<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADLI</td>
<td>Association Beity, Association for the Defence of Individual Freedoms</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>AFTURD</td>
<td>Tawhida, Association of Tunisian Women for Research and Development</td>
</tr>
<tr>
<td>ALCS</td>
<td>Association de Lutte Contre le Sida</td>
</tr>
<tr>
<td>AMPF</td>
<td>Association Marocaine de Planification Familiale</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>ATFD</td>
<td>Tunisian Association of Women Democrats</td>
</tr>
<tr>
<td>ATL</td>
<td>Association Tunisienne de Lutte Contre les MST et le SIDA</td>
</tr>
<tr>
<td>AUB</td>
<td>American University of Beirut</td>
</tr>
<tr>
<td>CAPMS</td>
<td>Central Agency of Public Mobilization and Statistics</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organisation</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Committee on the Elimination of All Forms of Discrimination against Women</td>
</tr>
<tr>
<td>CCM</td>
<td>Country Coordinating Mechanism</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organisation</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Surveys</td>
</tr>
<tr>
<td>DU</td>
<td>Drug User</td>
</tr>
<tr>
<td>EDHS</td>
<td>Egypt Demographic and Health Survey</td>
</tr>
<tr>
<td>EFPA</td>
<td>Egyptian Family Planning Association</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
</tr>
<tr>
<td>FOCCEC</td>
<td>Forearms of Change Center</td>
</tr>
<tr>
<td>FPD</td>
<td>Family Protection Department</td>
</tr>
<tr>
<td>FSW</td>
<td>Female Sex Worker</td>
</tr>
<tr>
<td>GDM</td>
<td>Gestational Diabetes Mellitus</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>HIP</td>
<td>Health Insurance Organisation</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HN</td>
<td>Hospital Network</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
</tr>
<tr>
<td>IDI</td>
<td>In-Depth Interviews</td>
</tr>
<tr>
<td>IDU</td>
<td>Injecting Drug Users</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
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</tr>
<tr>
<td>IFH</td>
<td>Institute for Family Health</td>
</tr>
<tr>
<td>IMC</td>
<td>International Medical Corps</td>
</tr>
<tr>
<td>(I)NGO</td>
<td>International Non-Governmental Organisation</td>
</tr>
<tr>
<td>IOM</td>
<td>International Office of Migration</td>
</tr>
<tr>
<td>IRC</td>
<td>International Rescue Committee</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine Device</td>
</tr>
<tr>
<td>ITPC-MENA</td>
<td>International Treatment Preparedness Coalition - Middle East &amp; North Africa</td>
</tr>
<tr>
<td>JAFPP</td>
<td>Jordanian Association for Family Planning and Protection</td>
</tr>
<tr>
<td>JHAS</td>
<td>Jordan Health Aid Society</td>
</tr>
<tr>
<td>JICA</td>
<td>Japanese International Cooperation Agency</td>
</tr>
<tr>
<td>JPFHS</td>
<td>Jordan Population and Family Health Survey</td>
</tr>
<tr>
<td>KII</td>
<td>Key informant interview</td>
</tr>
<tr>
<td>KM</td>
<td>Kilometre</td>
</tr>
<tr>
<td>KP</td>
<td>Key Populations</td>
</tr>
<tr>
<td>LCRP</td>
<td>Lebanon Crisis Response Plan</td>
</tr>
<tr>
<td>LGBTQI+</td>
<td>Lesbian, Gay, Bisexual, Trans, Queer, and Intersex</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MENA</td>
<td>Middle East and North Africa</td>
</tr>
<tr>
<td>MISP</td>
<td>Minimal Initial Service Package</td>
</tr>
<tr>
<td>MoE</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MOHP</td>
<td>Ministry of Health and Population</td>
</tr>
<tr>
<td>MoPIC</td>
<td>Ministry of Planning and International Cooperation</td>
</tr>
<tr>
<td>MoSA</td>
<td>Ministry of Social Affairs</td>
</tr>
<tr>
<td>MoSD</td>
<td>Ministry of Social Development</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>MTCT</td>
<td>Mother-to-Child Transmission</td>
</tr>
<tr>
<td>NACP</td>
<td>National Aids Control Program</td>
</tr>
<tr>
<td>NAP</td>
<td>National AIDS Program</td>
</tr>
<tr>
<td>NCW</td>
<td>National Council for Women</td>
</tr>
<tr>
<td>NFPO</td>
<td>National Family and Population Office</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Name</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations International Children's Emergency Fund</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNRWA</td>
<td>United Nations Relief and Works Agency for Palestine Refugees</td>
</tr>
<tr>
<td>USAID</td>
<td>U.S. Agency for International Development</td>
</tr>
<tr>
<td>UN WOMEN</td>
<td>United Nations Entity for Gender Equality and the Empowerment of Women</td>
</tr>
<tr>
<td>VAW</td>
<td>Violence Against Women</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td>WASH</td>
<td>Water Sanitation Hygiene</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Program</td>
</tr>
<tr>
<td>WiTD</td>
<td>Women in their Diversity</td>
</tr>
<tr>
<td>WLHIV</td>
<td>Women Living with HIV</td>
</tr>
</tbody>
</table>
The authors would like to extend their sincere thanks to all the people and organisations who contributed to this study, most of whom are not mentioned here to preserve their anonymity as research participants. Our gratitude goes especially to the WiTD and focal points who shared invaluable information and without whom this research would not be possible.

We appreciate the assistance of numerous organisations and experts who mobilised their resources and contacts to arrange interviews, provided input into the research results.
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1. Introduction

1.1 Assessment Rationale and Objectives

The COVID-19 pandemic has generated strained health care systems and disruptions in all kinds of care, due to local or national lockdowns as well as economic slowdowns. These consequences have indirectly and negatively impacted sexual and reproductive health and rights (SRHR) of Key Populations living in the Middle East and North Africa (MENA) region, and more particularly SRHR services provision to Women in all Their Diversity (WiTD).

To enable a better understanding of COVID-19 impact on the SRHR services for WiTD in the MENA region, MENA Rosa has commissioned a mapping assessment, under the Global Fund to Fight AIDS, TB and Malaria (GFATM) grant “HIV: Sustainability of Services for Key Population in MENA region”, of SRHR services to WiTD in Egypt, Jordan, Lebanon, Tunisia, and Morocco. The purpose of this rapid assessment is to identify changes in SRHR services provision to WiTD during the COVID-19 pandemic.

Findings and prioritised list of recommendations developed in this report are based on data collected between July and October 2021 (See Annex 2: Project Workplan and Timeframe). The report provides guidance to policymakers, donors, and other relevant stakeholders, as well as it highlights the importance of recognising SRHR needs for WiTD during the pandemic response and recovery periods, as well as in any emergency situation. The report includes final recommendations at the national and regional levels to ensuring provision and accessibility of the SRHR services to WiTD during the pandemic response and recovery periods as well as in any emergency. This will, in turn, enable countries and stakeholders to develop and implement an emergency action plan for future emergencies in the MENA region.

More specifically, the objectives of this study are to:

Identify SRHR services related to WiTD before the COVID-19 pandemic and assess the changes and challenges in accessibility during said pandemic in the five countries under the GFATM grant.

Identify WiTD practices related to SRHR before the COVID-19 pandemic and assess how these practices changed during said pandemic in the five countries under the GFATM grant.

Synthesise feasible recommendations on a regional and national level to ensure provision and accessibility of the SRHR services to WiTD during the pandemic response and recovery periods as well as in similar emergencies.

