A Participatory Assessment on the Mental Health Status and Needs of Key Populations in 5 Countries in the Middle East and North Africa Region
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This document was written by Professor Joseph El-Khoury, Ms. Sara Abu Fakhr, and Ms. Karen Youssef as a Participatory Assessment on the Mental Health Status and Needs of Key Populations in 5 Countries in the Middle East and North Africa Region.

MENAHRA wishes to thank all the participants and organizations who contributed to the development of this document. This document was developed with the support of the Global Fund.

**List of Abbreviations**

<table>
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<tr>
<th>Abbreviation</th>
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<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ATIOST</td>
<td>Association Tunisienne Information &amp; Orientation Sur Le Sida &amp; La Toxicomanie</td>
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<td>ATL</td>
<td>Association Tunisien de Lutte Contre les MST et le Sida</td>
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<tr>
<td>ATUPRETT</td>
<td>Association Tunisienne de Prévention contre la Toxicomanie</td>
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<tr>
<td>CBT</td>
<td>Cognitive Behavioral Therapy</td>
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<td>COVID-19</td>
<td>Coronavirus disease 2019</td>
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<td>CSO</td>
<td>Civil Society Organisations</td>
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<td>GSMHT</td>
<td>General Secretariat of Mental Health</td>
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<td>HCPs</td>
<td>Health Care Providers</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>KI</td>
<td>Key Informant</td>
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<td>KII</td>
<td>Key Informant Interview</td>
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<td>KP</td>
<td>Key Population</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>LGBTQ</td>
<td>Lesbian, Gay, Bisexual, Transgender, and Queer</td>
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<td>MENA</td>
<td>Middle East and North Africa</td>
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<tr>
<td>MENAHRA</td>
<td>Middle East and North Africa Harm Reduction Association</td>
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<td>MENAPLUS</td>
<td>Middle East and North Africa Plus</td>
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<td>MENAROSA</td>
<td>Middle East and North Africa - Rosa</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<td>MOPH</td>
<td>Ministry of Public Health</td>
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<td>MSM</td>
<td>Men Who Have Sex with Men</td>
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<td>NASP</td>
<td>National AIDS Strategic Plans</td>
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<td>NGOs</td>
<td>Non-Governmental Organizations</td>
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<td>NHSP</td>
<td>Non-Specialized Mental Health Professionals</td>
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<td>OST</td>
<td>Opioid Substitution Treatment</td>
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<td>OUD</td>
<td>Opioid Use Disorder</td>
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<tr>
<td>PLWHA</td>
<td>People Living with HIV/AIDS</td>
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<td>PWUO</td>
<td>People who use Opioids</td>
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<tr>
<td>PLHIV</td>
<td>People living with HIV</td>
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<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
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<tr>
<td>SIDC</td>
<td>Society for Inclusion and Development in Communities and Care for All</td>
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<tr>
<td>SUD</td>
<td>Substance Use Disorder</td>
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<tr>
<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Previous reports have highlighted the epidemiological link between intravenous drug use and the spread of HIV/AIDS.

Approximately 11 million individuals use drugs intravenously globally (UNODC, 2022).

The estimated number of patients living with HIV/AIDS stands at 38 million today around the world (WHO, 2022).

Both conditions carry a psychological and emotional burden separately and in tandem.

To our knowledge this report is the first to directly shed light on the mental health needs of two key populations (KPs) in the Middle East and North Africa region from a harm reduction perspective: opiate drug users and people living with Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome (HIV/AIDS) (PLWHA).

These two populations overlap in a number of ways. The harm reduction approach has served their health and wellbeing for decades through service delivery and advocacy (MENAHRA, 2017).

Given the stigma surrounding both conditions in the Middle East and North Africa (MENA) region, harm reduction Non-Governmental Organizations (NGOs) are often the main, if not the only, source of information and service provision for these populations.

This report attempts to consolidate the body of knowledge on this topic. It is divided into the following parts:

A background section that leads into an overview of the international perspective on mental health in the two above-mentioned populations.

The situation in each country is then addressed through a literature review and a thematic analysis resulting from a proactive consultation of selected stakeholders. A general discussion with recommendations for the region concludes the report.
Despite the forward leap in mental health care, driven by advances in the understanding of its etiology and improvement in the interventions available, several significant gaps remain.

This notably affects key vulnerable populations and specifically in the Global South.

The populations considered vulnerable do vary between countries but generally include individuals diagnosed with Substance Use Disorder (SUD), PLHIV and others who belong to sexual minorities, such as Men Who Have Sex with Men (MSM).

Often, these categories overlap and complicate the situation further. As early as 2004 a call for action for providing targeted services was put forward by experts in the field (O’Brien et al., 2004).

The overlap between these populations also varies from one country to another.

The MENA region, which mostly consists of Arab countries, is a region where awareness of mental health needs and subsequent investment in response and intervention has been trailing behind other parts of the world. With relatively limited resources, harm reduction initiatives have contributed somehow to reducing the burden of opiate use on individuals and communities.

Where the association between opiate use and HIV/AIDS is significant, interventions targeting one group were shown to have a positive impact overall for example from the perspective of viral transmission. On the other hand, the mental health of KPs specifically, whether in the form of symptom reduction or overall wellbeing, is rarely a primary designated target. As a consequence the topic of mental health and psychological wellbeing deserves further exploration in countries of the region where a diverse range of harm reduction services or campaigns have been active. These include the countries chosen for this report: Egypt, Jordan, Lebanon, Morocco, Tunisia.
Attempts at providing recommendations for addressing the mental health needs of people living with HIV (PLHIV) who use drugs and also belong to the Lesbian, Gay, Bisexual, Transgender, and Queer + (LGBTQ+) community are very context specific.

In countries where HIV/AIDS is closely linked to intravenous drug use addressing them as one entity and in one setting is usually possible. (Buckingham et al., 2013).

Opioid Substitution Treatment (OST) has been shown to successfully reduce exposure to HIV/AIDS across income strata, confirming the close connections between Opioid Use Disorder (OUD) and the disease (Lawrinson et al., 2008). Both disorders share the requirement for privacy, confidentiality, and cultural sensitivity amongst others (SAMHSA Advisory, 2021).

Opiate use disorder is included in the official classifications under the substance use disorders category.

It covers any psychoactive substance and all possible negative consequences of their use on an individual, including dependence and addiction.

Global surveys reveal that the use of mental healthcare services by SUD patients is low. It is slightly higher when this disorder is comorbid with another psychiatric disorder, such as depression, anxiety or otherwise (Harris et al., 2019).

In the United States where regular national surveys are undertaken, the more severe the co-morbid psychiatric illness the more likely treatment for it was made available.

Still many went without any form of treatment, whether pharmacological or psychotherapeutic. A major identified barrier to treatment was financial cost (Novak, 2018). A helpful concept for addressing mental health and substance use is that of ‘dual diagnosis'.

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It encompasses three distinct groups of patients:

1-Patients whose mental health is affected negatively by drug use. This could for example be an individual with depression who consumes alcohol which worsens his/her depression status/condition.

2-Patients whose drug use is triggered by their mental diagnosis. This could for example be an individual who misuses benzodiazepines without medical supervision to help his/her anxiety.

3-Patients where the interplay between substance use and the psychiatric disorder is not clearly established. This could be a patient with psychosis who uses regular cannabis and has frequent relapses.

In a number of developed countries specialist dual diagnosis (or ‘dual disorder’) services were established in order to comprehensively meet the needs of at least one of these three groups (Adan & Torrens, 2021). Dual diagnosis cases are individuals who suffer from a psychiatric disorder and a substance use disorder regardless of which disorder is primary or secondary. The implementation and sustainability of these services have been inconsistent and subject to criticism (Pacini et al., 2020).

