment. Along with the civil Penal Code, Islamic Sharia law is also in force in Qatar, although only applicable to Muslims. The offence of "Zina" (adultery) makes any sexual act by a married person outside of marriage punishable by death, while sexual acts by non-married persons are punished by flogging – both are offences whether they were heterosexual or homosexual.
SAUDI ARABIA	Saudi Arabian Penal Law is not codified. The country's courts apply the strict Sharia law (Islamic law), which criminalizes all sexual acts outside of marriage, including homosexual acts. For a married man, the penalty is death by stoning. For a single person, the penalty is public flogging and banishment of one year.
SOMALIA	**Penal Code decree N°5, of 1962, came into force on 3 April 1964:** **Article 398, paragraph 4:** "Definition of carnal intercourse: penetration by the male sexual organ." **Article 409: "Homosexuality":** "He who has carnal intercourse with a person of the same sex shall be punished if the act does not constitute a more serious crime, by imprisonment for 3 months to 3 years. Where the act committed is an act of lust which is different from carnal intercourse, the penalty shall be reduced by one-third." **Article 410:** Security measures for persons convicted under Article 409: police surveillance to prevent the convicted person from committing the same acts.
SUDAN	**Penal Code of 1991 Act No. 8** **Article 148 , Sodomy:** "(1) Any man who inserts his penis or its equivalent into a woman's or a man's anus or permitted another man to insert his penis or its equivalent in his anus is said to have committed Sodomy. (2) (a) Whoever commits Sodomy shall be punished with flogging one hundred lashes and he shall also be liable to five years imprisonment. (b) If the offender is convicted for the second time he shall be punished with flogging one hundred lashes and imprisonment for a term which may not exceed five years. (c) If the offender is convicted for the third time he shall be punished with death or life imprisonment."
SYRIA	**Penal Code of 1949** **Article 520:** "Any unnatural sexual intercourse shall be punished with a term of imprisonment of up to three years of imprisonment."
TUNISIA	**Penal Code (revised in 1964):** Article 230: "Sodomy between consenting adults- up to three years imprisonment."
UNITED ARAB EMIRATES	**Federal Penal Code, Law N°3 of 1987** **Article 354:** "Capital punishment for any individual who forcibly compels a female to carnal copulation or a man to sodomy." Article 80 of the Abu Dhabi Penal Code makes sodomy punishable with imprisonment of up to 14 years. Article 177 of the Penal Code of Dubai imposes imprisonment of up to 10 years on consensual sodomy.

YEMEN	Penal Code 1994, N°12
	Article 264:
	"Homosexuality between men is defined as penetration into the anus. Unmarried men shall be punished with 100 lashes of the whip or a maximum of one year of imprisonment, married men with death by stoning."

Remember!

- A health context analysis is a fundamental process when planning MSM programmes.

- The social, cultural, and religious contexts can put pressure on MSM to get married, which sometimes puts their wives at risk of being infected with HIV or other STIs.

- Knowledge of the law is a crucial step in designing an outreach programme.

- It may not be sufficient to create new laws in favour of a population within a context that is not ready for the implementation of these laws. Reviewing existing laws can help identify the gaps related to vagueness and misinterpretation of some laws that lead to discrimination in their enforcement against MSM.

1.2 Population analysis

According to WHO/UNAIDS Guidelines focusing on the prevention and treatment of HIV and other STIs among MSM and transgender people, the term "*men who have sex with men*" is defined as:

"*an inclusive public health construct used to define the sexual behaviours of males who have sex with other males, regardless of the motivation for engaging in sex or identification with any or no particular "community". The words "man" and "sex" are interpreted differently in diverse cultures and societies, as well as by the individuals involved. As a result, the term MSM covers a large variety of settings and contexts in which male-to-male sex takes place*".

In countries of the MENA region, the terms designating "MSM" differ. These terms are often the feminine construction of a masculine noun, and can be a way to discriminate against people to whom they are assigned.

This section explains the different subpopulations of MSM in MENA region and explains the importance of meeting with this population.

SUBPOPULATIONS

If MSM form a population, this population would be composed of subpopulations that require particular approaches and that should not be overlooked.

Risks vary according to the populations depending on several criteria, such as epidemiological, behavioural and economic factors, and social situations.

Subpopulations of MSM include young people below the age of 18 years, sex workers, people living with HIV, people who use drugs, mobile populations, and partners and clients. Each of these subpopulations is discussed below.

Young MSM below the age of 18 years

Outreach programmes are faced with difficulties in promoting health, HIV prevention, treatment, care and support for young MSM who have not yet reached the age of majority. For HIV testing and counselling, parental consent is usually required. However, according to WHO/UNICEF policy requirements for HIV testing and counselling, if a parent refuses HIV testing and life-saving treatment is available, the provider has an ethical responsibility to test the young person and initiate treatment. In all circumstances, the best interest of the young person below the age of 18 years should be the guiding principle. Similarly, distribution of condoms is problematic, because parents of young MSM below the age of 18 years may find them.

Initiatives involving young MSM require a lot of flexibility. Creating an environment of trust is fundamental. One must be vigilant in order to ensure that programmes protect young MSM from sexual exploitation including through appropriate procedures to ensure professionalism and accountability of programme staff. Some outreach programmes for young MSM in the MENA region have been accused of paedophilia and incitement to debauchery, and therefore, these programmes should have maximum transparency.

This subpopulation requires a specific approach, taking into consideration age, sexual practices and effective ways to communicate with individuals.

Sex workers

According to UNAIDS Guidance Note on HIV and Sex Work, sex workers are defined as "*adults or young people aged 18-24 who receive money or goods in exchange for sexual services, either regularly or occasionally*".

Sex work remains taboo, and is often subject to misconceptions, such as: "*It's easy money*", "*It is only a temporary situation*" or "*They love it*". In fact, sex work only exists to meet market demand. This rule concerns the entire world, not just the MENA region.

Male sex work includes homosexuals, gigolos, escorts and transgender people. Some men make money by having sex with men without considering themselves as homosexuals, because money is their sole motivation. Studies in the MENA region show that the quest for a regular income is the most recurrent reason cited by MSM who engage in sex work. Therefore, they seek to improve their situation, but find themselves confronted with new challenges.

Different techniques are used by MSM sex workers: flirting in cafés, bars and bath houses; arranging appointments by telephone, Internet, etc. Because of advances in communication technology, sex workers can easily discuss sex practices and prices before any sexual encounter.

The specific approach most suited for this subpopulation will depend on the different types of sex work (street sex work, establishment sex work, sex work using the Internet), the various subpopulations of sex workers (migrants, people who use drugs, people who are illiterate, people living with HIV etc.), and the risks specific to each subpopulation.

HIV prevention among sex workers should always include in-depth work with the clients. Commercial sex would not exist without clients; there is a need to address the perception that by paying they have greater control including whether or not to use a condom.

People living with HIV

Sex between men without protection increases the risk of HIV transmission. In particular, unprotected anal penetration is a high-risk means of transmission. HIV prevention, treatment, care and support programmes should not neglect MSM living with HIV.

These programmes should provide protection and support for people, as well as measures to reduce risk-taking behaviour. Programmes should also establish partnerships with NGOs that are working for and with people living with HIV.

As with any member of society, it is also important to promote human rights and equal opportunities of people living with HIV. They need to live a healthy and satisfying life, as would any other person.

Outreach workers should have a deep understanding of the different needs of people living with HIV in the areas of HIV prevention, treatment, care and support. This will help them provide people living with HIV with information, guidance and support, as well as mediate on their behalf with various services (medical, legal, etc.).

Within the framework of an approach towards people living with HIV, it is important to put in place the tools that provide explanations on how to live with HIV. Several tools or guides have already been developed to provide information on all essential points that a person living with HIV should know.

People living with HIV should be significantly involved with their peers in activities aimed at engaging this subpopulation. More generally, they should be involved in creating the enabling environment and helping in advocacy. Involvement should not be superficial and in response to a unilateral request expressed by NGOs to attend ad hoc activities.

People who use drugs

Recreational and addictive drug use is widespread in the MENA region, although consumption patterns differ among countries. It is also common to combine drugs and alcohol, and these actions are observed among some MSM. This increases risk-taking behaviour:

- Frequently, drug use can be associated

with risky sexual behaviour as places where people congregate for drug or alcohol use can also be places where people make sexual contacts. Also, drug or alcohol use can be disinhibiting and sometimes creates excuses for unsafe sex.

■ Injecting drugs leads to risks of contamination when unsterilized syringes are exchanged among users.

This subpopulation deserves special attention in terms of prevention and care. Response to this problem should be considered early on in programme planning.

For more information on a comprehensive package of core interventions for Injecting Drug Users, please consult WHO/UNODC/UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (*See section of Resources, page 11 of this document*).

Mobile populations

Several studies have shown a correlation between the mobility of populations and their vulnerability to HIV infection. Some MSM are constantly moving, which makes supporting and caring for them complex. This mobility may be voluntary or involuntary, and falls under two main types:

■ **Internal mobility** – MSM moving from one district to another within the same city, or from one town to another within their own country.

■ **External mobility** – MSM crossing country borders and visiting or moving to a foreign country.

The mobility phenomenon leads to various questions concerning people's origin, transit, destination and return, such as the following:

- Why do they leave?
- What are the places they pass through?
- What are their behaviours and interactions during this mobility?
- Where do they go?
- How are they received in a new place?
- Do these individuals return to their homelands, or do they stay where they arrived?

In many MENA countries, the internal mobility of MSM can be caused by the sensitive nature of their practices. MSM populations often move away from their families and communities to seek more privacy. Moving allows them to avoid police repression, insults and physical assault.

For others, such as sailors, fishermen or truck drivers, high mobility is the result of their profession. MSM who work in such trades are particularly vulnerable to HIV.

Cross-border migration is linked to sociocultural factors and search for better economic opportunities. Such travel is associated with conditions and behaviours that increase the risk of HIV infection among migrant populations. Loneliness, peer pressure, lack of resources and loss of a comfort zone can encourage people to take risks – particularly by engaging in sex work – which leads to an increased risk of being infected with HIV. Migrant MSM may suffer discrimination, exploitation and lack of legal protection. They have limited access to health systems, prevention, HIV testing, treatment, care and support. In conclusion, the search for

discretion and a better life can make MSM even more vulnerable than they were in their original home.

A specific approach should be planned to address the problem of mobility:

- It must be flexible and easy to implement in order to meet the dynamic nature of mobility, especially that the mapping changes with the movement of the population. It is also necessary to have multilingual outreach workers who can speak the languages of migrants. Therefore, it would be suitable to select people from the community itself to become outreach workers.

- It should be participatory, involving MSM and people affected by HIV in the development and implementation of policies and programmes.

Partners and clients

Some MSM have multiple sexual partners, including their wives, who may not know about their spouses' behaviour. MSM can have sex for pleasure only or for money.

The outreach approach aims to reach these different sexual partners of MSM. Experience has demonstrated the important role of peer educators, who identify clients and convey the message of prevention to them. Some clients prefer to be approached verbally, and often do not want to receive brochures.

MSM who are sex workers can help provide HIV prevention information through questionnaires they share with clients.

MEETING THE POPULATION: ADVANTAGES AND OBSTACLES

There are several advantages to meeting MSM:

- Meeting with MSM allows one to acquire more accurate information about MSM communities and their environments, as well as their HIV-related knowledge and behaviours.

- The data collected allow organizations to adapt programmes that focus on:
  - teaching how to reduce risk-taking behaviour regarding HIV
  - meeting specific needs
  - involving MSM in the development, implementation, monitoring and evaluation of programmes.

- It often facilitates outreach opportunities with other MSM through their existing networks.

However, the biggest challenge in working with MSM in MENA is stigma and discrimination.

The political environment and discriminatory laws reinforce the hostility against MSM communities, thus bringing about a defence mechanism on their part. Indeed, according to qualitative studies conducted in MENA region, many MSM withdraw into themselves, prefer silence and isolation, and are afraid of being questioned about their sexual behaviour. They stigmatize and undervalue themselves, and sometimes fight a continuous battle with themselves for their own identity.

To identify and meet with the MSM populations, one must first gain their trust. The dialogue established during the first contact needs to be pursued until attainment of the programme objective, namely the reduction of risky behaviour.

Meeting with the MSM population can open up a fundamental dialogue within the framework of the analysis of the situation and the responses to it.

Remember!

- A specific approach should be followed for the different subpopulations of MSM including young people below the age of 18 years, sex workers, people living with HIV, people who use drugs, mobile populations, partners and clients.

- The subpopulation of young MSM below the age of 18 years is very difficult to access, especially due to the legal context. Young MSM are more vulnerable to sexual exploitation.

- Initiatives among young MSM below the age of 18 years require a lot of flexibility and subtlety. Outreach programmes for young MSM need to ensure that they protect them from sexual exploitation and that they maintain good standards of professional conduct so that they can protect themselves against accusations of encouraging paedophilia and incitement to debauchery.

- Decreasing the risk of HIV infection among sex workers should always include in-depth work with the clients. Commercial sex would not exist without clients; there is a need to address the perception that by paying they have greater control, including whether or not to use a condom.

- Programmes intended for MSM living with HIV require a specific approach in terms of guidance, support and monitoring. It is very important to involve MSM living with HIV in planning, implementing and monitoring of programmes intended for them.

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- Sappe R. *Le SIDA et les rapports sexuels entre hommes en Afrique noire.* Bruxelles, Facultés Universitaires Saint-Louis, 2003.

WEBSITES

- Àmbit prevenció fundació: **www.fambitprevencio.org**

- European Network for HIV/STI Prevention and Health Promotion among Migrant Sex Workers (TAMPEP): **www.tampep.eu**

- Joint United Nations Programme on HIV/AIDS (UNAIDS): **www.unaids.org**

HIV AND OUTREACH PROGRAMMES WITH MEN WHO HAVE SEX WITH MEN IN THE MIDDLE EAST AND NORTH AFRICA

MODULE 2/4
OUTREACH PROGRAMME: FROM REFLECTION TO CONCEPTION

2 – Outreach programme: from reflection to conception

This module describes the three essential steps to bring a programme from reflection to conception. First, an enabling environment should be established for designing the programme (2.1). Second, an exploratory phase using mapping should be undertaken (2.2). Finally, the response programme should be planned (2.3). Programme models developed in the region are presented at the end of the module (2.4).

This module has been designed for National AIDS Programmes and partners of National AIDS Programmes (donors, UN system, Non-governmental organizations).

2.1 An Enabling Environment for Programme Design

Creating an enabling environment for designing a programme necessitates work in the following areas:

1. Advocacy
2. Networking
3. Participatory approach
4. Ethical Framework

ADVOCACY: A CONTEXT OF COMMITMENT

In the *HIV and AIDS toolkit for local communities*, the Health Economics and HIV/AIDS Research Division (HEARD) explains that advocacy "consists of including a problem to an agenda, [to] provide a solution to the problem and [to] build a support base for acting against and resolving this problem". The participation of all partners – including NGOs, the MSM communities and service providers – is important for advocacy.

Advocacy should be a multisectoral initiative and approach, based on strategic information and experiences from the field (e.g. legal cases, testimonies). In all cases, MSM should be placed at the centre of the response.

Advocacy is a vast programme…

And it involves numerous stakeholders!

In reality, advocacy has two targets:

- **The internal environment.** This involves campaigning for the population's cause within the MSM community, to reduce discrimination and self-stigmatization within the population.

- **The external environment**. This involves ensuring the respect of the rights of MSM among the institutions surrounding them, such as families, religious authorities, professional environments, policy makers, etc. Such a strategy should decrease the vulnerability of MSM by limiting stigmatization, while providing them with the means and the capacity to cope with the HIV epidemic.

In fact, advocacy describes the problem, then offers solutions and asks for commitment to the response. The voice of the MSM community is extremely important in this process. MSM should play the roles of both partners and ambassadors.

The mission of advocacy is to create an environment that is favourable to the AIDS response.

It enables relationships to be built within the community, and between the community and various social and political institutions. This way, it reduces the gaps between MSM and society.

For efficient advocacy in favour of HIV prevention and treatment among MSM, a strong leadership should emerge. The leader must demonstrate modesty, have good listening and understanding skills, and have the courage to guide and manage.

Advocacy should be based on constructive arguments and adapted to the context. Advocacy actions that are not tailored to the context may risk blocking a programme's development process.

The advocacy agenda should adopt a perspective that expands progressively with time and success.

NETWORKING

Do the different institutions that are interested in HIV prevention work alone?

No. Networking and synergy are the keys to success! But we need to take many things into account.

Many stakeholders and partners need to be involved in the AIDS response with key populations at higher risk. Networking is a tool that promotes synergy among different stakeholders to respond more effectively to problems identified.

The International Council of AIDS Service Organizations (ICASO) defines networking as *"a process by which two or more organizations and/or individuals collaborate to achieve common goals".* ICASO also states that networking "is a powerful testament of our commitment to building solidarity and uniting in common cause".

Advantages of networking

■ Enables a programme to accomplish an objective through collective efforts that could not be accomplished by one entity

"Networking strengthens the response to HIV. It also helps us reduce costs thanks to free access to services."
Outreach worker

in order to rationalize the use of resources and minimize costs.

■ Strengthens social action.

■ Influences others – inside and outside the network.

■ Broadens the understanding of an issue or intervention by bringing together different points of view.

■ Avoids duplication of efforts.

■ Promotes the exchange of ideas, insights, experiences and skills.

■ Provides a needed sense of solidarity, and moral and psychological support.

■ Under certain circumstances, mobilizes financial resources , especially that donors often favour projects that are supported by networks.

Elements that can cause failure

■ Not defining the programme and the scope of intervention of each stakeholder.

■ Poor understanding of how networks operate.

■ Lack of transparency.

■ Competitive relationships.

■ Non-participation of the communities concerned (e.g. MSM, people living with HIV)

- Not taking into account the realities in terms of human resources; some stakeholders do not participate in the meetings to monitor programmes due to their heavy workload.
- Lack of coordination.
- Not establishing a common monitoring and evaluation system.

You need to know that there are two types of networking: informal and formal.

An informal network of services can be established by the MSM community. This network emerges with the help of the address books of the MSM communities and, at times, committed professionals. It may be the main source of recruitment for the selection of friendly service providers. The network can become formal through the contractual agreement with these professionals to join the programme.

PARTICIPATORY APPROACH

The participatory approach is the key to all outreach programmes and it facilitates health promotion.

Plans that do not involve MSM communities have less impact on them. The participatory approach is the result of the willingness to involve key populations in brainstorming, planning, implementing, coordinating, monitoring and evaluating outreach programmes. In this approach, MSM gradually take over

the actions of all partners, thereby taking ownership of the process.

