



**IAS EDUCATIONAL FUND MEETINGS
15-17 March 2017
Casablanca, Morocco**

**“A scientific response to HIV in North Africa: Translating
best practices into policies”**

OUTCOME REPORT



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This report was developed in collaboration with the Association de Lutte Contre le Sida. The views expressed in the report do not necessarily reflect the views of the International AIDS Society.

Acknowledgements

The IAS Educational Fund meetings in Morocco were organised in collaboration with the Association de Lutte Contre le Sida (ALCS). The ALCS would like to extend its appreciation to Gilead and ViiV Healthcare for their financial support for the meetings.

The meetings were endorsed by Coalition PLUS, which works against HIV and hepatitis around the world, and the ALCS would like to thank them for their support.

Finally, the ALCS would also like to acknowledge all the presenters, participants and the organizations that they represent, for contributing their knowledge and expertise and for contributing to the success of the meetings.

List of acronyms

ALCS	Association de Lutte Contre le Sida
CSOs	Civil society organizations
CNDH	National council of human rights
HIVST	HIV self-testing
HTS	HIV testing and counselling services
IAS	International AIDS Society
KPs	Key populations
MENA	Middle East and North Africa
MoH	Ministry of Health
MSM	Men who have sex with men
NGOs	Non-governmental organizations
NSP	National Strategic Plan
NICTS	Network for Information and Computer Technologies
PCR	Polymerase Chain Reaction
PMTCT	Prevention of mother to child transmission
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
RDTs	Rapid diagnostic tests
STIs	Sexually transmitted infections
SW	Sex workers
TasP	Treatment as prevention
WHO	World Health Organization

Executive summary

The third IAS Educational Fund meetings took place on 15, 16 and 17 March 2017 in Casablanca, Morocco. The meetings were aimed at informing participants about the latest HIV science and translating it into concrete policies in the North African region. The workshop, symposium, group work and discussions were spread over three days, as follows:

Day 1 – Workshop: Key messages from the International AIDS Conference in Durban, AIDS 2016 (Wednesday, 15 March)

Day 1 was dedicated to reviewing key messages and main recommendations from the 21st International AIDS Conference, which took place in Durban, South Africa, in July 2016. The participants aimed to explore and discuss the most significant updates in relation to scientific achievements and new strategies. This first day was also dedicated to presenting the national contexts of HIV responses in Algeria, Mauritania, Tunisia and Morocco. Representatives of each country provided a situational analysis of the HIV response: they described the status of their country regarding prevention, the patient care cascade, the environment of intervention and the role of civil society. Participants also formed working groups to define priorities for innovative prevention, cascade improvement, interventional environment and civil society involvement.

Day 2 – Scientific symposium: From theory to practice: How to translate scientific achievements into concrete actions (Thursday, 16 March)

Day 2 consisted of a scientific symposium. The objective of this day was to find ways to translate the scientific achievements into concrete measures based on the priorities selected on the first day.

The symposium began with a roundtable on HIV testing and counselling services (HTS). Presentations on the following topics were delivered: recommendations on HTS (WHO); the Moroccan experience of lay providers and community-based HIV testing; and a guide on good practices of HIV testing in the Maghreb region. This was followed by a discussion panel about pre-exposure prophylaxis (PrEP) as an example of innovative prevention. Participants took also part in a roundtable discussion about the improvement of the environment of intervention (regarding prevention programmes among selected key populations and the legal framework). They presented their work and discussed ways to strengthen their capacities.

Day 3 – Experts/implementers meeting: Call to action (Friday, 17 March)

On Day 3, experts and stakeholders gathered and focused on setting up an action plan with concrete measures, propositions and policies to be implemented in the next two years in the different countries represented at the meetings. The day started with a summary of the first two days. This was followed by group work on innovative ways to leverage HTS and the HIV cascade, on the implementation of an enabling and favourable environment of intervention, and on how to strengthen the role of civil society. The meeting ended with discussions and consolidation of the outcomes of the group work, a summary of the priority actions, and next steps in the HIV response in the region.

Background

The International AIDS Society (IAS) is the largest association of HIV professionals around the world. It works to advocate and implement measures and programmes to reduce the global impact of HIV.

In 2016, the IAS launched its Educational Fund Programme, aimed at closing the gap between HIV scientific research and its concrete implementation. Indeed, this gap remains the main challenge to being able to respond effectively and efficiently to the HIV epidemic. The intention is to help scientists, policy makers and civil society access scientific innovations and support them in implementing advances that could stem the local HIV epidemic.

In this perspective, the IAS Educational Fund organizes regional meetings, which are an opportunity to share scientific research results and to discuss how to implement these advances in practice according to the local epidemic situation, contexts and previous experiences. Hence, participants will discuss strategies to be adopted for filling the gap between scientific theories and advances and programme implementation.

Prior to the meetings in Morocco, IAS Educational Fund meetings were held in Nigeria in October 2016 and in Senegal in November 2016.

The third IAS Educational Fund meetings were held in Casablanca, Morocco, in collaboration with the Association de Lutte Contre le Sida (ALCS) on 15-17 March 2017. The meetings were entitled “A scientific response to HIV in North Africa: Translating best practices into policies”.

The three-day meetings brought together experts on HIV/AIDS issues (clinicians, policy makers, members of CSOs, HIV service providers, etc.). Participants discussed the latest science and its implementation. The main topics were HIV prevention, new strategies, test and treat, improvements of the HIV cascade, the role of civil society, and improvement of the operating environment.

The Casablanca meetings offered the chance to share recommendations from the International AIDS Conference in Durban (AIDS 2016) with regional stakeholders who had not been able to attend. In addition, the meetings were an opportunity to share good practices and successful experiences implemented in the North Africa region, thanks to the presence of stakeholders from the health sector, non-governmental organizations (NGOs) and community-based organizations (CBOs) from Mauritania, Tunisia and Algeria. Those countries share the same epidemiological, social and cultural contexts. It was noted that at the IAS conferences, not just medical and scientific experiences are shared, but also community and activist experiences.

Finally, the meetings occurred while funding for the response to HIV is being reduced. Funders and policy makers are pulling back from the HIV issue because of quite low prevalence in the region. However, AIDS remains a huge concern and a massive challenge for the North Africa region, as everywhere else.

Detailed meeting report

Day 1: Key messages from the International AIDS Conference in Durban, AIDS 2016 (Wednesday, March 15)

Themes: Feedback on Durban conference and regional Maghreb context of HIV response
Chaired by: H Himmich (President of ALCS); **co-chaired by:** B Spire (IAS)

This first day of the IAS regional seminar was aimed at presenting the context of these meetings: sharing scientific advances and recommendations related to AIDS 2016; understanding the national Maghreb contexts of the HIV response; and defining priorities for action.

Introduction:

Pr Hakima Himmich, President of ALCS, welcomed participants and briefly described the purpose of the meetings. She also reported back on the previous IAS Educational Fund meetings (in Abuja and Dakar). As she explained, a key objective of the meetings was: How to improve our operating environment.

Andrea Nannipieri, Senior Manager for Strategy and Planning at the IAS, also said a few words of welcome and thanked the event's donor: ViiV Healthcare.

Participants introduced themselves and their organizations.

HIV counselling and testing (HTS): Latest developments from Durban

a) Latest developments from Durban (Mehdi Karkouri – ALCS)

Mehdi Karkouri spoke about the status of HIV testing and counselling services (HTS) before and after AIDS 2016 in Durban. He recalled the main recommendations from the WHO and some lessons learned from the Durban conference, and also described implementation suggestions from field experiences.

He briefly talked about the main the WHO recommendations released a year before AIDS 2016 regarding HIV testing services, a package of interlinked services. In particular, the WHO updated all the previous HIV testing and counselling recommendations, gathered them into a unique document, and called for an update of the practices in light of scientific advances. The WHO also recommended emphasizing quality, yield, strategies of simplification and referrals.

Mehdi Karkouri then presented the new advances and recommendations from the AIDS 2016 conference held on 18-22 July 2016. The "5 Cs" were highlighted during the conference: **C**onfidentiality, informed **C**onsent, **C**ounselling, **C**orrect test result, and **C**onnection with patient care services. The conference also marked the emergence of lay providers of community-based HIV testing (lay providers are trained but do not have a medical background). This is a successful strategy wherever it has been implemented despite some governments' reluctance to allow non-medical staff to provide HTS, and HIV self-testing in some specific settings.