In general, integrated care is considered the gold standard for treatment, while in reality, it tends to happen in parallel (i.e delivered by separate clinicians or clinical teams working simultaneously) or in series (treating or at least stabilizing substance use first then assessing for other psychiatric disorders).

A more recent interest in the association between substance use and psychiatric disorders has been focused on self-medication using prescription medication or street drugs in Attention Deficit Hyperactivity Disorder (ADHD).

This interest has grown in the context of a recognition that ADHD can persist or indeed by being diagnosed de novo in adulthood. Screening and structured medical treatment for this condition is now recommended in updated guidelines (Van de Glind et al., 2020) (Tcick et al., 2020).

In addition, we also enquired about any gray literature such as internal reports and unpublished data.

These were then screened and filtered by our subject experts for relevance.

Second, a participative component using semi-structured interviews with Key Informants (KIs) in the 5 designated countries using snowball sampling starting with pre-identified individuals and organizations directly involved in the fields of advocacy, clinical care, policy, service development, and provision.

This was deemed necessary given the sensitivity of the subject and the difficulty in openly recruiting.

We followed the qualitative approach method. Special precautions to ensure participant safety, autonomy, and confidentiality. Interviews were conducted with a variety of participants, including patients, psychologists, psychiatrists, infectious disease experts, and other clinicians, as well as managers and peer support workers from NGOs and policymakers/government representatives from the Ministries of Public Health and Health.

We interviewed 22 people out of a total of 24 prospects, with two people participating in one interview in pair. The gender distribution was 42% men to 58% women.

The interview questions were carefully designed to establish the mental health needs and challenges of Key Populations (KPs) who suffer from OUD, belong to sexual minorities and PLHIV. The interviews were semi-structured and open-ended so that participants could express their opinions and share their experiences in a more open and free manner, which was critical for this study.
This also aided in learning new aspects from the selected participants. Questions were framed so that they helped to collect proper and high-quality data properly and effectively. The semi-structured interviews took place via Zoom.

**Every Interviews lasted 30-40 minutes.**

The data collectors informed participants of the aims of the study and their right to decline to participate, sought verbal consent/assent before any data collection and before recording, de-identified the data to protect confidentiality, and used password-protected files.

Interview records will be deleted after 3 years. The interview questions covered various aspects of the mental health of the targeted KPs such as perceptions on mental health, causes and risk factors of mental health issues, challenges to reach mental health services, services available and those needed by KPs in the 5 countries.

Some participants were fluent in English, but most of them were free to express themselves in their native language; thus, all the questions were prepared in English, and the interview was conducted in Arabic and translated to English during transcribing. The interviews were recorded after taking consent and transcribed.

The data was analyzed using Thematic Analysis, and the themes were generated from the data to answer the research questions.

An initial reading of transcripts allowed the development of a preliminary list of emerging themes. The themes highlighted were perceptions on mental health, current factors contributing to the success of delivery of mental health services to KPs, causes and risk factors of mental health, mental health needs among KPs, impact of lack of mental health services on KPs.

Data was anonymized by country through number-based coding of participants and data was then organized into categories and identified relationships among and between categories, allowing to understand explanatory patterns.
1- Egypt

a. Background

The cumulative global shocks that have occurred in the past couple of years including the Coronavirus Diseases - 2019 (COVID-19) pandemic, the war in Ukraine, and the refugee crisis has impacted Egypt’s attempts for economic growth and development. According to the World Bank database, urban and core inflation accelerated to 13.1% and 13.7% respectively during March–August 2022 (World Bank, 2022).

With the burden on the population’s living standards comes the increased need for mental health care. Over the past decades, Egypt has been making considerable forward steps in enhancing mental health services.

The Mental Health Act of 2009 (Okasha et al., 2022) has led to major changes in the country including higher investments in mental health services, a rise in awareness-raising campaigns, alongside advancement in education and training in the mental health field.

According to the latest report, the General Secretariat of Mental Health (GSMHT) has 18 hospitals and centers that provide mental health and addiction treatment services in 13 governorates.

However, major gaps are still very much present: Psychiatric hospitals are mostly centered in urban areas; there are insufficient mental health services targeting children and adolescents; and stigma and discrimination is still a huge barrier in seeking and approaching those services.

The stigmatization of those diagnosed with SUDs is even more pronounced. ‘Shaming’ is a major contributor to psychological distress, depression, anxiety, and stress in this population (Mohammed Ali, 2019).

Stereotypes associated with substance use, as well as shame, rejection, and lack of social support have been countered by some anti-prejudice public health interventions and awareness campaigns in Egypt.
Stigma and discrimination were not only directed toward substance users but also independently against persons carrying the HIV/AIDS virus.

This has prevented HIV patients from accessing medical care which causes serious physical health consequences (Galal et al., 2022).

On the mental health aspect, studies targeting People Living with HIV (PLHIV) in Egypt have shown that this population has historically endured and continue to endure dissatisfaction with HIV services due to experiencing stigmatization (Ballouz et al., 2020) (Elsharkawy et al., 2022).

When researching the mental health needs and services provided for the LGBTQ+ community in Egypt; little to no research is available publicly.

From what is known through advocacy groups The LGBTQ+ community has been facing major legal challenges from the security forces which includes entrapment, prolonged detainments, and torture.

This excludes social exile from families, friend groups, jobs, etc.

Those factors are all known contributors to distress and mental illness that this community is likely to suffer from and that needs to be further explored.
b. Findings:

Our KIs came from a variety of backgrounds. Most agreed that extensive stigma and discrimination were the main risk factor for mental health problems in Egypt. The confirmed that KPs suffer from being stigmatized by family members, society, and most commonly Health Care Providers (HCPs). In health care settings, PLHIV suffer a double burden, the burden of the disease itself; having the virus with all its physical manifestation, and the burden of stigma and discrimination from those meant to care for them. `Yes of course, the doctor himself refused to allow me in for another consultation so that was one of the things I was exposed to personally, and the stigma, the health care system is the most stigmatizing thing” (KI 6).

“The idea of stigma makes it very hard on them to seek treatment. Because over the course of years, the treatment centers are in themselves stigmatizing due to the cultural concept within society in general being built in cities that are considered rural areas not in the middle of the country or in the center of the people (KI 21).”

Moreover, KIs identified the need for services dedicated to abused women, especially among PLHIV who are exposed to violence and harassment: “What I meant that the service providers are there but this issue its not a priority area for them and at the same time based on our tradition here as Egyptians when a woman is practicing health risk behaviors or she has been, she has encountered harassment of any type especially sexual harassment. She feels ashamed to go and report so we should work on both sides.

We should work on psychiatrists themselves as service providers and potential clients who may be the target” (KI 3b).

A few KIs mentioned that hate speech is common against LGBTQ+ in the media and compounded by active harassment from official bodies who use dating applications as methods of entrapment. In parallel, People Who Use Opioids (PWUOs) are neither accepted nor financially supported by their families or their social circles. They also engage in self-rejection removing themselves from society. KIs explained that this has resulted in engagement in illegal activities and crime in order to fund their opioid consumption, which leads to further social prejudice. KIs reported that a large proportion of KPs suffer from psychiatric comorbidities, such as depression. Efforts should be made to reintegrate KPs into the community at both micro and macro community levels. Acceptability should start from the person himself.
According to Key Informant Interviews (KIs), KPs need support to be able to gain awareness of their situation in order to better understand how to manage it and adapt on the long term. Starting at micro-community level with household members who should be reassured regarding the risk of infection and encouraged to treat the condition as any other chronic medical problem. This type of awareness is already practiced at Caritas where the KP is asked whether they wish to invite a partner/friend/household member to be involved in the care plan. This lessens the psychological burden within the direct social circle of KPs as KI 6 indicated: “My parents provided somewhat sufficient support, and I had the support of people around me … (5:31) really great support.”

