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Annex: Secure HIV Programs for Key Populations, a Resource for Humanitarian Settings in the Middle East and North Africa (MENA)

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Annex: Secure HIV Programs for Key Populations, a Resource for Humanitarian Settings in the Middle East and North Africa (MENA)

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As of February 2019, the International HIV/AIDS Alliance is Frontline AIDS.

LINKAGES

LINKAGES is the largest global project dedicated to key populations—sex workers, men who have sex with men, people who inject drugs, and transgender people. The project is led by FHI 360 in partnership with IntraHealth International, Pact, and the University of North Carolina at Chapel Hill.

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Background, overview, purpose, and audience

Humanitarian settings, defined based on criteria articulated in the Sphere Standards, include "a range of situations including natural disasters, conflict, slow- and rapid-onset events, rural and urban environments, and complex political emergencies.[1]" A security toolkit developed by FHI 360 and the Arab Foundation for Freedoms and Equality (AFE), *AMAN MENA. Security Protections for Organizations Working with Key Populations to Strengthen HIV Programming in the Middle East and North Africa* (November 2020), describes how to securely operate HIV programs for key populations in the Middle East and North Africa (MENA) region but does not articulate specific guidance for those operating in humanitarian settings.

Given the widespread nature of humanitarian crises in MENA, and the importance of meeting the needs of the most vulnerable in these contexts—such as people living with HIV (PLHIV) and key populations (KPs) most affected by HIV—it is important to offer additional considerations and recommendations for safe HIV programming in humanitarian contexts in MENA. To that end, this annex to *AMAN MENA*:

- Briefly describes the wide-ranging humanitarian settings in the MENA region and the challenges, and particularly security challenges, to HIV programming in these settings
- Reviews international guidance for HIV programs in humanitarian settings
- Provides recommendations for implementing secure HIV programs within humanitarian contexts in MENA.

The intended audience for the annex includes HIV program implementers (including health care workers and other medical staff); local, national, and regional networks working on KP issues and/or HIV; international nongovernmental organizations (NGOs), donors, government ministries and national AIDS programs; United Nations organizations; and other aid organizations operating in humanitarian contexts within MENA. For those on the front lines of implementation, the annex provides case studies that may offer practical ideas for secure HIV programming in humanitarian contexts. For donors and others supporting HIV programs in humanitarian contexts in MENA, this annex summarizes the challenges of implementation and makes recommendations—based on international guidelines and relevant programmatic experience—to mitigate and overcome these challenges.

This annex was developed in collaboration with Joint United Nations Programme on HIV/AIDS (UNAIDS) MENA Regional Office. The process for developing the annex included a desk review of relevant policies and standards, interviews with those implementing HIV programs in humanitarian settings in the MENA region, and review by consultants familiar with HIV programs in humanitarian contexts.

[1] Sphere Association. 2018. The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response, fourth edition. Geneva: Sphere Association. Available at https://www.spherestandards.org/handbook (accessed September 20, 2020)

The humanitarian context in MENA and its impact on HIV programming

According to United National Refugee Agency (UNHCR), the MENA region bears some of the "most adverse and prolonged humanitarian crises globally."[2] The region continues to pose overwhelming challenges, with complex emergency and protection situations of unprecedented scale and magnitude. The volatile security conditions in Libya, the Syrian Arab Republic (Syria), and Yemen have severe and widespread impacts, not only on refugees and the internally displaced but also on host countries and communities. Economies, public and social services, and civil and political structures are stretched to the limits.[3] For example:

- Syrians constitute the largest refugee population worldwide. Over 5.6 million people have fled Syria since 2011, seeking safety in Lebanon, Turkey, Jordan, and beyond. Around 13.1 million people are in need of humanitarian support in Syria, including 6.6 million internally displaced persons, and 2.98 million people in hard-to-reach and besieged areas.[4]
- In Yemen, years of relentless conflict have devastated the lives of millions of people. With a protection and humanitarian crisis engulfing a large part of its population, Yemen has become the largest humanitarian crisis in the world. An alarming 24.1 million people—more than two-thirds of the population—need some kind of humanitarian or protection support.[5]
- In Iraq's post-conflict context, there are approximately 1.4 million internally displaced persons and 4.1 million people in need of humanitarian assistance.[6]
- In Libya, an estimated 823,000 people, including around 248,000 children, need humanitarian assistance as a result of persisting political instability, conflict and insecurity, the breakdown of the rule of law, a deteriorating public sector, and a dysfunctional economy. People needing assistance include internally displaced persons, returnees, non-displaced conflict affected people and host communities, and refugees and migrants.[7]
- Across Sudan, about 9.3 million people require humanitarian support in 2020. Some 1.9 million people remain displaced and face protection risks and threats even as they attempt to rebuild their livelihoods or return to their homes.[8]

As humanitarian crises extend and expand, vulnerability to HIV increases and the need for HIV-related services grows acute. In MENA, needs for health and HIV services have increased steadily

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[2] United Nations High Commission on Refugees (UNHCR). 2019. "Global Focus: Middle East." Available at https://reporting.unhcr.org/node/36 (accessed on September 22, 2020

[3] UNHCR. N.D. "Middle East and North Africa," Regional Summaries. Available at https://reporting.unhcr.org/sites/default/files/ga2019/pdf/Chapter_MENA.pdf (accessed September 21, 2020)

[4] UNHCR USA. N.D. "Syria Emergency." Available at www.unhcr.org/syria-emergency.html (accessed September 21, 2020)

[5] United Nations Office for the Coordination of Humanitarian Affairs (OCHA). N.D. "Crisis Overview." Available at https://www.unocha.org/yemen/crisis-overview (accessed September 21, 2020)

[6] OCHA. N.D. "Iraq." Available at https://www.unocha.org/iraq#:~:text=In%20Iraq's%20post%2Dconflict%20context,people's%20ability%20to%20return%20home (accessed September 21, 2020)

[7] OCHA. N.D. "About OCHA Libya." Available at https://www.unocha.org/libya/about-ocha-libya (accessed September 21, 2020)

[8] OCHA. N.D. "About OCHA Sudan." Available at https://www.unocha.org/sudan/about-ocha-sudan (accessed September 21, 2020)

due to the increased vulnerability and destruction of health care facilities, including those that offer voluntary HIV testing and counseling and antiretroviral therapy (ART) services. Human resources for health are constrained in many crisis-affected countries, with a limited number of trained providers to address client needs. Agencies operating HIV programs in humanitarian settings face enormous challenges in achieving their desired program outcomes, including the commitments of the 2016 Political Declaration on Ending AIDS and fast-track targets. The challenges (which are often inter-related) include:

1. **Limited funding and political will for HIV and KP programs**

- **Lower prioritization:** HIV is de-prioritized in the humanitarian response, because of the concentrated nature of the epidemic in the region and competition from other urgent priorities
- **Limited investment:** Governments, development partners, and humanitarian organizations invest insufficient resources on the national HIV response, leaving key and vulnerable population unable to access high-quality HIV services.
- **Diminished access to services**: In the context of a humanitarian crisis, interventions such as needle and syringe programming, condom distribution, and HIV testing for KPs may be discontinued entirely. Even where services continue, disruption of the procurement and supply management systems in MENA have led to stockouts of antiretrovirals (ARVs), HIV test kits, condoms, and other HIV prevention and treatment commodities.
- **Widespread misinformation among potential** beneficiaries: Long periods without prevention programming and predominant cultural taboos on sexuality may leave some KP without even basic information about HIV, including on transmission, effective prevention methods, or the benefits of ART.