The participatory approach facilitates the MSM community's awareness of risk-taking behaviour and its relationship to HIV infection. It encourages dialogue and partnerships. It tends to clarify roles and suggests the division of responsibilities and decision-making among partners. It draws its strength from the knowledge and perception that key populations have of their own environments. Peer educators can also foster and stimulate the participatory approach within the MSM community.

The participatory approach aims to decentralize information, know-how and services. This helps organizations avoid creating programmes based on a limited number of people who unwittingly monopolize the interactions and contact with the MSM community. All social levels and subpopulations within the MSM community concerned must be involved. This allows for appropriate diagnosis and analysis of needs, and relevant planning.

The participatory approach is part of an ethical framework (see below), which implies that the different partners demonstrate a mutual respect. It can be defined as a partnership of equals that recognizes the knowledge and know-how of the MSM communities. The partners should have a mutual commitment towards pursuing a common goal, which involves a constant dialogue.

Some researchers and experts make the mistake of engaging the MSM communities only in the data collection process. This makes it difficult for MSM to understand the usefulness

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of the information collected, nor do they understand the strategies implemented after data analysis. As a result, the programmes generated by this approach would have less impact on the key populations.

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What you're telling me seems very logical, Fadel.

Yes, but certain conditions have to be respected for the participatory approach to be productive!

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- The various partners should accept one another's presence.

- Everyone should respect equality in the partnership.

- Everyone's role should be defined, and coordination and information sharing should become a ritual.

- The capacities of different partners should be strengthened to develop effective programmes.

- The various partners should use the same communication tools.

- The solution to any issues should come from the MSM communities by

addressing problems through a dialogue between partners and the communities concerned. Knowledge and skills of MSM communities should not be underestimated.

- No one within the MSM community should monopolize the participatory approach, since its objective is to decentralize information and exchange.

ETHICAL FRAMEWORK

For the programme to have a real impact, all stakeholders – NGOs, service providers and the community – should commit to a code of ethics. This code of ethics should precede any programme activities, and should be in harmony with the internal charter of the associations concerned. It can be defined as a protocol identifying access to quality services for MSM as a human right, without any religious, ethnic, sexual or political considerations. The notions of solidarity, respect and fairness are the founding principles of the ethical framework. In the case when a steering committee is established (which is highly recommended), it is the latter which is responsible for ensuring compliance with this code of ethics.

Remember!

Establishing an enabling environment for programme design requires work in the following areas :

- Advocacy in favour of HIV prevention and treatment among MSM: for it to be effective, strong leadership should emerge. The leader should demonstrate modesty, have good listening and understanding skills, and have the courage to guide and manage. Leadership is a process that builds up gradually and within a group dynamic.

- Networking: a tool that promotes synergy among different stakeholders to respond more effectively to problems identified.

- Participatory approach: the result of the willingness to involve key populations in brainstorming, planning, implementing, coordinating, monitoring and evaluating outreach programmes.

- The ethical framework: it can be defined as a protocol identifying access to quality services for MSM as a human right, without any religious, ethnic, sexual or political considerations.

2.2 Mapping

The outreach programme should be strategic and prioritize geographic areas where the epidemic potential is greatest. Answering the following questions would determine the appropriate activity sites:

- Where is the largest MSM population?

- Where are the highest levels of risk behaviours?

- Where is the highest prevalence of HIV or the highest number of reported cases that suggest an HIV epidemic has already been established? indicating "concentration" of the epidemic?

Once the activity sites are identified, the programme team should draw a map of typologies, times and places frequented by MSM. It is necessary to identify specific areas to consider the activities in geographical and temporal terms.

Mapping is a long process, but it is ABSOLUTELY necessary to reach the community.

Fine! Can you explain to me the steps to draw a map

Three steps are needed for mapping:

Phase 1: Observation
Phase 2: Establishing the map
Phase 3: Keeping the map updated

PHASE 1: OBSERVATION

Maps are drawn by mappers, who could be outreach workers, or researchers accompanied by field workers. The mappers should reach out to the MSM community, and should make repeated and regular visits to the same places. However, before thinking about the regularity of visits in a defined space and at a given time, an observation phase is needed and this consists of two steps.

1) **Organizing visits to locations where the MSM populations are reported to be present.**

Here, for example, Adel and Fadel went to a location known for being frequented by MSM to simply observe the place.

2) **Identifying the most suitable time slot for visiting when the location turns out**   **to be a possible one for interaction.**
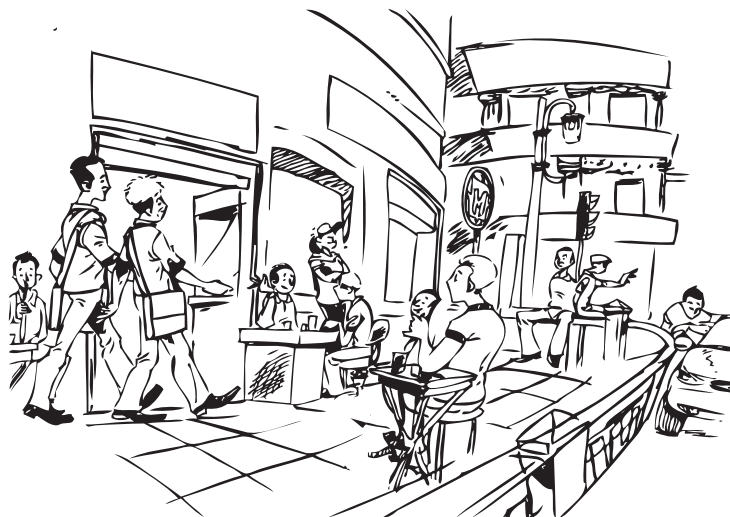
Here, for example, Adel and Fadel go to a café in the location identified in Step 1 on a regular basis to identify the peak time when MSM congregate

The two steps allow mappers to familiarize themselves with the area and test approaches for interaction.

Mappers should also come into contact with other liaison persons who can introduce them to MSM. The purpose is not to broadcast a preventive message, but to confirm that the information collected is correct. These people are often initially reluctant to help the mapper, and they wonder why the mapper is searching their locations. It is thus necessary for mappers to explain that the mapping will help inform an HIV prevention programme.

Once contact and trust are established in the field, liaison persons and other individuals met can provide an estimation of the population size.

PHASE 2: ESTABLISHING THE MAP

1) Establishing the programme activity zone

Technically, how does one get acquainted with a programme activity zone?

The mapping is carried out in several stages.

To establish a programme activity zone, it is necessary to have a recent map of the location, which can usually be obtained from geography departments of the country's various institutions (e.g. territorial administration). If no map is available, it is best to draw one using addresses as well as evidence from fieldwork. Mapping may start with a study of the city center before focusing on specific neighbourhoods.

On each site, the surrounding familiar places should be listed, which helps to refine the profile of the area. Drawing a location's profile also includes determining the number of people that the area can hold.

Mapping is quite simple in the end.

Yes, but there is one more stage left. The map, in its current design phase, cannot provide all the elements. We haven't spoken of the typology of the key population yet.

2) Topography of meeting places and key populations

A precise space typology will further facilitate interactions thereafter, since the MSM will be identified, and their accessibility and availability will be known.

Moreover, the topography of the concerned population and its profile completes the mapping. The profiles of MSM include their socioeconomic status, linguistic and ethnic aspects, clothing, etc., and identifies the possible presence of sex workers. In the latter case, it is necessary to obtain information on prices and trade terms.

It is very important that the community gets involved with the mapper during the creation of the map!

In this way, the mapper will know who the MSM are, and what attitude to adopt to get access to and stay in touch with them.

I agree! But are there simple methods to do the mapping?

It is true that defining the precise locations on a map can be difficult and will depend on the quality of the map. However, GPS could possibly make our job easier.

Mapping using the global positioning system

Using the global positioning system (GPS) can identify geographical areas simply by pressing a button. The system calculates the position based on a signal between a hand-held GPS unit and a satellite. The location is expressed in terms of longitude and latitude, corresponding to a point on the map. The location can be recorded using mapping software.

How can we record the data provided by a GPS in a report?

Nowadays, this type of transfer is relatively easy. Most mapping software is able to interact directly with a GPS.

For example, locations that are downloaded by the system (e.g. Garmin or Magellan) can be used with Google Earth to map the areas.

However, these systems can be expensive, and the decision to purchase one depends on the precision required for mapping. Mappers often have very effective and simpler tools to create maps. Therefore, it is probably unnecessary to purchase a GPS device just to map a population.

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Sounds good. But what exactly will I need to develop my mapping system with the help of a GPS?

Most of the tools you will need can be purchased in any computer store.

The following will be needed to map a population using a GPS.

- **A computer**. It is preferable that the computer contains a hard disk with a large memory and small graphic cards. The computer should be powerful enough to run the applications, but the budget should be kept in mind.

- **An ADSL connection of 512 kilobytes per second or more**. To download any free software, it is necessary to be connected to the Internet.

- **GPS device and a download cable compatible with the computer and the appropriate software**. The number of these tools required will depend on the size of the mapping team. At least one GPS will be needed to collect the data.

- **Software**. Most mappers use specialized systems. As part of outreach programmes and for mapping, the software should be compatible with Google Earth or similar.

- **Knowledge**. Somebody should know how to use the system and be able to train others. GPS devices are relatively easy to use. However, using the software could cause problems.

This method seems fantastic! But I can imagine that it isn't as simple as you say it is.

Indeed… using the GPS for mapping can generate some difficulties, but these aren't necessarily linked to the GPS or the software.

Any GPS needs to communicate with multiple satellites to receive the positioning signal. It is therefore possible to lose the connection with the satellite and no longer be properly positioned by GPS; for example, inside large buildings. In this case, it is possible to mark the location from the outside.

In reality, the biggest problem that mappers are likely to encounter is an issue of personal safety and data security. The use of a GPS, like the use of mobile phones, can lead to the danger of theft, as they are easy devices to sell. It is therefore advisable to be discreet and careful.

Depending on the objective of the mapping process, the populations whose locations are identified may be reluctant to accept this approach. In addition, since mappers identify sensitive populations, they may also attract the attention of other agents such as the police, who might be interested in knowing the location of this population. Some countries require GPS or satellite phone users to have specific authorization, since they consider the use of these devices as potential threats to their security. Similarly, it is not recommended to use a GPS near politically sensitive facilities, such as police stations or military bases. Under these conditions, a GPS user could be considered a spy, and hence exposes himself as well as the project to great risks.

In this regard, it is important to remember that data collected on areas where MSM gather could be used by any person or

institution wishing to discriminate against them. It is therefore absolutely necessary to ensure data security.

Data security can be improved by ensuring the GPS unit only contains data for the current day. Previous data collected on other areas must be kept on a computer and deleted from the GPS before it is used in another area. Once this becomes an integral part of the operational process, it will be easy to follow daily. It is also possible to encrypt data, making it inaccessible to people outside the programme.

To ensure data security, it is also possible to use a specialist outside the programme to begin the data collection process using GPS.

The computer should also be password protected. Ideally, only a few people should have user rights, in order to avoid the loss or theft of data. All data should be backed up once a week in a protected area.

Finally, it is important to remember that if the police want to obtain the data, they can always get the map. Mappers should inform populations about security issues and recommend that they protect themselves.

GPS advantages/disadvantages

GPS advantages	GPS disadvantages
■ Easy to use	■ Data is not very secure; therefore, all reasonable attempts must be made to protect it
■ Allows rapid identification of several zones	■ Data collection can lead to personal risks for outreach workers
■ Can be used with different types of software	■ It is necessary that the GPS is connected with a satellite. In some places the connection is broken
■ Allows the creation of a precise map	■ Devices can be cumbersome due to their size
■ Avoids having to carry a map on site	■ It is necessary to establish a process for downloading data, which should be repeated daily
■ Allows data to be easily shared among various partners	
■ Ensures a standardized data collection process	
■ Can facilitate the process for estimating population size	

PHASE 3: KEEPING THE MAP UPDATED

Once you've completed the mapping, you have nothing left to do but to go into the field.

Actually, the mapping has to be constantly updated.

The information collected during the mapping exercise regularly changes. The MSM population is known for its mobility. Mapping should be updated regularly. This update is part of the continuous analysis of the situation.

For example, when an establishment such as a café or nightclub closes or changes its activity, the population that frequents the establishment will move to another location, and this would alter the appearance of the map. The data should also be updated according to the

seasons of the year, during religious holidays, etc. It is therefore strongly recommended to be flexible and ready to work in a place at different times, whether during the day or at night, depending on the season and on certain events.

Mapping is ever-changing, according to economic, political and social developments.

To ensure that mapping is carried out precisely and that information can be updated easily, it is important to always specify the address, the day and time of the places where MSM congregate, and the names and contact details of the liaison persons on the maps. Remarks should also be added regarding the roles and responsibilities of liaison persons in the MSM community.

Remember!

The establishment of the mapping consists of 3 steps:

- The observation phase:
  1) Organizing visits to locations where the MSM populations are reported to be present;
  2) Identifying the most suitable visiting time slot for possible interaction.
- The mapping:
  1) Establishing the programme activitiy zone;
  2) Topography of meeting places and key populations.
- Regular updating of the map, which is part of the continuous situation analysis.

2.3 Design of the outreach programme

Planning is an essential strategic element that should be based on the long term. The process of planning includes:

- defining the long-term objectives
- developing plans and strategies to meet these objectives
- verifying that these objectives are achievable.

Several factors influence planning. For MSM, one should take into account the social, economic, political and environmental factors as these affect their behaviours.

I imagine that planning varies according to the key population.

Exactly! It is impossible to develop one single plan for all.

Planning within the framework of outreach programmes among key populations varies according to different populations and subpopulations.

As a result, planning offers programmes tailored to different needs using different approaches, because standard planning does not help to achieve goals.

Each component of tailored planning takes into account practical ways to adapt a range of programmes and services to meet the key populations' needs.

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So, there is a specific process to follow to plan a programme:

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1. Defining the internal and external environments of key populations

2. Deciding upon a programme that can be adapted to specific needs

3. Proposing quality services

4. Planning documentation of the whole process of implementation, from design to evaluation

DEFINE THE INTERNAL AND EXTERNAL ENVIRONMENTS OF KEY POPULATIONS

The internal environment

To determine the needs of the key population and develop strategies that address them, a deeper knowledge of the population's general characteristics is required. Characteristics can be defined by age, gender, ethnicity, practices related to HIV transmission, health condition, socioeconomic status, etc.

The external environment

A programme plan should assess the socio-cultural and legal contexts, and key actors that can potentially help provide an appropriate response or, on the contrary, slow it down.

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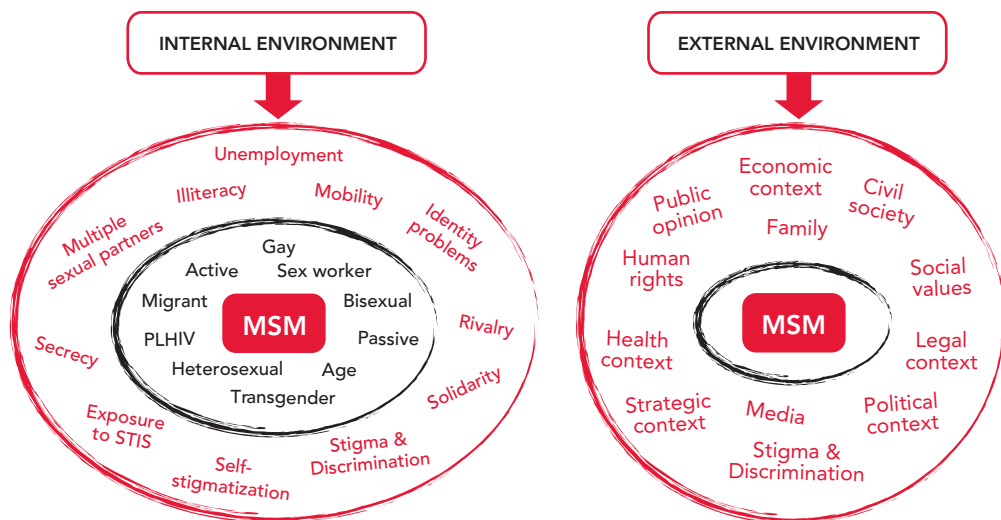
The two diagrams shown above enable reflection upon the population's weaknesses and allow these to be converted to strengths.

DECIDE UPON A PROGRAMME THAT CAN BE ADAPTED TO SPECIFIC NEEDS

Develop a vision statement

The vision of a programme should highlight the programme's ultimate goal, namely the reduction of HIV transmission among MSM and their sexual partners. The vision is based on the situation analysis and should be developed with the active participation of all partners involved in the design and implementation of programmes engaging MSM.

Develop clear and measurable objectives

Programme objectives should be aimed at MSM and focused on results such as change of risk behaviour, quality of the services provided and satisfaction of people receiving the services. Objectives help professionals assess the results and adjust their plan. The key person in this course is the MSM.

Collaboration with various stakeholders will help achieve the objectives. It is also important to define the identity of various stakeholders and their roles.

Develop strategies and set priorities

Once the objectives are defined, it is possible to develop strategies that will contribute to achieving these objectives by improving people's access to MSM quality services in a non-discriminatory and non-stigmatizing manner. It is best to establish priorities and

link them with existing programmes to eliminate gaps and redundancies.

Elaborate a specific approach

The relevant approach and tools will be selected according to the population's needs for HIV prevention, treatment, care and support. The outreach approach therefore allows for adjusting the response according to the context of the specific community of MSM.

It is possible to propose different approaches

One can make use of existing approaches, or create new ones to fill in the gaps. There is no absolute "right way" to do this, as the needs of MSM determine the most appropriate approach. To this effect, answering the following questions would be useful as a starting point:.

- Who will the programme support?

- What are their needs and what resources are available to meet their requirements?

- Where will the programme be proposed?

- What tools will be used for monitoring?

- When will the programme be available?

- Why will the programme matter?

- How will the programme address the existing gaps?

Establish and mobilize programme funding

After defining the strategies and programmes that will be implemented, a proposal should be developed to request funding for human resources, capital expenditure and operating expenses.

Some guidelines

- It can be useful to consider development programmes in the same way as the programmes of a profit-making company, with close attention to getting results.

- As part of the outreach programme for MSM, all partners should have clearly defined responsibilities. This ensures the autonomy of the institution and the ownership of the action by the organization vis-à-vis donors.

- The culture adopted by the organization should enable and encourage innovation and the development of alternatives. Any future system must be built from the existing system. Innovation will consist of extending services and strengthening the foundations. It will be an evolutionary process that will lie within a structural framework and ethical guidelines that define the planning directives and stages. For a system to be effective, it should promote reforms, improvements and alternatives to become a perfect system that is adapted to the context.

- For the programme to be sustainable, it should not be based only on international funds. The programmes may consider creating income-generating activities or involving national donors. "Where there is a will there is always a way".