As for social integration at the macro level, it includes healthcare providers and the wider community. All KIs indicated that up until the day of writing, mental health is not a priority area of intervention for most healthcare providers and in most healthcare settings. More work is needed to increase the number of specialist HCPs and mobilize the available ones through training them on how to deliver services in a stigma free manner “Even in the treatment centers, the private and public hospitals, he is treated as if he is less, not as a patient and the situation that he is in is not in his power” (KI 18).

“I think they are not skillful enough because I went once to a psychiatrist and I told him I have HIV; he asked me to leave” (KI 6).

In addition, the majority of KIs emphasized that there is also more space to raise public awareness on topics such as drug abuse, opioid users, availability of treatment, and the importance of psychotherapy. Additionally, KIs suggested awareness raising for parents and adolescents through television programs, schools, and in universities. According to KIs, specific awareness messages should be spread in the community on the fact that PLHIV and PWUOs are patients in need of help and care. In the case of PWUOs, more awareness of the fact that some of the KPs’ actions are in response to a dependence and not voluntary lifestyle choice.

The second prominent barrier to mental health services delivery for KPs that emerged from the interviews were legal hurdles. There are no laws or policies that advocate for or protect the mental health of KPs.
Moreover, legally speaking, there is a gap between the legal provisions and what happens on the ground, especially when HCPs are concerned. The health care rights of every citizen, regardless of color, race, religion, or any other condition is enshrined in the Egyptian constitution. Nonetheless, addicts are criminalized and even PLHIV and LGBTQ+ are widely discriminated against when seeking care or support.

One KI explained that; theoretically, set laws regulate the treatment of PWUO and PLHIV. Yet in application, PWUO are criminalized by other sets of laws and are rarely supported by NGOs. For example, the ‘drug law’, which should be applied under the supervision of the ministry of justice and ministry of interior affairs in collaboration with the Ministry of Health (MOH) ensures that anyone arrested with an addiction problem, offered as an alternative to indictment and imprisonment in the form of treatment and rehabilitation. Another example is law 71 that came out in 2009 and targets mentally ill patients and addicts. This law supports a collaborative approach with the patient and the principle of confidentiality. It also ensures the patient’s right in relation to inheritance. Based on discussions with KIs, these two progressive laws aim to rationalize the management of addiction cases. Yet, neither are truly implemented. As for PLHIV, a legal advisory center is available in a few NGOs such as Caritas which has a legal unit found only in Alexandria whereby it’s training a group of lawyers in order to encourage the legal environment.

In terms of access to care, matters are also slow to progress. Harm reduction was virtually inexistent across the country. PWUO would either get opioids on the black market or decide to stop, by staying home or going to an abstinence based center whereby the main treatment was inpatient detox. The prevention package distributed by a small number of NGOs does not include substitution treatment or Naloxone. Neither of these globally established medication are included in a standard treatment plan for opioid dependence. An OST memorandum of understanding was only recently signed and is yet to be implemented. For most KIs securing OST is a necessity. KIs also stressed the fact that providing treatment for opioid users in addition to providing counseling and psychotherapy will reduce nationwide waiting lists and improve the quality of care. Most importantly, KIs pointed out the necessity of securing the medication that prevents overdose (naloxone injections), which is not currently available in pharmacies in Egypt but only in select Toxicology centers.
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The dearth of funding for mental health services was raised as a challenge, with many KIs highlighting a reduction in funding for mental health services recently. Although advocacy networks are working in many Arab countries yet the subject remains delicate. Very Few NGOs are thus able to provide psychological services consistently.

Exceptions include psychological counseling and group support by Caritas for PLHIV, and psychotherapy by external psychologists through the Middle East and North Africa - Rosa (MENAROSA). KIs also recommended that there should be dialogue between the NGOs and also between **NGOs** and the authorities.

Emphasis was placed on improving collaboration in outreach roles for KPs with the aim of referring more people to treatment. "The key population or the ones that occur with addiction problems are adolescents.**

**Most of those who start addiction, there are some that don’t have testing, so it becomes harder to do screening for it or to be able to find the problem earlier" (KI 21).
Service availability in both the public and private sectors were addressed in the interviews. Some initiatives were implemented by the Government and the few interested Civil Society Organizations (CSOs) to deliver mental health services. Their impact is difficult to assess but the scale of these efforts is certainly not sufficient to address the mental health gap.

KIs reported that Egypt has only three hospitals that are considered to be providing good mental health services. These hospitals are concentrated in large cities mainly in Cairo and Maamoura in the center and are staffed by a multidisciplinary workforce consisting of psychiatrists, psychologists, social workers, and other healthcare providers.

These collaborate as part of a treatment plan for individuals suffering from a mental illness and/or addiction. Abstinence-based programs or treatment through detoxification often in combination with cognitive behavioral Therapy (CBT) and group therapy are prioritized. The practice of ‘Peer support’ is available in Hummiyat (حمايات) hospitals only in Cairo and Alexandria for PLHIV. As for governmental centers, one KI reported that although Egypt has 28 governorates, there are only 20 mental health professional centers/addiction centers. This means that entire governorates do not provide specialist care, which impacts the quality of life and health of their populations. Rural areas are the most underserved with no appropriate geographical coverage of mental health services.

One KI also explained that in available governmental centers, the capacity of the inpatient department for addiction treatment does not match the need. This makes it harder for a lot of people to reach services and are deflected to outpatient treatment.

According to one of the KIs, the governmental approach has now been upgraded with the introduction of a daycare unit.

In their opinion this is a transitional level of care that was much needed and helps bridge the gap between inpatient and outpatient care, hence reducing dropout and relapse rates.

Adding to that, relatively new programs were mentioned by one KI as being currently implemented by the Ministry such as “Taafi” which is an evidence-based program that is built on CBT and addiction treatment management in public hospitals.
It is considered community-based because it is tailored to match and complement the community resources that hospitals and centers have.

Yet, few KIs reported that there is no psychiatric hospital or psychiatric ward inside Egypt’s public hospitals.

Furthermore, one KI indicated that there is a national lifeline for the treatment of substance use which provides treatment with very low prices which has increased inpatient treatment yielding to very long waiting lists.

On the other hand, the majority of KIs mentioned that they were not aware of specific mental health or counseling being made available for PLHIV, except in NGOs like MSF where the recipients are Egyptian nationals and refugees.

One small clinic opens once per week but based on a few KIs the utilization and impact is difficult to assess.

The private sector, which is unaffordable to the great majority of the population, offers some specialist services in facilities distributed across the country.

All KIs stated their concern that this leaves people in need of help with double expenses: transportation as the service is far and cost of services “Yes, of course. I used to get treated. At one point, I wanted to stop my addiction and I used to go to a session. That cost me more than 20$ in addition to the transportation fee which would add up to 30-40$.

That is for one session, other than the sweating, fatigue and the waiting. It was a big issue” (KI 15).
a. Background

A recently published report by WHO has shown increased general pressure on the healthcare system in Jordan.

Jordan faces several challenges due to the escalation in the number of refugees, alongside its internal demographic and epidemiological concerns.

In terms of HIV epidemic, Jordan has one of the lowest official global prevalence rates, estimated at 0.02%, in the general population.

It also does not seem associated with opiate use or substance use in general.

According to a Middle East and North Africa Harm Reduction Association (MENAHRA) report, 1,943 HIV tests were done in rehabilitation centers between 2012 and 2013 where all patients tested negative for HIV (MENAHRA, 2017).

Yet, the wellbeing of PLHIV in Jordan is still largely ignored as the psychological, social, or financial needs of this population are underserved compared to its physical needs (Algaralleh et al., 2020).

With MSM being one of the most hidden risk groups for HIV, little is known about their level of awareness and their prevention related behavior.

In one study conducted among MSM stigmatization was found to be a major obstacle to seeking testing and treatment. On the scale of the general population, poor understanding of HIV was still prominent.