2. **Limited organizational strength and/or complete reliance on government-delivered services**

- **Weak operational capacity:** Organizations with HIV KP programming skills may have limited procedures and protocols for standardizing operations, including security-related protocols.
- **High levels of staff turnover:** In the limited job markets within humanitarian contexts, staff join organizations not because of their dedication to an organizational mission but because a given position was the only opportunity available. Once employees have developed skills, they are quick to move on to other opportunities.
- **Stigmatizing beliefs among staff:** Organizations struggling with competing priorities and limited funds may not invest in staff training and sensitization. As a result, staff may not be able to identify and address their own stigmatizing attitudes and beliefs about members of the PLHIV community who are also members of vulnerable populations.
- **Lack of trust in government-led responses:** If KPs fear status disclosure (being outed as HIV-positive) or discriminated against during service provision, government services may have limited uptake, even where robust services exist.
- **Refugee services based on official registration:** National programs that limit services to registered refugees may leave significant populations completely without services.

3. **Direct security challenges to implementers**

- **Strong government surveillance:** Civil society organizations (CSOs) that are subject to government surveillance may be unable to address or speak against violations by the state, even when they harm implementers or beneficiaries.
- **Lack of trust in CSOs perceived to align with opposing factions:** If implementing programs are not part of the sect, ethnic group, or religion of the community they are serving, the community may believe that the implementers seek to cause them harm, and may attack program staff. Implementers not personally known by community members may also be attacked.
- **Ransom and kidnapping:** The increased risks to foreign staff or individuals perceived as connected to international development agencies can restrict their mobility. This can obligate local staff to remain in more difficult areas without reprieve.
- **Heightened violence targeting KPs:** Members of key populations who work as implementers face greater risk of personal and professional violence. Violence against program participants also increases the mental health strain on implementers, who may witness these abuses almost constantly.
- **Limited mobility:** When an individual, especially a KP member living with HIV, makes themselves visible to support an HIV program, that person may need to quickly leave the locality or even the country to avoid violence or harm. In humanitarian settings, and particularly in the context of COVID-19, evacuating community members who have been targeted, to safe places is becoming more and more difficult. UNAIDS and other organizations receive many ad hoc requests for support, limiting their ability to respond efficiently.

Though these factors are described in three distinct domains, they overlap. Furthermore, each domain contributes to insecurity for implementers. For example, funding limitations mean that an organization may not be able to afford security upgrades, such as bars on doors and windows. Similarly, partners with limited organizational capacity may lack guidance on protecting their workers from sexual harassment, hostility from communities, and constant security challenges—which in turn affects workers' mental health and well-being.

International laws, conventions, and guidelines to inform HIV programming in humanitarian contexts

Although HIV programming in humanitarian contexts is difficult, it is an obligation that countries across MENA have agreed to address in view of the global guidelines, frameworks, international laws, and conventions.

- In 2004, the Inter-Agency Standing Committee (IASC) issued the guidelines *Addressing HIV/AIDS Interventions in Emergency Settings* to help guide those involved in emergency response, and those responding to the epidemic, to plan delivery of a minimum set of HIV prevention, care and support interventions to people affected by humanitarian crises. The revised version of the guidelines draws on the experiences of governments, the United

Nations (UN), inter-governmental and nongovernmental organizations, and the Red Cross Red Crescent movement, and also on recent developments in the field.[9]

- The *Arab AIDS Strategy, 2014–2021* was developed by the League of Arab States and endorsed by the Council of the Arab Ministers of Health (March 2014).[10] It has a component that guides HIV programming in humanitarian settings that includes specific mention of the services that should be available to members of key populations.
- Protection of key populations and PLHIV is an integral and critical aspect of the AIDS response in humanitarian settings. Human rights frameworks, conventions, and treaties must guide the work on protection of KPs and ensuring their full access to HIV services. This includes full implementation by states of their obligations under[11]:
  - International refugee and human rights law as articulated in the 1951 Convention Relating to the Status of Refugees (among others) [12]
  - International Covenant on Civil and Political Rights[13]
  - International Covenant on Economic, Social and Cultural Rights[14]
  - Convention on the Elimination of All Forms of Discrimination against Women[15]
  - Convention on the Rights of the Child, and related regional human rights instruments, as well as norms of customary international law[16]
  - Political Declaration on Ending AIDS adopted by the United Nations General Assembly in 2016.[17]
- For populations forced to leave their countries due to conflict, the 1951 Convention Relating to the Status of Refugees, and other human rights instruments, stipulate that countries of asylum are responsible for ensuring equal and non-discriminatory access to existing health services for refugees.
- For people internally displaced within their countries (IDPs), the *International Guiding Principles on Internal Displacement* (1998) reaffirm that IDPs are entitled to the same rights