He pointed out some weaknesses. The first of the 90-90-90 targets (90% of all people living with HIV will know their HIV status) has barely been reached anywhere in the world and definitely not in the Middle East and North Africa (MENA) region, which has one of the lowest

HIV testing rates. Advice emerged from AIDS 2016, such as the use of new strategies and innovations (via social networks, combination approaches, etc.), and emphasis on lay providers of community-based testing and self-testing. WHO's supplement to the HTS guidelines, released on November 2016, emphasized HIV "self-testing and partner notification".

Discussion points brought up following Mehdi Karkouri's presentation were as follows:

- **90-90-90:** How do we reach the first 90 by 2020? Testing is still done too late, especially for patients co-infected with other diseases.
- **Testing by lay providers:** To meet the 90-90-90 targets, it is important that non-medical lay providers can do testing, but this is still too weak; it would help to reduce testing at more advanced stages.
- **Partner notification:** There were concerns about misuse and inappropriate and forced testing.
- **Rapid tests:** In Mauritania, three tests are currently needed. It was recommended that only two tests be conducted due to limited financial resources and low HIV prevalence.
- **Self-test:** There has to be assistance for HIV self-testing (HIVST) (with or without attendance depending on the level of instruction provided). Self-testing also should be connected to the circuit of patient care. Innovative methods must be used.
- **Counselling:** The stringent pre-test counselling requirement has to be relaxed, especially for clients who are already well informed. Currently we talk about pre-test information; **post-test counselling has to be reinforced**, particularly to reduce attrition of clients who need follow-ups.
- **Loss to follow up (of patients needing support):** Several initiatives have been implemented to avoid it: physical accompaniment; sending an SMS with appointment reminders; and patient navigation. **A service that includes testing, confirmation and introduction to treatment should be proposed.**

b) *Feedback on the International AIDS Conference in Durban – Bruno Spire, IAS*

Bruno Spire compiled a balance sheet of the Durban conference. He outlined his presentation in which he talks about the state of progress on the Durban recommendations, the new treatments, the results of the studies led since Durban, unresolved problems, and new issues. He began his presentation by highlighting significant aspects of the conference, such as the attendance of numerous African representatives, the presence and visibility of activism (especially from sex workers), and the discourse change when talking about funding. He discussed several topics that can be summarized as follows:

- **Basic research:** Regarding a vaccine, a Phase 3 study took place in South Africa, which prompted the pharma industry to commit and to allocate resources to this (Janssen, for

example). Bruno Spire also highlighted the new concepts used around vaccination, such as highly neutralising antibodies, which are effective on several strains of the virus. Regarding HIV cure and treatment (HIV eradication and remission), the aim is to purge the latent virus reservoirs. Gene therapy was also suggested.

- **Development of patient care:** He underlined the emergence of new antiretroviral drugs, which are less toxic, more effective, and present less adverse drug interactions.

- **Test and treat strategy:** Knowledge about cohorts from the results of the START trial study allowed the adoption of the test and treat strategy in Latin America and elsewhere.

- **WHO's new recommendations:** WHO recommends that treatment is initiated regardless of CD4 count, but some countries are still applying the threshold of a CD4 count of 500, with exceptions for co-infected patients and other specific populations.

- **But there are still unresolved questions:**

- Are people who refuse immediate treatment at risk?
- Are clinical events (like cancers) that are observed in some patients in the START study linked to HIV or not?
- To what extent has efavirenz resulted in significant side effects (like suicide or death of unknown causes)?
- Could integrase inhibitors be used in first-line treatment in light of their advantages and despite their high cost? (They are less toxic, easy to use and present fewer drug interactions.)

- **Dual therapy:** Could treatment be reduced? This question was raised by the French National Agency of Research on AIDS and Hepatitis. The current convention is triple therapy, but it depends on the effectiveness of the treatment and the size of the viral reservoirs. Moreover, some studies show that dual therapy can be as effective as triple therapy, and that the use of anti-integrase can also help reduce the treatment. For now, dual therapy is still not included in the recommendations, but they are started to be used in research protocols.

- **Therapeutic window:** Experienced in the "4D" pilot test, which involves taking four days of antiretroviral treatment followed by three days without treatment. It could be a new interesting treatment, but it should be confirmed by a randomized controlled trial.

- **Long-term antiretroviral treatments by injection** could be used in hospitals: This alternative could be interesting for young or very mobile people (like truckers), but it still needs validation studies, especially regarding the acceptability of such a treatment.

- **PrEP:** The IPERGAY study has shown that PrEP is very effective and very well tolerated, and that irregular use of condoms during treatment does not have a big impact on contamination. PrEP is now fully reimbursed in France. But there are still big issues for PrEP, such as the diagnosis of other STIs for people on PrEP, the development of non-oral PrEP (vaginal rings, injectable PrEP, implants), and the use of injectable cabotegravir as PrEP, which sets a problem of pharmacokinetics (molecules staying in the blood). Moreover, intramuscular injections are painful.

- The Treatment as Prevention (**TasP**) trial is quite disappointing (not at an individual level) because of non-evidence of different incidence at the end of the trial due to the bad recommendations to patient care. One hypothesis to explain the poor performance is the lack of community actors involved in the study.

- **The 90-90-90 targets:** In order to improve viral response, HIV-positive people have to be treated immediately upon testing. Access to treatment has to be decentralized, human resources have to be increased, and follow up of patients has to be improved. In terms of biomedical prevention, the PARTNER cohort showed that TasP is an effective prevention strategy. Regarding the testing issue, diversification of strategies and improvement of the testing cascade are essential for achieving the first 90 target.

- **The funding issue:** Bruno Spire talked about the important increase of the number of PLHIV under treatment (HIV diagnoses have doubled since 2011) and the decrease in the contributions of donors. Receiving countries should participate in the funding of the HIV response.

- **Societal challenges:** A united movement against punitive laws is emerging, more attention is being paid to gender equality in discussions, interventions to reduce stigma have been started. However, equity in access to care and prevention is still a huge challenge.

To conclude, Bruno Spire stressed the benefits of the **test and treat strategy**, the dangers of efavirenz and the **benefits of integrase inhibitors**, the importance of **PrEP and TasP** in achieving the 90-90-90 targets, and the **need for basic research, funding, human resources, decentralization, struggle for human rights and community involvement**.

Discussion points brought up following Bruno Spire's presentation were as follows:

- Questions about gene therapy: He said it would depend on recommendations for each country.
- Questions about ARVs: Since they are less toxic, could the treatment for patients already under treatment be changed? He said that there was currently no real change from triple therapy to dual therapy.
- The expense of integrase inhibitors while they are recommended in first line in some countries.

Maghreb regional contexts of the HIV response (prevention, cascade's improvement, operating environment, role of civil society)

a) *Algerian context – F Razik (Infectious Diseases Specialist, CHU Algiers and APCS)*

In her presentation, F Razik presented a brief analysis of the HIV response after 10 years of fighting against AIDS in Algeria. She brought to light weaknesses of the HIV response and the insufficient presence of civil society.

In Algeria, there is low prevalence of HIV among the general population (less than 0.1% of HIV-positive people). It is concentrated among people with higher exposure to HIV infection, such as men who have sex with men (MSM) and people who inject drugs (PWID) (prevalence higher than 5%). The National Strategic Plan (NSP) for 2016-2020 foresees the reinforcement

of combination prevention's actions and the intensification of HIV testing activities, especially for the most-exposed populations. The NSP stresses that the HIV response should be based on decentralization, monitoring and evaluation at all stages of the response.

Several sentinel surveillance studies estimated prevalence for sex workers (SW) to be around 3.5%. In 2012, a bio-behavioural study showed that 92% of SW had been HIV tested and are aware of their status. This study also reports that 4.6% of SW are living with HIV. Another study, in 2014, concluded that community combination prevention was successful: in 2012, 42% of SW had used a condom during their last sexual intercourse, and this went up to 84% in 2014. However, F Razik explained that the numerous objectives set by the current NSP are too ambitious: for example, 85% of MSM should have used a condom during their last sexual intercourse until 2020, whereas 12% currently are. In terms of results, the number of people going for institutional testing has increased by a 10-fold from 2013 to 2014.