Integration of disease education and awareness at community level needs to be addressed to encourage those infected to seek the correct treatment (Abu Moghli et al., 2017). Efforts to cover this issue included the National AIDS Strategic Plans (NASP) which is mostly outsourced to local NGOs covering around 10 governorates. With the aforementioned refugee crisis, there was reduced attention to the HIV cause and reduced investment in harm reduction services.
With regards to substance use, there are several legal issues that need to be addressed.

In a study addressing Jordanian SUD patients, the findings showed that community pharmacies played a major role in providing SUD patients with illegitimate prescription medications and called for reinforcing protocols and reexamining the legalization of certain drugs such as benzodiazepines (Yasin et al., 2020).

In addition, the country has a tough approach against drug use.

Under the Jordanian Law drug users hold the same rights as every Jordanian citizen arrested, yet abuse of power is common in the handling of this population (MENAHRA, 2021).

This degradation of human rights plays a big role in the lives of Jordanian drug users and their mental health.

In terms of its mental health care system, Jordan has a relatively strong psychiatric care program actively supported by the Jordanian MOH.

It is also advocated for by an empowered mental health movement that demands increased access to mental health care in Primary Health Care (PHC).

The National Mental health and Substance Use Action Plan is working towards strengthening mental health services in the country alongside supporting the national strategy to combat drug use (WHO & Ministry of Health, 2020).

It also works on enhancing the availability of Substance use care such as detoxification and OST.
b. Findings:

KIIs in Jordan indicated that stigma and discrimination and quality of mental health services are the two main burdens that cause mental health issues for KPs. PLHIV are stigmatized by family, friends and by HCPs. As one KI indicated, PLHIV women in particular face denial of service at the point of care.

Birth delivery services were highlighted as an example, as HCPs usually avoid these cases. “The important part is that they didn’t want to help me with my delivery. I tried 5 different doctors that were highly known in my country and they didn’t agree to deliver my baby.” (KI 14).

PLHIV are also at a high risk of losing their jobs or being jobless especially if the job necessitates testing “losing their right to work, there is no one person that is living with HIV and can talk about it and still be in the job, the nation rejects and refuses to employ people living with HIV, therefore the case of people living with HIV is the most complicated and most vulnerable to facing violation of rights” (KI 16).

The CSO’s perspective on LGBTQ+ is strongly influenced by the dominating culture of the country which considers the topic of sexual intercourse as a taboo.

So, KIs explained that due to this fact, LGBTQ+ are rejected and thus discriminated against socially.

According to KIs, social integration for KPs starts from society and does not end with legislative institutions “We need more work to raise awareness in society, more work with social influencers, social leaders, clergymen, media, governments.

We need more work on the definitions of human rights and work on the bases of laws and not social or individual basis and basis of social system” (KI 16).

In terms of services, KIs explained that the provision of mental health services to KPs in Jordan was weak. MENAROSA and Sawaed Center were mentioned by KIs as the very few NGOs that exist in the field of mental health. MENAROSA provides psychological (group and one to one support), and Sawaed Centers provide in addition to the above, psychiatrists support and specialists in addiction consultations. Governmental centers like Mashoura provide mental health services especially for PLHIV. More than one KI described the service in this center as not encouraging to KPs seeking mental health consultations. Few KIs added that they were not aware of centers that provide mental health services that would support them psychologically.
They also believed that they only become aware of the implications of their medical condition quite late “there is ignorance, no one knows what HIV is.

Even I, myself I didn't know had it not been for the workshops that were done, I wouldn't have understood it” (KI 14).

In contrast to the official assessment, Jordan was described as lacking specialists in the field of mental health “But we need psychologists, we need to have in the center psychologists honestly. We are in need of that, we really are.

Had it not been for what MENAROSA does in Sawaed, we really would be disregarded.

Let us talk about those who are living with the illness, we are disregarded in society.” (KI 14)

KIs explained that the majority of available CSOs intervene only in the field of awareness against drug use.

These CSOs implement educational programs aiming to spread awareness aiming at preventing drug use.

According to KI 16 “…Civil society organizations work on the prevention of drugs and provide educational programs which are not based on scientific knowledge.”

KIs highlighted the importance of these types of interventions, yet recommended that awareness programs should be based on evidence, scientific knowledge, and available protocols.

As for the public sector level, PWUOs receive detox services as a treatment without any psychological interventions “…remove the chemicals from the body, there are no other services given” (KI 16).

Legally, PWUOs are criminalized and face several punishments. Therefore, KIs suggested that these laws should be reviewed to fit with the needs of KPs, support them, and mitigate the consequences of drugs on them.
A few KIs also emphasized the necessity to work to stop abusive processes against KPs under the cloth of legality.

They supported creating legislations that punish people who violate the human rights of KPs.

One Ki also discussed the fact that CSOs such as Sawaed are actively lobbying governmental bodies to start implementing the child law that is already ratified and pushes for establishing a center dedicated to the treatment of drug users that are under 18 of age.
a. Background

Lebanon has been going through an acute economic and political crisis over the last 3 years superimposed on chronic instability that has impeded sustained development of mental health services in line with expectations (Chahine & Chemali, 2009) (WHO-AIMS, 2015).

In terms of the attention given to substance use disorder Lebanon remains the only Arab country offering a national opioid substitution program, based on the provision of buprenorphine on an outpatient basis.

This program has been running since 2012 and relies on a network of NGOs funded for the specific purpose of reducing the burden of opioid use and of HIV/AIDS on the community. (El-Khoury et al., 2016)

The program has survived the instability and has been an example of systemic resilience as it continues to face internal and external challenges (Ghaddar et al., 2017).

The mental health burden in Lebanon is aligned with identified global needs (Karam et al., 2002).

In addition, the series of collective traumas faced by the population also require a fresh evaluation of the role of self-medication and reliance on substances as inappropriate coping strategies (Bizri et al., 2021).

It faces stigma, lack of awareness, underfunding (Ministry of Public Health, 2017) and also centralization in the capital Beirut and the surrounding coastal areas.

This discrepancy is currently being addressed with the opening of prescribing and dispensing centers for opioid substitution where additional mental health support is integrated (Ministry of Public Health, 2017).

This prompted the recognition of a high level of comorbidity between any substance use and psychiatric conditions such as anxiety and depression (Hallit et al., 2019).
On a separate note, the burden of mental disorders amongst PLHIV in Lebanon was estimated at 94% according to one study. (Abou Kassem et al., 2021).

Poor quality of life was significantly associated with high levels of psychological distress directly and indirectly (Abboud et al., 2010).

A more recent exploration of the needs of the HIV/AIDS population revealed that psychological stress remains a major problem independent of the provision of appropriate medical care (Khoshnood et al., 2022).

The mental health of the LGBTQ+ community has been subject of research over the past few years.

One organization has been leading on addressing the specific needs of this population in the context of broader sexual health in general.

Major academic centers and university hospitals where psychiatric and psychological care is offered are receptive to LGBTQ+ patients and tend not to stigmatize them.

The same can be said about the NGOs, whether traditionally established (Skoun, SIDC) or who recently joined the clinical field (Embrace).

In addition, international NGOs (Medecins Sans Frontieres, Médecins du Monde etc.) are also open about including this community as a priority for their services, whether amongst the Lebanese or the refugees or migrant working population.

On the other hand, this trend does not always extend to other clinical centers and organizations, especially those affiliated with traditional religious institutions. Examples of discrimination or rejection have been shared on social media platforms by various sources.

A list of ‘LGBTQ+ friendly’ clinicians is also made available online, although the criteria for it is unclear. Research into the mental health of the LGBTQ+ population in Lebanon consistently reveals an overrepresentation of psychiatric disorders compared to the general population.
b. Findings:

The interviews reveal several risk factors for mental health disorders faced by KPs.

The most commonly cited cause according to KPs is social pressure in the form of explicit and implicit stigma, discrimination, and self-stigma.