- Ideally, a platform or steering committee should be set up at the national level. It brings together the various thematic and non-thematic, public and private partners. It coordinates and supervises their HIV programmes and activities. The steering committee acts as a stimulator by directing, developing and overseeing standards of service delivery on the ground. To be functional, it should meet regularly.

PROPOSE QUALITY SERVICES

Access to quality services is an unquestionable human right. However, confusion with claiming the right to choose one's sexual orientation sometimes gets in the way of certain services that are designated for MSM.

Several services can be provided to MSM through approaches tailored to local circumstances. (*see page 36, examples of outreach models developed in the MENA region*).

HIV-related Information and tools

What do outreach workers provide to MSM met in the field?

Outreach workers provide MSM information and education on HIV, focusing on modes of HIV transmission and prevention, as well as HIV prevention kits. I advise you to also check Module 3, which gives more information on the outreach approach.

HIV prevention kits

Outreach workers give MSM condoms and lubricating gels, and they can also explain how to use them. A brochure could be given with these items.

In some countries in the MENA region, outreach workers provide MSM with a box containing condoms, gel and a leaflet with the following information:

- The addresses of various services
- An AIDS/STI information hotline number
- Instructions for using a condom.

Some advice on condoms and lubricating gels

1. Outreach workers should encourage consistent condom use.

2. Outreach workers should suggest condom use within the framework of HIV prevention, and independently from sexual orientation.

3. Outreach workers may recommend the use of different types of condoms (different brands, sizes and flavours) to determine which one best suits the individual.

4. Outreach workers should systematically advise the individual to negotiate condom use before engaging in sexual relations.

5. A condom can be used in a seductive and erotic manner; for example, it can be applied with the mouth. Flavoured condoms and others made of stimulating materials are also available.

6. Men with heterosexual partners and wives should not use their marital status to understate the need to use condoms during sex with their spouses.

7. Condoms must be used consistently among extramarital sexual partners.

8. The use of lubricating gel during anal sex is important, as it helps prevent damage to condoms. Water-based gel is recommended because it is not harmful, unlike some other lubricants.

Approved service providers

What information does the outreach worker provide on service providers?

The outreach worker should always explain the advantage of consulting a friendly service provider. He should direct the individual towards these services while providing him with the addresses and hours of consultation.

Most service providers should be identified within the informal network and trained on how to welcome MSM, provide good consultations, and help with monitoring and evaluation. All service providers should sign a code of ethics allowing them to be part of the programme.

Signing such a document is essential in the MENA region since some service providers form the assumption that homosexuality is a mental illness. Therefore, it is important to pose basic rules through the signing of a common code of ethics, which demonstrates their commitment not to stigmatize or discriminate against MSM.

Access to services for MSM should be on the same basis as for other populations. In some cases, if the MSM is unable to pay for the consultation, the programme may assume all or part of the cost, but this should not become a rule as, generally, outreach programmes are not intended to be programmes of aid for service attendance. In general, programmes based on an integration of populations into existing services and involving them in the payment of these services ensure greater sustainability.

Service providers should participate actively in monitoring and evaluating programmes for MSM. In general, NGOs have difficulty obtaining information from service providers, due to lack of motivation or incentive to share data. Although this challenge is always present, one should invest in building strong contacts and the formalization of relations between the two parties - service providers and implementing agencies. Such investments have paid off in some countries.

Medical consultation

The recommended medical consultation services provide MSM with easier access to treatment.

Physicians who provide the consultations are general practitioners, infectious disease specialists, dermatologists, etc. They are selected through informal references provided by MSM, and are people who respect the individual, his privacy, sexual orientation, etc. Outreach workers provide the following information:

- names of physicians

- specialization of physicians

- addresses and telephone numbers

- consultation days and opening hours

- consultation fees.

MSM can consult a physician when they suspect that they have undertaken risky behaviours and they want to talk about it or obtain a diagnosis.

Legal counselling

Legal counselling can help MSM if they are confronted with problems related to their sexual orientation. They may have been victims of violence, or subjected to stigma and discrimination because of their sexual orientation.

Outreach workers provide the following information:

- names of lawyers

- addresses and telephone numbers

- days and hours open for counselling

- consultation fees

Psychological counselling

Recent qualitative studies conducted in several MENA countries have identified psychological counselling as an important need for MSM populations. During counselling, the individuals can openly discuss various problems, especially those that relate to their sexual orientation. Therefore, counselling provides an open door to dialogue with a professional.

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Outreach workers provide the following information:

- names of psychologists and psychiatrists
- addresses and telephone numbers
- days and hours open for counselling
- potential costs

HIV testing and counseling

If an MSM wants to take an HIV test, the outreach worker may guide him to HIV testing centres. This HIV test should be voluntary and confidential. The decision to take the test should be of the individual's own initiative, and should be made based on adequate information and full understanding of the implications of the test.

Individuals who feel that they have taken risks may wish to take an HIV test. Although the decision whether or not the test is an initiative of the MSM, the outreach worker can encourage them to do it. In both cases, the outreach worker should be able to guide the MSM towards the services offering the HIV test, and their working hours. He should therefore have complete and reliable information on these services.

A person wishing to be tested for HIV will also receive HIV counselling by a specialist before and after the test. The test and its results are confidential.

Any information disclosed by an MSM during the process of testing, or the test results, cannot be disclosed to third parties without the consent of the MSM who was tested. Tests are conducted differently in each MENA country, but they follow a generic pattern. In the majority of MENA countries,

three serial HIV tests are required to establish a positive HIV status.

- If the confirmatory test is positive, the counsellor will:
  - Explain the results of the test;
  - Explain the care and treatment that will be needed in the future and refer the MSM to appropriate services;
  - Provide the MSM with information on HIV transmission, and advice on behaviour adjustments that ensure maintaining health and preventing transmission to others.

- If the confirmatory test is negative, the counsellor will:
  - Explain the test results;
  - Provide the MSM with information on HIV transmission and advice on behaviour adjustments that ensure remaining HIV negative;
  - Advise the person to re-test for HIV at least annually if the risk taking behaviour continues.

For more information on HIV testing, please consult the website of WHO in the Resources section of this document (*page 67*).

AIDS hotline number

An AIDS hotline number is a number that anyone can call to obtain information about HIV and STIs, as well as information on adequate health services. Outreach workers should provide their particular country's hotline number to the MSM, as well as the times when the telephone lines are open.

This number should appear on the leaflet that is given with the prevention kit (*see table below*).

Hotline number operators should be properly trained and sensitized about MSM issues.

AIDS hotline number - MENA Region

ALGERIA	Ministry of Health	115	
	NGOs	AIDS Algerie : +213 21 74 15 28 APCS : +213 41 42 14 05	ANIS : +213 38 86 14 94 El Hayet : +213 21 73 19 63	Solidarite AIDS : +213 21 96 03 57
EGYPT	08007009000		
JORDAN	Amman: 06 5673436 / 06 5697933	Irbid: 02 7243482	Zarqa: 05 3936060
MOROCCO	ALCS: 0801002525	OPALS: 0801003040	
YEMEN	175		

Accompanying the individual

Occasionally, the MSM may want or need to be accompanied to other services, especially if he does not speak the local language (migrants, for example) or is illiterate.

The outreach worker can then play the role of an intermediary, and at times, a mediator. For this, he should be familiar with the services offered, their locations, schedules, etc.

Accompanying the person means familiarizing him with the services without making any decisions for him or interfering in his decisions.

Accompanying the person does not mean that one should know the details of the individual's file. Thus, the person does not have to reveal his HIV status or any other confidential information.

However, accompanying the person should not become the rule. It should be the exception since the objective is to maximize the autonomy of the MSM by making their own decisions.

2

PLAN DOCUMENTATION

....

Documentation should be a full
component of the programme,
and it should accompany
each stage.

But, I don't understand
its use!

Documentation
describes the processes,
functioning and lessons
learned from the programme.
It should contribute to the development
and improvement of the prevention
strategy over time.

....

Documentation is an integral part of planning. Although it seems obvious, it is often overlooked. As information and experiences build up, programme managers are less able to remember their actions.

Documentation contributes to monitoring and evaluation. It is a dynamic memory that allows for programme improvement and experience sharing. Documentation also plays a role in advocacy.

Documentation comes in different forms, such as:

- books
- educational tools
- terms of reference
- security guides for outreach workers
- networking guides
- contracts
- programme plans
- programme proposals
- reports
- videos

- descriptions of activities
- charters
- activity guides
- information appearing on web sites.
- lessons learnt.

By making an inventory of certain experiences in the region, this handbook is essentially a part of the documentation.

2.4 Outreach models developed in the MENA region

....

What is the situation
in the MENA region?

Different programmes
have been put into place
to respond to the needs
identified under each context.

....

In MENA region one can delineate three approaches used to **provide services** to the MSM community (*see page 36, examples of outreach models developed in the MENA region*):

1 Establishing a drop-in center within an NGO
2 Outreach work
3 Referral to other services

Drop-in Center

The drop-in center is intended to provide a welcoming space exclusively for MSM, which can protect them from human rights violations. This model is particularly suited to contexts intolerant to MSM.

However, this model is particularly expensive. In the event of a lack of funds, the services will stop working and MSM lose their service-related comfort zone areas. Furthermore, having a specific location for MSM could increase stigma and discrimination against them, and does not help reduce the gap between them and society.

Outreach work

Direct contact with the MSM community in places they frequent allows the programme to increase coverage of a population that is difficult to access. However, in MENA it is not realistic to use this approach for all services. In general, this approach is useful for sensitizing the population and distribution of prevention kits.

Referral to other services

Referral to other services is to integrate the MSM into existing systems, while working on raising the awareness of these systems in favour of the population. This model is generally based on fieldwork with a solid referral system that includes public and private service providers, and offers a comprehensive package of medical, legal, psychological, counselling and testing services.

Outreach workers trained in HIV prevention programmes identify potential beneficiaries in locations where MSM congregate. The outreach workers then follow a plan to engage them and provide them with the programme's services.

Such an approach reduces the stigma and the gap between the key population, service providers and the society, as it facilitates the integration of MSM in structures receiving the entire population. In addition to creating a favourable external environment for HIV prevention programmes for MSM, this approach further diminishes the cost of implementation.

However, if the different partners in the referral network do not share the same ethics, the same methodology of monitoring and evaluation or the same spirit of co-operation and motivation, the goals are threatened.

Programme management also varies between countries in the MENA region. At the date of publication of this handbook, there were three main models:

1 Only one leader NGO with branches throughout the country;

2 An umbrella NGO enjoying the experience and leadership that mobilizes other structures;

3 A response team within the national AIDS programme.

Leader NGO

This management model facilitates access to quality services managed and directed by a leading association in this area.

This model focuses more on the creation of new branches instead of strengthening existing structures or networking with other NGOs.

This model could be less cost effective if it expands its own offices and services at the expense of engaging other partners.

2

Umbrella NGO

The umbrella NGO mobilizes other structures through the following process:

1. selection of facility-based structures and partner NGOs

2. provision of information and training

3. implementation of the programme

4. provision of common monitoring and evaluation

5. ensuring gradual autonomy of partner NGOs

6. supporting ownership of programmes by various partner NGOs.

The umbrella NGO provides technical support and consultation. It does not resign from all its functions after mobilizing the other structures, and may continue to participate in programme implementation. For example, it can continue to lead the outreach approach with the MSM community.

The umbrella NGO should establish an internal steering committee composed of representatives from each partner organization. A person responsible for data collection should be a member of the steering committee, and is responsible for collecting data from various partners and overseeing the analysis. A quarterly report, such as a newsletter, is communicated to all partners. The umbrella NGO strengthens its leadership by transferring skills to other partners. No new structures are being created and hence the cost of implementation of the programme diminishes. The involvement of several thematic and non-thematic partners also strengthens the awareness and advocacy about programmes engaging MSM.

However, a strong monitoring and evaluation system is required since the information is scattered among all organizations led by the umbrella NGO. Otherwise, it will be difficult to evaluate the impact of the programme on the MSM community. Moreover, if the umbrella NGO does not share the information with partners, the programme will have a unilateral profile. Partners will never see the link between their actions and activities, and the programme's impact on MSM. The implication would then only be partial, and ownership of the programmes by implementing NGOs would not be possible. It is therefore necessary to share information and regularly discuss the follow-up plans with all partners.

A response team within the National AIDS Programme

Preliminary steps are required before the programme team becomes operational. First, the response team, which includes field coordinators and outreach workers, is selected. Second, a unit is chosen to host the team for their regular meetings with the National AIDS Programme.

The team can also break away gradually by including in its agenda an advocacy component with the government, in order to obtain the status of an NGO. When it breaks away to become an NGO, it continues the same outreach.

This approach has a certain advantage in the regional context. The team can strengthen and mobilize the community to take ownership of its problems and needs, and subsequently advocate with the government for supporting its cause. The creation of an NGO becomes unnecessary if the community manages to gain power and find its place in public policy.

However, the fact that the sexual orientation of MSM is penalized in various countries in the MENA region, makes them invisible, inaccessible and frightened of all contact with public authorities. Identifying MSM and establishing contact with them can be time consuming and energy intensive compared with models involving NGOs. Furthermore, a political power shift may have a positive or negative impact on the programme. The sustainability of the programme depends on political trends and continuation of government support.

Remember!

There is a clear process to follow for designing the programme:

■ Identify the internal and external environments of key populations.

■ Decide on a programme adapted to the needs. This involves developing a vision, clear and measurable objectives, strategies, specific approaches, and mobilizing funds for the programme.
Approaches or models presented above do not constitute an exhaustive list of existing models in the region. Each has its advantages and disadvantages. All have the merit of having been put in place despite the hostile environment.

■ Propose quality services while ensuring the confidentiality of the relationship between MSM and approved service providers.

■ Service providers should participate actively in monitoring and evaluating programmes for MSM. In general, NGOs have difficulty obtaining information from service providers, due to lack of motivation or incentive to share data. Although this challenge is always present, one must invest in building strong contacts and the formalization of relations between the two parties - service providers and implementing agencies.

■ Plan the documentation of the whole process of implementation, from design to programme evaluation.

Profiles of main NGOs working with MSM in MENA

Association for Information on Drugs and AIDS (AIDS Algerie)

ALGERIA   *www.aidsalgerie.org*

MISSION:

Works to preserve the health of individuals, communities and the welfare of the family unit in a healthy and balanced society.

YEAR ESTABLISHED:

| 1980 | 1985 | 1990 | 1995 | 2000 | 2005 | 2010 | 2015 |

1990

MAIN HIV PROGRAMMES:

1   Prevention of HIV transmission;
2   Advocacy and mobilization of national and international partners in the fight against HIV;
3   Fight against stigma and discrimination;
4   Studies and operational researches on HIV.

FOUNDING PRINCIPLES:

1   Human rights and equity
2   Consideration of social and cultural contexts
3   Universal Access
4   Development of partnership

POPULATIONS OF CONCERN:

| Men who have sex with men | Sex workers | Migrants | People Living with HIV | Prisoners | People who inject drugs | Women | Young people | Children |

MAIN PARTNERS:

Public sector		Ministry of Health, Population and Hospital Reform; Ministry of Religious Affairs; Ministry of Justice; Ministry of Education; Ministry of Higher Education and Scientific Research; Ministry of Youth and Sports; General Directorate of National Security
Civil society	NATIONAL	Local Associations; Magistrates; community leaders
	INTERNATIONAL	
Bilateral agencies / Multilateral organizations		United Nations system; European Union; Embassies of Canada, France, Netherlands and U.S.A
Networks		Regional /Arab Network Against AIDS (RANAA); AFRICASO; Réseau Algérien de défense des droits de l'enfant (NADA)

Men who have sex with men programme

GEOGRAPHIC COVERAGE:	TOTAL MSM REACHED 2011 *(as reported by the NGO)*	NUMBER OF OUTREACH WORKERS:
ALGER & Oran	200	5

START-UP ASSESSMENT:

Mapping	Size estimation	Identification of existing services	Information from studies
✓		✓	✓

SERVICES PROVIDED	Outreach	Drop-in-Center	Referral	Comments
Information & Awareness:				
Prevention	■	■	■	
Know your HIV status	■	■	■	
STI	■	■	■	
Stigma	■	■	■	
Where to go (referral)	■	■	■	
Condom provision	■	■	□	
Lubricant provision	■	■	□	
HIV Testing - rapid	□	■	□	Depending on availability; and in small quantities
HIV Testing – non-rapid	□	□	■	
Pre-test HIV counseling	□	■	■	
Post-test HIV counseling	□	■	■	
STI screening & treatment				
Screening	□	■	■	
Treatment	□	■	■	
Legal support / counseling	□	□	□	
Psychosocial support				
Peer support group	□	■	□	
Individual counseling	■	■	□	
Family mediation	□	□	□	

ADVOCACY

National authorities	Local authorities	Police	Community	Religious leaders	Media	Lawyers	Other NGOs
✓	✓	✓	✓				✓

Association for the Fight against STI / AIDS and Health Promotion (Anis)
ALGERIA

MISSION:

Strengthen solidarity and mobilization in the implementation of HIV prevention, treatment, care and support programmes and health promotion.

YEAR ESTABLISHED:

| 1980 | 1985 | 1990 | 1995 | 2000 | 2005 | 2010 | 2015 |

2003

FOUNDING PRINCIPLES:

1   Holistic response based on human rights
2   Participatory and inclusive approach
3   Communities' responsibility

MAIN HIV PROGRAMMES:

1. HIV Prevention among key populations;
2. Advocacy programme targeting various leaders and policymakers to improve the social environment;
3. Comprehensive care for people living with HIV including mediation activities, medical, psychosocial, economic and legal support;
4. Operational research related to the context of HIV.