Develop an advocacy plan for civil society, community, non-governmental organisations (NGOs), based on the collected data (See Annex 1: Advocacy plan).

2. Methodology

A multiple case study approach was used as a methodology for this study, focusing on the following GFATM grant countries: Egypt, Jordan, Lebanon, Morocco and Tunisia as specified in the TOR. Using a case study approach helped identify key gaps in SRHR accessibility during the COVID-19 pandemic within the contextual and institutional frameworks of each country. The assessment also used a qualitative approach, which included a mix of qualitative data collection methods, namely, structured individual interviews with key informants, MENA Rosa focal points (FPs)[1] and WiTD as well as a desk review of relevant documents. The document review was carried out using google and google scholar, with the following key terms used

[1] Focal points are women on the frontline and peer educators who support WiTD, in particular WLHIV and their partners and families. Focal points reach out to WLHIV and women at risk of HIV infection and support them though providing care, treatment, and prevention services and building their capacities. Focal points also advocate for the expansion of care, treatment, and prevention services offered to WLHIV and women at risk.

In total 45 interviews were carried out, of which nine were in Egypt, six in Jordan, 11 in Lebanon, nine in Morocco, four in Tunisia and six interviews were conducted with focal points from international and regional organisations. Moreover, of the 45 interviews, 31 were with key informants (KIs), seven with MENA Rosa Focal Points and seven with WiTD. Table 1 shows the distribution of interviews per country (See Annex 2 for a list of key informants interviewed for the purpose of this study). All interviews were conducted remotely; 38 interviews were carried out through online telecommunication applications such as Zoom, Skype and WhatsApp, and two interviews were conducted via email correspondence.

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Egypt</th>
<th>Jordan</th>
<th>Lebanon</th>
<th>Morocco</th>
<th>Tunisia</th>
<th>International/Regional</th>
<th>Total</th>
</tr>
</thead>
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<td>Focal Points</td>
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<td>1</td>
<td>2</td>
<td>1</td>
<td>7</td>
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<td>WiTD</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>KIs</td>
<td>5</td>
<td>4</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>31</td>
</tr>
<tr>
<td>TOTAL</td>
<td>9</td>
<td>6</td>
<td>11</td>
<td>9</td>
<td>4</td>
<td>6</td>
<td>45</td>
</tr>
</tbody>
</table>

### Ethical Considerations

An ethical protocol was developed during the inception phase of this consultancy (See Annex 4 for the Ethical protocol). An information sheet and informed consent form was also shared with all participants, and either verbal or written consent provided prior to participation in the interview (See Annex 5 for consent form and information sheet).

### Limitations

The consultants were not able to complete the anticipated number of interviews; as non-response rate was high. While the expectation was to reach 70 interviews, we were able to complete 45. Moreover, there were discrepancies in the number of interviews completed by country due to variances in response rates. The consultants extended the data collection period to address the non-response rate and complete as many interviews as possible. Although data saturation was not achieved, the consultants compensated this with a thorough desk review.

The data collection was conducted remotely, which may have limited access to more diverse WiTD, however, this was not possible because of travel and social distancing restrictions due to the COVID-19 pandemic.
3. Findings

3.1 Regional Findings and Recommendations

Collaboration, partnerships and referrals
Across the countries there were reports for a need to improve collaboration and partnerships between organisations to enhance access to SRHR services to WiTD, and to focus on ensuring accountability of these organisations. The MENA Region is also a long way from providing comprehensive SRH education throughout the life-course of WiTD. Moreover, social media, while limited in accessibility, is still an important source of information that can be utilised to improve SRHR knowledge and awareness, particularly in emergency situations such as COVID-19. During an interview with a KI from United Nations Entity for Gender Equality and the Empowerment of Women (UN WOMEN), the interviewee highlighted the importance of strengthening referral systems in the MENA region to better respond to emergency situations such as COVID-19. Several KIs also highlighted the importance of having a contingency plan at the organisational, national and regional levels on how to ensure service continuity when similar crisis happens, and for there to be different scenarios to ensure continuity of services. The financial benefit of investing in emergency plans will also be an economic benefit at a country and regional levels.

Peer educators play a critical role in the design, implementation, monitoring and evaluation of SRHR interventions targeting WiTD, particularly those who are from KPs such as WLHIV. They are important for building trust with KP communities, ensuring outreach to those who are hardest to reach, as well as making sure that interventions are catered to meet their needs. Creating an enabling environment for peer educators to take leading roles in emergency preparedness and planning for situations such as COVID-19 is important. Without the needed resources and capacities, the impact and sustainability of peer educators is challenged. Furthermore, the importance of understanding that like WiTD, peer educators are not a homogenous group and that diversity when working with peer educators is needed to ensure that ‘no one is left behind’.

Barriers to accessing SRH services
The de-stigmatisation of sexuality and particularly female sexuality is key for all women to access SRHR services, particularly those who are vulnerable to it. There are some countries that are progressing, and it is important to use them as case studies to explore new approaches to dealing with such issues in the MENA region context. Moreover, reframing SRHR and HIV along issues that are important for governments and working on systems strengthening as well as thinking creatively of ways to put forward issues such as HIV and SRHR is also necessary (KI, CSO, Lebanon).

Looking at the modalities in which countries responded to COVID-19 in the MENA region, is a valuable way of identifying good practices. During an interview with a KI, the interviewee reported that one of the main issues for PLHIV is access to medications, and in Arab countries like Kuwait and Saudi Arabia, they considered providing a delivery system for them. However, in the case of Lebanon this was not the situation, the focus was more on “mitigating the COVID-19 pandemic, keeping the numbers down, and now efforts on vaccination”. While the KI emphasised that these are also important efforts, it is important to focus on other measures (KI, AUB, Lebanon). HIV and SRH programming is also not integrated into other sectors, so it is more difficult to be accessible to all. A KI interviewed reported publishing a regional review of 11 Arab countries looking at the extent to which SRH services were integrated into private health care, “and when it came to post-natal care, and HIV, there is a big gap”. The KI highlighted how countries such as Lebanon, which are focused primarily on the private health care system, are more likely to be affected by crisis situations such as COVID-19. In addition to COVID-19, there is also the economic crisis in Lebanon which further challenges access to health systems and particularly in the case of women, who tend to deprioritise their needs. As one KI said,
Moreover, the risk is greater for women who need close follow-up such as those with HIV or those who give birth. Changing norms from childhood at schools, as well as changing attitudes and behaviours, is an important part of addressing barriers to accessing SRHR services and is something that resonated in the findings across the five countries. COVID-19 has also highlighted inequalities in health and brought forward the need to address such inequalities in order to achieve the sustainable development goals (SDGs)[2].

**Gender Based Violence (GBV)**
In the MENA region, there are reports highlighting an increase in prevalence of GBV and domestic violence during COVID-19. During an interview with a KI from UN WOMEN, the interviewee reported increased incidences of online violence. The KI also highlighted the need for more research on the different forms of violence experienced by WiTD as well as the challenges that they experienced in accessing SRHR services during COVID-19. Collecting good practices on how civil society continued provision of SRHR services during the pandemic is also important. Moreover, according to a study conducted by UN WOMEN in 15 countries including Jordan, Egypt, Lebanon, Morocco, and Tunisia, findings indicated that the COVID-19 pandemic had more impact on vulnerable women (such as refugees, migrants, women living with disabilities, ethnic minorities, and sexual minorities) compounding inequalities and vulnerabilities experienced by these women. The study highlighted that access to services by survivors of violence was disrupted, including legal services which forced police and other actors to resort to informal justice mechanisms, such as community or family mediation[3].