F Razik presented more details about PWID. In a testing centre in Algiers, 14% of PWID were HIV positive and 51% were positive for hepatitis C. Their situation is particularly worrying but would be detailed on the second day of meetings in presentations of the harm-reduction programme in Algiers.

The discussion points brought up following F Razik's presentation were as follows:

- There is a need for additional information about sizes of key populations and about prevalence via bio-behavioural studies, and larger samples to collect reliable data.
- Regarding the political analysis presented, participants questioned some of the official data. Is it certain that 90% of PLHIV in Algeria are heterosexual and that this is how 90% of transmissions occur? F Razik replied that the data come from the Algerian Pasteur Institute and that it is possible to find other data. However, she added that key populations generally represent only 1% of the people tested in testing centres. She also pointed that there are some contradictory data and there is an urgent need for reliable data in order to adapt the HIV response in Algeria.

b) Tunisian context – M Chakroun (Infectious Diseases Specialist, CHU Monastir and President of CCM, Tunisia)

M Chakroun spoke about the Tunisian context of the HIV response. Tunisia has low HIV prevalence (0.014% among the general population) and a concentrated epidemic, which explains why key populations (KPs) are important in the fight against AIDS. Tunisia has implemented specific testing and prevention programmes for KPs (but PrEP is still not included in the intervention package offered to KPs). M Chakroun also exposed weak aspects of the HIV response, such as KPs' still inadequate access to prevention and insufficiencies in the patient-care cascade. As far as the operating environment is concerned, PLHIV are still discriminated against – despite a national awareness campaign in 2016. There are also problems in the social environment because of: social norms that condemn sexual relationships outside marriage and between men; socio-economical vulnerability and low educational levels among SW and PWID; and marginalization of PWID. These are all major barriers to HIV testing, prevention and care. The legal environment is also unfavourable due to legal repression of the sex trade, sexual relations between men, and use of drugs. Regarding social issues, civil society must play a major role in building awareness, prevention and local support.

Discussion points brought up following M Chakroun's presentation were as follows:

- Is **notification of people who test HIV positive** necessarily nominative? He answered that testing is anonymous, but notification to health authorities is nominative but nonetheless confidential.
- The **role of the civil society in advocacy**: A participant noted that in Tunisia, involvement of political parties in human rights is more visible than involvement of community organizations. M Chakroun answered that it is the civil society that has adopted a law about use of drugs. Besides, civil society now has to fight the law that discriminates against MSM and criminalize homosexuality as a sexual orientation, rather than sexual practices such as anal sex.
- What is the **prevalence of HIV-positive people in key populations**? Mohamed Chakroun answered that in Tunisia, there are about 9,000 PWID, 28,000 MSM and 48,000 SW. He said that most new infections are diagnosed among key populations. He explained that HIV prevalence in testing centres is only about 0.3-0.4% because only 10% of the beneficiaries supported in the centres are from KPs.
- What is blocking authorization of mobile and **community-based testing**? M Chakroun explained that doctors favour community-based testing, and advocacy is in progress, but there is still institutional slowness delaying testing by lay providers. In Morocco, thanks to convincing results of a pilot study, community-based testing is valued, especially since KPs are stigmatized in public patient care centres; extension to the whole territory is pending.

c) Mauritanian context – Djibril Sy (SOS Pairs Educateurs)

Djibril Sy spoke about the Mauritanian context of the HIV response. Firstly, the epidemic is poorly documented, the level of awareness about the risks is low, and the population's knowledge about transmission modes and means of prevention is low. This fuels high-risk sexual practices. Prevalence is quite weak among the general population (0.48%), but higher among KPs; a study shows that HIV prevalence among MSM could be as high as 44%. Djibril Sy spoke about the improvement of the patient-care cascade, reinforcement of counselling and testing for the PLHIV's relatives and entourage, and support and follow-ups for PLHIV.

In terms of prevention, he said that Mauritania is organizing awareness and advertising campaigns for use of condoms, and also adopting the "combination prevention" approach. However, there are some problems: there is still a high level of loss to follow up among patients and a high rate of therapeutic failures; and testing is still on a voluntary basis and at the initiative of the healthcare provider.

Regarding the operating environment, there are barriers: religious obstacle for premarital testing; early marriages; and non-compliance with human rights and especially KPs' rights.

To conclude, he pointed to positives: financial contributions to respond to HIV; and a law protecting PLHIV rights. He stressed the major role of the civil society in advocacy and development of community-based interventions.

The discussion points brought up following Djibril Sy's presentation were as follows:

- **Prevalence among MSM**: Is the figure of 44% prevalence among MSM accurate? Djibril Sy answered that the sample used was not representative. He added that we do not know much about the MSM population in Mauritania, most of them are bisexual or

married men. MSM who are sex workers are already more informed about HIV than their clients.

- Regarding the **stigma of PLHIV**, there is a law that prohibits discrimination of PLHIV, but many stakeholders do not know about this law and it is still not applied, so this legal protection is not really efficient (there are no reported prosecutions).
- In Mauritania, there are only six **patient care centres** – clearly **insufficient** for this vast territory.

d) Moroccan context – Aziza Bennani (Head of the Department of STI/HIV, Ministry of Health)

National prevalence in Morocco is low (0.11%); it is higher among KPs, as in previously presented countries. The Cascade Analysis of 2014 showed loss to follow up of 20% because of the delays between appointments, hesitation after diagnosis confirmation, etc. Aziza Bennani proposed a situational analysis of the Moroccan HIV response. Some interventions are already implemented: reinforcement of prevention programmes; decentralization of care for PLHIV; improvement of coverage by antiretroviral treatment; and implementation of a national specific strategy on HIV and human rights, especially through the NSP 2017-2021 with high-level national political involvement in the HIV response.

She highlighted the involvement of civil society and presented the goals of the NSP 2017-2021, including reduction of new infections by 75%, reduction of the death rate linked with HIV by 60%, reduction of discrimination against PLHIV, improving access to psychosocial support, and reinforcement of governance and sustainability of the response to HIV.

The discussion points brought up following Aziza Bennani's presentation were as follows:

- The **sentinel surveillance** in Morocco stopped in 2012 because of ethical issues, such as the decorrelation of samples not allowing HIV-positive clients to be traced after testing to inform them of their status and link them to care. Instead, there is surveillance of pregnant women throughout the year in the context of PMTCT.
- **Loss to follow up:** The reference system for support and care is not efficient. WHO recommends use of a unique identification code, but there are still some challenges in its implementation in Morocco.

Group work: Definition of priorities

a) Group 1: Innovative methods of prevention and HIV cascade improvement – L Ouarsas (ALCS) and Bruno Spire (IAS)

This workgroup aimed to discuss and highlight the new methods of prevention and the innovations that improve the HIV care cascade. The group elaborated on these priorities:

- HIV testing services and PrEP must be promoted, particularly via social media (such as WhatsApp and Facebook). The implementation of a geo-location-based approach led by valid cartographies and the integrated approach of combination

prevention were suggested, as was the use of incentive methods for promotion of HIV testing.

- Community-based testing provided by lay providers should be generalized. Testing campaigns should be reinforced. Pilot trials for assisted HIV self-testing and a PrEP feasibility study should be implemented.
- The strategy of rapid testing confirmation must be clarified.
- Patient follow up and the tracing of patients lost to follow up should be reinforced.

b) Group 2: Improvement of the operating environment and role of the civil society – V Pelletier (International AIDS Coalition PLUS) and M Karkouri (ALCS)

This workgroup discussed how to improve the environment and involvement of civil society in the HIV response. The main points:

- The group identified the **main environmental barriers**: discrimination and stigmatization of PLHIV and KPs, criminalization of KPs, and dependency on international funding.
- **Civil society** has a primary role in the fields of: advocacy, capacity building for key actors, definition of the roles between governments and civil society, innovation, improvement of access to community-based interventions, evaluation of public policies, and reporting of human rights violations.
- The **main priorities** identified by the group based on the barriers are:
 - To **act on the social environment** by raising awareness of the necessity of complying with the rights-based approach, raising awareness of the general population, and partnering with religious leaders to build positive images of PLHIV
 - To **act on the key actors**, specifically healthcare professionals, lawyers and police officers
 - To **act on the legal environment** by lobbying to withdraw laws criminalizing key populations and regulations discriminating PLHIV, and by making sure that protective laws are enforced.