KPs suffer from social rejection that limits their access to humanitarian assistance and health services.

Stigma does not only expressed by their family, friends, and social circle but also by HCPs who are not well trained on dealing with KPs.

This is a major burden on their mental health and leads to chronic psychological stress.

Legal hurdles limit KPs' accessibility to mental health services.

Being a substance user is still considered a crime in Lebanon, which deters people from seeking care.

PWUO who manage to overcome a state of denial despite not being able to manage their daily activities feel that they will not be accepted by anyone and avoid reaching out for help from their usual circle.

PLHIV especially women are considered a primary target for discrimination in Lebanese society.

They are often subjected to gender based violence especially if they are single mothers, sex workers, or former inmates.

In many cases, women living with HIV have no choice but to disclose their seropositivity to their family/children to prevent vertical transmission, thus increasing stigma towards them.

Many members of the LGBTQ+ community live a closeted life hiding a significant element of their identity, while those who choose to reveal their sexual orientation have to deal with wide scale rejection, especially from
their parents. The discrimination towards LGBTQ+ extends beyond the public to healthcare providers who are not equipped to deal and communicate with this minority group without discrimination.

“Specifically, for the past four years. Everyone was going through a lot.

Emotional instability, poverty, unemployment, etc.

Mental health services in particular are not accessible in Lebanon for everyone, particularly the LGBTQ+ community, why? Because not everyone or every therapist accepts this community” (KI 4).

An additional burden on KPs is the humiliation they face in the job market especially in instances when they are fired from their jobs or are not granted jobs when the word is out on them being HIV or belonging to the LGBTQ+ community.

This fear of discrimination also hinders their ability to seek jobs internationally as well. Thus, social integration is a necessity for KPs.

All KIs concluded that it is very important to spread awareness in society through anti-discriminatory and anti-stigma messages against KPs.

More acceptability should be adopted in society towards them. KIs who identified themselves as PWUO mentioned that they need rehabilitation centers that include not only mental health services but also give them the chance to learn something new that makes them more hopeful and feel motivated to to go back to a productive social role.

Many KIs believed that mainstream mental health services should be diverse and provided to everyone, as creating services exclusively for KPs risks encouraging more discrimination against them.

Moreover, services provided to all populations are more sustainable in terms of seeking funding than those targeting KPs only. However, few KIs stressed that some specificities in the implementation should be taken into account such as those of LGBTQ+ in order to ensure a stigma-free provision of services.
One KI discussed that there is room for improvement especially when it comes to training mental health professionals and psychiatrists on conversion therapy in particular with LGBTQ+ and towards evidence-based therapies. Training healthcare professionals will help in decreasing stigma as it incapacitates them not to involve their own religious or cultural biases when working with KPs.

KI 10 suggested that trainings can be initiated by official and/or governmental bodies “so some specific trainings for psychiatrists and psychologists can be done and now we are lucky to have the Lebanese psychiatric society and newly established order of psychologists through which such training can be streamed” (KI 10).

When KPs feel more confident and comfortable with HCPs, their tendency to seek care where they should will be higher.

KIs expressed their concerns about funding for mental health services in Lebanon which is low, especially from international donors and the Ministry of Public Health (MOPH) has a limited budget. So that has led to lack of new major initiatives and relying on the limited resources to be able to keep the currently available services.

The current Mental Health program at MOPH does not provide direct services.

Based on the discussions with KIs, the program is actually a governing body for the mental health system in Lebanon and it collaborates with several partners to improve the different areas ranging from laws, policies, coordination mechanisms, and normative documents, to service implementation. The program has issued evidence-based guidelines for mental health for the LGBTQ+ community and aims within its strategy of substance use to integrate mental health for PLHIV and those who use opioids through detection, screening, and referring to specialized NGOs.

The current mental health program works also to integrate mental health into primary health care through specific packages based on age gap.

It also provides the emotional support and suicide prevention hotline, and one KI indicated that a big percentage of the callers are from the LGBTQ+
community as well and the WHO-MOPH guided self-help intervention.

With the limited support given to the national mental health program within the MOPH, the strategy relies on the private institutions and NGOs in leading the implementation of mental health services.

CSOs are thus implementing a range of mental health activities starting from providing psychologists & psychiatrists consultations, OST, harm reduction kits, legal help to protect them, help to find a job, and comprehensive treatment program for people who use opioids (MHPSS treatment program), capacity building workshops and advocacy efforts, and publishing studies that show the importance of introducing substitution inside prisons.

A few KIs also worry that access to mental health services is a big issue, especially among women.

In fact, women living in rural or remote areas don’t really know their rights to HIV treatment. So sometimes their partner/ husband or their family is challenged to go and get the treatment especially for women living in remote and rural areas, small towns or villages whereby there is a centralization of most of these services being in Beirut and surroundings.

Most mental health needs mentioned in the study were related to the delivery of services.

KIs mentioned the need for a full mental health program should be considered meaning: the provision of therapy, follow-up with psychiatrist/psychologist, and inpatient for people who have acute psychiatric or acute substance use disorder (that is not private hospitals).

Most KIs also mentioned the importance of group sessions in sharing experiences and improving their mental well-being; in addition to one-to-one sessions to discuss more privately.

More awareness should be spread about available mental health services centers which should be decentralized to ensure more access. Available services whether governmental or private should be listed and disseminated in society and among HCPs in all health settings.
Women especially living in rural areas should be supported to reach out to mental health services.

With all the work on awareness on mental health being done by NGOs, many people become more aware of the importance of seeking help, yet the demand became way more than the capacity of the services available currently by NGOs.

Only two governmental hospitals offer psychiatric or substance use support to inpatients. In terms of outpatient services, there are five NGOs across Lebanon that are centralized in Beirut.

Thus, mental health services are barely available for KPs despite the high demand for these mental health services “Everybody is leaving, the few that remain here already have several jobs at once. So yeah they are overloaded and it is also impacting the quality of the work that they’re doing”(K1 2).

Long waiting lists discourage patients who face the issue of fully booked appointments. All KIs discussed that what made the situation worse was that following the several crises and economic deterioration in Lebanon, the majority of specialized psychologists, psychiatrists and mental health workers left the country.

With the current high demand on mental health services, an increase in the number of specialized professionals is needed to be able to provide services to KPs.

External referrals to specialized clinics are very expensive.

Regardless of the free or semi-free mental health support, KPs face financial burdens in seeking care.

The cost of transportation to centers and the cost of external consultations is a big burden.

With the financial burden at the moment, KPs cannot consider mental health as important as any physical issue they might have.

Financial support for KPs would also improve their mental health well-being.
The financial burden on KPs hinders their ability to afford to seek care. “Those services are not covered by insurance, and like every other medical service you have a discrepancy and that some people can access services others not for financial reasons- in terms of healthcare coverage for the people living in this country irrespective of their gender, orientation, and diseases.” (K|7)

Thus, KIs highlighted that financial support helps the patient to be able to buy their medications, go to the hospital, afford transportation, and commute to the NGO or primary care center where the services are available.

**KPs also live in hard life conditions and need food aid.**

Thus, KIs mentioned that they need help to find job opportunities as they consider it an opportunity “To be able to be alive again” (K|12).

Job opportunities lessen the feeling of emptiness and weakness among KPs, especially with their social isolation and self-stigma.

Additionally, KIs raised the issue that KPs cannot afford the cost of the medications, especially those related to drugs that are not fully covered.

The costs of detox and rehabilitation also became higher.

Thus, access to and availability of psychiatric medications was identified by KIs as a major need to patients and to PWUO, given that they are partially subsidized and that some medications are not available at all.

Some initiatives were done to tackle this issue such as the Middle East and North Africa (MENAPLUS) holding regional consultations regarding the shortage of medications.