During an interview with a KI from UNAIDS, the interviewee highlighted the impact that COVID-19 has had on women and the importance of focusing on GBV issues. She gave the example of women not being able to go to shelters during lockdown, to be removed from their homes if experiencing domestic violence. Another example provided was the reduction in screenings and SRHR service provision because hospital staff have been preoccupied with COVID-19 issues.

**Changing modalities of implementation**
During COVID-19, reports across the five countries highlighted a change in modality of implementation of organisations to adjust their service delivery methods in order to ensure continuity of service provision. This included increased communication through technology-based platforms and social media. However, online platforms did not mean universal access to services, as some women could not afford internet access, and others did not have access to smartphones or lacked the knowledge in using certain applications. In addition, some GBV survivors could not use these platforms due to being trapped with their abuser[4].

**Recommendations**
Further research is needed on the SRHR needs of WiTD – particularly for those who are KPs during emergency and non-emergency situations in the MENA region. More research is needed on understanding the different forms of violence that women are exposed to during such situations, and the challenges they face, as well as the strategies used to access SRHR services. Identifying these challenges will be a first step to addressing them. Furthermore, in the case of Lebanon, rather than focusing on COVID-19, a more complex understanding of the multiple and accumulated layers of crisis and how they intersect to influence access to SRHR for WiTD is needed.

Invest in developing regional and national preparedness plans, which take into account the needs of vulnerable populations including women, children, elderly, PLHIV, persons with disabilities (PwDs) and refugee groups, and identify ways in which to address them during emergencies. In addition to a preparedness plan that defines how the work will be carried out during an emergency crisis, it is important to have a workforce that is trained for emergency preparedness at all levels (not only at the level of clinical services providers, but also at the level of emergency responders, social workers, and international non-governmental organisations (INGOs working with WiTD on SRH issues). Countries need to have in place a national coordination body to take leadership and responsibility of such work. In terms of funding, it is important to pitch this to policy makers, in a way that shows investing in preparedness plans and in capacity building for preparedness plans saves money during emergencies.

Peer educators play a pivotal role in facilitating access to SRHR services for WiTD and are also instrumental in any preparedness plan for emergency situations such as COVID-19. Engaging them in the preparedness plan process is necessary. As important is the need to mobilise resources to invest in their capacities and create an enabling and safe environment for them to engage in any emergency response plan, as they are the link between KPs and organisations working with such target groups.

Ensure that peer educators play a key role in the design, implementation, monitoring and evaluation of SRHR and HIV programs is critical. As important is the need to provide them with required resources and capacities to fulfil their roles in a proper, supportive, and safe environment. Including them in the process of emergency planning and preparedness planning is also imperative.

Consider integrating SRHR and HIV services into other sectors, such as education, livelihoods, economic empowerment, and WASH programming among others, in addition to pushing for more gender friendly services.

Strengthen referrals and coordination between the different stakeholders involved in SRHR and HIV services for WiTD, in order to avoid duplication of resources and increase impact and outreach of interventions. Innovative approaches to partnership are also encouraged beyond the standard partnerships that exist within the ‘HIV and SRH circle’. Fostering a culture of that promotes ‘working together and in partnership with each other’ rather than one that is competitive, between the stakeholders involved in SRH and HIV in the region is important.

Work towards dismantling patriarchal notions that consolidate discriminatory beliefs, practices and treatment towards WiTD. Encouraging SRHR education from childhood and throughout the life-course is an important way of fostering the sexual and reproductive health and rights of WiTD.

More comprehensive SRHR programming for WiTD, and particularly WLHIV, is needed which includes, in addition to clinical support, attitude and behaviour change interventions.

Conduct advocacy campaigns that tackle stigma and discrimination against WiTD and prevent women from accessing SRHR services. These campaigns should be multi-targeted, focusing on individuals and families within households (micro level), communities and schools (at meso level), as well as policy and decision-makers (at a macro level).
3.2 Country Level Findings

3.2.1 EGYPT

Introduction

Egypt is a lower-middle income country with a population of about 102.5 million. It is estimated that females constitute around 51% of the population.[6] People living with disabilities in Egypt are estimated to represent 10.64% of the population.[7] The majority of the Egyptian population lives around the River Nile, and about 57.8% live in rural areas. According to Central Agency of Public Mobilization and Statistics (CAPMS), 30.8% of females in Egypt are illiterate, 10.8% have a university level education, and 0.4% have an above university level education.[8]

Prevalence of HIV among general population is low (less than 0.1%) and concentrated among people who inject drugs (PWID) and men who have sex with men (MSM).[9] However, Egypt has the fastest growing HIV rate in the MENA region. [10] Prevalence of HIV is estimated to be around 6.7% in the MSM population, 2.5% in the PWID population, and 2.8% in the sex working population (SW). In 2020, the total number of PLHIV in Egypt, was estimated to be 24,000; 5,000 of those are women aged 15 and over, and less than 500 are children aged 0-14. Around 44% of PLHIV and 38% of WLHIV receive Antiretroviral therapy (ART). ART treatment is provided to citizens and refugees by the National AIDS Program (NAP) at the Ministry of Health and Population (MoHP).[11]

According to the National HIV strategy, Egypt aims to reduce new HIV infections by 50% by 2022. Egypt’s strategy is aligned with the global targets of HIV/AIDS quality of care “Ensure 90% of all people living with HIV know their HIV status by the end of the strategic framework by 2022”, and on HIV/AIDS testing and diagnosis “Ensure 90% of all people living with HIV who know their HIV status are enrolled in treatment by the end of the strategic framework by 2022”.[12]

Situation of SRHR Services Prior to COVID-19 Pandemic

SRHR Services and Needs Related to WiTD

The first National reproductive health strategy in Egypt was launched in 2015. The strategy which covers the years 2015-2020, aims to promote reproductive health rights, increase the use of family planning methods to 71% (up from 59%), and increase the sexual awareness of the youth up to 50%. The strategy has three pillars, the first is to support and strengthen the health system, the second is to raise awareness on reproductive health and rights, and the third is to develop and support SRH programs for adolescents and youth. [13]
Interview participants identified different SRH services provided to women in Egypt in the public health system, which include family planning, management of reproductive health including antenatal, postnatal, labour and birth services, and management and testing of sexually transmitted infections (STIs) and urinary tract infections. Key informants explained that the private sector provides these services as well noting that it focuses more on antenatal and delivery services. In addition, a couple of KIs noted that the public sector is stronger in the provision of family planning services. A KI mentioned that full SRH packages are usually not offered in one facility. This is confirmed by other research indicating that the majority of essential SRH services are not offered at the primary health care (PHC) level. In Egypt, a package of SRH services typically includes antenatal, postnatal, neonatal, and child health care, and family planning is not usually integrated with these services. [14]

<table>
<thead>
<tr>
<th>Services</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family planning</td>
<td>X</td>
</tr>
<tr>
<td>Antenatal care</td>
<td>X</td>
</tr>
<tr>
<td>Labour and delivery</td>
<td>N/A</td>
</tr>
<tr>
<td>Postnatal care</td>
<td>X</td>
</tr>
<tr>
<td>New-born and child health</td>
<td>X</td>
</tr>
<tr>
<td>Prevention of unsafe abortion and post abortion care</td>
<td>N/A</td>
</tr>
<tr>
<td>Emergency contraception</td>
<td>X (only private facilities)</td>
</tr>
<tr>
<td>STI/RTI screening, diagnosis and treatment</td>
<td>N/A</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>N/A</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>X</td>
</tr>
<tr>
<td>Prevention and management of GBV</td>
<td>N/A</td>
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</tbody>
</table>