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[9] Joint United Nations Programme on HIV/AIDS (UNAIDS). 2010. "Guidelines for Addressing HIV in Humanitarian Settings" (2010 Revision). Available at https://www.unaids.org/en/resources/documents/2010/20100409_jc1767_iasc_doc_en.pdf (accessed September 21, 2020)

[10] Council of the Arab Ministers of Health. March 2014. "Arab AIDS Strategy" Available at https://www.menahra.org/images/pdf/Arab_AIDS_Strategy_-_English_-_Final.pdf (accessed September 22, 2020)

[11] UNHCR. N.D. *UNHCR Note on HIV/AIDS and the Protection of Refugees, IDPs and Other Persons of Concern*. Available at https://www.unhcr.org/publications/operations/444e20892/note-hivaids-protection-refugees-idps-other-persons-concern.html (accessed September 21, 2020)

[12] UNHCR USA. N.D. "The 1951 Refugee Convention." Available at https://www.unhcr.org/en-us/1951-refugee-convention.html (accessed September 21, 2020)

[13] OHCHR. December 1966. "International Covenant on Civil and Political Rights." Available at https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx (accessed September 22, 2020)

[14] OHCHR. December 1966. "International Covenant on Economic, Social and Cultural Rights". Available at https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx (accessed September 22, 2020)

[15] CEDAW. 1979. "Convention on the Elimination of All Forms of Discrimination against Women". Available at https://www.un.org/womenwatch/daw/cedaw/text/econvention.htm (accessed September 22, 2020)

[16] OHCHR. November 1989. "Convention on the Rights of the Child". Available at https://www.ohchr.org/en/professionalinterest/pages/crc.aspx (accessed September 22, 2020)

[17] UNAIDS. JUNE 2016. "Political Declaration on Ending AIDS". Available at https://www.unaids.org/sites/default/files/media_asset/2016-political-declaration-HIV-AIDS_en.pdf (accessed September 22, 2020)

and freedoms as non-IDPs, but must be assisted and protected according to their specific needs, and should not be discriminated against on the basis of their displacement.[18]

- The *Sphere Standards* put forward 10 Core Principles in their Code of Conduct to govern all aid in humanitarian settings.[19]
  1. The humanitarian imperative comes first.
  2. Aid is given regardless of the race, creed or nationality of the recipients and without adverse distinction of any kind. Aid priorities are calculated on the basis of need alone.
  3. Aid will not be used to further a particular political or religious standpoint.
  4. We shall endeavor not to act as instruments of government foreign policy.
  5. We shall respect culture and custom.
  6. We shall attempt to build disaster response on local capacities.
  7. Ways shall be found to involve program beneficiaries in the management of relief aid.
  8. Relief aid must strive to reduce future vulnerabilities to disaster as well as meeting basic needs.
  9. We hold ourselves accountable to both those we seek to assist and those from whom we accept resources.
  10. In our information, publicity and advertising activities, we shall recognize disaster victims as dignified human beings, not hopeless objects.
- The Sphere Handbook includes sections on vulnerable groups. Those particularly relevant to this annex are quoted in Box 1.

[18] Internal Displacement Monitoring Centre. N.D. "Guiding Principles on Internal Displacement". Available at https://www.internal-displacement.org/internal-displacement/guiding-principles-on-internal-displacement (accessed September 21, 2020)

[19] Sphere Association. 2018. The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response, fourth edition. Geneva: Sphere Association. Available at https://www.spherestandards.org/handbook (accessed September 20, 2020)

Box 1. Sphere Handbook: Considerations for PLHIV and LGBTQI Individuals in Emergencies [20]

People living with and affected by HIV
Knowing the HIV prevalence in a specific context is important in order to understand vulnerabilities and risks and to inform an effective response. Displacement may lead to increased HIV vulnerabilities, and crises are likely to cause disruption in prevention, testing, care, treatment and support services. Specific measures are often needed to protect against violence and discrimination among high-risk populations. This can be compounded by gender inequality and discrimination based on disability status, gender identity and sexual orientation. In turn, this may discourage people living with HIV to seek services in a crisis, if any are available. Violence, discrimination and negative coping strategies such as transactional sex increase vulnerability to HIV transmission, especially for women, girls and LGBTQI communities. Those at the highest risk include men who have sex with men, people who inject drugs, sex workers, transgender people, persons with disabilities, and people in prisons and other closed settings.