Closing – M Karkouri (ALCS)

To conclude the first day's discussions, M Karkouri summarized the main points raised. He pointed out the **importance of using innovative and relevant means for testing** key populations, and the **primary role of civil society**. He repeated the main recommendations formulated during the day, especially **bringing patient care closer to the populations** and addressing issues in the **legal and social environment**. Finally, he said that **this work must be done with the involvement of all the relevant actors**.

Day 2: From theory to practice: How to translate scientific achievements into concrete actions (Thursday March 16)

Themes: Priority focus areas in North Africa

Chaired by: K Marhoum El Filali (Infectious Diseases Specialist CHU Casablanca); **co-chaired by:** F Razik (Infectious Diseases Specialist CHU Algiers and APCS)

The second day of the meeting was aimed at defining concrete actions that can be implemented according to recent scientific advances in order to improve the efficiency of the HIV response. The presentations and discussions of that day revolved mostly around PrEP implementation and improvement of the operating environment.

Introduction

Kamal Marhoum El Filali and Bruno Spire welcomed participants. Bruno Spire thanked Gilead (the main sponsor of Day 2), the IAS and other partners. Pr Marhoum El Filali presented the agenda and objectives of the day – to provide essential information and background to build an action plan on Day 3.

Main WHO recommendations on HIV testing and counselling

a) WHO recommendations on HIV testing services – Yves Souteyrand (WHO Representative, Morocco)

Yves Souteyrand started his presentation by outlining the UNAIDS 90-90-90 targets for 2030 (90% of PLHIV know their status; 90% of people who know their status have access to treatment; 90% of PLHIV on treatment have their viral load suppressed). The first target will be the hardest to reach as 40% of PLHIV are still unaware of their status, and this has an impact on the rest of the cascade.

WHO published comprehensive recommendations on HIV testing services in July 2015 (including on HIV community-based testing and testing by lay providers) and complementing recommendations on HIV self-testing and partner notification in December 2016. The overall aim of these recommendations is to help bridge the gap for testing by:

- Enabling better access to testing for key populations
 - Ensuring reduction of time between testing and care services
 - Improving targeting of the most-exposed populations
 - Improving quality of rapid tests to limit the number of false positives and negatives.
- **The WHO recommendation on testing by lay providers was formulated: “Lay providers who are trained and supervised can independently conduct safe and effective HIV testing using RDTs.”**

A lay provider can be defined as any person who performs functions related to healthcare delivery and has been trained to deliver specific services but has not received a formal professional or paraprofessional certificate or tertiary education degree. Lay providers usually come from the same communities as KPs, which is why we talk of community-based testing. Y Souteyrand presented the arguments supporting the implementation of testing by lay providers:

- Increasing the capacities of testing services will lead to an increase in testing numbers
- The quality of services is equivalent to testing by professional health workers
- The satisfaction and support of beneficiaries are improved as lay providers come from their communities' culture
- Lay providers can deliver services that surpass HIV (TB, other STIs, etc.)
- Task shifting to lay providers can be cost effective, even though it is not the main rationale.

In fact, **the implementation of testing by lay providers must include a selection of adapted profiles from the communities, constant training and support, monitoring and evaluation systems, and adequate remuneration.**

Y Souteyrand gave supporting arguments for the implementation of the **WHO recommendation on the HIV self-testing:**

- It increases testing frequency.
- It does not increase risk behaviours.
- It does not increase social risk (suicide, violence).
- It needs implementation of complementing policies to be safe, such as monitoring and evaluation, and a limited age for use.

The discussion points brought up following Y Souteyrand's presentation were as follows:

- **Partner notification**

It was asked: What is partner notification? Y Souteyrand explained that WHO recommends giving guidance on professional assistance to assist PLHIV in notifying their partners on their serological status. The purpose is to support PLHIV in this event and to help reduce the harm. He also explained that the notification method must be chosen by the PLHIV and is not necessarily attended by them. Dr Rhoufrani (Morocco) noted that it is possible for a health professional, through a contract or engagement, to ask for authorization to notify the partner in their place. Bruno Spire responded that in France, this is not possible because of medical secrecy and the fact that people can change their mind and hence put the doctor in a difficult position.

- **HIV self-testing**

Dr Yousfi (Algeria) talked about the high cost of HIVST devices, which limits access for middle/lower income countries, whereas the tests cost 3 euros in France. H Himmich responded that the tests must be used more and more in order to drive down the prices, which is a goal that UNITAIDS is working on.

- **Community-based testing**

A participant asked about task shifting to lay providers, which can be considered for vaccination, for example, but this needs implementation of precautionary measures and close monitoring.

b) *Experience of lay providers in community-based testing in Morocco – Fatima Zahra Hajouji, ALCS*

The presentation started with a brief contextual explanation of the epidemiological setting in Morocco. The epidemic is concentrated in three regions (Agadir, Marrakech and Casablanca) and among three populations (MSM, SW and PWID). The epidemic is growing (1,200 new infections every year and 900 related deaths; 60% of infections occur among KPs and their partners) and hidden (49% of PLHIV are unaware of their status and 50% of people diagnosed are at an advanced stage). The main identified barriers to testing access are difficulties to talk freely to health professionals, the fear of discrimination, the fear of a positive result, and because healthcare centres are not adapted for testing (location and opening hours).

Given the concentrated epidemic, the high number of undiagnosed people, and the difficulties and barriers faced by KPs in accessing testing, new testing strategies are needed in Morocco. After WHO endorsed lay providers for community-based testing for KPs as an additional testing strategy, ALCS applied to the MoH and obtained authorization to conduct a pilot project to evaluate feasibility of lay providers conducting voluntary testing and counselling using RDTs. The pilot study was conducted in four cities (Casablanca, Rabat, Agadir and Marrakech) from March to October 2015 and showed excellent results, summarized as follows:

- It is feasible in all sites.
- It enabled reaching people who were never tested before.
- Beneficiaries themselves contributed to the mobilization of targeted populations.
- Beneficiaries showed great satisfaction about service quality: easier communication, better welcome and listening, good testing quality, respect of confidentiality, better opening hours, and proximity.
- Lay providers were greatly satisfied by peer recognition.

The discussion points brought up following FZ Hajouji's presentation were as follows:

- **Divulging of serological status and related risks**

In the case of testing by lay providers, the risks of divulging the person's serostatus should be limited. It is specified that lay providers are properly trained by doctors and that a technical committee validates the modules. Their training was constantly updated throughout the pilot trial. Lay providers are required, like all healthcare professionals, to comply with strict confidentiality. In addition, Dr Fall (Mauritania) raised the point that more problems were identified when divulging was done by doctors than by lay providers.

During the pilot experience in Morocco, no incidents or refusals from beneficiaries were reported, but some lay providers required more coaching during the first steps to handle HIV-positive status disclosure to the tested client. Solid monitoring and evaluation procedures were implemented with coaching by physicians at the start; a testing quality assurance programme was implemented in parallel.

- **Testing yield**

The question was asked: Is there a difference observed in testing yield between conventional and lay providers' community-based testing? ALCS reported that 56% of people who tested HIV positive were oriented to care during the pilot, against only 46% for conventional testing; the result in terms of loss to follow up is also in favour of lay providers doing the testing. The MoH has contracted a consultant to work on improving reference and counter-reference mechanisms in order to improve patient follow up.

- **Community-based testing**

Community-based testing in Morocco is also implemented via mobile strategies; indeed, a mobile unit and testing cases were used for the remote sites and in partner structures (CSOs).

The participants from Morocco expressed their strong support for lay providers doing community-based testing as a strategy that will allow doctors to spend more time on care with their patients and less time on testing; it will have a high impact on HIV response. A call was made to the representative of the MoH, Aziza Bennani, to quickly **scale up this strategy in Morocco**.

c) Guide on HIV testing good practices in Maghreb – Mr Chakroun (representing the MENA platform)

Mr Chakroun started by describing the epidemiological and testing situation in the region: a hidden epidemic; concentrated among key populations where prevalence is 10 to 100 times higher than in the general population; unattractive testing strategies and little innovation; and a low rate of HIV positive status (0.8% instead of 1.25% with community-based testing in Morocco). As a response, the “MENA platform”, a consortium of civil society organizations (from countries that include Morocco, Mauritania, Algeria and Tunisia) with a permanent secretariat hosted by ALCS, decided to produce a guide on good practices for HIV testing in the region.