Discussions with key informants reveal that SRH services in Egypt tend to be concentrated around family planning and maternity services, while STIs are generally neglected. Similarly, an assessment of SRH service access in Egypt conducted in 2009, suggests that services were centred around family planning and maternity care. The study revealed that SRH services primarily targeted women of reproductive age, whereas men and youth – both females and males – were neglected. The latter results in women carrying the burden of contraception. In addition, the study highlighted how unmarried women and men are often excluded from SRH services. For example, most of the physicians interviewed in the study, stated that caring for youth who practice sex outside of marriage is against their religious beliefs and cultural norms. This practice are fortified by the Code of Ethics of Profession in Egypt which allows doctors to deny services that contradict their religious and cultural beliefs unless it was an emergency.[16][17] Couples who are not married or married informally (where the marriage is not registered) are not considered as populations that need access to condoms by health providers, increasing their risk of HIV and STI infections. [18]

Abortion in Egypt is prohibited by law unless it is for a medical necessity. Therefore, any woman who wishes to terminate an unwanted pregnancy for any reason even for rape, extramarital relationships, or other economic or social reasons, cannot get the operation done in health facility. However, women find ways to get abortions such as resorting to private clinics who are willing to provide abortion services. However, poor women often must use private clinics that lack supplies and proper sanitation. [19]

The NAP under MoHP is responsible for HIV/AIDS response in Egypt. It offers testing, treatment, management and counselling services for PLHIV and populations at risk. According to MoHP, PLHIV are routinely tested for hepatitis C and B as established by the National protocol. PLHIV who have hepatitis C co-infection are registered in the national treatment system for free. Hepatitis is a common co-infection among PLHIV in Egypt, and according to MoHP, there has been progress in addressing the hepatitis C epidemic, especially through the “100 million health campaign”. Moreover, NAP offers free treatment to WLHIV and infants born. [20] KIs also noted that NAP provides formula milk for children of WLHIV for free up to 6 months.

Key informants highlighted few government initiatives that provide SRH services for women in Egypt including the Egyptian Women’s Health Initiative and the decent life initiative “Hayah Karima”, both launched in 2019. Under the decent life initiative “Hayah Karima”, the Egyptian government allocated EGP 103 billion Egyptian Pounds to improve the wellbeing of vulnerable populations in rural areas. The initiative targets around 58% percent of Egypt’s population living in 4,658 villages. Under the health theme, new health units will be established, and a new universal health insurance will be activated. [21] Currently, hospitals and health units are being established in rural areas under the first phase of the initiative. [22] The Egyptian Women’s Health Initiative aims to improve early detection of breast cancer in women and other diseases such as diabetes, blood pressure and obesity. The initiative provides free examination for women over the age of 18 for the mentioned diseases, in addition to raising awareness about risk factors. It also provides family planning and reproductive health services. [23][24]

**Coverage and Quality of SRH Services**

According to the World Health Organisation (WHO), Egypt has extensive health care infrastructure. Health facilities are accessible within less than 5 kilometres (KM) to 95% of the population. However, the distribution of the healthcare force is uneven as rural and remote areas face issues with understaffing. Primary health care service units in Egypt include family health units, maternal and childcare units, health offices in addition to the primary care units of the health insurance organisation. It is estimated that in 2010, 50% of outpatient care was provided by the private sector, 20% by the public sector and 30% by pharmacies. In addition, two thirds of births took place in private health care facilities. [25]

During interviews, SRH services in Egypt were perceived as generally available in big cities but lacking in rural areas and frontier governorates. One KI explained that, in frontier governorates, private facilities are usually the main SRH providers and are typically affordable. However, the KI noted that mobile clinics have eased access in these locations in recent years. Several initiatives operate mobile clinics to reach rural and vulnerable populations in Egypt, such as MoHP mobile clinics which target rural villages under the decent life initiative, [26] the MoHP family planning mobile clinics supported by UNFPA[27] , and the Egyptian Red Cross mobile clinics. [28]

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On the other hand KIs reported that WLHIV face difficulty in accessing SRH services are even denied these services and discriminated against by medical professionals.

One KI mentioned that at times a ‘connection’ is needed in order to facilitate access for WLHIV to certain SRH services. Interviewees highlighted the vital role of community based organisations (CBOs), NGOs and community networks in helping WLHIV access services. However, research suggests that organisations targeting PLHIV do not usually have the resources to offer a wide range of SRH services and have to refer WLHIV to other facilities. [29]

When asked about the quality of SRH services, some KIs felt that it was adequate, noting that the quality of public facilities has improved. Other KIs were of the opinion that the quality of SRH services, especially those provided for WLHIV is poor and inadequate. Lack of skilled doctors who are able to deal with WLHIV was mentioned as a challenge. One KI particularly mentioned how the NAP hotline is inefficient. KIs reported that PLHIV and PwDs are often disrespected and treated poorly by doctors. Referring to this issue, one interviewee commented “health care workers are very unequipped, unqualified, and lack awareness on HIV. There is still so much discrimination and shame regarding the subject” (FP1, Egypt). Moreover, interviewees reported that many women resort to private facilities due to quality issues in the public sector, however, because of high costs, these services are not accessible to all women.

Affordability of services is a major factor impacting WiTD access to SRH services. SRH services in public facilities were reported to be affordable during interviews. However, in some rural areas, the cost of transportation presents a barrier, preventing poor people from accessing services. [30] Another issue that came up during interviews is that, to avoid stigmatisation and obtain quality health care, some WLHIV have resort to private health providers that are known to deal with WLHIV, which can be costly.

Interview findings also indicated that SRH services available to WLHIV are usually not offered at the same health facilities that provide HIV services. Other research confirms there is minimal integration of HIV services in SRH care (integration refers to the provision of all HIV and SRH services under one facility). HIV counselling, prevention, treatment and management are not recognised as responsibilities of SRH health professionals. [31][32] Oraby and Tawab (2014) emphasise that the vertical structure of health service delivery in Egypt impacts accessibility and quality of services offered to WLHIV. Vertical structures mean that HIV/AIDS health providers are not trained on providing stigma free SRH services or aware of WLHIV needs. [33]
Challenges to accessing Health Services

Regarding general barriers to accessing health services, women surveyed in the 2014 Egypt Demographic and Health Survey (EDHS), indicated that the most common barriers to accessing health care were related to concerns about lack of drugs available (54%) and lack of health providers (47.5%). Other barriers reported included concerns about lack of female providers (28.9% of women surveyed), not wanting to go alone (31.3%), having to take transport (20.9%), distance to health facility (18.2%), getting money for treatment (10.5%), and getting permission to go to treatment (7.3%). [39]

Stigma and Discrimination in Accessing Services

All key informants discussed how stigma and discrimination continues to be one of the major challenges that WLHIV suffer from. The MoHP states that addressing stigma is a priority, and that policies exist and are implemented “requiring healthcare settings to provide timely and quality health care regardless of gender, nationality, age, disability, ethnic origin, sexual orientation, religion, language, socio-economic status, HIV or other health status, or because of selling sex, using drugs, living in prison or any other grounds”.