Factors such as a reduction in mobility over time and greater access to services for crisis-affected populations can decrease the risk of HIV. To avoid discriminatory practices, dispel any possible misconceptions that the presence of PLHIV will increase lead to increased risk of HIV transmission or will increase HIV prevalence in the community. People living with HIV are entitled to live their lives in dignity, free from discrimination, and should enjoy non-discriminatory access to services.

LGBTQI people
People who identify as lesbian, gay, bisexual, transgender, queer or intersex (LGBTQI) are often at heightened risk of discrimination, stigma, and sexual and physical violence. They may face barriers to accessing healthcare, housing, education, employment, information and humanitarian facilities. For example, LGBTQI people often face discrimination in assistance programmes that are based on "conventional" family units, such as for emergency accommodation or food distribution. Such barriers affect their health and survival and may have long term consequences on integration. Include specific, safe and inclusive protection responses in preparedness and planning. Ensure meaningful consultation with LGBTQI individuals and organisations at each stage of humanitarian response.

Recommendations for secure HIV programs in humanitarian contexts

While the challenges are many, there are programs reaching key population members with HIV services in humanitarian settings. Their work aligns with the core principles described above and moves countries toward fulfilling their obligations under the many international treaties that govern the right to health, including for those living in humanitarian contexts.

[20] Sphere Association. 2018. *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response*, fourth edition, Geneva: Sphere Association. www.spherestandards.org/handbook (accessed September 21, 2020)

Building on successful local programming examples in humanitarian contexts and the original recommendations in the main body of the toolkit, this annex presents eight recommendations to keep HIV program implementers safe in humanitarian contexts. Not all recommendations will be relevant in each humanitarian setting or may only be relevant with adaptation. Security is always contextually determined. Readers should adopt those recommendations that seem relevant, safe and feasible in their context.

1. Support local organizations to do the work

Mistrust of outsiders can make foreign or international implementers more vulnerable, increasing security risks and costs for HIV programs. Furthermore, in contexts where local organizations can do the work needed to provide life-saving care, delivery of HIV services by international organizations can create an unnecessary barrier to service access. Organizations such as the International Organization for Migration (IOM) and other NGOs should build the capacity of *local* organizations to provide quality HIV programming, as these local organizations have the best chance of reaching marginalized populations, including through partnerships with local leaders (see Box 2).[21] Building local capacity entails training staff at local organizations, including through sensitization to work with key populations; supporting development of systems and protocols that standardize their work and ensure its quality; and helping these organizations develop mechanisms to ensure accountability to donors and priority populations.

Box 2. Innovative Partnerships by Local Organizations in Lebanon

In Lebanon, Soins Infirmiers et Développement Communautaire (SIDC) works with gatekeepers from each refugee camp. They always inform the Shawish "the person nominated by other refugees to act as the settlement supervisor and decision-maker." (UNHCR, 2018) Most of the shawish in Lebanon are men. about activities and obtain his approval before engaging in an activity. SIDC communicates the importance of the intervention to the Shawish, working over a long period to establish trust, and avoiding changing the staff person who connects with the Shawish. At the organizational level, SIDC carefully selects individuals chosen to interact with the Shawish, and monitors them closely to ensure ethical behavior.