The partners decided on a methodology that includes the following aspects:

- How to improve access?

To improve access, the 5 Cs must be respected and we must fight against coercive HIV testing practices, including by partners and family members. Orientation towards testing centre and test quality should be improved. It also needs a favourable environment and the implementation of efficient referral systems.

- Who to test?

KPs should be especially targeted and invited to retest at least once a year.

- When to test?

HIV testing is always voluntary; it can be provider initiated, in healthcare settings or community based, and may be provided by lay providers. For pregnant women, HIV testing should be included in the prenatal care package of services. In detention settings, voluntary HIV testing should be part of the package of services offered.

- How to test?

Testing must include pre-test information, a rapid test, and after obtaining the informed consent of the client, post-test counselling and linkage to prevention and/or care.

- How to adapt testing and prevention to KPs?

The testing and prevention strategies could be more adapted to KPs by adopting a combination of prevention approaches: behavioural change, microbicides, vaccines, PrEP, TasP, PMTCT,

male and female condoms, counselling and testing for HIV and STIs, male circumcision, single-use injecting material, etc.

- How to promote a favourable legal environment?

To foster a favourable operating environment, we must: adapt information to the beneficiaries' age; fight discrimination in health centres; promote the right of adolescents to make decisions regarding their health; and enable voluntary testing for adolescents (there is divergence on this subject between countries).

The discussion points brought up following M Chakroun's presentation were as follows:

- **Issue of testing and treatment for migrants**

Pr H Himmich asked if national policies in the region have allowed migrants to be treated for free if HIV positive. Indeed, this issue was not documented to produce a regional guide. In Morocco and Algeria, migrants can access the treatment; in Tunisia, it depends on the availability of ARVs, and advocacy for systematic free treatment for migrants is ongoing.

- **Prevention of mother to child transmission (PMTCT)**

Pr Himmich asked if the countries of the region have succeeded on that topic, apart from Morocco where much still needs to be done. The representative of the Moroccan MoH, Aziza Bennani, said that a lot has already been accomplished in Morocco, and women represent 56% of people on treatment. She added that community involvement is lacking. H Himmich pointed out that the MoH had excluded civil society from PMTCT. In Mauritania, testing among pregnant women is efficient but many women are lost to follow up during the treatment. In that regard, Mauritania is trying to draw from the Senegalese experience, which is a model in the region.

Panel Discussion on PrEP

Facilitators: Bruno Spire (IAS) and Fatiha Razik (CHU Algiers and APCS)

Panellists: Aziz Tadjeddine (APCS) / Ridha Kamoun (ATL MST SIDA) / D Sy (SOS Pairs Éducateurs) / Younes Yatine (ALCS) / Mustapha Sodqi (CHU Casablanca) / Morgane Ahmar (ALCS and International Coalition Plus) / Aziza Bennani (Ministry of Health, Morocco).

Bruno Spire introduced the panel with a reminder of what PrEP is: a biomedical prevention tool consisting of a dual therapy, which has shown excellent efficacy in preventing HIV transmission. PrEP can be taken "on demand" (on the occasion of sexual intercourse) or continuously on a daily basis.

The panellists introduced themselves, and Fatiha Razik launched the discussion.

- *First panellist: Ridha Kamoun, ATL MST-Sida Tunisia*

Ridha Kamoun expressed his "ignorance" on PrEP. However, he considered it a very interesting scientific breakthrough that could enable people to lead normal lives and sexual lives. For him, risks of PrEP (secondary effects as for all medicines) do not outweigh its great benefits, and it should be implemented in Tunisia. However, PrEP has not yet been discussed with Tunisian authorities. National and regional advocacy must be carried out.

- *Second panellist: Aziz Tajeddine, APCS Algeria*

Aziz Tajeddine said that PrEP is a very interesting prevention tool that will enrich the range of available combined prevention strategies. The efficacy of PrEP has been proven with important research results, and Truvada is already available in France. He raised the point that PrEP is generally associated with MSM. It is however also interesting for women and migrants. In Algeria, there is little chance that PrEP will be implemented in the coming years. However, there must be advocacy – there is no reason Algeria should be left behind. If all work together and find the right strategies, he said, there could be success. APCS needs support on training volunteers and health professionals on PrEP.

- *Third panellist: Djibril Sy, SOS Pairs Éducateurs Mauritanie*

Djibril Sy described himself as “literate” on PrEP, notably thanks to Bruno Spire who presented on PrEP during the ALCS conference in January 2016. In Mauritania, PrEP was included in the concept note submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria. However, even with available funding, he expressed the fear that it would remain on paper only and never be made concrete, partly because the definition of key populations itself is not accepted in Mauritania. He also expressed the hope that the proximity of *SOS Pairs Éducateurs* with KPs and the Moroccan experience can help implement PrEP in Mauritania.

- *Fourth panellist: Mustapha Sodqi, Infectious Diseases Specialist in CHU Casablanca and ALCS Morocco*

According to Mustapha Sodqi, PrEP’s efficacy should not to be debated any longer, as we already know its ability to substantially reduce the risk of HIV transmission. Practitioners delivering PrEP should make sure that people on PrEP are HIV negative and observant in their treatment. In Morocco, several questions on risks of PrEP use were raised, including STIs upsurge, treatment resistance and renal failure. However, it was shown in other studies that: people on PrEP consult doctors more frequently and thus their STIs are diagnosed earlier; the risk of resistance is extremely low; and the benefits are higher than the risks of renal failure. Moreover, no evidence for risk compensation in sexual practices, such as decreased condom use or more sexual partners have emerged in any PrEP studies or programmes.

ALCS obtained an agreement from the MoH to launch a pilot study to evaluate feasibility and potential obstacles of PrEP in the Moroccan context. Some questions still need to be answered to allow scale up and generalization of PrEP, such as its availability in national health centres and associations, and its targeting of key populations or wider groups.

- *Fifth panellist: Younes Yatine, ALCS Morocco*

Bruno Spire asked Younes Yatine: Have MSM heard of PrEP and if yes, what is their opinion of it? On the field level, there is very little discussion about PrEP, and it is ALCS’s role to take the information to its volunteers and beneficiaries. However, users of smartphone apps, such as Grindr in Morocco, are very aware of PrEP. At registration, there are questions about HIV status and PrEP use, and therefore people go and search for what PrEP is. In Marrakech, ALCS has implemented a prevention internet platform: one out of three people ask questions on PrEP or ask for access to PrEP. A key question regarding PrEP implementation remains the training and framework needed for KPs to access it. The best solution for Morocco is implementation of sexual health centres adapted to KPs to dispense the PrEP, using the same model as ALCS’s Marrakech clinic of sexual health.

- *Sixth panellist: Morgane Ahmar, ALCS and Coalition Plus, Morocco*

Bruno Spire asked Morgane Ahmar: PrEP seems to raise interest in the region, but what advocacy should be conducted to ensure availability of PrEP soon?

Morgane Ahmar briefly described the steps to enable the launch of a PrEP pilot project in Morocco:

- Exploring causes of reluctance from the medical community, at the institutional level and in the field from civil society organizations
- Production of adapted and informed guidelines
- Diffusion of guidelines to the MoH and authorization by the MoH to conduct a pilot
- Production by the ALCS of a methodological guideline on the pilot, and research for co-financing by WHO.

Morgane Ahmar stressed that the implementation of PrEP in North Africa is not just necessary (especially for key populations who face obstacles in the use of traditional prevention methods, such as condoms, as it constitutes evidence of sex work for police officers). It is also possible, given the large amount of evidence on the efficacy and importance of PrEP, the low price of generic PrEP (50US\$ per patient per year) and the cost effectiveness of its implementation. She also stated that civil society was the only actor that could push for change on that issue and that all the tools produced for Moroccan advocacy, including the methodological guidelines for the pilot, are shareable.

- *Seventh panellist: Aziza Bennani, MoH Morocco*

Bruno Spire asked Aziza Bennani: Is the Moroccan MoH enthusiastic, “wait-and-see” or resistant to PrEP?