According to MoHP, there have been online and social media campaigns to combat discrimination, as well as university campaigns to raise awareness. WHO conducted a stigma reduction workshop in collaboration with NAP in health facilities, and the International Office of Migration (IOM) organised a training session for 19 doctors which tackled topics related to PLHIV including stigma and discrimination.[41] However, despite these policies and campaigns, WLHIV experience discrimination and denial of service, including access to maternity service, labour and birth. To deal with stigma, one KI stated that they encourage PLHIV not to disclose their HIV status unless necessary to avoid being denied treatment. Interview findings are consistent with other studies researching WLHIV’s access to SRH services. For example, Oraby and Tawab (2014) highlighted women’s experiences with stigma when seeking SRH services. Their research findings show that women were either denied services, treated with neglect, or humiliated. Some women reported being unable to find a doctor willing to perform a C-section forcing them to deliver vaginally with no medical assistance. Those who did not disclose their HIV status, often failed to convince doctors to deliver their children via C-section, as they believed that there was no obstetric need. Some women resorted to private health care providers who are willing to deal with their case, however this option is not affordable for many. Furthermore, women who gave birth stated that they received no information from health providers about how to care for their HIV positive babies. [42] Another study conducted by Abdelrahman et al. (2015) revealed that health care staff also fear being stigmatised for providing medical care for PLHIV. Some health care providers are uncomfortable with providing care for PLHIV, for example due to moral judgments and blame, negative connotations towards HIV or due to fear of the risk to their own health. [43]

KIs also discussed how LGBTQI+ women and disabled women, and sex workers face discrimination as well. While same sex acts and transgender people are not explicitly criminalised in Egypt, [44] the government uses an old debauchery law to prosecute LGBTQI+ people. One of the worse crackdowns happened in 2017, when dozens of LGBTQI+ people were arrested for displaying a rainbow flag. It is worth noting that Egypt used to offer free gender affirmation surgery for people who were diagnosed with “gender identity disorder”. However, these services stopped in 2016 due to the government’s concern about the “morality of the operation”. [45]

SRH Awareness and Attitudes around HIV

Findings revealed that the knowledge of WittD on SRHR remains limited in Egypt. On this subject, one interviewee commented “women here in Alexandria are very naive and have no knowledge or background on the subject of disease [HIV]” (FP1, Egypt), and another stated that “women don’t understand that protection does not mean inserting an IUD, they must use condoms” (KI, Egypt). According to the 2014 EDHS, 75% of currently married women aged 15-49 hear about STIs, however there is a large disparity in awareness between geographical areas. Women from Urban and Lower Egypt were more likely to know about STIs than women from Upper Egypt. As for knowledge about HIV/AIDS, 69% of ever-married women aged 15-49 have heard about HIV/AIDS. However, the percentage of women knowledgeable of ways to reduce infection risks was low. 2014 EDHS classified only 4% percent of women as having comprehensive and accurate knowledge about AIDS. In addition, the survey indicated that only one third of ever married women aged 15-49 were aware of the possibility of transmission of HIV to child through breastfeeding, while 15% knew that the virus can be transmitted through pregnancy and can be prevented through drugs. [46]
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Interviewees stressed the importance of increased education on HIV prevention and underlined the need for providing WLHIV with more information once they are diagnosed in relation to their reproductive and sexual health (for example how to get pregnant safely, PMTCT, and methods of family planning). Interview participants also mentioned that awareness campaigns must target WiTD to increase their knowledge on their sexual and reproductive health and rights. Furthermore, interviews highlighted that there is a need to provide comprehensive messages that consider the needs and rights of different groups of WiTD, delivered to them through convenient and appropriate ways to guarantee their engagement.

Another barrier to access mentioned by KIs is WiTD's limited knowledge on available SRH services and how to access them. One KI stressed that SRH services should be advertised in mediums that are appropriate to the context to ensure effective communication with target populations. For example, in rural settings where women cannot read, posters used to announce services do not communicate availability of services to illiterate women. In these contexts, information can be relayed to women through community workers, pharmacists, and trusted individuals.

SRHR youth education was highlighted during interviews as an integral issue. While efforts to increase youth knowledge and public health education has increased over the past years, there remains a large gap in the SRHR knowledge of young people. Young people receive very limited information on SRHR through the formal school system. They lack understanding of basic concepts and often receive misleading and inaccurate SRH information.[47] Official statistics measuring awareness in the 2014 Demographic and Health Surveys (DHS), report that only 7% of males and 4% of females correctly identified ways of preventing sexual transmission of HIV.[48] Young people's knowledge of HIV/AIDS and STIs is low, even if they hear of it, few can identify all possible routes of transmission. In a survey of young people in Egypt (aged 10-29), only 3% of respondents over the age of 15 identified all possible routes of transmission. Most of the respondents cited the media as their primary source of information, followed by school and friends.[49]

In addition, KIs discussed the lack of trained health professionals that can offer stigma free and quality SRH services to WiTD, especially to WLHIV and women at risk of HIV infection, sex workers and women from the LGBTQI+ community. These reports echo findings of other research which highlights that WLHIV often have to deal with health care professionals who are not trained to care for PLHIV and have misconceptions regarding their medical care. For example, one misconception is that PLHIV should only be treated in specialised fever hospitals or that they need to be treated in isolation. [50]

Cultural norms and GBV

GBV is a violation of human rights and a serious public health issue. Violence against women was discussed repeatedly by interview participants as a major barrier affecting WiTD’s SRHR. Evidence shows that women are at a higher risk of HIV infection if they are physically abused.[51] Interview participants mentioned that there are no linkages between SRH services and GBV services in Egypt, however, GBV packages usually include counseling which involves information on HIV and STIs. One KI stated that physicians in Egypt are not usually sensitive to issues relating to GBV and women. The KI continued to say that although health care professionals are required to report cases of violence against women, many are reluctant to report GBV cases when they suspect it in their patients out of fear of being harmed by the woman’s family.

In Egypt, an estimated three in ten women were experiencing domestic violence prior to the pandemic. Husbands were the most common perpetrators of violence against women, followed by mother/stepmothers, and fathers/stepfathers. Only one third of women who experience violence seek support services.[52] The National Council for Women (NCW) in Egypt offers GBV support services in 27 branches.[53] In 2015, NCW launched the 2015-2020 National Strategy for Combating Violence Against Women. The Strategy aims to protect women from violence and promote gender equality in public and domestic spheres.[54]

Female genital mutilation (FGM) in Egypt is a widespread practice that continues to severely undermine the sexual and reproductive health of women. 2014 EDHS reports that 92% of ever married women aged 15-49 have undergone FGM. The prevalence of the practice is higher in rural areas than in urban areas (95.4% versus 86.3% respectively).[55] There has been a shift in attitudes towards FGM in Egypt, and some studies suggest that proportion of girls experiencing FGM declined substantially over the last few decades.[56] However, the practice is still part of the social fabric and associated with religious beliefs. FGM was criminalised in Egypt in 2008, and in 2007 the MoHP banned anyone including health professionals from performing FGM.[57] FGM is associated with many health risks including shock, death, and infection. Women who suffered FGM are more likely to experience adverse long-term physical consequences including difficulty in urination, having sex and childbirth.[58]

Economic Barriers

WLHIV are also disproportionately affected by financial challenges, and they are often left unemployed once they disclose their HIV status.[59] Several KIs reported that many WiTD cannot afford transportation to access services, as one interviewee stated “financial barriers are the most prevalent. Most WLHIV have terrible financial situations and struggle to even eat. It is very difficult for them to find jobs due to their weakened immune systems. Some women are really struggling due to poverty.” (FP, Egypt). Moreover, access to private health care (which is in many cases necessary in the case of WLHIV due to discrimination and lack of awareness) is a privilege that many WiTD cannot afford. Expensive prices in the private sector prevent WiTD from seeking the SRH services they need.