[21] UNHCR Lebanon. June 2018. "Syrian refugee challenges traditions in community leader role". Available at https://www.unhcr.org/lb/11806-syrian-refugee-challenges-traditions-community-leader-role.html (accessed September 22, 2020)

2. Assess the risks of implementation realistically and comprehensively

Security must be included from the planning stage of any HIV program, but there should be particular care to provide adequate attention to risk assessment in humanitarian settings. Risk assessment and costed risk mitigation plans should be part of the development of proposals or work plans. The risk assessment should include understanding the local legal context—not only the laws on the books, but also how both real and more ad hoc "laws" are enforced.

3. Provide adequate funding for secure HIV programs in humanitarian contexts

Many implementers interviewed during the development of this annex highlighted funding as a barrier to adequate security, including physical security protections, adequate staff compensation to ensure retention, and staff support to prevent burnout and attrition. Notably, staff turnover is also a barrier to critical local partnerships, such as those described in Box 2, since building trust is a time-intensive investment. Donors should provide the sufficient funding to enable staff to work as safely as possible in a humanitarian context. The Global Fund's Middle East Regional Grant (Box 3[22]) is an example of a well-designed, flexible funding initiative. Funded security should include insurance for workers, mental health care for workers, physical and digital security at the organizational level, and safe transport/outreach options for those working in the field. A more complete list of security strategies for physical spaces, digital communication and data storage, and outreach appear in Tool 2 of the original toolkit.

Box 3. Middle East Regional Grant

The International Organization for Migration (IOM) serves as principal recipient for the Global Fund's Middle East Regional Grant. This mechanism seeks to make "more flexible investments with a more focused scope [to] enable implementing partners to adjust their programs as the country context changes, thus reaching key and vulnerable populations with quality services and more effective interventions." The grant, which supports HIV programs for refugees in Syria, Lebanon, Jordan and Iraq, helps to keep highly mobile PLHIV on uninterrupted treatment, and to make HIV testing available in humanitarian contexts. Responding to the epidemic context in the region, it has a specific mandate to support key and vulnerable populations.

4. Develop the necessary infrastructure and partnerships to provide comprehensive services within and linked to HIV programs

One way for organizations to remain secure is to offer high-quality care. When communities view an organization in their midst as adding value, it is less likely to come under attack. The quality of care in HIV services should be tailored to the context.

HIV and gender-based violence (GBV) are twin epidemics; each increases the risk of the other. In places with increased GBV against both women and girls and LGBTQI people—a reality in many humanitarian crises—there should be GBV response services within HIV programs. Key interventions include post-exposure prophylaxis, treatment and prophylaxis for sexually

[22] The Global Fund. 2019. "Focus on the Middle East Response." Available at https://www.theglobalfund.org/media/7642/publication_middleeastresponse_focuson_en.pdf?u=637321466423670000 (accessed September 21, 2020)

transmitted infections, emergency contraception, and psychological first aid for survivors. It is also imperative that programs offer robust linkages to the referral services needed by survivors of violence. GBV response services help both beneficiaries and implementers: they increase the community's positive perception toward the organization providing this care; and they enable implementers to access these services when needed in their personal lives. Staff of implementing organizations can also experience stress and burnout when they constantly meet with clients who have survived GBV or other violence and are unable to meet these clients' urgent needs.

Often, the most effective approach for providing additional services such as GBV support is to establish partnerships with local women's organizations. Women, girls, and KP members have higher risks in humanitarian settings. When such groups are engaged in service delivery, there must be adequate security mechanisms in place to address their unique vulnerabilities. These measures could include security plans specific to outreach, or additional resources for safe transport.

5. Go digital when physical is not an option

When a local organization cannot safely provide physical services to KP members in a humanitarian context, it may be most appropriate to connect to potential beneficiaries online. This can include sharing information, such as on how HIV is transmitted and prevented, and how to live positively with HIV. Online support organizations can also connect KP members in conflict areas to supportive communities outside of their physical location—while posing limited danger to the implementing organization (Box 4).

Box 4. Offering digital support to reach countries with no or limited

M-Coalition provides accurate information on HIV prevention and treatment, which can be easily shared by local organizations supporting KP members and PLHIV in settings where it is not safe to operate. M-Coalition can also be reached via their Facebook page to help answer questions that come in from across the region on where HIV services can be found in specific countries, how to get ARVs in other countries if they are not available in one's own country. M-Coalition also provides information and support to LGBTQI people and those living with HIV on seeking asylum in other locations.