Therefore, a few KIs such as K|10 suggested a systematic external evaluation of the OST program in Lebanon to learn what has been happening, what was going well and what needs to be changed leading to proper scaling up OST in Lebanon, and to the development of the new modality of services.
4- Morocco

a. Background

Over the last three decades, Morocco has shown significant improvement in addressing mental health since psychiatry was first introduced in the country as a distinct medical field.

Limited data was found on the prevalence of mental disorders and the level of services provided.

A trusted database reported a significant lack of human resources in the country with 8.8 professionals per 100,000 inhabitants (El Kirat & Filali, 2014).

It also highlights the inadequacy in the training of Non-Specialized Mental Health Professionals (NHSPs) compared to the need.

Field specialists are calling for more dedicated study, development of human resources, and guaranteeing availability of the latest generations of drugs (Aroui et al., 2017).

With respect to the mental health of individuals living with HIV, Morocco is considered a pioneer in the MENA region for advocating this mission.

Although the country has a low HIV prevalence rate of 0.14% among the general population, it is highly prevalent within people who inject drugs, sex workers, and MSM; who equates to 67% of new HIV infections (Mumtaz et al., 2013).

PLHIV in Morocco face several barriers to accessing healthcare.

Some barriers are explained by the lack of awareness on HIV indicators which results in a missed opportunity to access care and testing (Marih et al., 2021).

Other barriers include not only external stigma but also internal HIV-related stigma as well as low self-esteem (Bernier et al., 2019) that impact the life decisions and willingness to access healthcare (Moussa et al., 2021).

In terms of interventions, Morocco was the second country in the MENA region to establish a harm reduction strategy. Its activities varied between
distributing injection and inhalation kits, self-support groups, HIV rapid testing, and recreational activities.

A study addressing the health status and quality of life of heroin addicts treated using Opiate Substitution Treatment with Methadone (STM) in Morocco has shown improvement in several aspects of the drug users' lives including sleep, nutritional health, and social and relational status (IdriSSI et al., 2018).

Around six methadone centers and some OST programs were established for drug users yet a lot of restraints limit drug users from receiving the appropriate help (Himmich & Madani, 2016).

Legal restraints and violations are one of the main barriers that drug users suffer from.

During judicial prosecution for instance, drug users are dealt with violently, deprived from appointing an attorney, and are not diverted to treatment as an alternative to prison sentence (MENAHRA, 2021).
b. Findings:

According to KIs from Morocco, stigma and discrimination on one hand, and quality of mental health services on the other are the biggest challenges for KPs.

KPs who resort to governmental or public sector mental health services face stigma, discrimination, and rejection.

KPs are burdened with self-stigma and societal stigma.

For example, in many cases, KPs refuse to go alone to these services and ask that they be escorted by social workers from supportive NGOs. In other cases, KPs stop visiting government facilities altogether and rely fully on NGOs instead.

According to KIs, this is mainly due to the fact that NGOs follow values that are based on human rights and acceptance and refuse to stigmatize and discriminate against them.

KPs thus find themselves respected and welcomed in the NGO setting. The majority of KIs added that there is a trust and support relationship between the NGO’s team and this population.

Stigma was also frequently mentioned when discussing familial, friendship and even doctor-patient relationships.

Some KIs shared their personal experiences of healthcare centers where physicians communicated about their health conditions (PLHIV and Drug addiction) in a stigmatizing manner leaving them distressed.

As for society, an LGBTQ+ identity or behavior is not acceptable and can lead to physical abuse in the streets.

PLHIV face the same rejection and are also incapable of being openly themselves in society“...psychologically drained.

I opened up my eyes on society after being in a coma away from society.

I opened up my eyes on society, and I found a society that doesn’t empathize.

I can tell you that I (7:11).

He’s homosexual, and he used to be a drug user, and we don’t know what he has done"(KI 19).

Therefore, given the high risk factor stigma is creating on KPs’ mental health, KIs stressed on the importance of developing an acceptability culture through awareness campaigns with a focus on social media platforms and digital newspapers etc.
As for delivery of services, few KIs highlighted that the presence of methadone in centers across Morocco has been very helpful in the treatment of PWUOs.

Yet, mental health services at governmental centers might be complicated for KPs as they are required to follow several administrative procedures and wait for a long time before seeing a specialist.

KIs thus recommended removing bureaucratic hurdles where possible.

Another barrier discussed frequently by KIs was that mental health services are geographically difficult to reach for those outside of large city centers “…in the big cities, not everything. Some people benefit and some don’t, such as the women that live far away from the cities where the association is found in. They don’t benefit from the psychologists.

Not everyone benefits “(KI 11).

Thus, KIs advocated for a better geographical spread for mental health services.

Morocco also suffers from a shortage of specialists as a few KIs explained.

In one of the KIIIs, the KI mentioned that some statistics have shown a major deficit in the number of psychologists. With this shortage, KIs discussed the huge gap in mental health treatment as the emphasis in some services is on the psychiatrists mainly.

“What was helping me were not the psychologists, because of their lack of availability in my area of living….. There are psychiatrists but not psychologists.

There is no psychological support……So this was a reason for me to enter the mental hospital. It is called the hospital for mental and psychological disorders but that was not the case” (KI 19).

Most KIs explained that psychiatrists work in mental hospitals and thus there aren’t enough doctors to be placed in addiction centers.

Therefore, based on KIIIs, NGOs such as Hasnuna will strive to find
psychologists; even if on a volunteer basis, that will help the team in accompanying those with psychological and behavioral problems to optimize outcomes.

KI’s thus pointed out the need to raise the number of students who study psychology as this profession is much needed in Morocco.

In addition, most KIs recommended consistent training of HCPs to be able to work with the population that uses drugs, LGBTQ+, or PLHIV.

KI’s also expressed the need for hospitals whether governmental or private to provide psychological consultations and not just rely on medication based approaches.

KI’s explained that despite the efforts done by the government to start the social protection for jobless individuals (whereby the government pays for healthcare) NGOs are still requesting the enrollment of KPs in the scheme.

Where psychological consultations are free such as in few NGOs, waiting times are so long and appointments are scheduled every 2-3 months which damages continuity of care.

“They are also sometimes in a position where they can’t respect the very complicated administrative procedures where they require them to come and wait for a long time.

Especially here we are talking about drug users who live in a closed circle of consumption that makes it difficult for them to come to the centers and wait in long lines to get a number, appointment, and so on” (KI 20).

KI’s explained that the cost of private psychological consultations is high as the demand is huge in comparison to the number of available HCPs.

Thus, all KIs urged the need of free mental health services for KPs who are in deep need but unable to afford them. Adding to that, the high transportation costs on KPs to reach mental health services while they can barely afford the necessities.

Moreover, KI’s discussed the double lack of awareness of the need for
mental health support and of the already available mental health services as a barrier to accessing mental health support when needed.

“No one directed me at all. During this time, no one directed me.

I used to go to the hospital, do my check-ups and come back. Even once, I felt that psychologically I was very tired” (KI 11)

KIs spoke up about the lack of funding facing CSOs which, according to few KIs, threatens the sustainability of their activities and make it hard to maintain the level of quality of healthcare.

Few KIs thus recommended a call for countries to reflect collectively in order to find resources and support the workforce.

Legally speaking, KIs decried the absence of clear strategies to improve the mental health of KPs considering the fact that there is a shortage of doctors in general.

KPs face heavy criminalization especially PWUOs who instead of having the choice between prison and rehabilitation (based on an available law), are readily imprisoned even for consumption.

Thus, a few KIs considered the need to prioritize a better legal definition of this population, and its rights and to have laws to socially protect them.
a. Background

Tunisia being a lower-middle-income country, it is considered a success story when it comes to its delivery of mental health care when compared to other countries with similar resources.

It nonetheless faces the usual challenges of over-centralization of facilities in the large cities and the weakness of community services. Tunisia has a reasonable ratio of psychiatrists and psychologists matched by increasing demand for mental health treatment from the public (Charfi et al., 2021).