SRHR Services and Needs Related to WiTD during the pandemic

As with countries around the world, findings revealed that the health sector in Egypt experienced severe disruptions because of restrictions introduced to control the COVID-19 pandemic. Resources were shifted to COVID-19 response, resulting in large reduction in health services offered and deprioritising several services including some SRH services. This is validated by a survey conducted by the Partnership for Evidence-Based Response to COVID-19 (PERC) in February 2021. For example, the survey indicated that 28% of respondents who needed medication reported difficulty in obtaining it. According to PERC, mortality in Egypt, may have increased by 60-80% during pandemic peaks, including COVID-19 deaths or other causes that can be attributed to the crisis. [79]

During interviews, KIs identified several negative impacts of the pandemic on the quality and availability of SRH services. Interviewees reported that access to SRH services was restricted across the country. The latter increased the financial burden on WiTD who had to pay for private services or cover transportation costs. Interview findings revealed that service providers were overwhelmed with the COVID-19 response, hospitals were overloaded, and some were shut down due to quarantines, and doctors were re-deployed to support the COVID-19 response. Therefore, WiTD had limited or no access to family planning services and SRH care, as services like gynaecology, delivery and labour were severely reduced. In addition, there was a stock out in family planning methods. One study indicated that some public facilities had shortages of contraceptives such as oral pills and three-month injectables during lockdown months, and some private pharmacies were out of one-month injectables and some brands of oral pills. Furthermore, the study reported that health care professionals were cautious of dealing with patients, and discrimination against WLHIV became worse. Women were denied SRHR services, as health care workers were afraid of getting COVID-19. For example, some women were denied intrauterine device (IUD) insertion. [81]

Interview findings revealed that disruptions in services particularly affected WLHIV. Testing for WLHIV became difficult and inaccessible. KIs mentioned that testing was available during COVID-19 lockdowns, however it was not regular, and opened on an amended schedule due to curfews. A survey carried out with WLHIV in Cairo, Giza, Qalyubia, Faiyum, and Beni Suef governorates showed that, during lockdowns, only 21.5% of WLHIV had follow-up testing to monitor their status. [82] Another issue that WLHIV experienced, according to interviews, was a shortage in their medication, however, most WLHIV were not affected (supply of HIV medication was interrupted for two-weeks from mid-June to the beginning of July). Moreover, one KI stated that formula milk was very difficult to get during COVID-19. According to the interviewee, formula milk provided to children of WLHIV was not enough in some cases; and some of the milk provided also had close expiry dates. In addition, KIs interviewed in the study mentioned that WLHIV were afraid of collecting their medication. At the beginning of the pandemic, the government of Egypt designated fever hospitals as testing centres for COVID-19. The latter impacted access of WLHIV to testing to monitor their status. [82] Another issue that WLHIV experienced, according to interviews, was a shortage in their medication, however, most WLHIV were not affected (supply of HIV medication was interrupted for two-weeks from mid-June to the beginning of July). Moreover, one KI stated that formula milk was very difficult to get during COVID-19. According to the interviewee, formula milk provided to children of WLHIV was not enough in some cases; and some of the milk provided also had close expiry dates. In addition, KIs interviewed in the study mentioned that WLHIV were afraid of collecting their medication. At the beginning of the pandemic, the government of Egypt designated fever hospitals as testing centres for COVID-19. The latter impacted access of WLHIV to their medications, as fever hospitals were the only centres that dispense ART. PLHIV were afraid of going to fever hospitals out of concern of contracting COVID-19. [84] To respond to this issue, NAP started offering treatment once every three months instead of every month to minimize PLHIV travel to hospitals.

Some of the main NGOs that work in SRHR in Egypt include the following:

**Caritas:** has an AIDS intervention unit. The unit works with key populations and most vulnerable groups. Their programs are implemented in collaboration with NAP. They work in three areas: prevention, care, and support. Caritas offers all services related to HIV such as testing and counselling, legal assistance, support groups, psychosocial support (PSS), outreach and awareness initiatives. Caritas offers training programs for healthcare professionals to remove barriers to PLHIV healthcare access. It also coordinates with hospitals to offer antenatal care, delivery, and postnatal care for WLHIV.

**UNAIDS:** works on HIV/AIDS response in Egypt, supporting and catalysing activities. They lead activities of 10 different UN agencies in Egypt. They work on advocating for the alignment of national strategies with global AIDS strategies. UNAIDS also works closely with CSOs that work on the HIV response, as well as on SRH and GBV. UNAIDS has a program that provides SRH for WLHIV and women at risk, through the MoHP.

**UNICEF:** their health unit offers maternal and child health services for WLHIV through the MoHP. HIV-related services are integrated in the services they offer in the health unit, such as antenatal care, awareness sessions, and immunisations. UNICEF also provides training, capacity building, and community outreach. The unit procures HIV medication for the MoHP. It also serves refugees and asylum seekers, and targets adolescents and different age groups.

**Egyptian Family Planning Association (EFPA):** provides family planning services including awareness and outreach. It coordinates the delivery of family planning services by other NGOs in Egypt. According to one KI, EFPA’s clinics are spread across Egypt, and EFPA was the first to launch youth friendly clinics in the country.

**Sihati min Bi‘ati:** is a CBO that targets PLHIV of all ages, and people at risk of HIV infection including LGBTQI+ people and PWID. Most of their work revolves around facilitating beneficiaries’ access to SRH services. The organisation’s staff are mostly volunteers and PLHIV. The organisation previously implemented a project with UNICEF which provided SRH services to WLHIV. Under the project, the organisation provided pregnancy related SRH services in addition to contraceptives. The project also provided care for children of WLHIV.

**UNFPA:** has a family planning program in Egypt that works to increase the use of family planning methods.

The majority of KIs stated that women’s SRH is a priority in Egypt, as evidenced by presidential initiatives targeting women’s health and the work of NCW. As for HIV-related services, Egypt is the recipient of the GFATM grant for the period of 2019-2022. Four million US dollars were allocated for HIV-related programs. The grant is implemented by Caritas, and other CSOs secured funding from the French initiative AL-Shehab.

Some KIs noted that coordination between different entities working on SRH needs strengthening, particularly to enhance monitoring and evaluation and avoid duplication in activities. These reports are echoed by other research conducted in 2015, which suggests that there is an absence of coordination between different organisations working in SRH in Egypt, including public and private organisations and NGOs. On the other hand, Caritas representative noted that there is a strong referral system between initiatives working on the HIV/AIDS response, adding that “Caritas has a big role in connecting relevant [HIV/AIDS] institutions to CSOs. Caritas is the secretary of the Egyptian network of organisations working on AIDS” (KI, Egypt).

