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THE MIDDLE EAST RESPONSE GRANT: DELIVERING HIV PROGRAMS IN CHALLENGING SOCIOCULTURAL AND REFUGEE SETTINGS

Deeply entrenched conservatism stemming from limited knowledge and fear of open discussion on matters of sexual health, coupled with religious and cultural dogmatism, are reflected in punitive legal frameworks and engrained stigma and discrimination that threaten the success of the Middle East's HIV response. In our follow up to the Global Fund Observer's article on the Middle East Response (MER) grant (The Middle East Response multi-country grant: engaging partnerships to serve people on the move), we ask what the Global Fund could do to improve the context for HIV service delivery in the MER countries.

The MER grant was originally designed to help six countries in the Middle East address the health issues of their mobile populations. The response to the three diseases is more important than ever in countries increasingly affected by conflict, disasters and economic crises; but the worst refugee crisis in recent times particularly affects the Middle East, where the Global Fund has designated the countries as having challenging operating environments (COE). This article focuses on the obstacles to providing HIV services in countries with complex sociocultural settings and key populations who are refugees, migrant or internally displaced. The Global Fund supports MER's HIV component in Jordan, Lebanon, Palestine, Syria and Yemen: countries which have either had their health systems destroyed by years of conflict or whose stronger health systems have been overwhelmed by the influx of migrants and mobile populations (MMPs).

HIV in refugee camps is a ticking time bomb –

– states an article from 2018. Perhaps no marginalized group has been in the spotlight more in recent years than MMPs; yet there have been few studies conducted on HIV prevalence rates in these communities and none in the Middle East. Case-by-case studies indicate that HIV rates are always context-specific; some studies note that HIV rates among migrants are often lower than host communities. In 2019, the International Organization for Migration (IOM) factsheet on HIV and population mobility stated, 'while migration does not automatically equal HIV vulnerability, and not all MMPs are at increased risk of HIV as a result of their mobility, in many contexts these groups are exposed to a unique set of sociocultural, economic and environmental factors that render them more vulnerable to HIV including lack of access to health services, information and environments that are conducive to engaging in high-risk behaviour'.

Unfortunately, there are no disaggregated data on MMPs and HIV in this region. However, the case for HIV programs targeting MMPs with a combination of HIV, sexual and reproductive health (SRH), including sexually transmitted infections (STIs), and tuberculosis (TB) services, is strong although regionally, as well as globally, MMPs continue to be excluded.

In 2010, one study found that 57% of countries with Global Fund co-sponsored national HIV strategic plans failed to include internally displaced persons (IDPs) and another 48% omitted migrants and refugees. Only 21% of countries included explicit activities targeting refugees and IDPs. Since there is no more updated information, the lack of data sends a clear message about the importance attached to this topic. With more than 80 million people globally forcibly displaced by mid-2020, a significant number of people are being left out of HIV programming. These same communities are subject to other detrimental factors which can increase vulnerability to HIV transmission, including sexual assault, forced prostitution and trafficking in return for food and other goods, and increased domestic violence and abuse; issues which impact young women and boys the most.

Structural and biobehavioural constraints to HIV programming in the Middle East

Successful HIV programming requires an analysis of the sociocultural factors that drive the epidemic, and the development of interventions to address them. The MER countries share general cultural characteristics that provide an insight into attitudes and perceptions of sexuality, health and access to knowledge and information, an understanding of which is of key importance for HIV activities. Traditional conservative culture and particular interpretations of religious doctrines often limit the acknowledgment of sexual behaviour, access to sexual health information, and seeking HIV services.

By and large, HIV is not discussed, understood or acknowledged in the region. The lack of data, and especially disaggregated data, means that the real numbers of key and vulnerable populations (KVPs) are generally unknown, and HIV and other STIs are likely to be under-reported and, indeed, make HIV less of a pressing issue. The association with 'homosexuality' and drug use is attached to a sense of stigma and shame that prevents KVPs from addressing their HIV concerns or seeking information and support. Moreover, there is a double 'whammy' when it comes to KVPs who are also people-on-the-move: not only due to their heightened vulnerability to disease and the shame of being infected, but also the stigma from belonging to one of these largely unwanted and excluded population groups.

“There are three red lines in Arab societies ? politics, religion and sex — topics that you are raised not to chal
Shereen El Feki, Regional Director for the Middle East and North Africa at UNAIDS. “But these lines are not is
strokes.They mingle and intertwine like calligraphy; change one, and the meaning of the rest also shifts.” Hen
importance,according to Dr El Feki, of opening the space and catalyzing conversations on HIV and SRHR, as
to tacklingsocieties’ other challenges — among them the needs and interests of displaced populations.