Aziza Bennani said that the Moroccan MoH had given permission to proceed for PrEP implementation in Morocco through a pilot project and was going to buy Truvada, which shows its commitment. Acceptance by the MoH came after the Secretary General’s participation in the High-Level Meeting on HIV/AIDS in New York in June 2016 where PrEP was intensely discussed. Scale up of PrEP in the country will be envisioned at the end of the pilot trial, but PrEP has already been included in the next National Strategic Plan for HIV. Aziza Bennani also pointed out the importance of complementing prevention strategies for sex workers who fear using condoms and hence being arrested, which is a major barrier to access to care.

How to improve the intervention environment?

Facilitators: Mr Chakroun (Infectious Diseases Specialist, CHU Monastir and President of CCM-Tunisia), F Rhoufrani (ALCS)

a) Implementation of a harm-reduction programme in Algiers

Members of APCS described their harm-reduction programme. First, APCS has led a quick-diagnosis mission on the use of injectable drugs in Algiers. The main objective of this was to analyse the components linked to drug consumption in this particular context. This study was conducted in 2016 with 43 PWID in Algiers through interviews and focus groups. Most of the study participants were men (90%), 22-34 years old (90%) and in a precarious situation. Regarding education, most of them had reached either a secondary school or university level. They also reported that 75% have already shared their drug materials. About consumption, it is an individual and daily activity in most cases. The PWID interviewed also reported difficulties

in access to the care system, and the absence of associations that support them. APCS concluded that a lot of work still needs to be done on that subject.

The discussion points brought up following APCS's presentation were as follows:

- The **sourcing of Subutex** in Algeria is uncertain. Some participants thought it came from Tunisia while others thought it more likely originated from France. The president of ALCS (Morocco) explained that Moroccan civil society was fighting for the introduction of Subutex (methadone is already available) and was going to have to fight reluctance due to diversion risks. She also explained that France and other countries have accepted these risks, which are inevitable, and risks should not stop us.
- Are there **clear links** shown by the study in Algeria **between drug injection and HIV contamination** as the study showed that most PWID injected individually? APCS answered that the study involved 43 people, a sample too small to have valid conclusions. However, it added that half of the sample stated that they shared needles, a number significant enough to be worrying. However, APCS explained that a comprehensive cartography would be produced in the coming months, and that more will be understood on patterns and risk behaviours in Algeria.
- More needs to be done with PWID in terms of psychosocial support and not simply testing strategies, as a lot of the PWID studied are young people in situation of distress.

b) Prevention programmes with MSM in Tunisia – Fouad Boutemak, ATL MST Sida

Fouad Boutemak said that the prevalence of HIV among MSM in Tunisia is high: from 4.9% in 2009, it rocketed to 14% in 2011 and then dropped to 9.1% in 2014. MSM also face frequent human rights violations, which makes it difficult to access care. These extremely high numbers and barriers have led ATL to focus prevention and advocacy efforts on this population in several programmes, presented as follows:

- Prevention, testing and care:

Community-based testing in Tunisia at ATL takes place in two cities: Tunis and Sousse. Fouad Boutemak stressed the importance of peer educators and their role in prevention, testing and care in the MSM programme.

- Human rights and advocacy:

In 2005, the alliance started funding a small advocacy project, and in 2010, the first bio-behavioural study was conducted, enabling ATL to get a clearer picture on advocacy needs. In 2011, the Tunisian revolution created an increase in prevalence and critical situations for MSM, while human rights violations kept happening with arrests, anal tests, etc. The ATL proceeded in several steps:

- Situation analysis: identification of MSM beneficiaries' needs
- Outreach work: peer educators, prevention, capacity building, cartographies for better targeting, etc.
- Advocacy at the national and regional levels.

Among advocacy activities conducted at the national level, ATL advocated with the CCM, the national Strategic HIV Plan and created an observatory for human rights violations for information collection and legal support. ATL also established a collective of 40 organizations fighting for the defence of individual freedoms. Today, it works as a watchdog advocating for legal changes on issues such as depenalization of homosexuality and anal intercourse, and the end of anal tests to incriminate MSM. At a regional level, ATL has worked with religious leaders and produced a toolkit on MSM and HIV. ATL also conducts innovative activities, such as street theatre for awareness raising and online prevention with the creation of HIV prevention profiles, and is implementing an electronic programme (ReACT) to computerize data needed for advocacy.

To conclude, Fouad Boutemak highlighted the next challenges, including financial sustainability, mobile clinics, the fight against homophobia, awareness raising, behavioural change, prevention promotion in ambulatory services, and the increase of geographic coverage.

The discussion points brought up following Fouad Boutemak's presentation were as follows:

- On article 230 of the Tunisian Penal Code, which criminalizes homosexuality:

Questions were asked about advocacy efforts to withdraw this article and whether any successes were expected. As explained in the presentation, many Tunisian CSOs are working collectively on the issue; their intention is to pursue the case in court to declare the article anti-constitutional. Regarding anal tests to prove homosexual sexual intercourse, the representative of the association explained that ATL tells its beneficiaries to refuse the test when police officers ask for it.

- On community-based testing:

Hakima Himmich (Morocco) raised a point on the significance of community-based testing at ATL. It is conducted by lay providers from communities, volunteers or nurses; therefore, it can be defined as de-medicalized testing rather than community-based testing. What is meant by community-based testing seems to vary according to the context. **Participants spoke of the necessity of a clear harmonized definition to make sure that the same language is used in the region.**

- On the project of a human rights violations observatory:

Details about the Tunisian observatory and lessons learned were asked for since Morocco is interested in implementing a similar mechanism. A participant explained that people who come to the observatory are either those who have experienced human rights violations or ATL peer educators or intermediaries. Among the major observations made so far are: 20% of violations affect migrants; and 40% of violations happen in healthcare settings. Another point was raised: the bar association has forbidden lawyers to intervene freely for observatory cases, and the ATL has contracted a lawyer. Soon, ATL will implement the ReACT tool that will enable electronic information to be collected. The launch of the project is planned with Lebanese associations in April.

c) *Review of the legal environment in Morocco – Rachid Aboutaieb, Researcher, Consultant for the National Human Rights Council, Morocco*

Rachid Aboutaieb presented a review of the legal environment in Morocco, which he conducted on behalf of the National Human Rights Council. This review was conducted as part of the national HIV and human rights strategy, and it was due to the efforts of the MoH and human rights and HIV NGOs. Its main objective was to analyse the positive and negative impact of laws on the HIV response, and more specifically on PLHIV and people at higher risk of HIV infection. This was in order to evaluate obstacles and develop recommendations to improve the legal environment. To conduct this review, these steps were followed: collection of international commitments and treaties ratified by Morocco; analysis of the situation among PLHIV and KPs; and presentation of recommendations and an action plan in a national workshop.

He summarized his review as follows:

Main protective legal texts:

- Several protective laws were extracted from the Constitution (right to life, non-discrimination, gender equality, right to information, etc.)
- Penal Code: non-discrimination based on gender, age and health state, punishing of people and discriminatory behaviour, article on protecting confidentiality of personal data, etc.
- Labour Code and Family Code: non-discrimination, debate on the prenuptial certificate (it is supposed to protect but can have negative effects, and its utility is not demonstrated).

Main blocking legal texts:

- Penal Code: criminalization of homosexual relations, consenting sexual relationships outside of marriage, sex trade and prostitution.

Main discriminatory practices outside of the legal framework:

- Discrimination in institutional settings (work, healthcare)
- Lack of confidentiality in healthcare settings, work settings, tribunals, prisons.

Main components of the action plan developed:

- NGOs will produce a memorandum outlining appropriate measures in healthcare settings
- MoH will draft a bulletin on medical secrecy and disciplinary measures in case of refusal of care or of discrimination
- Analysis of constitutional dispositions on protection against discrimination
- Awareness raising among judges and lawyers for the effective application of laws on non-discrimination
- Implementation of an observatory on PLHIV and KPs discrimination
- Organisation of a working group on the revision of HIV testing regulations to enable testing of adolescents without parents'/tutor's consent and launch of a national debate on the subject.

The discussion points brought up following Rachid Aboutaieb's presentation were as follows:

- On criminalization of transmission:

There is no recommendation on that subject (from outside the medical and scientific world) but jurisprudence. There is a divergence between judges and prosecutors in that regard: for the judges, there is no condemnation if exposing did not lead to transmission. However, for the prosecutor, a simple exposition leads to a condemnation. There have not been real advances but the ALCS keeps raising awareness.