On the other hand, when scrutinizing the mental health needs of substance users in Tunisia, evidence shows that efforts are still required to cover estimated needs.

It is important to note that there is no publicly available epidemiological data that can allow a comprehensive assessment of the substance abuse situation in Tunisia.

In addition, the absence of a network of specialist centers, primary care physicians’ knowledge of substance use disorders and involvement in prevention and treatment remains underdeveloped.

A study has shown inadequate responses from primary care physicians to mental health related to substance use disorders. Some recent efforts are in force through the national substance use prevention strategies to improve the screening of drug use and implement campaigns battling stigma (Spagnolo et al., 2018).

Some organizations were also established to raise awareness and prevention such as the Tunisian organization for the prevention of drug addiction (ATUPRETT) and the Tunisian Organization for information and Guidance on AIDS and Drug Addiction (ATIOST) (Aounallah et al., 2014).

However, with respect to HIV prevalence in Tunisia, some data has been given showing a significant national rate of PLHIV. Between 1990 and 2017, the prevalence rate per 100,000 increased from 2.26 to 30.3 respectively (Shakiba et al., 2021).
The prevalence is considered low within the general population yet significantly higher among MSM and people who inject drugs (MENAHRA, 2017).

Compared to these prevalence rates, little to no research was found on the services provided for this population and the psychiatric burden on individuals living with HIV.

According to Tunisian law, HIV patients enjoy the same rights as every other Tunisian citizen including the right to healthcare access without any stigma or discrimination. However, it is not clear to what extent these laws are being applied and ethical dilemmas resolved (Mesrati et al., 2017).
b. Findings:

All KIs in Tunisia spoke of how stigma and discrimination are responsible for the mental health struggles of KPs. This is at the familial/societal level and even through the services they would usually benefit from at hospitals or health care centers.

“This person experiences stigma and discrimination for the fact that he is a user. For example, in the family, the family stops accepting that person. In the society, in the neighborhood, he’s living in, in his work. He becomes frustrated “(KI 17)

“There is stigma and discrimination, there are certain perspectives, sometimes from a psychologist, a social worker, or anyone; personnel of health.

This causes those people not to seek these services.”(KI 5)"

Stigma and discrimination meaning how they look at you, certain looks, that you have a sexual orientation “(KI 5)

KIs expressed that above the explicit discrimination from HCPS, HCPs are not well trained on values, confidentiality and professionalism while dealing with cases such as PLHIV, PWUO and LGBTQ+.

According to KIs, psychologists who deal with PWUO, in particular, need to have a high level of expertise and knowledge.

Thus, most KIs indicated that psychology graduates and professionals need more training on delivering mental health services for KPs.

Additionally, KIs highlighted the necessity of previous experience with KPs for HCWs who work in CSOs specially while communicating with PWUO and LGBTQ+.

Financial barriers are the second most recurrent theme elicited from KIs as a risk factor for mental health issues in Tunisia.

One of the examples mentioned by KIs is that a PWUO faces a serious issue of unemployment and inability to find a job which leads in some instances to resort to illegal ways to get money to buy drugs.

In many cases KPs' financial status burdens them from seeking mental health care.

In particular, transportation cost to and from the clinic was frequently mentioned by all interviewees as a barrier to seeking care.

All KIs expressed that KPs who seek care, especially in governmental centers that provide mental health services have to commute long distances due to the large catchment areas.
KIs have thus suggested the need for transportation allowances for KPs as a motivational measure “And I told MENAROSA to start sending money for transportation for those living with HIV in Tunisia because they are below zero with money.

Send them money so that they are able to continue to come to sessions.”(KI 5)

As for the delivery of services, few KIs mentioned that ‘Amal Hospital’ specializes in drug use and few NGOs are known to provide these KPs legal and psychological services (mainly support groups for PLHIV such as MENAROSA and one-to-one sessions such as the Association Tunisien de Lutte Contre les MST et le Sida (ATL).

However, KIs discussed that CSOs abilities are limited as they are not only short on staff but also have limited working hours in comparison to the huge need.

“Yes, exactly. Services and personnel. Personnel meaning 3 people do not equate 1,500 person” (KI 16)

Furthermore, the absence of an OST program was frequently mentioned by KIs as a main problem given that Tunisia does not allow any type of substitution treatment till today.

Finally legal hurdles such as imprisoning drug users without treatment or alternative punishment and criminalizing LGBTQ+ create a burden on KPs seeking mental health services.

“LGBTQ+ are criminalized and even arresting them and are subjected to a test (fahes I jarashi).

So the problem is a legal one, especially with the (12:50) which is a French law that France does not use anymore. But Tunisia still uses this law” (KI 18 A)
In order to address the topic comprehensively, a mixed method including a combination of individual KIs, focus group discussions, and structured surveys would have been ideal.

The scope of the study, the resources available, and the timeline meant that some intersectionality between KPs was not addressed in depth.

This included the specific needs of the LGBTQ+ population and specifically the MSM subgroup beyond their utilization of harm reduction services.

The research group also faced some difficulty in interviewing a broader group of informants, relying for some countries on already established national and regional networks of patients, carers, activists, and advocates.

Given the challenges of interviewing remotely and maintaining full anonymity, it is likely not all perspectives were reached and exposed in this report.

No potential conflict of interest was noted in this study.

The researchers were fully autonomous and had the privilege to choose the interviewees, carry out the analysis and reach their conclusions independently.
Despite the differences between countries in terms of size, population characteristics, healthcare ecosystems, and socio-economic factors our findings confirm a general trend of generalized and significant mental health burden in the targeted KP.

The series of interviews were consistent with previous findings and commentaries in the literature from the region.

Of note is that this literature itself is rather thin and unable to provide a comprehensive overview of mental health at population level, let alone when it comes to minority groups such as our KPs. It also does not allow one to draw comparisons between countries.

A lack of collaboration between local academic circles and frontline activist organizations may account for this limited output.

Whatever the reasons it means that policy advisors and international donors have to rely on assumptions rather than facts and numbers.

This is gap that could relatively be easily filled through research capacity building at NGOs, regional networking and collaboration with international academic centers.

The KIs provided invaluable local insight that can translate into specific recommendations for each country and when within country.

For the research team it was noted that themes were recurring almost identically between countries and from KIs coming from a diverse background adding validity and credibility to the findings.

Table 1 attempts to classify the themes highlighted by the KIs interviewed and the literature on the subject. The theme of stigma appears as the most consistent cause of psychological burden across the five countries.

Unavailability or unaffordability of care comes a close second again across countries.

The quality of the care provided when noted is a concern in Jordan, while legal hurdles are of relevance in Egypt. KIs are generally aligned in their perspective on the need and the way forward to provide adequate care, regardless of their identified role as service users or service provider.
Harm reduction services appear to be one of the frameworks suitable for diagnosing and treating mental health conditions in the KP, but not exclusively.

The widest possible range of treatment settings and approaches is likely to encourage the utilization and reduce stigma, which often includes self-stigma.

### Table 1: The Most Recurrent Relevant Themes in the Interviews by Country

<table>
<thead>
<tr>
<th>Most recurrent Themes</th>
<th>Quality of Mental Health care</th>
<th>Unavailability of Centre/Services</th>
<th>Unavailability of Specialists</th>
<th>Shortage of Medications</th>
<th>Financial Barriers</th>
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<td>Lebanon</td>
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</table>

<table>
<thead>
<tr>
<th>Most recurrent Themes</th>
<th>Lack of Funding</th>
<th>Legal Hurdles</th>
<th>Governmental Barriers for QST</th>
<th>Social Pressure on KPs (Stigma)</th>
<th>Lack of new initiatives</th>
<th>Lack of awareness about available services</th>
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<tbody>
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<td>Lebanon</td>
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</table>
Additional insight that emerged from a consultation with leading advocates from the region further backed our findings and identified a number of priorities across the countries surveyed and beyond them.