However, going digital will come with its own costs and security concerns. This can include the actual tablets/phones/computers necessary to do the work as well as financial or equipment support to address power or internet outages. Going online should always include investments in digital security (firewalls, encryption, safe cloud storage, updated programs that are more difficult to hack) and digital security training. Digital security efforts should focus on both keeping data safe—especially sensitive health information—and on protecting communications that could allow malicious actors to know the locations, names, or social networks of staff or program participants.

Box 5. Communicating and collaborating with governments in Yemen and Jordan

In Yemen, Aden created a WhatsApp group with government actors and HIV service providers that keeps implementers up to date on government services available to PLHIV and creates a space for exchanging experiences on the current needs of PLHIV and KP members. This helps build government buy-in for and attention to the needs of these groups, which in turn improves Aden's ability to operate safely.

In Jordan, Forearms of Change Center to Enable Community (FOCCEC) provides services to key populations. It established a coordination committee consisting of ministries (including the Ministries of Health, Planning, and Social Development, and Administrations for Drug Enforcement and Family Protection), government departments, experts, and specialists to oversee its programs and services. The coordinating committee played a role in the successful implementation of programs and activities, and in strengthening partnership and cooperation between FOCCE and government agencies. To promote partnership with the Ministry of Health, FOCCE has involved the Ministry's National AIDS Control Program in its activities within a mutually integrative and transformative relationship. These relationships have enabled FOCCE to operate with greater security.

6. Work in careful alliance with government

In some locations, government facilities provide the only services available. Organizations working in humanitarian settings can assess how safely KP members can attend a government site, and then share this information with clients. This can increase clients' willingness to obtain services at a government facility, and the implementers would not have to offer parallel services, which would put them at risk and could lead to duplication of effort. Establishing relationships and strengthening communication with government counterparts can help build government support for HIV services and ensure that implementers receive relevant information quickly (see Box 5).

7. Develop a central mechanism to report on and respond to danger to implementers

Organizations and individuals put themselves at risk to provide HIV services in humanitarian contexts. Even when security measures are in place, providing services can result in severe danger to implementers. Many HIV service implementers, especially those who are also outspoken in their advocacy for rights, may need help to relocate quickly. Having a central mechanism where individuals and organizations could report imminent danger and receive an immediate response (as opposed to a bureaucratic process that take several weeks) would make it safer for implementers to continue their life-saving work. Such a system should include rapid, flexible funding and strong mechanisms to protect confidentiality while confirming facts related to the request for support.

8. Invest in a central mechanism to document and share efforts to meet the security needs of HIV program implementers in humanitarian crises

There is no central mechanism to capture efforts to keep HIV service implementers safe in humanitarian contexts in the MENA region nor to share those efforts with others. Indeed, many of those interviewed had not systematically considered security as a part of their HIV program, a problem that could begin to be resolved by more widely publicizing both the importance of and

specific strategies to secure programs. As noted above (Recommendation #3), making investments in the security of HIV program implementers is essential to providing immediate protection. Documenting these investments and their impacts, in order to call attention to need, share promising examples and inform efforts in the future, will benefit those operating in humanitarian contexts now and in the crises to come.

Conclusion

It will not be possible to achieve ambitious 95-95-95 goals unless all people—including KP members and PLHIV in humanitarian settings—have unfettered access to HIV prevention, care, and treatment services. Failing to safeguard HIV service implementers working in humanitarian contexts will ultimately limit the availability of information, commodities, and care to those who need it most. Protecting implementers, by taking action on the recommendations above, is a realistic and practical response the risks that take to achieve the collective goal of an AIDS-free future. Such protection will make it possible that one day that dream will become a reality.

It is our hope that humanitarian context-specific HIV program support, such as the Middle East Regional Grant for HIV, TB, and Malaria, will continue to expand along with investments in implementer security; and that all MENA-based HIV programs in humanitarian settings will commit to the safety of their implementers.

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