POPULATIONS OF CONCERN:

Men who have sex with men	Sex workers	Migrants	People Living with HIV	Prisoners	People who inject drugs	Women	Young people	Children

MAIN PARTNERS:

Public sector		Ministry of Health; Ministry of Justice; Ministry of Youth and Sports; Ministry of Education; Ministry of social security; Health professionals
Civil society	NATIONAL	Religious leaders; other associations
	INTER-NATIONAL	Handicap International; World Aids Campaign (WAC); International Development Law Organization (I.D.L.O); SIDACTION
Bilateral agencies / Multilateral organizations		United Nations system; Embassy of France; Belgian Technical Cooperation (BTC)
Networks		Middle East and North Africa Harm Reduction Association (MENAHRA); Plateforme ELSA (Ensemble Luttons Contre le Sida en Afrique); Regional Arab Network Against AIDS (RANAA); International Treatment Preparedness Coalition (ITPC)

Men who have sex with men programme

GEOGRAPHIC COVERAGE:	TOTAL MSM REACHED 2011 (as reported by the NGO)	NUMBER OF OUTREACH WORKERS:
Eastern Algeria	500	41

START-UP ASSESSMENT:

Mapping	Size estimation	Identification of existing services	Information from studies
✓	✓	✓	

SERVICES PROVIDED	Outreach	Drop-in-Center	Referral	Comments
Information & Awareness:				
Prevention	●	○	●	
Know your HIV status	○	○	●	
STI	○	○	●	
Stigma	●	○	●	Group of lawyers inform MSM about their rights
Where to go (referral)	●	○	○	
Condom provision	●	○	○	
Lubricant provision	○		●	Not available/too expensive
HIV Testing - rapid	○	○	○	
HIV Testing – non-rapid	○	○	●	
Pre-test HIV counseling	●	○	●	
Post-test HIV counseling	●	○	●	
STI screening & treatment				
Screening	○	○	●	
Treatment	○	○	●	
Legal support / counseling	●	○	●	
Psychosocial support				
Peer support group	●	○	○	
Individual counseling	●	○	●	Psychologist associated with the NGO
Family mediation	●	○	●	

ADVOCACY

National authorities	Local authorities	Police	Community	Religious leaders	Media	Lawyers	Other NGOs
		✓	✓	✓	✓	✓	✓

Association of Protection against AIDS (APCS) (El Hak Wikaya)
ALGERIA

MISSION:

Meet unmet needs in the area of information, education, communication and HIV prevention for the general public, especially people in need and living in precarious and / or difficult conditions.

YEAR ESTABLISHED:

| 1980 | 1985 | 1990 | 1995 | 2000 | 2005 | 2010 | 2015 |

19 98

FOUNDING PRINCIPLES:

Prevention and risk reduction based on health and human rights

MAIN HIV PROGRAMMES:

1. HIV/STIs prevention;
2. Advocacy and defense of the rights of people living with HIV and vulnerable populations, especially the fight against stigma and discrimination;
3. Comprehensive care including medical and psychosocial support.

POPULATIONS OF CONCERN:

Men who have sex with men	Sex workers	Migrants	People Living with HIV	Prisoners	People who inject drugs	Women	Young people	Children

MAIN PARTNERS:

Public sector		Ministry of Health, Population and Hospital Reform; Local authorities; Police
Civil society	NATIONAL	
	INTER-NATIONAL	International HIV/AIDS alliance ; AIDES France ; Fonds des Droits Humains Mondiaux (FDHM); Africagay contre le sida ; Comité Français pour la Solidarité Internationale (CFSI) France
Bilateral agencies / Multilateral organizations		Embassy of France, Alger; UNAIDS
Networks		Réseau afrique 2000

Men who have sex with men programme

GEOGRAPHIC COVERAGE:	TOTAL MSM REACHED 2011 *(as reported by the NGO)*	NUMBER OF OUTREACH WORKERS:
Oran and West Algeria	1500	100

START-UP ASSESSMENT:

Mapping	Size estimation	Identification of existing services	Information from studies
✓	✓	✓	✓

SERVICES PROVIDED	Outreach	Drop-in-Center	Referral	Comments
Information & Awareness:				
Prevention	■	■	□	
Know your HIV status	■	■	□	
STI	■	■	□	
Stigma	□	■	□	
Where to go (referral)	□	□	□	
Condom provision	■	■	□	
Lubricant provision	■	■	□	
HIV Testing - rapid	□	■	□	
HIV Testing – non-rapid	□	□	□	
Pre-test HIV counseling	□	■	□	
Post-test HIV counseling	□	■	□	
STI screening & treatment				
Screening	□	□	■	
Treatment	□	□	■	
Legal support / counseling	□	■	□	Lawyer in the NGO
Psychosocial support				
Peer support group	□	■	□	
Individual counseling	□	■	□	
Family mediation	□	□	□	Psychologist in the NGO

ADVOCACY

National authorities	Local authorities	Police	Community	Religious leaders	Media	Lawyers	Other NGOs
✓	✓			✓	✓	✓	

Al Mofid Association for Development and Training

EGYPT

www.almofid.org

MISSION:

The association works on enabling civil society organizations to perform efficiently their roles and to achieve their goals and objectives in order to achieve integrated and sustainable development. It works on addressing social issues, supporting the marginalized and deprived populations and giving them the opportunity in participating in decision making regarding their lives through working with all local partners.

The HIV programme, established with the support of UNAIDS, began in 2009 with funding from Ford Foundation. It was the first programme for MSM in the country.

YEAR ESTABLISHED:

1980	1985	1990	1995	2000	2005	2010	2015

2007

MAIN HIV PROGRAMMES:

1. Raise awareness about HIV among MSM and the community;
2. Provide prevention tools and stigma free services to MSM;
3. Expand the knowledge base on HIV and prevention among key populations in Egypt;
4. Support men who have sex with men who are living with HIV.

FOUNDING PRINCIPLES:

1. Affirming human rights
2. Equality and social justice
3. Spreading the culture of dialogue and expression of freedom
4. Spreading the culture of peace, coexistence and tolerance
5. Affirming the value of truth, goodness and work

POPULATIONS OF CONCERN:

Men who have sex with men	Sex workers	Migrants	People Living with HIV	Prisoners	People who inject drugs	Women	Young people	Children

MAIN PARTNERS:

Public sector		Ministry of Social Affairs; Ministry of Health and Population; Ministry of Awqaf; Ministry of Youth and Sports
Civil society	NATIONAL	Family and Childhood clubs; Cultural and Social clubs; other NGOs; Egyptian NGO Network against AIDS (ENNA)
	INTER-NATIONAL	
Bilateral agencies / Multilateral organizations		UNAIDS; Ford Foundation
Networks		Egyptian NGO network Against AIDS

Men who have sex with men programme

GEOGRAPHIC COVERAGE:	TOTAL MSM REACHED 2011 *(as reported by the NGO)*	NUMBER OF OUTREACH WORKERS:
Cairo/ Giza	1600 ♂	10 🚶

START-UP ASSESSMENT:

Mapping	Size estimation	Identification of existing services	Information from studies
✔	✔	✔	✔

SERVICES PROVIDED	Outreach	Drop-in-Center	Referral	Comments
Information & Awareness:				Also provided through the web
Prevention	🟥	⬜	⬜	
Know your HIV status	🟥	⬜	⬜	
STI	🟥	⬜	⬜	
Stigma	🟥	⬜	⬜	
Where to go (referral)	🟥	⬜	⬜	
Condom provision	🟥	⬜	⬜	
Lubricant provision	🟥	⬜	⬜	
HIV Testing - rapid	⬜	⬜	🟥	
HIV Testing – non-rapid	⬜	⬜		
Pre-test HIV counseling	⬜	⬜	🟥	
Post-test HIV counseling	⬜	⬜	🟥	
STI screening & treatment				
Screening	⬜	⬜	🟥	
Treatment	⬜	⬜	🟥	
Legal support / counseling	⬜	⬜	🟥	
Psychosocial support				
Peer support group	⬜	⬜	⬜	
Individual counseling	⬜	⬜	🟥	
Family mediation	⬜	⬜	⬜	

ADVOCACY

National authorities	Local authorities	Police	Community	Religious leaders	Media	Lawyers	Other NGOs
✔	✔		✔	✔			

The National Association for Family and Societal Development (NAFSD)
EGYPT

YEAR ESTABLISHED:

1980	1985	1990	1995	2000	2005	2010	2015

1995

FOUNDING PRINCIPLES:

Accessible education and opportunities for all

MISSION:

To act as an epicenter for development through all stages of life (from childhood through old age). The organization implements a multitude of activities on site that aim to assist families and society as a whole in developing and obtaining better life opportunities (such as a nursery, language courses, computer center, meeting rooms, dormitory and more). In addition, the organization acts as an umbrella organization to large projects with several sub-NGOs and in this way has reach all over. The HIV programme began in 2010 with technical support from UNAIDS and funds from USAID.

MAIN HIV PROGRAMMES:

1. Raise awareness about HIV among MSM and the community;
2. Provide prevention tools and stigma free services to MSM;
3. Expand the knowledge base on HIV and prevention among key populations at higher risk in Egypt;
4. Support men who have sex with men who are living with HIV.

POPULATIONS OF CONCERN:

Men who have sex with men	Sex workers	Migrants	People Living with HIV	Prisoners	People who inject drugs	Women	Young people	Children

MAIN PARTNERS:

Public sector		Ministry of Social Solidarity; Ministry of Health and Population; Alexandria governorate
Civil society	NATIONAL	Caritas
	INTER-NATIONAL	
Bilateral agencies / Multilateral organizations		UNAIDS; USAID
Networks		

Men who have sex with men programme

GEOGRAPHIC COVERAGE:	TOTAL MSM REACHED 2011 *(as reported by the NGO)*	NUMBER OF OUTREACH WORKERS:
Alexandria	1303	10

START-UP ASSESSMENT:

Mapping	Size estimation	Identification of existing services	Information from studies
✓	✓	✓	✓

SERVICES PROVIDED	Outreach	Drop-in-Center	Referral	Comments
Information & Awareness:				
Prevention	🟥	⬜	⬜	
Know your HIV status	🟥	⬜	⬜	
STI	🟥	⬜	🟥	
Stigma	🟥	⬜	⬜	
Where to go (referral)	🟥	⬜	⬜	
Condom provision	🟥	⬜	⬜	
Lubricant provision	🟥	⬜	⬜	
HIV Testing - rapid	⬜	⬜	🟥	
HIV Testing – non-rapid	⬜	⬜		
Pre-test HIV counseling	⬜	⬜	🟥	
Post-test HIV counseling	⬜	⬜	🟥	
STI screening & treatment				
Screening	⬜	⬜	🟥	
Treatment	⬜	⬜	🟥	
Legal support / counseling	⬜	⬜	🟥	
Psychosocial support				
Peer support group	⬜	⬜	🟥	Friends of Life for MSM living with HIV
Individual counseling	⬜	⬜	🟥	
Family mediation	⬜	⬜	⬜	

ADVOCACY

National authorities	Local authorities	Police	Community	Religious leaders	Media	Lawyers	Other NGOs
✓	✓		✓		✓		

Positive Vision Association for People Living with HIV
JORDAN

YEAR ESTABLISHED:

1980   1985   1990   1995   2000   2005   2010   2015

20**10**

FOUNDING PRINCIPLES:

Human rights-based approach with an emphasis on the rights of people living with HIV and the recognition of their full potential

MISSION:

Contribute to collective efforts aiming at a healthy society with low HIV prevalence.

MAIN HIV PROGRAMMES:

1. Development and update of a database with information on members living with HIV and key populations at higher risk in the capital city Amman;
2. Outreach programme targeting key populations at higher risk;
3. Psychosocial interventions that respond to people living with HIV needs and further contribute to their improved wellbeing.

POPULATIONS OF CONCERN:

Men who have sex with men	Sex workers	Migrants	People Living with HIV	Prisoners	People who inject drugs	Women	Young people	Children

MAIN PARTNERS:

Public sector	🏛	Ministry of Public Health; Ministry of Social Development
Civil society	NATIONAL ... INTER-NATIONAL	
Bilateral agencies / Multilateral organizations		United Nations system; USAID
Networks		

Men who have sex with men programme

GEOGRAPHIC COVERAGE:	TOTAL MSM REACHED 2011 *(as reported by the NGO)*	NUMBER OF OUTREACH WORKERS:
Amman	**300** ⚧	**6** 🚶

START-UP ASSESSMENT:

Mapping	Size estimation	Identification of existing services	Information from studies
✓		✓	

SERVICES PROVIDED	Outreach	Drop-in-Center *	Referral	Comments
Information & Awareness:				
Prevention	⬜	🟥	⬜	
Know your HIV status	⬜	🟥	⬜	
STI	⬜	🟥	⬜	
Stigma	⬜	🟥	⬜	
Where to go (referral)	⬜	🟥	⬜	
Condom provision	⬜	🟥	⬜	
Lubricant provision	⬜	⬜	⬜	
HIV Testing - rapid	⬜	⬜	⬜	
HIV Testing – non-rapid	⬜	⬜	🟥	
Pre-test HIV counseling	⬜	⬜	🟥	
Post-test HIV counseling	⬜	⬜	🟥	
STI screening & treatment				
Screening	⬜	⬜	🟥	
Treatment	⬜	⬜	🟥	
Legal support / counseling	⬜	⬜	⬜	
Psychosocial support				
Peer support group	⬜	🟥	⬜	Support not structured and specialized/ provided by the head of the NGO and few of the active members
Individual counseling	⬜	🟥	⬜	
Family mediation	⬜	🟥	⬜	

* The NGO does not have a drop-in center. The services are provided in the NGO premises

ADVOCACY

National authorities	Local authorities	Police	Community	Religious leaders	Media	Lawyers	Other NGOs
	✓		✓				

Soins Infirmiers et Développement Communautaire (SIDC)
LEBANON

www.sidc-lebanon.org

MISSION:

Meet the health needs of the youth, elderly and the most vulnerable individuals and groups in Lebanon through community empowerment.

YEAR ESTABLISHED:

| 1980 | 1985 | 1990 | 1995 | 2000 | 2005 | 2010 | 2015 |

1992

MAIN HIV PROGRAMMES:

1. Raise awareness among the general population and vulnerable groups;
2. Provide social, health and financial support to people living with HIV and their relatives.
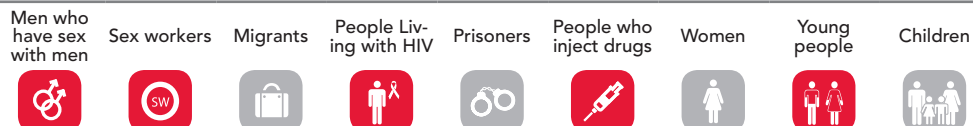
FOUNDING PRINCIPLES:

1. Human rights- based approach
2. Reaching out for the neediest and the most marginalized groups of the population

POPULATIONS OF CONCERN:

| Men who have sex with men | Sex workers | Migrants | People Living with HIV | Prisoners | People who inject drugs | Women | Young people | Children |

MAIN PARTNERS:

Public sector		Ministry of Public Health including National AIDS Programme; Ministry of Interior; Ministry of Social Affairs; Ministry of Education
Civil society	NATIONAL	Other NGOs and health care associations; religious leaders
	INTER-NATIONAL	International HIV/AIDS Alliance; Ensemble contre le sida (sidaction); Sida Info Service
Bilateral agencies / Multilateral organizations		United Nations system; Naval Medical Research Unit no 3
Networks		Middle East and North Africa Harm Reduction Association (MENAHRA); Regional/Arab Network against AIDS (RANAA)

Men who have sex with men programme

GEOGRAPHIC COVERAGE:	TOTAL MSM REACHED 2011 * (as reported by the NGO)	NUMBER OF OUTREACH WORKERS:
Beirut	5785 ⚢	10 🏃

* Number reached by the 3 NGOs: SIDC, Helem and Oui pour la Vie

START-UP ASSESSMENT:

Mapping	Size estimation	Identification of existing services	Information from studies
✓		✓	✓

SERVICES PROVIDED	Outreach	Drop-in-Center	Referral	Comments
Information & Awareness:				
Prevention	■	■	▫	
Know your HIV status	■	■	▫	
STI	■	■	▫	
Stigma	■	■	▫	
Where to go (referral)	▫	▫	▫	
Condom provision	■	■	▫	
Lubricant provision	■	■	▫	
HIV Testing - rapid	■	■	▫	Mobile unit used for outreach work
HIV Testing – non-rapid	▫	▫	▫	
Pre-test HIV counseling	■	■	▫	
Post-test HIV counseling	■	■	▫	
STI screening & treatment				Medical care available at the center and in the mobile unit for HCV and HBV and other STI if necessary in close collaboration with MOH
Screening	▫	■	■	
Treatment	▫	▫	■	
Legal support / counseling	▫	■	■	
Psychosocial support				
Peer support group	▫	■	▫	For PLHIV/MSM available at the center
Individual counseling	▫	■	▫	By professionals in counseling
Family mediation	▫	■	▫	With consent of the individual

ADVOCACY

National authorities	Local authorities	Police	Community	Religious leaders	Media	Lawyers	Other NGOs
✓	✓	✓	✓	✓	✓	✓	✓

Helem-Lebanese Protection for Lesbians, Gays, Bisexuals and Transgendered   *LEBANON*

www.helem.net

MISSION:

Helem leads a peaceful struggle for the liberation of Lesbians, Gays, Bisexuals and Transgendered (LGBT), from all sorts of violations of civil, political, economic, social, or cultural rights.

YEAR ESTABLISHED:

| 1980 | 1985 | 1990 | 1995 | 2000 | 2005 | 2010 | 2015 |

2004

FOUNDING PRINCIPLES:

Rights of LGBT

MAIN HIV PROGRAMMES:

1. Lobbying for the removal of articles in the Lebanese penal code incriminating homosexuality and trans-sexuality;
2. Preparing and developing MSM and LGBT-specific educational and sexual health materials;
3. Prevention of HIV and STIs including a hotline/ helpline providing information and support for the LGBT;
4. Comprehensive care for people living with HIV.

POPULATIONS OF CONCERN:*

Men who have sex with men	Sex workers	Migrants	People Living with HIV	Prisoners	People who inject drugs	Women	Young people	Children

* Also Lesbians; Bisexuals; Transgendered

MAIN PARTNERS:

Public sector		Ministry of Public Health including National AIDS Programme; Ministry of Social Affairs; Police
Civil society	NATIONAL	Youth advocacy networks; health networks; other NGOs including SIDC and Oui Pour la Vie
	INTER-NATIONAL	International HIV/AIDS Alliance; Astrea
Bilateral agencies / Multilateral organizations		United Nations System; Norwegian Embassy; German Embassy; Ford Foundation
Networks		

Men who have sex with men programme

GEOGRAPHIC COVERAGE:	TOTAL MSM REACHED 2011 * *(as reported by the NGO)*	NUMBER OF OUTREACH WORKERS:
Beirut	5785 ⚤	7 🚶

* Number reached by the 3 NGOs: SIDC, Helem and Oui pour la Vie

START-UP ASSESSMENT:

Mapping	Size estimation	Identification of existing services	Information from studies
✓		✓	

SERVICES PROVIDED	Outreach	Drop-in-Center	Referral	Comments
Information & Awareness:				Also provided through the web
Prevention	■	□	■	
Know your HIV status	■	□	■	
STI	■	□	■	
Stigma	■	■	■	
Where to go (referral)	■	□	□	
Condom provision	■	□	■	
Lubricant provision	■	□	■	
HIV Testing - rapid	■	□	■	Mobile unit for outreach work
HIV Testing – non-rapid	□	□	□	
Pre-test HIV counseling	■	□	■	
Post-test HIV counseling	■	□	■	
STI screening & treatment				
Screening	□	□	■	
Treatment	□	□	■	
Legal support / counseling	□	■	□	Lawyer and legal counselor at Helem
Psychosocial support				1 social worker, 3 psychologists and 1 counselor for PLHIV
Peer support group	□	□	■	Meetings done with a social assistant
Individual counseling	□	□	■	
Family mediation	□	■	□	Booklet for the family developed. Social worker or psychologist support.