- On testing and medical certificates:

Hakima Himmich (Morocco) raised issues on prenuptial certificates, stating that a lot of corruption happens behind closed doors (doctors give certificates for 100 dirhams without checking the patients). In addition, discrimination in healthcare settings does not happen in HIV-specific health centres, but rather in departments not dealing directly with PLHIV. Dr Tibari (Morocco) stressed the need to work not only with Moroccan national institutions but also with embassies as there are many cases of abusive medical testing for people who want to obtain travel visas.

- On making concrete recommendations and bringing sustainable change:

A participant pointed out a lag between the commission's recommendations on the legal framework and real life where discrimination cases happen largely outside the legal framework's scope and depend on individual will. For example, medical tests are imposed for people working in hotels, and an ALCS volunteer was recently arrested in Marrakech on the basis of "incitation to debauchery" for distributing condoms even though nothing in the law prescribes such a thing. Governmental bodies should be involved in every case when civil society has partnerships with them.

Another participant expressed the importance of improvements that enable efficient combined prevention strategies, and asked how the legal review was going to be made concrete. In response, Rachid Aboutaieb explained that the committee will act upon labor legislation so that occupational doctors will not be under the companies' orders as is the case today. In addition, ministries will be encouraged to engage with key actors to be aware of situations of criminalization and discrimination that overstep the legal framework.

The national coordinator of ALCS explained that the association conducts activities to raise awareness among police officers and judges, but has no power to bring real changes and no funding for these trainings to be sustainable and conducted indefinitely. Here, Rachid Aboutaieb concluded that civil society is still the only actor that can bring real change as the governmental sector lacks will.

Conclusion of second day – Amal Benmoussa (ALCS, Morocco)

Amal Benmoussa gave a summary of the main topics and debates of the day:

1. Testing

Dr Yves Souteyrand presented the main WHO recommendations on testing and partner notification. The pilot experience on community testing in Morocco was presented and it was shown that it is more efficient to test KPs than classic approaches and that it should be generalized in the Maghreb region. Dr Chakroun (representative of the MENA platform) presented a testing frame of good practices in the region currently being produced by the MENA platform.

2. PrEP

A panel on PrEP discussed this biomedical tool that has shown great efficacy and must be implemented in the region. However, a few constraints were raised, and it was decided to wait for the results of the pilot project about to start in Morocco to then decide how to implement PrEP.

3. Improvement of the intervention environment

Dr Tajeddine presented the experience of APCS in the implementation of a programme for PWID in Algeria. Fouad Boutemak described the interventions targeting MSM conducted by ATL MST-SIDA in Tunisia. In addition, Pr Aboutaieb explained the process of the legal environment review conducted in Morocco to help advocacy for protection of PLHIV and KPs.

Day 3: Call to action (Wednesday March 17)

Themes: Call to action

Chaired by: K Alami (ONUSIDA); **co-chaired by:** B Spire (IAS)

The objective of the last day of the meetings was to consolidate the recommendations of the first two days in a regional action plan that will lead to the implementation of priority programmes in accordance with scientific advances.

This session began with feedback on the identified priorities and main recommendations of the first two days. Working groups then focused on priorities in order to establish an action plan.

Group work: Establish a regional action plan and define mechanisms of follow up in identified high-priority fields

a) Group 1: Innovative prevention and HIV cascade

The first group discussed new strategies of prevention and care that must be implemented as soon as possible to improve the HIV cascade. The participants identified several fields as priorities of action:

• *PrEP implementation*

The group recommended implementing PrEP for KPs (MSM and SW) in Morocco as soon as the results of the pilot trial are gathered. In the National Strategic Plan, 1,100 people are expected to be under PrEP treatment by 2021. A reassessment of this figure is planned halfway in the pilot, and this will include up to 10,000 people (10% of KPs).

The participants also advised sharing the methodological guideline of the pilot trial with other countries in the region so that they can advocate for financing similar pilot trials and sharing the results of the Moroccan study in the frame of regional workshops.

A pilot trial is already planned in Algeria for MSM and SW.

In a long-term perspective, pilot trials with PWID should be conducted and civil society should advocate for PrEP availability in pharmacies. However, it was pointed out that PrEP for PWID is not a WHO recommendation. For this population, the priority is access to needle-exchange programmes. The importance of integrating the recommendation to implement risk-reduction programmes in all countries in the region (needle-exchange and substitution treatments like Subutex and methadone) and the need to accelerate coverage of substitution treatment in Morocco were also highlighted.

• *Non-medical lay providers and community-based testing*

Lay providers doing community-based testing must be institutionalized and generalized. The group recommended ensuring that lay providers are available after hours, especially in the evening, to improve access to HIV testing. They also advised training more community counsellors and sharing training documents in the region. Lastly, community-based testing good practices should be documented and diffused at a large scale; this is already in progress with the development of a common guide via the MENA platform.

• *Implementation of innovative strategies of prevention and testing*

The group recommended the use of social networks, such as the initiative of prevention

messages on websites or apps that target KPs, like Grindr for MSM. Regarding self-tests, pilot trials for feasibility and acceptability should be implemented. This pilot should be integrated into the Global Fund to Fight AIDS, Tuberculosis and Malaria concept note for Morocco. Negotiation with providers for price decreases should be undertaken for the region.

- *Achievement of combination prevention systems*

In order to complete the combination prevention systems, the group recommended implementing a network of services at a regional level and at central points in cities and regions, with new approaches focused on individuals. To achieve this, data needs to be managed digitally.

- *Test and treat*

This strategy, from the WHO 2015 recommendations, should be adopted in all countries in the region. National patient care guidelines should also be updated. The participants stressed that it is important to increase decentralization of care, of the viral load analysis (PCR) and its operability. Moreover, general practitioners and gynaecologists should be informed about detection of HIV/AIDS symptoms, for example, via trainings and brochures.

The group also advised computerizing patient files and the management system for drugs and reagents.

Participants recommended initiating multi-diseases testing campaigns (HIV, HCV, syphilis, etc.). It was recommended that HIV testing be linked to hepatitis testing and syphilis testing.

Lastly, participants pointed out the importance of pursuing advocacy for testing of minors, as is currently conducted in Morocco by the National Council of Human Rights.

- *HIV-positive people support systems*

In order to improve the support system for PLHIV, some measures have to be implemented, such as reminder systems by phones, SMS or house visits. In that regard, a joint project by UNAIDS and Orange will be activated in Morocco to send appointment reminders by SMS. The group recommended closely monitoring this initiative and initiating these projects in other countries in the region (need to find similar partnerships with local operators).

Another way to provide support is to mobilize and train people who physically escort HIV-positive people to care centres to avoid any patients being lost to follow up. The group recommended that incentives for this activity should be offered.

Implementation of these recommendations would be strengthened by improvement and empowerment of PLHIV leadership.

- *Improvement of the referencing system*

The group recommended implementing a unique identification code in the different testing structures (NGOs, Ministry of Health) to be assigned to all HIV-positive people.

b) *Group 2: Favourable environment and role of civil society – Summary of priority actions*

This second group discussed the role of civil society and suggested priority actions in order to improve the operating environment. The proposals and recommendations of the group can be summarized as follows:

- *Training*

The group emphasized the importance of training for health professionals and community actors on PrEP and testing, for junior human resources and community actors on advocacy, and also training on the NICTs use for prevention and awareness (e-learning, short movies as advocacy support) via media and social networks.

- *Development of regional common tools*

The group pointed to the need to harmonize support tools for the region. Hence, they recommended implementing a communication tool about scientific advances, targeting the general public and governing bodies, an awareness guide targeting imams, and a short movie to raise awareness of HIV/AIDS issues (news, restrictions, etc.).

- *Create synergies between governments and civil society organizations*

The group emphasized the importance of the awareness levels of decision makers about issues linked to AIDS. To achieve this, it is necessary to target people who are already favourable to the cause for advocacy; this should involve civil society organizations.

A clarification of the respective roles and missions of government and civil society is required, especially through the development of partnership conventions. Moreover, the group encouraged the Ministry of Health to embark on campaigns about TasP.