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[67] This list is not comprehensive, it reflects main organisations working in SRHR in Egypt and other organisations mentioned in interviews
Situation of SRHR Services During COVID-19 Pandemic

The first case of COVID-19 was detected in Egypt on February 14, 2020. About a month later, the WHO declared COVID-19 a pandemic. In response to the pandemic, in late January, all flights between China and Egypt were suspended. Starting from late March 2020, the Egyptian government took several measures to control the spread of COVID-19, including, suspension of all flights; closing all places of worship, educational institutions, non-essential businesses, and public places where large gatherings can happen; imposing a curfew from 7:00 pm to 6:00 am; and encouraging public sector employees in non-essential sectors to work from home. The government also carried out a large-scale disinfection program of public spaces and institutions. By the end of April, the government started easing the restrictions; shopping malls and retail outlets were allowed to open on weekends until 5:00 pm, and restaurants could offer takeaways. In May, hotels were permitted to operate in limited capacity. The night curfew was shortened by one hour in the beginning of June and was lifted by the end of the month. By July 2020, a gradual opening of the economy was initiated, including resuming air-travel, opening restaurants with limited capacity, and allowing public transportation to operate between 4:00 am and midnight. In late August, parks and gardens were allowed to open at 50% capacity and by the end of September 2020, funeral prayers and weddings were allowed to be held in open air venues with a maximum limit of 300 people. [71-76]

As of October 26, 2021, there were 324,619 reported COVID-19 cases in Egypt, resulting in 18,285 deaths. A total of 25,083,832 vaccine doses have been administered by October 23, 2021. However, a report by the World Bank reveals that Egypt has one of the worst undercount death ratios in the world (an undercount ratio related excess deaths against reported COVID-19 deaths). A high undercount ratio implies that unknown and unreported COVID-19 deaths and other deaths were missed in the official count.

As a consequence of the pandemic, Egypt endured substantial economic hardship, especially that Egypt's tourism industry, which contributes significantly to Egypt's revenue (around 12% of the country's GDP and 10% of employment), was severely impacted. To mitigate the economic impact of COVID-19, the government announced an EGP 100 million stimulus package, of which half was allocated to the tourism sector. Measures also included cash grants to irregular workers (EGP 500 for three months) and an expansion of existing cash transfer programs. In addition, EGP 5 billion was allocated to support the health sector to provide medical supplies and compensate medical staff. A fund of EGP 10 billion was launched to offer citizens low interest loans to pay for consumer goods. In addition, many tax-related measures were implemented. [77-78]

One of the biggest social protection programs in Egypt is Takaful & Karama Project (TKP). TKP is comprised of two programs: an income support program to families with children and an unconditional income support and social inclusion program that targets disabled and elderly people unable to work, and orphans under 18 years of age living outside institutions. The project is considered as pro-women and pro-children, transferring around 89% of cash payments to women. In Egypt, by law, there is no discrimination between people according to sex or behaviour when it comes to social protection. While policies for social protection recognise adolescent girls and young women, and PLHIV and families affected by HIV as key beneficiaries, it does not consider sex workers, gay men and MSM, PWID, and transgender people and prisoners as beneficiaries. [61]

**Stakeholders Involved**

Egypt’s health care system is run by a combination of governmental, parastatal and private institutions. The state runs and funds the government and para-statal sectors, which include the Teaching Hospitals and Institutes Organisation, and the Health Insurance Organization (HIO) (HIO covers around 60% of the population for primary and secondary care). [62] [63] The private sector includes for profit and non-profit organisations providing health services through midwives, private pharmacies, private clinics, and private hospitals, in addition to NGOs and religiously affiliated clinics. The MoHP is the major provider of primary, preventative, and curative care in Egypt, and has around 5,000 health facilities (health units, health centres and hospitals) spread across rural and urban areas. [64] The MoHP is responsible for providing family planning services for women in all areas in Egypt. The MoHP has 525 women health clinics, which provide counselling, family planning and reproductive health and antenatal services. [65]

Commenting on the private health sector in Egypt, a UNAIDS representative mentioned that the sector is fragmented and there is no entity that governs it (a WHO report indicates that regulation of the private health sector is weak [66]). The representative noted that CSOs play a considerable role in reproductive health but not in HIV response, adding that UNAIDS is trying to attract them to work on these issues. Another KI was of the opinion that the role of NGOs in HIV related services has diminished as a result of funding shortages.

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KIs pointed out that several SRH and HIV-related activities were affected, such as, outreach and awareness activities and training of health care providers. Activities were mainly conducted using remote and online modalities (i.e., phone calls, hotlines, telecommunication and messaging programs, and social media platforms).

KIs reported that the common challenges faced by WiTD such as stigma and discrimination, violence against women (VAW), and financial challenges, persisted throughout the pandemic. KIs reported that WiTD suffered from financial challenges and limited and unstable income during the pandemic. WLHIV lost their jobs, as many work in the informal economy which was affected greatly by the pandemic. Moreover, many did not receive their full salaries. Similarly, a study which surveyed 200 WLHIV in Egypt, showed that the pandemic had a negative impact on the livelihoods of 70.5% of women surveyed, with 24.5% losing their jobs and 19% experiencing a reduction in their salaries. As a result, 51.5% of women surveyed struggled to meet their basic needs. [85]

During the pandemic, VAW was aggravated due to financial stresses and home confinement. [86] KIs believed that the pandemic exacerbated violence against women and increased the physical and mental load on women, especially as they tend to bear the main responsibility of childcare and housework chores. A survey conducted by the NCW showed that 7% of married women were subjected to violence by their husbands for the first time ever during the pandemic. The survey also reported a 33% increase in problems within families and a 19% increase in violence among family members. To address GBV during the pandemic, the Egyptian government acted early and requested that shelters are prepared for the potential increase of GBV cases when partial lockdown was instated. GBV services continued to operate under NCW in its 27 branches. [87] Furthermore, NCW launched “Women Safety Units” in Al-Qasr Al-Aini, Mansoura and Ain Shams university hospitals to support GBV survivors. Under this initiative 190 doctors and nurses were trained. In addition, NCW implemented several social media awareness campaigns on topics such as GBV, cybercrimes and bullying. [88]
Stakeholders Involved

Interview discussions showed that the pandemic impacted organisations’ capacity to deliver SRH services to various degrees. The COVID-19 pandemic impacted the financial resources available for SRH services and HIV response. Some KIs reported funding issues, because of the shift of funding to the COVID-19 response, and for some organisations, this exacerbated existing financial issues. Some organisations had to reduce scope of activities and services offered, while others completely halted their activities. For example:

**Sihati min Bi’ati** organisation was not able to meet all their beneficiaries’ needs, whereas before the pandemic, they were capable of meeting all their needs.

A **UNICEF** representative reported that they prioritise allocating funds to the Covid-19 response. For example, they used to have an officer managing HIV services, but this is longer available.

Caritas and UNAIDS on the other hand, were not affected in terms of funding received for SRH programs. Part of their existing budgets were not used due to lockdowns and curfews, and as a result, activities were postponed, workplans were revised, and activities were shifted online.

**During interviews, KIs reported that their organisations adapted their services in the following ways:**

- Shift services and activities to online and remote platforms
  - Caritas offered support, and communicated with beneficiaries through social media
- Establish online and remote support groups
  - Sihati min Bi’ati established WhatsApp group for PLHIV.
  - Caritas created a WhatsApp group for PLHIV.
- Provide assistance to women
  - Sihati min Bi’ati distributed face masks, sanitizers, and food packages to PLHIV and people at risk of HIV infection.
  - Caritas collaborated with Global Fund to distribute food packages during COVID.
- Facilitate women’s access to SRH services during lockdowns and curfews
  - Sihati min Bi’ati helped women in accessing private clinics to give birth when hospitals were inaccessible.

One of the challenges highlighted with shifting to online activities, is that not all WiTD were able to access social media and some women had to attend online sessions at other women’s houses.