Risk factors and vulnerability to sexually transmitted infections

While programming often focuses on the violent conflict, displacement and refugee crises that impact HIV programs in this region, it is the existing social barriers and non-conflict-related realities that contribute to the root causes of vulnerabilities and sexual health risks.

It is difficult to address those factors independently, as there are direct and indirect links between issues such as female sexuality and SRH and rights, the imbalance of gender power dynamics between the sexes, markers of masculinities, and same-sex behaviour (especially among men).

Understanding other determinants of risk: intersections of class, political freedom/affiliation, education and economy

The ability to negotiate sexual rights and access to SRHR are connected to political freedom, education and socio-economic factors. Middle Eastern governments often undermine women’s rights movements as part of suppressing social participation in decision-making and target LGBTQ activists as a distraction from other political issues.

The narrative of the women’s rights movement in the region, which is closely related to SRHR, has been seen as a class-based one: that is, led by educated, relatively wealthy women. The association with the international gender justice movement contributes to that perception and subjects the movement to resistance from traditionalists and those resisting change.

Poverty and insufficient education mean that people lack the capacity (time, resources, etc.) to negotiate health provision and cannot access knowledge around sexual health.

The “foreign agenda” and the role of international non-government organizations (INGOs)

The five MER countries are the focus of intense international development and humanitarian action exacerbated by conflict and displacement. In Jordan, for example, SRHR services have multiplied significantly in the past ten years since the Syrian refugee crisis began. Studies[1] show that general knowledge and access to information on gender rights and sexual health has improved among both host and refugee populations during that period. However, there are two negative issues:

- The composition of INGOs and their knowledge about regional affairs is mostly western-based in its value system and methodology. Most organizations may employ local staff for front-line work but operate based on headquarters’ guidelines and ethical frameworks, and are usually directed by non-locals.
- Perceived elitism and mismanagement of resources within the INGO sector has built distrust and, at times, animosity from local populations. This creates barriers to promoting knowledge and awareness on sexual health if and when it is led by international actors.

The mistrust of INGO and donor motivation is clearly demonstrated by the example of the MER-1 HIV

grant in Yemen in 2018:

Yemen HIV program suspension

In April 2018, staff from Northern Yemen's National AIDS Program (NAP), Médecins Sans Frontières and the
arrested and placed in detention for a period of time ranging from a week to one month. The government susp
accusing the detainees of promoting sex and tarnishing the norms and values of Arabic and Yemeni culture.

The reason for the suspension was the substantial resistance from the local government authorities towards t
implementation of HIV activities for key populations such as sex workers (SW) and men who have sex with m
activities were put on hold until August 2018, and many beneficiaries were deprived of life-saving services inc
antiretroviral drugs.

The Northern NAP's suspension hugely affected program recipients since 70% of reported people living with H
are from Northern Governorates.

The strenuous efforts of the Principal Recipient, IOM, coordinated with those of the MER's Technical Support Group, managed to obtain the release of program and donor implementer staff, but the incident has done quite some damage. It has further increased fear and stigma not only among PLHIV but also among the HIV service providers. As a result, the upcoming MER-3 grant activities for Yemen were very carefully phrased and some HIV prevention activities such as condom promotion/distribution could not be included, thus constraining program impact.

MER-3 development was based on HIV Program Reviews for the five countries which provided information on the constraints hampering KVPs' access to health services, especially for HIV and STIs, in their countries.

Table 1: Barriers for KVPs and MMPs to HIV service access in the Middle East

Barrier	Impact on Affected Populations
Refugee or IDP status	• Many KVPs do not have access to health services, espe
Stigma, discrimination and violence	• Many are reluctant to access health services due to thei of violations of their rights. Even when they do attend he to offer appropriate and quality services, and frequently • KVPs experience violence in different forms i.e., intimate psychological violence, family abandonment.

Limited provision and/or coverage of HIV prevention services	• Little to no provision of targeted services. • Prevention interventions tend to be linked to global even distributed. • No focus on structural or socio-cultural changes, or char • Lack of recognition and operating space for KVPs and C • Over a decade of neglect in structural and capacity inve equipment, expertise and capacity to implement the curr
Limited access to HIV testing, treatment, care and support services	• Funding for KVP interventions is limited which in turn res treatment and care. • Accordingly, most KVPs do not know their HIV status or STI treatment when needed.
Limited evidence or research on KVPs	• The almost complete absence of data on the dynamics, for developing targeted HIV interventions. • This results in limited programs, services and funds spe
Inadequate multisectoral linkages, integration and communication between largely vertical programs	• KVP vulnerability to HIV and other health conditions is la • There are no formal plans/strategies for better integratio child and adolescent health, and STIs.