ADVOCACY

National authorities	Local authorities	Police	Community	Religious leaders	Media	Lawyers	Other NGOs
	✓	✓		✓	✓	✓	

Oui Pour la Vie (OPV)
LEBANON

www.ouipourlavielb.com

MISSION:

OPV represents a growing group of volunteers committed to reaching out to impoverished people and youth to identify their diverse needs and work on their fulfillment including through gathering donations, adopting a referral system, and spreading awareness among young people about risks.

YEAR ESTABLISHED:

1980	1985	1990	1995	2000	2005	2010	2015

2009

FOUNDING PRINCIPLES:

Proactively exploring people's needs and fulfilling them

MAIN HIV PROGRAMMES:

1   Awareness raising about the risks of drugs and their implications on youth, families and communities;

2   Health education and outreach programmes among key populations at higher risk;

3   Promotion of health and societal value.

POPULATIONS OF CONCERN:

Men who have sex with men	Sex workers	Migrants	People Living with HIV	Prisoners	People who inject drugs	Women	Young people	Children

MAIN PARTNERS:

Public sector	🏛	Ministry of Public Health including National AIDS Programme; Ministry of Social Affairs
Civil society	NATIONAL	Other NGOs including SIDC, Helem
	INTER-NATIONAL	International HIV/AIDS Alliance; Italian NGOs
Bilateral agencies / Multilateral organizations		United Nations System
Networks		

Men who have sex with men programme

GEOGRAPHIC COVERAGE:	TOTAL MSM REACHED 2011 * *(as reported by the NGO)*	NUMBER OF OUTREACH WORKERS:
El damour, Elshoulf, Saida and Tripoli	5785 ♂	5 🚶

* Number reached by the 3 NGOs: SIDC, Helem and Oui pour la Vie

START-UP ASSESSMENT:

Mapping	Size estimation	Identification of existing services	Information from studies
✓		✓	

SERVICES PROVIDED	Outreach	Drop-in-Center	Referral	Comments
Information & Awareness:				Also provided through the web
Prevention	🟥	🟥	⬜	
Know your HIV status	🟥	⬜	⬜	
STI	🟥	⬜	⬜	
Stigma	🟥	⬜	⬜	
Where to go (referral)	🟥	⬜	⬜	
Condom provision	🟥	🟥	⬜	
Lubricant provision	🟥	🟥	⬜	
HIV Testing - rapid	⬜	🟥	⬜	
HIV Testing – non-rapid	⬜	⬜	⬜	
Pre-test HIV counseling	⬜	🟥	⬜	
Post-test HIV counseling	⬜	🟥	⬜	
STI screening & treatment				
Screening	⬜	⬜	🟥	
Treatment	⬜	⬜	🟥	
Legal support / counseling	⬜	⬜	🟥	Helem
Psychosocial support				
Peer support group	⬜	🟥	⬜	
Individual counseling	⬜	⬜	⬜	
Family mediation	⬜	⬜	⬜	

ADVOCACY

National authorities	Local authorities	Police	Community	Religious leaders	Media	Lawyers	Other NGOs
✓		✓					

2

Association de lutte contre le sida (ALCS)
MOROCCO

www.alcsmaroc.ma
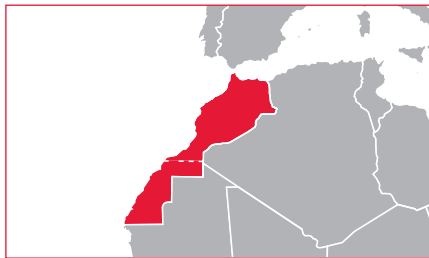
MISSION:

Fight for access to rights of persons affected by HIV.

YEAR ESTABLISHED:

| 1980 | 1985 | 1990 | 1995 | 2000 | 2005 | 2010 | 2015 |

1988

FOUNDING PRINCIPLES:

Respect for human rights and ethical principles of neutrality and confidentiality

MAIN HIV PROGRAMMES:

1. Prevention of HIV/ STIs;
2. Comprehensive care for people living with HIV including medical, psychological, physical, and social support;
3. Defending the rights of people living with HIV: the right to care, to work, to life.

POPULATIONS OF CONCERN:

| Men who have sex with men | Sex workers | Migrants | People Living with HIV | Prisoners | People who inject drugs | Women | Young people | Children |

MAIN PARTNERS:

Public sector	Ministry of Health; Ministry of Social Development of Family and Solidarity; Ministry of Education; Ministry of Justice; Institut national d'hygiène
Civil society	NATIONAL
	INTER-NATIONAL — Act Up Paris; AIDES; Coalition Plus; Sidaction; Sida Info Service; Plateforme Elsa
Bilateral agencies / Multilateral organizations	Global Fund; United Nations system; Open Society Fundation; Ford Fundation; Amfar; GSK; Drosos; Esther; Total
Networks	ICASO; Regional / Arab Network Against AIDS (RANAA); Afrique 2000; International Treatment Preparedness Coalition (ITPC) Global; ITPC MENA

Men who have sex with men programme

GEOGRAPHIC COVERAGE:	TOTAL MSM REACHED 2011 * *(as reported by the NGO)*	NUMBER OF OUTREACH WORKERS:
Tangier, El Jadida, Agadir, Marrakesh, Essaouira, Meknes, Tiznit, Casablanca, Rabat	40991	108

* Total number of old and new contacts

START-UP ASSESSMENT:

| Mapping	Size estimation	Identification of existing services	Information from studies
✔	✔	✔	✔

SERVICES PROVIDED	Outreach	Drop-in-Center	Referral	Comments
Information & Awareness:				Also provided through the web
Prevention	■	■	■	
Know your HIV status	■	■	■	
STI	■	■	■	
Stigma	■	■	■	
Where to go (referral)	■	■	■	
Condom provision	■	■	■	
Lubricant provision	■	■	■	
HIV Testing - rapid	■	■	■	Mobile unit for outreach work
HIV Testing – non-rapid	■	■	■	
Pre-test HIV counseling	■	■	■	Mobile unit for outreach work
Post-test HIV counseling	■	■	■	Mobile unit for outreach work
STI screening & treatment				
Screening	■	■	■	
Treatment	■	■	■	
Legal support / counseling	■	■	■	
Psychosocial support				
Peer support group	■	■	■	
Individual counseling	■	■	■	
Family mediation	■	■	■	

Clinic of MSM in ALCS Marrakech providing comprehensive treatment, care and support

ADVOCACY

National authorities	Local authorities	Police	Community	Religious leaders	Media	Lawyers	Other NGOs
✔	✔	✔	✔		✔		✔

2

Association Sud Contre le sida
MOROCCO

YEAR ESTABLISHED:

| 1980 | 1985 | 1990 | 1995 | 2000 | 2005 | 2010 | 2015 |

1990

FOUNDING PRINCIPLES:

1. Fight against AIDS within the context of denial especially in the early 1990's
2. Support people living with HIV

MISSION:

Mobilize needed resources to implement HIV prevention, treatment care and support programmes and promote health.

MAIN HIV PROGRAMMES:

1. Inform citizens about all aspects of STIs and HIV;
2. Ensure anonymous and free HIV testing;
3. Ensure psycho-social support to people living with HIV;
4. Implement prevention activities for populations at higher risk without neglecting the campaigns for the general public.

POPULATIONS OF CONCERN:

Men who have sex with men	Sex workers	Migrants	People Living with HIV	Prisoners	People who inject drugs	Women	Young people	Children

MAIN PARTNERS:

Public sector	Ministry of Health; Ministry of National Education; Ministry of Justice; local authorities
Civil society	NATIONAL / INTER-NATIONAL
Bilateral agencies / Multilateral organizations	Global Fund; Belgian Technical Cooperation (BTC)
Networks	Regional / Arab Network Against AIDS (RANAA); Alliance Marocaine de Lutte Contre le sida

Men who have sex with men programme

GEOGRAPHIC COVERAGE:	TOTAL MSM REACHED 2011 *(as reported by the NGO)*	NUMBER OF OUTREACH WORKERS:
Agadir	626	6

START-UP ASSESSMENT:

Mapping	Size estimation	Identification of existing services	Information from studies
✓		✓	

SERVICES PROVIDED	Outreach	Drop-in-Center	Referral	Comments
Information & Awareness:				
Prevention	■	■	□	
Know your HIV status	■	■	□	
STI	□	■	□	
Stigma	■	■	□	
Where to go (referral)	■	■	□	
Condom provision	■	■	□	
Lubricant provision	□	□	□	
HIV Testing - rapid	□	■	□	
HIV Testing – non-rapid	□	□	□	
Pre-test HIV counseling	□	■	□	
Post-test HIV counseling	□	■	□	
STI screening & treatment				
Screening	□	■	□	
Treatment	□	■	□	
Legal support / counseling	□	□	□	
Psychosocial support				
Peer support group	□	■	□	
Individual counseling	■	■	□	
Family mediation	□	□	□	

ADVOCACY

National authorities	Local authorities	Police	Community	Religious leaders	Media	Lawyers	Other NGOs
✓	✓	✓	✓				✓

2

Tunisian Association fighting against STIs and AIDS
(ATL MST/sida - Tunis)   *TUNISIA*

YEAR ESTABLISHED:

| 1980 | 1985 | 1990 | 1995 | 2000 | 2005 | 2010 | 2015 |

1990

FOUNDING PRINCIPLES:

Community participatory approach

MISSION:

Fight against the spread of HIV in Tunisia and reduce its impact at all levels.

MAIN HIV PROGRAMMES:

1. Prevention of HIV/STIs among key populations
2. Comprehensive care including psychological, legal, nutritional, and socio- professional support for people living with HIV;
3. Advocacy and stigma reduction towards key populations;
4. Capacity strengthening of ATL beneficiaries: youth; people living with HIV; key populations;
5. Conducting studies and action research.

POPULATIONS OF CONCERN:

Men who have sex with men	Sex workers	Migrants	People Living with HIV	Prisoners	People who inject drugs	Women	Young people	Children

MAIN PARTNERS:

Public sector		Local authorities
Civil society	NATIONAL	Religious leaders
	INTER-NATIONAL	International HIV/AIDS Alliance; AIDES France ; Sidaction
Bilateral agencies / Multilateral organizations		United Nations system; Embassies of USA and Netherlands
Networks		Regional / Arab Network Against AIDS (RANAA); Africagay contre le sida; Middle East and North Africa Harm Reduction Association (MENAHRA); MENA Rosa; Réseau Afrique2000; Réseau Associatif National Contre le sida (RANCS)

Men who have sex with men programme

GEOGRAPHIC COVERAGE:	TOTAL MSM REACHED 2011 *(as reported by the NGO)*	NUMBER OF OUTREACH WORKERS:
Grand Tunis (4 governorates), Sousse, Bizerte, Tozeur, Nabeul, Sfax	10498	32

START-UP ASSESSMENT:

Mapping	Size estimation	Identification of existing services	Information from studies
✓	✓	✓	✓

SERVICES PROVIDED	Outreach	Drop-in-Center *	Referral	Comments
Information & Awareness:				
Prevention	■	■	□	
Know your HIV status	■	■	□	
STI	■	■	□	
Stigma	■	■	□	
Where to go (referral)	■	■	□	
Condom provision	■	■	□	
Lubricant provision	■	■	□	
HIV Testing - rapid	□	■	■	
HIV Testing – non-rapid	□	□	■	
Pre-test HIV counseling	□	■	■	
Post-test HIV counseling	□	■	■	
STI screening & treatment				
Screening	□	□	■	
Treatment	□	□	■	
Legal support / counseling	□	□	□	
Psychosocial support				
Peer support group	□	□	□	
Individual counseling	■	□	□	Informal way
Family mediation	□	□	□	

* The NGO does not have a drop-in center. The services are provided in the NGO premises

ADVOCACY

National authorities	Local authorities	Police	Community	Religious leaders	Media	Lawyers	Other NGOs
✓	✓	✓	✓	✓	✓	✓	✓

2

AID Association
YEMEN

YEAR ESTABLISHED:

| 1980 | 1985 | 1990 | 1995 | 2000 | 2005 | 2010 | 2015 |

2007

FOUNDING PRINCIPLES:

A society that is knowledgeable about HIV prevention and compassionate with people living with HIV

MISSION:

Reduce the spread of HIV and STIs in the society, as well as empower people living with HIV and create an enabling environment for them.

MAIN HIV PROGRAMMES:

1. Raise awareness about AIDS among key populations and other vulnerable groups;
2. Undertake HIV/STI prevention activities;
3. Provide psychosocial support for people living with HIV and men who have sex with men;
4. Empower people living with HIV economically, and develop their life skills.

POPULATIONS OF CONCERN:

| Men who have sex with men | Sex workers | Migrants | People Living with HIV | Prisoners | People who inject drugs | Women | Young people | Children |

MAIN PARTNERS:

Public sector		Ministry of Public Health and Population including National AIDS Programme; National Population Council; Ministry of Youth and Sports; Ministry of Tourism; local council; a number of health care facilities, newspapers and local satellite channels
Civil society	NATIONAL	Family Care Association; Social Reform Society Charity; other local associations; Yemeni Red Crescent
	INTER-NATIONAL	Doctors without Borders; Progressio
Bilateral agencies / Multilateral organizations		United Nations system; Global Fund; USAID
Networks		Regional/ Arab Network Against AIDS (RANAA)

Men who have sex with men programme

GEOGRAPHIC COVERAGE:	TOTAL MSM REACHED 2011 *(as reported by the NGO)*	NUMBER OF OUTREACH WORKERS:
Sana'a	**90** ⚤	**3** 🚶

START-UP ASSESSMENT:

Mapping	Size estimation	Identification of existing services	Information from studies
✓	✓	✓	✓

SERVICES PROVIDED	Outreach	Drop-in-Center *	Referral	Comments
Information & Awareness:				
Prevention	🟥	🟥	⬜	
Know your HIV status	🟥	🟥	⬜	
STI	🟥	🟥	⬜	
Stigma	🟥	🟥	⬜	
Where to go (referral)	🟥	🟥	⬜	
Condom provision	⬜	🟥	⬜	
Lubricant provision	⬜	🟥	⬜	Supply in the NGO of limited quantity. Beneficiaries referred to pharmacies
HIV Testing - rapid	⬜	🟥	⬜	
HIV Testing – non-rapid	⬜	⬜	🟥	
Pre-test HIV counseling	⬜	🟥	⬜	
Post-test HIV counseling	⬜	🟥	⬜	
STI screening & treatment				
Screening	⬜	⬜	🟥	
Treatment	⬜	⬜	🟥	
Legal support / counseling	⬜	⬜	🟥	
Psychosocial support				
Peer support group	⬜	🟥	⬜	
Individual counseling	⬜	🟥	⬜	
Family mediation	🟥	⬜	⬜	Home visits by outreach workers according to needs

* The NGO does not have a drop-in center. The services are provided in the NGO premises

ADVOCACY

National authorities	Local authorities	Police	Community	Religious leaders	Media	Lawyers	Other NGOs
	✓	✓	✓		✓		

Abu Musa Al Ashari Social Charitable Association
YEMEN

www.alashary-ye.com

MISSION:

Contribute to the development of the society by means of providing needed services to certain segments, through effective local and international partnerships and qualified cadres.

YEAR ESTABLISHED:

1980	1985	1990	1995	2000	2005	2010	2015

1999

FOUNDING PRINCIPLES:

1. Transparency
2. Credibility
3. Partnership
4. Accountability
5. Quality

MAIN HIV PROGRAMMES:

1. Raise awareness of society about HIV;
2. Advocate with stakeholders;
3. Provide care and support to people living with HIV;
4. Implement outreach programmes for men who have sex with men and sex workers.

POPULATIONS OF CONCERN:

Men who have sex with men	Sex workers	Migrants	People Living with HIV	Prisoners	People who inject drugs	Women	Young people	Children

MAIN PARTNERS:

Public sector		Ministry of Public Health and Population including National AIDS Programme; National Population Council; National Women Council
Civil society	NATIONAL	A number of local charitable associations; developmental organizations; Yemeni Women's Union
	INTER-NATIONAL	World Assembly of Muslim Youth; Kattouf Foundation for Development; UAE Red Crescent; Makkah Al Mukarramah Charitable Organization; Soul for Development Organization; Global Humanitarian Forum; Progressio
Bilateral agencies / Multilateral organizations		United Nations system; European Union; International Islamic Relief Organization; German Society for International Cooperation (GIZ)
Networks		Regional/ Arab Network Against AIDS (RANAA)

Men who have sex with men programme

GEOGRAPHIC COVERAGE:	TOTAL MSM REACHED 2011 *(as reported by the NGO)*	NUMBER OF OUTREACH WORKERS:
Hoddeidah	100	0

START-UP ASSESSMENT:

Mapping	Size estimation	Identification of existing services	Information from studies
✓	✓	✓	✓

SERVICES PROVIDED	Outreach	Drop-in-Center	Referral	Comments
Information & Awareness:				
Prevention	□	■	□	
Know your HIV status	□	■	□	
STI	□	■	□	
Stigma	□	■	□	
Where to go (referral)	□	■	□	
Condom provision	□	□	□	
Lubricant provision	□	□	□	
HIV Testing - rapid	□	■	□	
HIV Testing – non-rapid	□	□	□	
Pre-test HIV counseling	□	■	□	
Post-test HIV counseling	□	■	□	
STI screening & treatment				
Screening	□	□	■	
Treatment	□	□	■	
Legal support / counseling	□	□	□	
Psychosocial support				
Peer support group	□	■	□	
Individual counseling	□	■	□	
Family mediation	□	■	□	

ADVOCACY

National authorities	Local authorities	Police	Community	Religious leaders	Media	Lawyers	Other NGOs
	✓	✓	✓				

Social Services Association (SSA)
YEMEN

YEAR ESTABLISHED:

1980	1985	1990	1995	2000	2005	2010	2015

2004

FOUNDING PRINCIPLES:

Social development of marginalized populations through social equality

MISSION:

To develop the local community through building capacities and free provision of educational, health, developmental and social services for the poor and marginalized populations, children, women and young people.

MAIN HIV PROGRAMMES:

1. Raise awareness about HIV;
2. Undertake HIV/STI prevention activities;
3. Advocate with stakeholders;
4. Provide care and support for people living with HIV.