These include the importance of providing women with services that are safer both physically, emotionally and psychologically.

Women are usually more stigmatized than men and can be denied care by their families on the basis of the shame attached to HIV/AIDS, Substance use and also psychiatric treatment.

The use of technology such as telemedicine and teletherapy could resolve this hurdle for women but also for those in isolated communities, low income and those who fear stigmatization. Training and incentivizing mental health professionals to join the field of harm reduction and specialize in therapies and approaches suitable for the KPs is another priority.

Working with this population requires experience and understanding of the specific challenges they face. Often one has to live a double life and hide sickness and distress from their families, partners and loved ones.

This increase in capacity of specialists could run in parallel with raising awareness amongst the general population of clinicians starting with primary care up to infectious disease doctors, psychiatrists, psychologists and nurses.

Even when provision of care is not desirable in the general setting, motivating patients to seek help and directing to the appropriate services needs to be done with the correct mindset and attitude.

The stigma against KPs coupled with fear and ignorance is often preventing this important step that could be life changing.

The importance of mental health should be emphasized for its own sake with the use of measurable outcomes around depression, anxiety, sleep quality and other symptoms that are commonly found in KPs. Another dimension is the secondary impact of positive mental health on adherence to medical treatment, healthy behavior and general wellbeing.
H- Conclusion

The report reveals a significant mental health burden in the two KPs of individuals with substance use disorder, specifically those with opiate use disorder, and PLHIV.

This need is due to the conditions in themselves but also to the personal, social, and economic stressors that result from them.

An intersection with the mental health needs of the LGBTQ+ population is also identified although the extent of it was beyond the scope of our report.

The burden seems equally present in all five countries researched with minor variations and also coupled with a deficit in the provision of mental health care that can be readily accessed.

Cost, stigma, and the absence of a specialized workforce contribute to this deficit. Current harm reduction services can be an appropriate setting for the delivery of such care but not exclusively, given that HIV/AIDS and SUD are now less intimately linked with the success of harm reduction initiatives at reducing intravenous needle transmission over the last decades.

Investment in confidential, effective, and integrated care is recommended starting with the established structures in each of the five countries and taking into consideration the specific socio-cultural and health system context.

For any initiative to be cost effective and impactful in a reasonable timeframe it needs to be part of a framework of ongoing survey of needs across the MENA region.

This report identifies a paucity of consistent data in all countries studied. An initial challenge is to unify data generation and define regional strategies accordingly. Adopting and adapting evidence based interventions from other parts of the world is also recommended. **More resources are needed that encourage the academic, policy, advocacy and clinical spheres to come together in the interest of the KPS.**
Annex 1 - Informant guide and structure of interview

We are conducting interviews with selected stakeholders to establish the mental health needs of individuals who suffer from Opioid use disorder and also those who belong to sexual minorities or have HIV/AIDS.

The study covers 5 countries (Lebanon, Jordan, Morocco, Egypt, Tunisia) and is done on behalf of MENAHRA. Your contribution is very important to help us establish the facts and make essential recommendations.

The interview will take between 30 to 40 minutes at most.

We will be writing a report based in part on the result of the interviews. We may also use some direct quotes. Your name will be mentioned in the report unless you specifically request to remain anonymous. A copy of the final report will be made available to you upon publication.

Semi structured interview:

NGO/Physician/Governmental Body:

How long have you been involved directly or indirectly in this field or with this population (individuals who suffer from Opioid use disorder and also those who belong to sexual minorities or have HIV/AIDS)?

Do you believe that opiate use disorders (in general) in your country is at a good standard? If yes, what is required to improve it further? If no, what do you believe are the major challenges, hurdles? Are there any specific mental Health services for People who use Opioids in your country? Please Explain more

Are there specific mental health services for individuals from the LGBTQ+ community/PLHIV in your country? If yes, what are they and what are your comments on them? If no, do you think they should exist? If so, in what form? (needs for KPs) Are there any additional risk factors for mental health problems among KPs in Lebanon?
- Are you aware of any current new initiatives for this population (OUD, HIV, LGBTQ+) in your country? Is it a priority? Are there countries you consider role models for service provision for these populations?

- What do you think is the impact of the lack of services (if there is a lack of services)

- What is the role of stigma in preventing this population from receiving the help it needs?

- Do you have anything further to add on the topics we covered today?

If you have any questions after this interview is over please email me at saraa151018@gmail.com (provide your email address)
Please tell us about your background and role (OR Tell us a bit about you – for patients and carers)

Tell us about your situation, challenges, impact on your life and your family (for patients and carers)

Tell us about any help, treatment and support (for patients and carers)
Do you believe that opiate use disorders (in general) in your country are at a good standard? If yes, What is required to improve it further? If no, what do you believe are the major challenges, hurdles?
Are there any specific mental Health services for People who use Opioids in your country? Please Explain more

Are there specific mental health services for individuals from the LGBTQ+/LPLHIV community in your country? If yes, what are they and what are your comments on them?
If no, do you think they should exist? If so, in what form? (needs for KPs)
Are there any additional risk factors for mental health problems among KPs in your country?

Are you aware of any current new initiatives for this population (OUD, HIV, LGBTQ+) in your country? Is it a priority? Are there countries you consider role models for service provision for these populations?

What do you think is the impact of the lack of services (if there is a lack of services)

What is the role of stigma in preventing this population from receiving the help it needs?

Do you have anything further to add on the topics we covered today?

If you have any questions after this interview is over please email me at saraa151018@gmail.com (provide your email address)
Informed Consent

Under the global fund, MENAHRA is implementing a mental health assessment to study the status and needs of its Key Populations in 5 countries in the MENA region. MENAHRA aims to understand the causes and risk factors for mental health problems among the KPs (individuals who suffer from Opioid use disorder and also those who belong to sexual minorities or people living with HIV/AIDS) and forms of support needed by them.

Objectives of the Assessment:

1. Highlight the causes and risk factors for mental health problem among KPs in Egypt, Jordan, Lebanon, Morocco and Tunisia.

2. Specify the mental health services needed by the KPs in these 5 countries. We are aiming to conduct key informant interviews from each of the above mentioned countries. We will be writing a report based partly on the result of the interviews. We may also use some direct quotes without mentioning names. A copy of the final report will be made available to you upon publication.

Your Role

As part of the assessment, we would like to ask you to participate in a Zoom interview answering questions related to your perceptions on the causes and risk factors for mental health problems among KPs, and the mental health needs of KPs in your country. The interview will take approximately 30 to 40 minutes to be completed. If you agree, we will be audio/video recording the interview to be able to capture all discussed ideas.

Possible Risks/Benefits

Participation in the survey is completely voluntary and you can stop the interview at any time. If you do not wish to answer any of the questions, we will move to the next one. If you do not want the interview to be recorded, notes will be taken instead.
Confidentiality

The discussion in the interview will be kept confidential. No names or identifiers will be mentioned in the report. Your confidentiality during the assessment will be ensured by using a research identification number. Recordings of this interview will be stored in password-protected files.

Your Rights

If you have any questions, concerns or complaints about this assessment, you may If you have any questions after this interview is over please email me at saraa151018@gmail.com.

Participant agrees to participate in the interview:

[ ] Yes       [ ] No

Participant agrees that the interview gets recorded

[ ] Yes       [ ] No

Name of the interviewer:    Date:


MENAHRA. (2017). Assessment of Situation & Response of Drug Use And Its Harms in the Middle East And North Africa. MENAHRA. Assessment of Situation and Response of Drug Use and Its Harms in the Middle East and North Africa (menahra.org)


Substance Abuse and Mental Health Services Administration. (2021). Treating Substance Use Disorders Among People with HIV. Advisory.