- *Awareness of decision makers*

The group recommended implementing actions to raise decision makers' awareness about HIV and the challenges facing the response. In this perspective, some events should be organized to gather civil society and decision makers (such as in seminars and meetings) in order to raise awareness and engage with decision makers. The participants agreed to organize meetings with their respective ministry representatives, as well as organizing awareness sessions for parliamentarians and decision makers, to try to mobilize institutions and to foster a favourable environment for the fight against HIV/AIDS.

Some participants drew attention to poor information exchange between the MoH and other departments (e.g., the MoH giving authorization for condom distribution and the Ministry of Interior arresting people who distribute condoms).

Some participants expressed scepticism about the relevance of imams' involvement in HIV awareness. As an answer, there already is an imams' association in Morocco working in the field of HIV; the first concrete actions could be to work with this association and to use it as a relay to spread the word about innovations.

The representative of the Moroccan MoH also noted that instead of sending hundreds of pages (National Strategic Plan) to other departments, they should be sent brief executive summaries of a few pages, synthesizing actions and programmes implemented, to increase their likelihood of being read.

- *Accessibility and conviviality*

The group recommended the creation of sexual health centres, as well as the creation of safe spaces for encounters and exchange to make them more attractive.

- *Use of existing networks*

The group recommended the use of existing networks in the MENA region (example of M Coalition), and the mobilization of monitoring mechanisms to ensure human rights are upheld.

- *Awareness for the general population*

The participants recommended multiplying the national events that reach the general public: for example, work by the Moroccan Sidaction has shifted the view on HIV since 2005. Indeed, those events are opportunities to send easy messages to the general public and KPs, and to also send specific messages to the institutional actors. Otherwise, they called on the MoH to increase the number of awareness campaigns among the general population.

Synthesis of priority actions and next steps (L Ouarsas)

To conclude the last day of the IAS meetings, Dr Lahoucine Ouarsas presented a synthesis of the working groups, summarized the identified priority actions, and summarized the next steps to be achieved in the next two years.

► **Main actions proposed**

The main actions recommended by the two working groups, based on the first two days' presentations and discussions, were as follows:

- **training of health providers;**
- **use of NICTs;**
- **development of regional guides;**
- **creation of synergies between state and civil society;**
- **organization of regional and local events;**
- **creation of attractive spaces to meet with key populations;**
- **associative networking;**
- **implementation of innovative approaches for prevention, testing and patient care;**
- **scaling up of PrEP;**
- **promotion of non-medical testing;**
- **implementation of auto-test pilot trials;**
- **support system and reduction of loss to follow up in care services and**
- **promotion of testing for minors.**

All these actions constitute a huge amount of work for advocates from the Coalition Plus MENA Platform. Several of these proposals are already in development and the process of seeking funding has begun. Others should be concretized and implemented as soon as possible.

► **Initiated concrete actions**

Dr Lahoucine Ouarsas compiled a list of already initiated actions. These included:

- the creation of mobile testing units in Mauritania;
- the expansion of community-based testing in Morocco to all ALCS sections;
- the support of countries that volunteer to conduct studies and dispose of strategic

- information (example of RDS study among PWID in Algiers);
- the support of sexual health centres' expansion in four Moroccan cities;
 - the coordination activities of patient care in Tunisia;
 - the development of a regional guide for combination prevention implementation and of regional workshops for sharing good practices;
 - a thematic day about PrEP at a regional level in order to present the results of the PrEP pilot trial in Morocco and to try to convince decision makers to implement this approach as soon as possible;
 - organizing a thematic day on cascade improvement at a regional level and
 - organizing a workshop on funding mobilization to implement services

Advocates of each country are driving a regional action plan for the MENA platform by establishing a programme of action for the next two years.

Conclusion

The IAS Educational Fund Meetings provided an outstanding opportunity for participants from North African countries to benefit from an exhaustive debriefing and update about the international AIDS 2016 Conference that took place in Durban, South Africa, in July 2016.

It allowed participants to update their knowledge and to take note of new advances and recommendations in the field of prevention, testing, treatment and care. The meetings also offered a safe space to share and reflect on self-practices and to define priorities for the countries of the region. The main priorities are improving the HIV cascade by promoting testing services and PrEP through social media, reinforcing patients follow ups to avoid attrition and rolling out and/or scaling up community-based testing provided by lay providers.

The regional character of the meetings allowed an exchange of experiences between the four participating countries. Participants also took advantage of these meetings to focus on a regional action plan to advance the HIV response against the priorities they defined. This plan took into consideration the national contexts and local capacities. The participants also committed to improve the operating environment by tackling stigma of key populations and to act on the legal environment to protect the rights of key populations. This is critical in order to translate scientific achievements into concrete actions.

Evaluation

Participants were requested to complete a survey to evaluate each day of the meetings.

For the post-AIDS conference workshop on 15 March, 48% of attendees completed the survey (32 out of 66 participants). For Day 3, 69% of attendees completed the survey (29 out of 42).

An electronic survey was emailed to participants regarding the scientific symposium on Day 2; it received a response rate of 38% (44 out of 115).

Overall, the feedback was very positive with much of the meeting content rated “good” to “excellent”. Participants put high value on the session chairing, as well as the questions, discussions and selection of topics.

The majority of respondents reported that they had gained a better understanding of HIV science and new findings, new ideas on how the latest findings in HIV can be applied to local issues, and new contacts.

Recommendations to improve future IAS Educational Fund meetings included:

- Organization of IAS Educational Fund meetings in other countries in the MENA region on a regular basis
- More involvement of community and key populations and of policy makers
- In terms of content, more focus on innovative ideas, best practices, recommendations and monitoring and evaluation mechanisms
- Provide a questionnaire to participants prior to the meetings for a selection of topics based on national and regional priorities.

Appendices

Agendas:

Agenda of Day 1: 15 March 2017

Introduction, objectives of the day and presentation of participants (H Himmich)

- **HIV counselling and testing: latest developments from Durban**
 - a) Latest developments from Durban – M Karkouri, ALCS, Morocco
 - b) Feedback on Durban – Bruno Spire, IAS
- **Regional Maghreb context of HIV response (prevention, cascade improvement, operating environment, role of civil society)**
 - a) Algerian context – F Razik (Infectious Diseases Specialist at Hospital of Algiers and APCS)
 - b) Tunisian context – M Chakroun (Infectious Diseases Specialist at Hospital of Monastir and President of CCM Tunisia)
 - c) Mauritanian context – D Sy (SOS Pairs Educateurs)
 - d) Moroccan context – A Bennani (Head of Department of STI/HIV and representative of Ministry of Health)
- **Working groups: description of priorities**
 - a) Group 1: Innovative methods of prevention and HIV cascade improvement – L Ouarsas (ALCS) and B Spire (IAS)
 - b) Group 2: Improvement of the operating environment and role of civil society – V Pelletier (International Coalition PLUS AIDS) and M Karkouri (ALCS)

Presentation of the group works and pooling/sharing - L Ouarsas (ALCS) Closing – M Karkouri (ALCS)

Agenda of Day 2: 16 March 2017

Introduction – Bruno Spire, Kamal Marhoum El Filali

- **Main WHO recommendations on HIV testing and counselling**
 - a) WHO recommendations on testing services – Y Souteyrand, WHO Morocco
 - b) Experience of community-based testing in Morocco – Fatima Zahra Hajouji, ALCS
 - c) Guide on HIV testing good practices in Maghreb – Mr Chakroun (representing the MENA platform)
- **Discussion panel on PrEP**
- **How to improve the intervention environment?**
 - a) Implementation of a harm-reduction programme in Algiers
 - b) Prevention programmes with MSM in Tunisia – Fouad Boutemak, ATL MST Sida

c) Review of the legal environment in Morocco – Rachid Aboutaieb, Researcher, Consultant for the National Human Rights Council Morocco

- **Conclusion of Day 2 – Amal Benmoussa (ALCS, Morocco)**

Agenda of Day 3: 17 March 2017

- **Summary of identified priorities and recommendations of Day 1 and Day 2**
- **Working groups: Establish a regional action plan and define mechanisms of follow up in identified high-priority fields**
 - a) Group 1: Innovative prevention and HIV cascade
 - b) Group 2: Favourable environment and role of the civil society
- **Synthesis of priority actions and next steps**