POPULATIONS OF CONCERN:

Men who have sex with men	Sex workers	Migrants	People Living with HIV	Prisoners	People who inject drugs	Women	Young people	Children

MAIN PARTNERS:

Public sector		Ministry of Public Health and Population; National Population Council; Local Council; Criminal Research Department
Civil society	NATIONAL	Other associations
	INTER-NATIONAL	Save the Children
Bilateral agencies / Multilateral organizations		United Nations system
Networks		Regional/ Arab Network Against AIDS (RANAA)

Men who have sex with men programme

GEOGRAPHIC COVERAGE:	TOTAL MSM REACHED 2011 *(as reported by the NGO)*	NUMBER OF OUTREACH WORKERS:
Aden	400 ♂	13 🚶

START-UP ASSESSMENT:

Mapping	Size estimation	Identification of existing services	Information from studies
✓	✓	✓	✓

SERVICES PROVIDED	Outreach	Drop-in-Center	Referral	Comments
Information & Awareness:				
Prevention	■	■	□	
Know your HIV status	■	■	□	
STI	□	□	□	
Stigma	□	□	□	
Where to go (referral)	■	□	□	
Condom provision	■	■	□	
Lubricant provision	□	□	□	Not yet provided as prices are expensive
***HIV Testing - rapid ***	■	■	■	
HIV Testing – non-rapid	□	□	□	
Pre-test HIV counseling	□	■	■	
Post-test HIV counseling	□	■	■	
STI screening & treatment				
Screening	□	□	■	Part of new project
Treatment	□	□	■	Part of new project
Legal support / counseling*	□	■	□	
Psychosocial support				
Peer support group	□	□	□	
Individual counseling	□	■	□	Done but on personal basis with manager-VCT
Family mediation	□	□	□	

* Mobile outreach team during WAD. Referral to other VCTs based on preferences of beneficiaries
** Currently on personal basis but lawyer to be provided in new project

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ADVOCACY

National authorities	Local authorities	Police	Community	Religious leaders	Media	Lawyers	Other NGOs
	✓	✓	✓				

2

Resources:

ENGLISH AND FRENCH

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HIV AND OUTREACH PROGRAMMES WITH MEN WHO HAVE SEX WITH MEN IN THE MIDDLE EAST AND NORTH AFRICA

MODULE 3/4
THE OUTREACH APPROACH

3 – The outreach approach

This module contains information on the outreach approach, particularly what is meant by direct contact of outreach workers with MSM (3.1); the required conditions for the selection of outreach workers and their roles (3.2); the areas of training necessary for performing outreach (3.3); and peer education (3.4). Some scenarios for field work are presented at the end of the module.

This module is designed for programme coordinators and outreach workers.

3.1 Contacts of outreach workers with MSM

Tell me, what do you know about the outreach approach?

DEFINITION OF DIRECT CONTACT

The outreach approach is a specific method that aims to reach key populations who are kept outside of services such as health facilities and promote access to these services. These populations may consist of MSM, sex workers, migrants, etc. This method facilitates the promotion of health through:

- increasing awareness of risk-taking behaviour;

- encouraging the reduction of risk-taking behaviour;

- providing prevention services according to individual needs.

Outreach work is accomplished by foot, day and night. The outreach worker takes the initiative to reach out to people, get close to them and make contact with them to initiate dialogue. In this way, opportunities to meet

people and make contacts increase considerably.

The outreach approach is characterized by the development of trusting relationships with key populations.

Making contact leads to establishing a relationship through a meeting.

Yes, but what value does the established contact have?

Establishing contact with someone should enable access to and knowledge about his environment.

To achieve this goal, the following recommendations should be considered:

- As a first step, it is important to assess whether the local context will enable contact with MSM. An outreach worker should carefully observe the individual to determine the appropriate moment to make contact. For example, the outreach worker should avoid interrupting the individual while working.

- The outreach worker should facilitate the approach by presenting himself and his institution to the person met: the individual should know who the outreach worker is, where he comes from and why he is approaching him.

- Knowing and using the specific languages and terminologies of the population to which the person belongs can help make contact.

- It is necessary to get the advice of MSM on how to approach and communicate

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with their community. For example, one should not call an MSM named Ahmed – who one finds effeminate – Hamida, unless he requests it.

- It is important for MSM to accept external intrusions into their population.

- Outreach workers should be cautious about comparing their experiences with those of the people they reach. Experiences are different and this difference should be recognized.

The definition of contact as approved by all parties should be included in the national written guidelines used by all civil society organizations working with MSM.

This harmonization effort will help compare results between implementing agencies and construct the national coverage indicator on MSM programmes (i.e. the percentage of MSM covered by prevention programmes). A recommended minimum package of basic services for MSM programmes includes:

- provision of information;

- provision of condoms and lubricants;

- referral to services (e.g. medical, legal, social).

When providing information, the outreach workers should also tell about the days and times they will be working in the field. Ideally, the same outreach workers are on duty in the field on the same day, at the same time and in the same locations every week.

A regular presence can build a relationship of trust between the outreach workers and the MSM.

"The outreach worker should be associated with credible services that are of high quality."
Outreach worker

Within this framework all information is provided on a regular basis.

One way of ensuring and monitoring programme uptake is to offer a code to MSM who may accept it. This code allows for the preservation of anonymity and safety in hostile and discriminatory contexts.

Assigning a code should be preceded by an HIV knowledge pretest, which evaluates the level of knowledge and the behaviours related to HIV transmission. A similar post-test should be performed on a regular basis to verify the changes in knowledge, behaviours and risk taking (*see Module 4, Programme Monitoring*).

Certain rules should be followed during field work. On next page you can find a table with the most important ones

PROCESS OF HEALTH PROMOTION

The outreach approach cannot be considered in isolation. It should be integrated in a process involving different stakeholders simultaneously, who share the same goals, and should be part of a health promotion process.

Ground rules for fieldwork

- Listen carefully.

- Favour speech during communication (i.e. do not rely on body language).

- Respect the language that is being used by MSM.

- Be flexible, neutral and available.

- Take care of the person as a whole.

- Accept that you may be pushed away or rejected – the person being approached does not have to listen.

- Respect distance.

- Respect the fear of others and remember that anyone may be afraid.

- Do not make promises that are impossible to keep.

- Take the time to approach the person and establish trust.

- Consider that meetings during fieldwork may cease.

- Meet the MSM on a regular basis to establish a relationship and overcome the legitimate suspicion of the person who is being approached. People often wonder why the outreach worker chose them rather than someone else.

- Pre-establish a weekly schedule of meetings indicating the date, place and time; irregular meetings can break up the relationship.

- Warn the field coordinator of any changes during the course of the programme.

Don't forget! the link that is established during a programme initiative must be part of a health promotion process.

To promote health, the following steps should be followed:

- **Awareness** is necessary to motivate people to participate in programmes that promote health.

- **Lifestyle changes and competence building** should take place gradually. Early in the process, a large amount of information is provided to allow for subsequent proper internalization of the health promotion principle. These two steps can only be carried out in a favourable environment, which enables a long-term impact.

- **Build a favourable environment**. This enables outreach workers to concentrate on the holistic approach that includes legal, political and other social parameters.

REDUCING STIGMA IN THE FIELD

But don't you think that outreach work may provoke even more stigma towards people who are being approached?

You are right, at first glance. In fact, there are means to limit stigmatization. It all depends on the approach that is adopted by the outreach worker.

Outreach work should be carried out on foot. This approach provides direct, frank, personal and anonymous contact.

It should systematically promote face to face contact. Nevertheless, telephone or Internet contact should not be neglected, and some MSM prefer keeping their anonymity through the use of these means.

The secret of successful outreach is the establishment of a trusting relationship. The MSM has the right to refuse contact, or might feel the need to justify himself and answer in a politically correct manner. The outreach worker should respect these behaviours.

Once the relationship of trust is established, focus should be given to the message to communicate. The purpose of the message is to inform an individual on HIV.

When outreach workers communicate their message, they assist in HIV prevention and guide the MSM to quality services. To be effective, the message should be:

- Concise, objective (as much as possible), clear and specific. However, it requires a certain period to mature so that it can be properly communicated. Field experience will help outreach workers to develop their communication skills.

- The message should correspond directly to the MSM needs. For example, it is irrelevant to recommend a certain physician to a sex worker who is about to go to court.

- The message should follow the community

codes to be understood. The message cannot be confusing, or the community will not understand it.

- Before conveying the message, it should be piloted with a sample of MSM and adjusted based on responses.

Messages should be monitored regularly using case studies and role playing. This technique ensures that the message remains clear and concise, rather than complicated, inappropriate and incomprehensible.

The two following evolution trends could cause poor communication of messages.

- The training path of some outreach workers may enable them to acquire new skills that cause the workers to distance themselves from the community.

- Some outreach workers can adopt a paternalistic behaviour in communicating the message, and look down on people.

In summary,
before conveying a message,
it is important to think!

A message that is not concise,
clear and thought-out
is useless, and amounts to,
as per the Arab saying,
"mixing water with sand".

USING THE INTERNET AND OTHER NEW TECHNOLOGIES

Can the Internet be useful in outreach?

Of course!
The Internet is a meeting place for the MSM community; it can therefore be quite useful for us.

The Internet is a meeting place for the MSM community, through which they seek love or sexual partners, or participate in discussion forums. For male sex workers, the internet can become an area of soliciting and offering sex.

All social classes use the Internet to interact with other people. This technology enables new means of communication. Rather than meeting face to face, the Internet user communicates under a nickname, through e-mail, chat sites (e.g. gay sites, Facebook, Twitter) and photographs.

The Internet sometimes replaces the usual means of interacting. It allows MSM to protect their identity from public scrutiny and harassment from the police. However, the Internet has some risks, especially when the person with whom the MSM is communicating is not honest. Traps could also be set by authorities to arrest people.

In countries of the MENA region, these web sites are often watched by national security agencies.

The widespread use of the Internet among MSM means it can also be used to promote HIV prevention and quality services. Outreach workers can use the Internet to meet MSM in chat rooms and convey their messages.

Other technologies allow MSM to contact one another in a semi-anonymous manner. For example, there are many mobile phone applications that are marketed to the MSM community that enable a user to detect the presence of another person and exchange private messages in real-time and based on their proximity to each other. Once two users are connected, they can share contact information and arrange to meet. Such applications are used often in parks, bars, cafés, nightclubs and gyms. A disadvantage of location-based services is that it could be misused by people and authorities looking to harm or threaten MSM.

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Remember!

- The outreach approach is characterized by the development of trusting relationships with the populations involved.

- The outreach approach should be integrated in a process involving different stakeholders simultaneously, who share the same goals, and should be part of a health promotion process.

- Once the relationship of trust is established, focus should be given to the message to communicate. To be effective, the message should be concise, objective as much as possible, clear and specific. However, it requires a certain period to mature so that it can be properly communicated. Field experience will help outreach workers to develop their communication skills.

- Outreach workers should be trained in new technologies and methods used by MSM to get together, including internet.

3.2 Selection of outreach workers

Is it enough to be an MSM to become an outreach worker? Can all MSM do this job?

To become an outreach worker, being an MSM can be very useful, but is certainly not sufficient!

Choosing the outreach workers is a selection process that begins on the street. The selection takes into consideration a number of criteria required to accomplish the task:

- **The position of these persons within the MSM population**: it is true that if the person is already a part of the MSM community, contact is easier. However, in similar initiatives, people already in contact with the community were able to contribute, even though they were not MSM. These people can be, for example, café workers, shisha sellers, bartenders, toilet staff, hairdressers or professionals who have shown an interest in the programme;

- Their **background**: experience in outreach work; experience as social workers, psychologists etc.;

- Their **attributes** (*see next page*);

- Their **age**: depending on the location of the outreach and the people met, only individuals of a certain age may be appropriate. MSM between 25 and 30 years old prefer an outreach worker of a similar age, since they will have common topics to share and communication will be established in a smoother manner;

- The possibility of being geographically mobile.

Attributes of outreach workers

Several attributes are required of the outreach workers, the most important of which are flexibility and the ability to integrate into a group. The outreach worker should:

- have in-depth knowledge of the key population addressed;

- be accepted by the community or demonstrate a flexible behaviour that will facilitate his integration;

- be prepared to perform outreach work – some physical and psychological capabilities are required;

- have the spirit of an explorer and be willing to work both day and night, in insecure places;

- be able to work in teams and demonstrate a spirit of collaboration;

- have strong negotiation and persuasion skills to convey the message;

- be discreet, neutral and ethical. This includes respect for the rule that he is forbidden to use the programme for personal purposes;

- have communication skills, particularly being able to communicate with different subpopulations that comprise MSM communities (e.g. sex workers, people who use drugs);

- be capable of empathy;

- be able to listen attentively;

- have good observation and memorization skills;

- be methodical and analytical;

- respect the confidentiality of information received;

- respect working hours;

- be open to the use of new technologies.

Workshops are organized to provide basic training on HIV. During these workshops, participants are made to face challenges, and their way of interacting with the group is observed.

This observation leads to the selection of future outreach workers, who then undergo individual interviews (*see section on Training Outreach Workers*).

3.3 Roles and responsibilities of outreach workers

We were talking about outreach workers. Who do you think they are?

They are people who meet with key populations to convey a message of HIV prevention. But I still don't know what the outreach worker must do during the outreach

I'm getting there! The outreach worker has various tasks

An outreach worker is an individual who meets with a population to provide information on health promotion and referral to quality services.

The ultimate goal of all interactions is to reduce risky behaviour and HIV transmission.

The outreach worker is responsible for:

■ locating meeting spots and setting up a mapping system in relation to the key population;

■ making contact with the key population, during day or night;

■ providing accurate and concise information about HIV, sexual health and the services offered through the programme;

■ distributing prevention kits containing condoms, lubricating gel and brochures (and sterile syringe kits, if the context permits);

■ guiding MSM to population-specific services, such as medical, legal, psychosocial, HIV testing or training services;

■ accompanying the person, if he so requests, to the services;

■ gathering information in the field using already agreed upon questionnaires. He should always have pens and paper carried in his bag, and be ready to write down information as quickly and discreetly as possible after the meeting;

■ entering data from the field into a database (e.g. to update the mapping system and ensure that each person is being monitored);

■ participating in programme trainings;

■ participating in studies and research concerning the programme;

■ attending weekly meetings (or more often, if required) to review collected information;

■ preparing monthly and quarterly reports;

■ participating in advocacy;

■ helping develop educational materials.

Approximate time allocated by outreach workers per activity
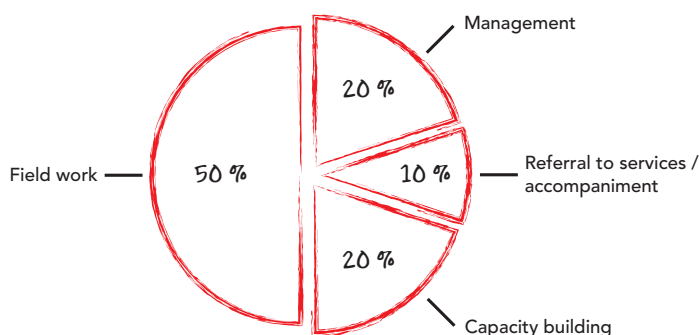
The outreach worker should:

- always carry his identity card and the document provided by the NGO or the National AIDS Programme allowing him to work;

- remain constantly with a co-outreach worker;

- introduce himself and the organization at the beginning of the conversation;

- carry a mobile telephone whose battery is charged, and with credit;

- carry money (a per diem provided by the NGO). The amount provided should be sufficient to fund public transport, charge the mobile phone, buy drinks in cafés or pubs where the outreach workers work, etc. The amount of funds depends on the location;

- always have a reference telephone number that can be called in case of emergency;

- wear discreet clothing;

- neither consume nor sell any alcohol or drugs in the workplace;

- always keep his drinks in front of him in cafés (outreach workers have had drugs poured into their glass without their knowledge);

- not use the workplace for personal purposes (e.g. flirting).

In return for his work, the outreach worker is entitled to receive appropriate payment. Volunteer outreach workers can be used, however, it is preferable to work with paid outreach workers, to ensure follow-up and sustainability of the programme.

TEAM DYNAMICS

Field experience in MENA region has shown that a team could consist of two MSM, or it could be mixed. This mix can be achieved by the intervention of:

- **An MSM and a non-MSM**. Both should possess the most important characteristics of a good outreach worker in the field – that is, empathy, acceptance of others, dedication and motivation to explore.

- **A man and a woman**. To plan for such a combination, one should ensure that the context is favourable. In Arab countries, this combination is complicated by the fact that many cafés are only frequented by men. Also, it is generally more discreet

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to only let men work in places such as streets or squares.

Why does a woman intervene in an exclusively male MSM community?

Sometimes, it may seem easier for some to confide in a woman who will be more understanding of the situation.

A few special cases may require one woman; in situations of male sex work, for example, outreach by men can raise suspicion. Here, the male outreach workers can be mistaken for police, clients, pimps or drug dealers.

Can an outreach worker go into the field alone?

Outreach workers inevitably move in pairs.

Moving in pairs has its advantages, as it gives the outreach workers the opportunity to:

- develop ongoing dialogue during fieldwork;

- face violence and insecurity, which may be unpredictable;

- collect more information, as being in pairs helps the workers remember more data between them;

- provide the individual who is being approached the opportunity to choose which worker to talk to;

- review together the information collected from the field for more accuracy and precision.

Intervening in pairs ensures the mental and physical security of each outreach worker!

When meeting an individual, involvement of a group of more than two outreach workers may be intimidating. Interaction with two workers is most appropriate, both for the outreach workers and the key population.

The pair must always remain the same for each activity to gain trust. If one of the outreach workers decides to leave, the second outreach worker should stay and be accompanied by a new outreach worker. That way, the people who are met in the field will maintain their comfort zone.

For the sake of their safety, under no circumstances should the outreach workers ever be separated.

Never forget that if one of the co-workers in the pair is absent, the activity should be cancelled.

SUPPORT GROUPS FOR OUTREACH WORKERS

It is beneficial for outreach workers to have monthly meetings led by a psychologist.

Outreach workers often ask for support for different reasons. This may be because they are confronted by:

- fear from other people
- their own fear
- several dramatic or difficult stories
- harassment

The job of an outreach worker can be stigmatizing itself, and some outreach workers may develop psychological problems related to their daily interactions with MSM. It is essential that the programme offers psychological counselling to avoid outreach workers becoming vulnerable to burnout.

Remember!

- Being an MSM is not sufficient to become an outreach worker; it is necessary to demonstrate specific attributes – in particular, the ability to be flexible and capable of integrating into a group.
- Regular visits by outreach teams contribute to a climate of trust. When contact is initiated on foot, it is more direct, honest and personal.
- The outreach worker should speak clearly, while using simple terms.
- An outreach team can be made of three different combinations: two MSM; one MSM and one non-MSM; or one MSM and a woman. The context determines the most appropriate combination.
- The outreach worker should respect basic safety rules.
- It is essential that the programme offers psychological counselling to avoid outreach workers becoming vulnerable to burnout.