Legal and human rights barriers	• Stigma and discrimination among the public and in servi • Lack of a favourable legal environment: (i) no comprehe enforcement mechanisms; and (iii) HIV transmission and • Legal status: if a refugee is unregistered or any other 'irr s/he risks deportation. • In some countries, criminalisation of certain behaviours s
Gender-related barriers	• Traditional cultural norms and practices such as early m property, criminalisation of abortion, discrimination, viole

Legal impediments to HIV service delivery

Sociocultural and religious conservatism is not the only hindrance to the design and rollout of HIV interventions. The legal framework for service delivery is not conducive to HIV programming and may hamper the delivery of services aimed at specific groups whose behaviour is criminalised. Community-based organisations can play important roles in the region's HIV response, but they are constrained in many countries by limited civic space and resources. Punitive laws and widespread stigma against PLHIV and KVPs present additional difficulties. Nevertheless, the extremely fragile state of these communities raises the need for a focused and targeted HIV services model.

Ideas for moving forwards

Many years of experience in working on these issues in the region suggest that the following actions in Table 2 are needed to address the issues discussed above. All of these could be supported by the Global Fund through HIV program funding.

Table 2. Proposed actions to help Middle Eastern HIV programs address sociocultural drivers of inequality

Actions

- Diverse data collection methods should be employed to include hard-to-reach populations,including partnerships with informal groups and employing community animators and use ofalternative research methods (e.g., innovative use of social media, arts, etc.).

- Costing should always take into consideration targeted training on alternative data collection and anonymous survey methods.

- Integrate culture competence principles in all strategy building, program design and funding structures, especially as at relates to:

  - A meaningful analysis and understanding of gender power imbalances that is unique to different local and sub contexts. The Middle East and Northern Africa (MENA) region is diverse in culture and social norms, and within countries there are vastly different subcultures, urban and rural, religious, class and economic diversity, etc.
  - A realistic understanding of sexuality and sexual identities, in particular as it relates to sexual behaviour among men and the gay-bisexual-transgender identities.
  - The meaningful involvement of religious leaders in a complex manner that integrates non-conformist experiences in the faith-based approaches to prevention and response (non-heterosexual behaviours, sex work, extra marital relationships, etc.).
  - An understanding of political influences and volatility on service provision and policies relating to HIV and integrating such political analysis and understanding in all future program design.

- Implement rigorous HIV education and awareness activities for service providers in the medical field and social work sectors. This is in response to the experiences of oppressive and discriminatory behaviour that PLHIV are often subjected to in the health care system.

- Address the legislative shortcomings that limit equitable service provision and counter stigma and discrimination. A legal gap analysis of all legislation and laws in the MENA region on all issues relating directly and indirectly to HIV would inform activism and efforts to evolve such structures in the region’s different countries

- Design national frameworks of action for each of the MENA countries that includes:

1. A legal gap analysis of laws and legislation (see above).
2. Mapping of all relevant actors, including service providers, educational institutions, media, civil society actors, faith-based institutions, etc. that have potential relevance to HIV work.
3. Design a strategy of action to address and fill gaps and shortcomings in service provision, advocacy efforts, legislative structures, etc.
4. Targeted behaviour and attitude change efforts.

In conclusion, the MER grants have succeeded in reaching many people in the region with life-saving

drugs and treatment, care and support. However, the longer the program runs, the greater are the Global Fund's expectations in terms of outcomes and impact. Yet little can be done to really tackle the region's HIV problems until a solution can be found to address the judgmental and punitive sociocultural and legal framework. Can the Global Fund navigate a way through the politics and conservatism of the region to influence the social drivers of the epidemic in the MER countries?

[1] This article is based on more than twenty years of intensive work on gender-based violence within refugee and host communities in the region and in particular in Jordan conducted over four years with the same populations and undertaken for the Arab Women's Organization and Alianza por la Solaridad.

Further reading:

- Shereen El Feki (2013). Sex and the Citadel: Intimate Life in a Changing Arab World
- Suhail Abualsameed (2018). Statistical Analysis of Men's Perspective on Gender-Based Violence in Jordan. Alianza por la Solaridad

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