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3.4 Training outreach workers

Are the previously discussed selection criteria for future field outreach workers sufficient for individuals selected to immediately intervene with the key populations?

Of course not! An entire training process must be followed. In reality, the selection process is not over.

The training portion is the last step in the selection process. Some of the individuals who complete the training do not become outreach workers. Training can reveal weaknesses in the individual who was shortlisted, or the person may realize that the job does not meet his expectations.

The training includes an initial part and a continuing part. Each training begins with a precise definition of final goals, against which the outreach worker's progress can be assessed.

The length of the training can vary according to the organizer's needs, equipment and human resources.

INITIAL TRAINING

To become an outreach worker, a person should already have all the competencies and personality traits described in the previous section "Selecting outreach workers". Nevertheless, this background is not enough. It is essential that the outreach worker follows a comprehensive training.

Initial training is carried out in two stages: overview and programme planning.

Stage 1 – Overview

Stage 1 trains participants in key notions, concepts and terminologies: The content of this stage of training is outlined below.

■ *Understanding the individual within society*. This part must be tailored to national contexts (Arab, sub-Saharan African, Christian, Muslim, Jewish, etc.). It forms part of a socio-anthropological approach that should enable one to understand the individual's place in society, the population's place in society, the individual's role within the population, the reasons for rejection of social "abnormalities", and the impact of media in building public opinion, be it positive or negative.

■ *Human rights, homosexuality, and gender*. This part addresses the issues of gender, differential treatment according to gender in the law, gender equality, Universal Declaration of Human Rights, dignity, homophobia, and law enforcement which is not always consistent with original texts.

■ *Sexual health*. Definition of sexuality, sexual practices between men and the risks related to these practices are discussed.

The training particularly addresses:

-   Sex education and reproductive health: what is the body, what are its functions, etc.

-   Sexually transmitted infections particularly HIV. The main topics to be discussed are:

    o   The national and international context of HIV

    o   Means of HIV transmission

    o   Methods of HIV prevention

    o   Voluntary and confidential HIV testing and pre and post counselling, guiding the individual if tested HIV positive or negative

    o   Methods of treatment, care and psychosocial support for people living with HIV according to national contexts
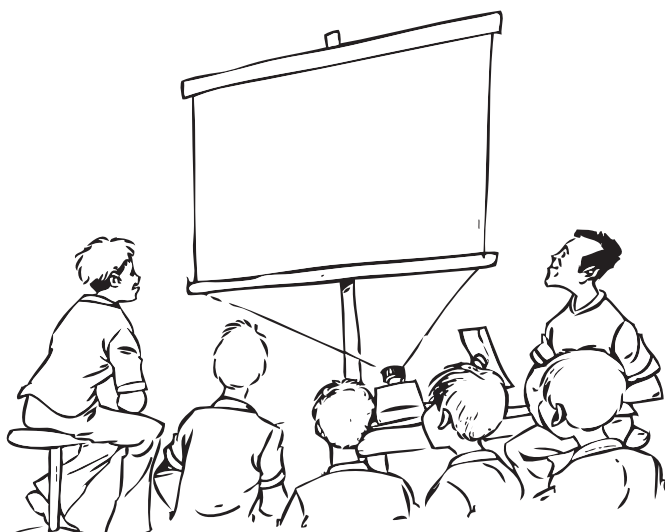
Stage 2 – Programme planning

Programme planning is an important part of an outreach worker's training. It provides recommendations after the analysis of the internal and external environments of an MSM community (*see Module 2*).

■ *Contextualization:* The first part of planning is to contextualize MSM, knowing that some of the training participants are MSM themselves. Questions such as the following are addressed:

- *Who are MSM?* What are the subpopulations within the population? How are the populations organized?

- *What are the sexual practices between MSM, and what are the risks related to these practices?*

- *What factors render MSM at risk in their own population?* What stigma do they suffer from within their population? What is self-stigmatization?

- *What external factors render MSM at risk?* How are bridges built between MSM and different authorities such as religious leaders, media, police, to reduce their vulnerability?

■ *Programme formulation:* The second part of planning is to formulate a programme that takes into account the responses to the questions addressed in the contextualization step. Several elements, discussed in Module 2, should be considered as part of the programme formulation: the overall vision; objectives; strategies; and action plan.

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CONTINUING EDUCATION

Continuing education aims to strengthen the outreach workers' skills, and give them the opportunity to progress. Several exercises and theoretical modules are offered during continuing education. These enable understanding all the topics included in this handbook and other topics briefly discussed below:

Training on information and messaging

This training includes exercises such as constructing messages, and marketing them.

Training on making contact with the key population

This training aims at developing communication skills.

Training about friendly service providers

This training aims at understanding:

■ the functioning and involvement of each medical, legal or psychological service;

■ how to ensure proper referral and support to these services.

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Training on advocacy, communication and mediation

This training has several objectives:

- develop the outreach workers' advocacy skills;

- teach outreach workers how to communicate with media, religious leaders and public institutions;

- teach outreach workers to prepare proposals for resource mobilization.

Training on leadership

This training aims to assess the strengths of participants and identify priorities for personal development.

Training on stress management

This training aims to understand the mechanisms of general adaptation syndrome or stress to better understand the sources of stress, and be able to respond to it.

Participants will learn ways to manage stress to ensure self-control and management of the situation.

Training on self-defence

This type of training concerns anyone exposed to violence. Its goal is to allow participants to act by analysing conditions that lead to violence and by using their own capacities to stop aggression.

Training on use of humour

This training gives people the key opportunity to express themselves and to provide answers to questions related to HIV prevention using humour. It helps develop the required competencies in many situations. The developed tools facilitate communication and internalization of prevention messages and avoid discouragement and lack of involvement.

Training in negotiation

This training teaches MSM about negotiating sexual relationships and condom use.

There are plenty of training courses!

New needs continuously emerge, and one should be ready to strengthen certain skills in accordance with what is happening in the field. A complementary approach to training is mentoring.

To strengthen outreach workers, some programmes in the region have set up a mentoring system. A mentor follows outreach workers to analyse their weaknesses and capabilities, and then put action items into place. Mentoring can be carried out by a field coordinator or an external person. It is important that outreach workers have a mentor.

In some programmes, people working as outreach workers cannot read and write. If an outreach worker who is illiterate is selected (perhaps because this person is so integrated in the community), it is essential that one of the objectives be to learn to read and write. It is also important that this person be always accompanied by a co-worker who is able to read and write.

EDUCATIONAL MATERIAL

Educational material presents educational messages resulting from consultations between the populations involved and the experts. Its purpose is to support the implementation of HIV prevention programmes among MSM as well as other communities.

The educational material is designed to better equip outreach workers in their HIV response strategy within their community.

Educational material can take various forms, such as:

- brochures
- recreational activities and games
- videos
- posters
- manuals
- artistic expression workshops (e.g. drawing, writing, singing).

The educational materials should be designed by the community for the community and should be useful for them. It must meet the objectives and needs of the community and be adapted to local circumstances.

Finally, the overlapping and duplication of educational materials should be avoided, which can be achieved through dialogue among the partners.

It is essential that the educational material come from the key populations, because it is addressed directly to them!

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Come see how a national working group in the MENA region thought of an educational tool based on backgammon ("tawla")!

Remember!

- The outreach worker receive training through field and academic courses. Ideally, capacity building should be gradual and continuous.
- Mentoring is a complementary method to the academic training. A mentor should support the outreach worker and help bring out his capacities.
- Educational material should be designed by the community, for the community, and it should be useful for them.
- The overlapping and duplication of educational materials should be avoided, which can be achieved through dialogue among the partners.

3.5 Peer education

Peer education can generally be described as the transfer of knowledge and practices. Public health professionals argue that using peer educators is the best way to convey information to individuals about HIV or other topics. In fact, the messages reach the key population more easily if they are communicated by people coming from within these populations: in other words, peers. Peers should serve as role models and should be sources of inspiration within their community.

In the context of programmes for MSM, a peer is someone who is similar to an outreach worker in age, gender, ethnicity and interest about health and HIV. The peer may be a friend, a neighbour, a colleague or a field outreach worker who could be hired within another programme. As the peer educator is a member of the community, he may intervene in specific situations to support the outreach workers in their efforts.

A peer educator should have specific characteristics. He should:

- be respected and accepted within the community;
- be charismatic;
- know how to read and write or work with another educator who can read and write;
- demonstrate good communication skills;
- be motivated to enhance and improve the situation of his community.

Outreach work and peer education should be seen as two sides of the same coin. Outreach workers are responsible for managing peer educators, including the regular evaluation of their performance. Therefore, they should be trained on how to manage peer educators to ensure close coordination between the two.

In the management of peer education it is important to be clear about the differences and similarities between staff outreach and peer outreach. Both are more or less similar in the content that is delivered in outreach. The difference lies in coverage of MSM. Since the outreach worker's time will also be used for a variety of other purposes including team meetings, documentation work and meeting with service providers and key stakeholders of the programme, he will not be able to reach as many MSM as he wishes

(see page 78. time allocated per activity). The peer educators will help expand the coverage.

SELECTION OF PEER EDUCATORS

Can anyone in the MSM community become a peer educator?

No, peer educators are selected in a two-step process.

The first step is based on the observation of interactions between the individual and his community. The community can also give advice and suggest certain people for the role of peer educator. The observation phase is important and will ensure that the people recommended by the community can play their role as peers.

During the second step of the selection process, selected individuals are made to face some challenges to demonstrate their skills to become peers. Thus, they should participate in theoretical trainings and practical exercises (role plays, etc.)

One should nevertheless be vigilant when choosing peer educators. Rivalries sometimes exist between the subpopulations.

ROLE OF PEER EDUCATORS

Peer education can be used to sensitize the community to all kinds of social phenomena and themes, such as HIV prevention. It aims to instil a dynamic within the community and mobilize it in a positive manner, so that it may develop qualities of commitment, participation and idealism. The aim of this awareness is to observe behaviour change

"Peer education strengthens the link with the communities."
Outreach worker

among MSM.

Several theories on the role of peer educator in behavior change have been developed (*see page 93, Resources*). These theories are all based on the fact that these individuals have an important influence on their community and act as agents of health promotion, providing role models for their community.

Peer education could also involve **back-up peer educators** who provide support on the ground in an adhoc manner. The back-up peer educator is responsible for:

- Supporting the establishment of a context of solidarity and understanding. He can, for example, organize awareness sessions in places where the MSM community feels secure. These sessions are moderated by the outreach workers.

- Distributing materials, or facilitating access to health and other services. This way, he would deliver the same message as an outreach worker and provide support in the field, particularly when the outreach workers are absent.

- Informing outreach workers of new individuals who have recently arrived in certain locations, or informing the community of the existence of outreach workers.

- Informing the programmes of changes that have taken place within the community or its surroundings. This information is essential, as it can generate modifications, for example, to the mapping system.

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It is very important that peer educators and back-up peer educators are considered as members of the community before being considered as members of the NGO. They might not receive a fixed salary, but they can receive daily allowances for their work. They should follow directives and respect the labour agreements that have been established with the NGO.

Both peer educators and back-up peer educators should be motivated through training. In reality, there is no specific adhoc training for peer educators. They receive the same training as the outreach workers (see page 81 Training of outreach workers), which covers the same topics, and a progressive development of skills to arrive at ownership of information and its usage in their work. Ideally, peer educators should be trained by the outreach workers themselves.

Remember!

- The selection of peer educators should go through two steps; an observation phase and a phase of selecting and embedding chosen individuals in theoretical trainings and practical exercises (role plays, etc.) .

- Training of peer educators should be continuous and provide the person with the tools to engage effectively.

Scenario 1

Ahmed and Ali prepare to meet an MSM in a café for the first time. The MSM is surprised and is not giving them the opportunity to communicate with him. He rejects them.

3
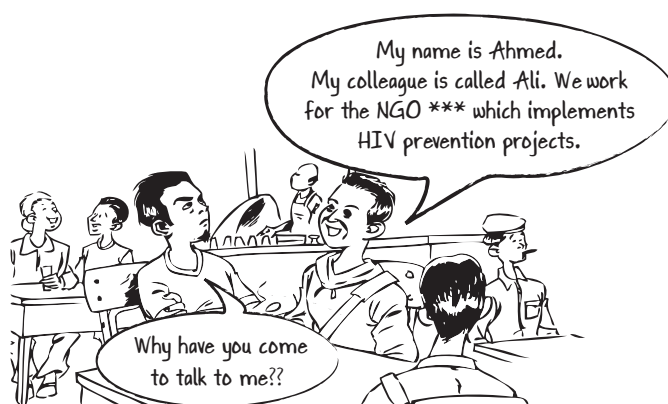
Scenario 2

The same MSM is sitting with another friend. Ahmed and Ali try to approach him. They talk about the project, but the MSM wants to socialize with new people rather than discuss an HIV prevention project.

Scenario 3

Ahmed and Ali try to approach Magdy again to talk to him about the project. He leaves them when he receives a telephone call.
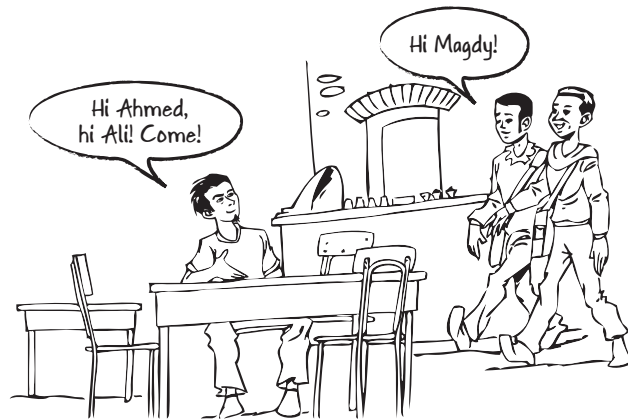
Scenario 4

Ahmed and Ali are sitting with Bassem at a table. Magdy comes over and joins them, surprised. Communication flows freely and contact is getting stronger.

> Hi Magdy!
> Let me introduce you to Ahmed and Ali! Have they told you about their project? It's really interesting for us!!

> We've already met! Hi Bassem !
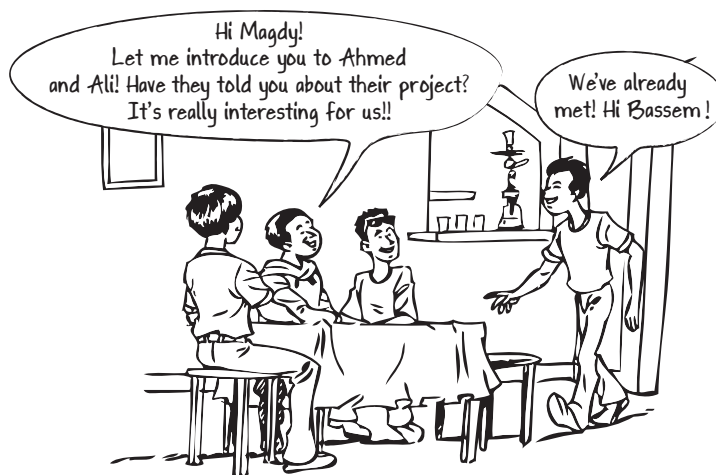
There is no single method for approaching a person. The situation varies by country, context and time.

Outreach workers should "feel" the field, so that they can make contact at the right time. They must be able to adapt to the context and grab the opportunities it offers.

> Establish contact with an MSM is not easy !

Resources

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- World Health Organization (WHO). *Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people*; Recommendations for a public health approach. Geneva, WHO, 2011.

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- Asia Pacific Coalition on Male Sexual Health (APCOM). *Policy brief: addressing the needs of young men who have sex with men*. Lucknow, APCOM, 2010.

- Soma. *Handbook of Peer Education; Self training module for Project Managers & Outreach Workers of Targeted Interventions*. Gujarat State AIDS Control Society & Project Support Unit (PSU), Kerala, India.

FRENCH

- Le Réseau des Chercheures Africaines (RECAF). *Guide des pair(e)s éducateur(trice)s pour la prévention du VIH/Sida*. Toronto, RECAF, 2004.

WEBSITES

- Alias: **www.alias-bru.be**
- Àmbit prevenció fundació: **www.fambitprevencio.org**
- Espace P: **www.espacep.be**
- European Network for HIV/STI Prevention and Health Promotion among Migrant Sex Workers (TAMPEP): **www.tampep.eu**
- Exæquo: **www.exaequo.be**
- Joint United Nations Programme on HIV/AIDS (UNAIDS): **www.unaids.org**
- **www.learning-theories.com/social-learning-theory-bandura.html**
- **http://people.umass.edu/aizen/f&a1975.html**
- **www.utwente.nl/cw/theorieenoverzicht/Levels%20of%20theories/macro/Diffusion%20of%20Innovation%20Theory.doc/**

3

HIV AND OUTREACH PROGRAMMES WITH MEN WHO HAVE SEX WITH MEN IN THE MIDDLE EAST AND NORTH AFRICA

MODULE 4/4
PROGRAMME MONITORING

4– Programme monitoring

This module describes the importance of a robust monitoring system (4.1), the key monitoring indicators (4.2), frequency of data collection (4.3), how to calculate and record indicators (4.4), and how to detect weaknesses in the monitoring system (4.5).

The module does not address the component of programme "evaluation" but provides a list of useful resources.

The module is designed specifically for programme coordinators and outreach workers.

Monitoring outreach programmes for men who have sex with men (MSM) forms an integral part of a national HIV monitoring and evaluation (M&E) system.

Monitoring MSM interventions involves many aspects of service and can be complex.

We need strong managers to adapt to the changing local situation and ensure resources are used effectively.

Some of the key challenges encountered are:

- **addressing multiple hard-to-reach mobile populations**
- **finding easily accessible outreach services**
- **coordinating services by an NGO network with different perspectives and capacities.**

4.1 Why use a monitoring system?

The monitoring system helps **to better understand services use over time**. It poses, for example, the following questions:

- Are trends in service delivery increasing, decreasing or staying the same?

- Are there any periods when the supply of service is exceptionally high or low?

- Are these periods due to how the programme is managed, or to other factors in the environment that the programme should try to address?

The monitoring system will help determine whether the programme is focusing on the right **subpopulations of the key population**.

- What is the profile of the subpopulations reached?

- Is it the highest risk subpopulation or just the subpopulation that is easiest to reach?

- Where to focus attention otherwise?

The data also help measure the **productivity** of each staff member or modes of service delivery by comparing a reasonable expectation of productivity to what is being achieved and the level of resources invested.

- Are staff members being used to their full potential?

- Is the programme operating on a sustainable, cost-effective basis?

These questions can be best answered during the regular coordination meetings involving programme coordinators and outreach workers, during which weekly achievements, challenges and bottlenecks are discussed, and solutions identified.

4

4.2 Key indicators for MSM programmes

Outreach workers can collect quality data if they understand why they are doing it and how this information can help them in their work and performance.

It is therefore important to ask the three following questions:

1. What is the objective of the programme?;
2. What information needs to be collected?;
3. Why is this information important?

Example:

- **What is the objective of the programme?** increase condom use by MSM.

- **What information needs to be collected?** number of condoms distributed per MSM; number of awareness sessions on prevention methods; level of knowledge of MSM on condom use as a preventive method; actual condom use by MSM.

- **Why is this information important?** An outreach worker may see that after a certain period, an individual who has received condoms and attended awareness sessions still do not use them, despite improved knowledge. The outreach worker can then discuss this with the MSM during their meetings, and identify ways to adjust the activities.

The core indicators of programme performance are measures of coverage of (1) outreach services, (2) service use and (3) the establishment of infrastructure. Programme coordinators need to select indicators from the list below that are relevant to their programme. The chosen indicators must also be in accordance with the priorities and quality standards set out by the national programme guidelines for MSM.

LIST OF INDICATORS

Coverage of outreach services:

- percentage of MSM contacted through outreach services
- number of condoms distributed to MSM.

Coverage of service use:

- number of individuals receiving a particular service;
- number of visits per service provided;
- percentage of MSM forecasted to come to the service;
- number of total visits per individual;
- number of MSM tested for HIV;
- number of MSM who have access to testing at the site during a one-year period compared with the total number of MSM in the area;
- number of MSM who participated in community mobilization activities;
- number of times stock-outs occurred during a reporting period;
- number of months or reporting periods in which no stock-out has occurred;
- processing time between receipt of an order for restock from a site, and delivery or receipt of the stock on-site;
- percentage of implementation sites receiving their regular supply of commodities on time;
- percentage of required funds for commodities that are in the budget.

Establishment of Infrastructure

This includes setting up physical locations for service sites, hiring and training staff, and establishing partnerships or obtaining support from opinion leaders or local authorities.

Two important infrastructure indicators should be assessed on an ongoing basis, as they are fundamental to implementation success.

1. Ratio of outreach workers to MSM covered by the programme.

   - Depending on the responsibility for commodity distribution, a ratio of 30–50 MSM to one outreach worker (working part-time and receiving some stipend or compensation) is a good benchmark for most programmes.

   - The maximum ratio should be specified by national guidelines, and each site can be regularly assessed to ensure sufficient workers are available to meet the demand for high-quality outreach.

2. Assessment of the local enabling environment, especially the incidents of raids, arrests or harassment of key populations by local police or other authorities.

   - This indicator is critical for interpreting other service statistics and should trigger follow-up action by managers through local advocacy.

4.3 Frequency of data collection

I am just worried that I have to spend my time with my colleagues collecting data instead of doing my outreach work! How often should I collect all these data?

First, you do not need to worry! You have to advise your manager not to select too many indicators at the beginning of the process. Once capacities increase, you can add more indicators.

Second, if you learn early how to collect and record the data, and understand why you are doing it, it will become easy over the long term. The key is to understand why it is important for you in your work to collect this specific information.

Coverage and service use data should be collected daily, in standardized formats, as services are provided. The data may be collated and analysed on a weekly, monthly or quarterly basis, depending on the indicator and how critical the information is to managing the programme. In general, services that are critical to the programme's success should be monitored more frequently.

The infrastructure indicators are more critical at the beginning phase of the programme, and should be assessed once or twice per year.

Records should be noted as the events happen (e.g. entered in the data system when clinical services become active) or deleted from the system (e.g. when peer educators no longer work for the programme).

4

4.4 Recording and calculating indicators

The concept of calculating indicators can most easily be explained using an example.

The number of people who have received a service is divided by the total number of people covered by the programme. This number is then multiplied by 100 to obtain the value of the indicator.

Here, I will only focus on coverage indicators, as these are the core indicators outreach workers should be familiar with in their daily work.

Indicator	Percentage of MSM who have received counselling and testing over a period of one year		20%
Numerator	Number of people who have received a service	Number of MSM who received counselling and testing in the voluntary counselling and testing centres covered by the programme	20
Denominator	Number of people who are eligible to receive or should receive the service	Total number of MSM covered by the programme	100

OUTREACH COVERAGE

NUMERATOR

The numerator is the number of MSM receiving the service. It sounds simple, but really, before any calculation can be done, all people involved in the programme will need to agree on two important issues, which will depend on the local context.

1. Define what type of interaction between outreach workers (or peer educators) and MSM constitutes an outreach contact.

For example:

- Is contact simply any interaction between the outreach worker and the person?

- Is contact defined by the amount of time spent with a person?

- Does contact depend on the content of the discussion?

- Does contact depend on the fact that commodities were distributed?

- Should contacts made with more than one person be counted the same as contacts made by an outreach worker with one person?

The definition of outreach contact is very important, and requires careful consideration and agreement of all stakeholders in the planning stage. The standards that stakeholders have agreed to should be part of the written instructions that define how programmes are implemented.

2. Decide on how to measure the numerator in terms of individuals or contacts.

Ideally, when measuring coverage, one should count how many individuals have benefited from outreach services but, in reality, it may be much easier to count the number of established contacts. The figure shown below illustrates the difference between counting contacts and counting individuals, and the implications for measuring coverage.

For simplicity, imagine that an outreach worker is covering a *hot spot* (a place frequented by the key population" that 10 MSM visit regularly).

Imagine the following situation (Case A):
The outreach worker only contacted two people, but made contact with each one five times during the week.

CASE A: Contact 2 people 5 times

5 X	0	0	0	0
0	5 X	0	0	0

Imagine another situation (Case B):
The outreach worker made contact with every person in the hot spot, but only once during the week.

CASE B: Contact 10 people 1 time

1 X	1 X	1 X	1 X	1 X
1 X	1 X	1 X	1 X	1 X

If the outreach worker records every contact in his notebook, he would have recorded 10 contacts in both situations.

If the measure of coverage is defined as individuals reached, the level of coverage looks very different: only 2/10 or 20% in Case A, compared to 10/10 or 100% in Case B.

CASE A		CASE B
10	← CONTACTS →	10
20%	← COVERAGE →	100%

In the long run, it is preferable to come into contact with all MSM in the hot spot at least once a week, so the outreach worker can give out commodities to everyone and try to encourage everyone to use them. If the outreach worker can give more than one condom set to an MSM at each contact, it is not necessary to see them every day.

If the programme decides to count the number of individuals monitored, it will be necessary to assign a code or a unique identifier to each beneficiary.

Assigning a code should be preceded by a pre-test of knowledge about HIV, which aims to identify the level of information and behaviors related to HIV transmission. A similar post-test should be performed regularly to check for changes in the information, behaviors, and risk taking.

So, it's better to count the number of individuals, and not contacts. When do programmes use contacts?

When a programme is new or has low capacity, or when the local context is not conducive to tracking individuals. But in this case, it should develop targets or standards for the number of contacts each team of outreach workers should make in a week or month.

4

Do you have any tips to give, in case we decide to measure the indicator in terms of individuals?

Yes! First, we must ensure that outreach services are properly organized. Second, use the right tools to record data.

Sensitivity of the unique identifiers for individuals of key populations at higher risk:

Due to the illicit status of MSM in MENA countries, many individuals may be reluctant to give real names. Moreover, the identifiers could be used against them if that information was obtained by local authorities. The system of unique identifiers – even if they are based on names – does not need to reflect real names. Instead, it can use code names or pseudonyms to help the outreach workers keep track of individuals without endangering them if for example a third party took note of information from the list or records.

A. Decide on how to organize outreach services.

One approach is to assign outreach workers a specific population of MSM to cover (e.g. a group of hot spots, or all people in a given geographical area). This helps outreach workers clarify the expectations of their work, develop long-standing relationships with the MSM, and report their activities more easily.

This type of approach to case management requires a system of unique identifiers, by which a number is assigned to each person who receives services or is regularly contacted by an outreach worker.

The mobility of MSM in a given geographical area may make it difficult to monitor the same individuals by the same outreach workers. In this case, outreach workers must be trained to refer the people they see to other colleagues working on the same programme in different places. The unique identifier will help track those people moving from one area to another.

The unique identifier helps the individual remain anonymous throughout the implementation of the programme or the provision of all services.

As an MSM moves between different areas, he will contact a certain number of outreach workers, depending on where he goes.

The identifier code will help to keep track of the contacts, no matter who has made them.

Remember that we are a team!
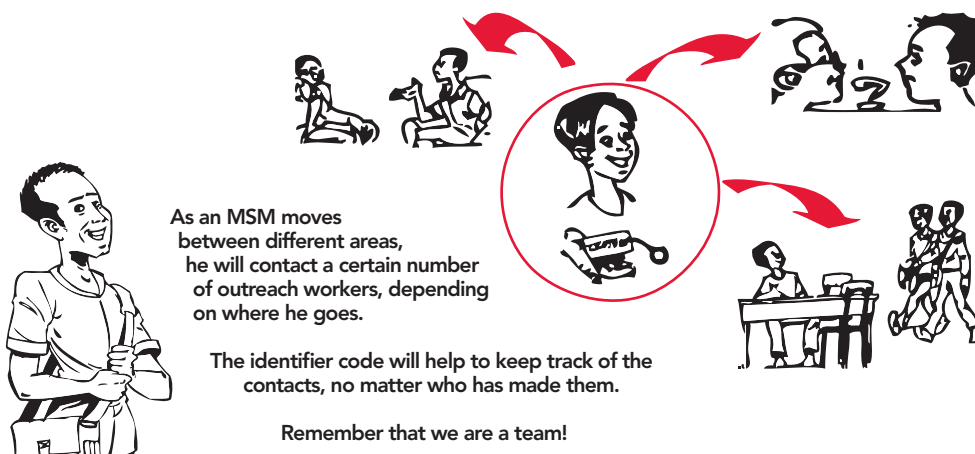
B. Decide on the right tools to record activities.

Once contact has been defined for the programme, outreach workers must have a way to record their activities, either in a general notebook or a specifically designed structured format.

In the situation given above, the outreach worker went to only one hot spot and contacted 10 MSM. On this scale, it may be relatively easy to make sure the worker contacts everyone. However, if programmes are operating at a larger scale, an outreach worker may have 30, 50 or more people to cover, and these individuals may be very mobile.

Managing and tracking a large number of people will require a more sophisticated system for recording outreach activity, to enable calculation of the number of individuals seen, the frequency of meetings and the number of condoms distributed. A form used to record outreach activity can be designed to monitor people over time.

This type of form is a tool to:

- Help outreach workers monitor individuals who are on their list of regular contacts, but have not been contacted for some time, and therefore need to be located.

- Assist the coordinator to record the daily activities of outreach workers

The key challenge is designing a form or process that makes data collection easier for outreach workers with low literacy skills. This may require the use of symbols instead of names for the identifiers. For example, some programmes have used a system of coloured dots or symbols to represent individuals. Other programmes have used a buddy system

to team up literate outreach workers with individuals who are illiterate to help fill in the individual tracking formats.

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Which system to choose for tracking outreach work: paper or electronic?

Tracking the services provided to individuals over time requires effort. Tracking can become even more difficult if MSM are highly mobile, or if outreach workers have contact with overlapping populations of MSM. To some extent, entry of daily outreach contacts into an electronic database may relieve the burden of tracking people on paper. Such a database could generate reports indicating who has not been recently contacted, or could easily calculate statistics on how many have been reached and with what level of service.

However, a monitoring system based on paper records has the advantage of always being available to outreach staff who maintain them (unless outreach staff enter their data in the electronic database). If the data are reviewed regularly, outreach staff will be able to adjust their outreach activities in a timely manner, and can do this more autonomously than may be possible if using electronic tracking.

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DENOMINATOR

The denominator is the size of the MSM population the programme intends to cover. This will depend on the funds required to provide a certain package of services to a specific number of MSM in a specific location. Sometimes, the budget is calculated on a cost-per-unit basis, assuming a specific number of MSM covered per unit. For example a service package costing $1000 for providing outreach and other services to 100 MSM per year.

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Where do I get the actual data on size of the key population?

Difficult to answer! Several methods are available to estimate the size of key populations at higher risk of HIV infection, including MSM.

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**However,
there is no single standard
methodology, due to the
complexity of the issues
in terms of people's
movement and the desire
to remain hidden.**

**Although every method has its strengths
and weaknesses, an important one
to consider in our case is mapping.**

The mapping approach (*see Module 2*) requires a field team to develop a comprehensive list of hot spots or sites where MSM can be found. This list can be created through observation and interviews with liaison persons, who help estimate the number of MSM at each site.

The results are added up, with some adjustments to represent mobility and the frequency at which MSM come to a site. An estimate of the overall size for the geographical area covered by the mapping can then be made.

Mapping also gives the programme a detailed description of the geographical distribution of MSM in an area. This data can contribute to outreach planning and a better understanding of the local environment where MSM operate, therefore allowing the programme to effectively offer the services that are most important to each community.

DISTRIBUTION OF ESSENTIAL COMMODITIES

**Here again, we need to properly
define the numerator and the
denominator and ensure that
they are properly recorded.**

NUMERATOR

The numerator is the number of pieces distributed over a specific period of time. The counts should reflect actual distribution, and not only supply or stock received. The calculations related to essential commodities can be reported separately by the method of distribution:

- Outreach: Daily registers kept by outreach workers.

- Fixed sites (clinics or drop-in centres): The clinic registers the commodities taken when visitors or patients are recorded.

- Self-service boxes: The programme must rely on an estimated number of condoms taken from the box, obtained through the process of restocking the box. The assumption is that those materials taken from the box were used by key populations for their intended purpose.

The different types of records are compiled and used to calculate the total number of commodities distributed for a certain time period.

This type of breakdown also informs managers about the efficiency or appropriateness of commodity distribution methods.

**Which system to choose for tracking commodity
distribution: paper or electronic?**

For a paper-based system, the programme needs to establish a data flow and clear responsibilities for who records the data and who compiles it.

For example, will supervisors collate data on commodities distributed from each of the workers they oversee, and will this data be reported centrally as part of a weekly outreach sheet across all supervisors? The data flow document must also address issues of data quality, and responsibility for reviewing

the primary records and ensuring that reporting is accurate and reliable.

In an electronic data system, the counts from different data forms may be entered and the electronic system can quickly calculate the number of commodities distributed through different channels. The key to making an electronic data system useful is to ensure that the collated results regularly get fed back to the individual sites distributing the commodities, so that information can be used to improve services. This is particularly important if data entry is done centrally rather than at the site level.

The rule is to ensure that the system is easy to use by outreach workers. Therefore, the choice will depend on the capacities of the programme.

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DENOMINATOR

The denominator is the expected number of commodities to be distributed. Targets should be clearly defined and based on expected need. The most effective targets are framed in terms of distributing a specified percentage of the assessed need for a commodity (see the box below).

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**Calculating the denominator
for condom distribution**

The needs of the population over a specified period of time are defined as "the number of risky sex acts per person per period of time multiplied by the number of that population in that geographical area".

Example

Number of risky sex acts: number of MSM in an area, multiplied by the number of male anal sex partners, multiplied by the time period (this assumes one anal sex act per male sex partner).

Mean number of anal sex partners per time period: data from representative surveys. Many standardized surveys provided by different guidance documents include questions to measure the frequency of risky acts.

Size of MSM in the area: data from representative surveys.

When these types of survey data are not available, it would be advisable to use anecdotal data, conduct small systematic surveys, or use data from other areas to approximate the need for essential commodities.

The assumptions and sources of data used to develop targets for these coverage indicators should be well documented in the M&E manual, to enable adjustment of the targets when more representative or updated data becomes available.

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4.5 Detecting problems when reviewing monitoring data

The following questions can help guide supervisors when reviewing the monitoring forms completed by the outreach workers.

- Are forms being filled in correctly and completely?
  - Do outreach workers understand how to use the form and know how the data is being used?
  - Are the forms difficult to use, or is the data difficult or impossible to collect?
  - Are the forms appropriate for outreach workers, or too complicated?

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- Are there other data that outreach workers want to collect that would make their job easier?

■ Are the reported numbers too consistent?

- Are outreach workers recording activities as they occur, or trying to fill in the form by memory?
- Are they filling in the form to meet quotas, meaning the data therefore does not reflect actual activities?
- Are they misunderstanding the use of targets and only working until the quota or targets are achieved?

■ Are the reported numbers inconsistent?

- Do outreach workers report an impossible number of contacts or services for the number of hours worked, or the number of MSM within their reach?
- Is the service delivery data consistent with the use of commodities or consumables according to stock records?
- Do the patterns of service delivery match with the timing of any service disruptions or population changes?

Remember!

■ Making an effort to develop a robust monitoring system for programmes aimed at engaging key populations at higher risk of infection – including MSM – is central for assessing the effectiveness of the national response.

■ Some of the most important indicators are those that measure the coverage both in terms of outreach services and commodity distribution.

■ Coverage and service use data should be collected daily in standardized formats as services are provided. The infrastructure indicators are critical at the beginning phase of the programme, and should be assessed only once or twice per year.

■ The definition of an outreach contact is very important, and needs careful consideration and agreement of all stakeholders at the initial phase of the programme. Once standards have been decided upon, they should be part of written guidelines that define how programmes are implemented.

■ When measuring outreach coverage indicators, the ability to count individuals reached is ideal and provides more useful information than only counting the number of contacts made. However, a programme should have the capacity to use an individual tracking system.

■ Managers at the site level should review and use the routine monitoring data to engage in early problem solving and take steps to improve the quality of their data.

Resources

ENGLISH AND FRENCH

- Saidel T, Loo V. *Monitoring and Evaluation for HIV/AIDS Programmes in Concentrated and Low Level Epidemics.* Regional Support Team, Middle East and North Africa. 2012.
  - Module 1: HIV Dynamics and Programme Prioritization in MENA
  - Module 2: Establishing and strengthening a Monitoring and Evaluation System
  - Module 3: Programme Monitoring
  - Module 4: Programme Evaluation
  - Module 5: Interpreting and usinG monitoring and evaluation data

- World Health Organization (WHO). *Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people*; Recommendations for a public health approach. Geneva, WHO, 2011.

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- Joint United Nations Programme on HIV/AIDS (UNAIDS). *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-at-Risk Populations.* Geneva, UNAIDS, 2008.

WEBSITES FOR PROGRAMME EVALUATION

- www.who.int/hiv/pub/operational/generic/en/index.html
- www.who.int/hiv/strategic/pubbss/en/index.html
- www.popcouncil.org/Horizons/ORToolkit/toolkit/hivtopics.htm
- www.fhi360.org/en/rh/pubs/booksreports/qrm_datacoll.htm

4

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