**Referrals and Coordination**

In general, KIs reported that during COVID-19 pandemic, referrals were done using online platforms or through phones. For example, UNAIDS representative mentioned that they expanded their work with NGOs in order to increase referral circles. UNAIDS supports NAP through a hotline that offers awareness on HIV and COVID-19, while also offering referrals for testing and treatment centers, as well as SRH services. UNAIDS created a CSO forum, which established a network for PLHIV in an effort to ensure that HIV/AIDS-related services are coherent and complementing each other. For some organizations, it was challenging to refer WiTD to SRH services during COVID-19, especially with the lack of financial resources.

**WiTD Practices Related to SRHR Prior to the COVID-19 Pandemic**

According to the 2014 EDHS, the fertility rate in Egypt is 3.5 births per woman (the rate in rural areas is 30% higher than in urban areas). This fertility rate does not reflect the desired rate by women surveyed which was estimated at 2.8 births. The survey showed that the age of childbearing in Egyptian women is typically early. More than one fourth of women surveyed, aged between 25-49, had their first birth in their teens. At the time of the survey, 7% of adolescent girls were mothers and 4% were pregnant. Overall, the median age at first birth was 22.6 years for women aged 25-49, and there was a large difference between the childbearing age of rural and urban women (21.7 years versus 24 respectively). In addition, the survey indicated that contraceptive prevalence rate is 59% in women, with 13% of married women having unmet needs for family planning. Survey findings indicated that the use of contraceptives is higher in Lower Egypt and urban governorates. [89]
The 2014 EDHS showed that a high percentage of births occur in health facilities (87%). The percentage of women receiving any antenatal care was reported to be 90.3%, while 82.8% of women had regular antenatal care. Women who gave birth in health facilities were more likely to receive postnatal care compared to women who delivered outside. The 2014 EDHS reported that 91% of women who gave birth at a facility received postnatal care in the two days following the delivery compared to only 7% percent of women who delivered outside (however, 11% received postnatal check-up within six weeks of delivery). [90]

During interviews, KIs discussed how financial limitations and lack of awareness of services available to WiTD, affected their SRH service seeking behaviour. One illustrative example was given of women seeking treatment in pharmacies if they have an STI or only seeking antenatal care at the end of their pregnancy. Interviews also revealed that fear of stigmatization deterred women from seeking SRH services and information. Unmarried women who have sex, WLHIV and women who inject drugs for example, are reluctant to disclose their status, which affects their willingness to seek healthcare.

Furthermore, KIs discussed how women’s lack of power in relationships increased HIV transmission risk. One interviewee noted that “we face issues with getting men to use condoms with their wives. Sometimes the husband is a drug user, is infected, is having affairs with either men or women, and so the wife is at risk of HIV infection”. In addition, KIs highlighted that this lack of control combined with limited knowledge on alternative contraception methods limits WLHIV’s reproductive choices and results in unwanted pregnancies. The latter is confirmed by one study, which adds that many WLHIV remain unaware of prevention of mother-to-child (PMTCT) interventions, which deters them from having children and in some cases causes them to consider abortion. [91]

During the pandemic, fear of COVID-19 infection was widely reported during interviews, as a barrier impeding women’s access to SRH services. As a result, most women relied on remote and online SRH services. Some women resorted to health facilities near their houses to avoid taking public transportation or going to public health facilities they perceived as unsafe. One KI mentioned that some women refrained from seeking services for any health issues they believed they could manage at home. Interview findings echoed the results of the PERC survey (mentioned earlier), which states that 19% of respondents in Egypt who indicated needing health care reported missing or skipping health services. The most common barrier preventing respondents from seeking care was fear of contracting COVID-19, where 50% of respondents, indicated that they were worried of getting infected either at the health facility or when leaving home. [92] Similarly, a study conducted by Abdel Tawab et al. (2021) report that fear of getting COVID-19 infection caused women either to delay seeking family planning services, ask a family member to get contraceptives for them, or use private health care providers instead of public facilities which were perceived as unsafe. The study reported that increase in costs and delays in care caused some women to discontinue their usual method of family planning. Some women reported having unintended pregnancies as a result of the lack of access to affordable contraceptives. [93] Shortages in the supply of certain contraceptives, as one KI indicated, led women to change their usual contraceptive method.

Factors that Enabled WiTD to Maintain Healthy Practices During COVID-19

Several interview participants mentioned that WLHIV and women at risk of HIV infection had a strong support network during the pandemic which helped them access support and maintain healthy practices. For example, interview discussions revealed that during the lockdown, WhatsApp groups helped provide support for women through spreading awareness about COVID-19. However, this mode of communication was not accessible to women who did not have smartphones or access to the Internet. KIs also reported that women supported each other by sharing medicines. These reports were consistent with a study that targeted WLHIV in several governorates in Egypt, which indicated that some WLHIV who experienced shortages in medication borrowed medicines from others who had an excess. [94] Another enabling factor that was mentioned during interviews was the role of CBOs and NGOs in supporting women through financial and material support (such as food packages, hygiene kits, and personal protective equipment), providing awareness and information to WiTD, assisting them in accessing SRH services, and providing SRH services through remote modalities such as hotlines, online meetings, WhatsApp groups and telephone calls.

Hala is a 42-year-old Sudanese divorced woman living in Cairo. She has been living in Egypt with her five children for four years. Hala’s eldest daughter is 18 (and is a member of MR). She also has four sons aged between 10 and 16. They are all in school. Hala has been divorced for three years now, since 2018. She is thinking of getting married again.

Hala has a BA in history. She has her own business and works from home. Hala has a partner in Sudan and brings in traditional items and sells them in Egypt. “With Corona work got affected” she said, “when corona first started, the borders were closed between Sudan and Egypt so work stopped”. She relies mostly on her business for work. She can teach history or geography, “but the problem is the salaries are so low, and the benefit is not worth it” explained Hala.

Sexual and reproductive health services are difficult for a divorced woman explained Hala. “These types of services are usually for women who have a miscarriage, pregnant women, someone wanting to have a baby, but for a divorced woman, she does not need SRH services. The divorced woman is oppressed socially, health wise, sexually, and psychologically in our part of the world”.

Before the COVID-19 pandemic, Hala mentioned having hormonal problems. She said, “I have a problem with my hormones, I tried to go to the doctor at a private clinic, and her first question was ‘are you married’; then she asked if I am interested in having babies, I told her no”. She explains that “in the public clinic, you will find that it is crowded and there is no confidentiality, so I prefer to be in a place where there is confidentiality”. Describing the confidentiality in public hospitals, she said, “if you are in a public hospital, there will be a woman sitting next to you, and sometimes some of the women bring their husbands with them, so they will hear everything when you talk to the doctor”.

Hala believed that the problem with the issue of SRH, “in Sudan and Egypt too, is that the girl since childhood is not taught sexual education. There is something called sexual education, but you as a girl don’t know about this, and grow up unaware of it, and that it is shameful to ask about these things. Even now, I feel ashamed to ask another woman about sexual issues, and this is because it is the way we have been brought up”.

Hala believed that there was no difference in the quality of private health care before and after COVID, “but the only difference is that before Corona, the doctor is available anytime. During Corona, however, the doctor is not always there”. She continued saying that “in Egypt the doctor receives you normally, but the working hours are short during Corona, and when it first started there was a time when the doctors were not even available”.

Hala mentioned that the MoH provides SRH services in Egypt, and the UNHCR also supports refugees. But even with the UNHCR, “you go to the same hospitals as Egyptians”. Hala said that there are also entities like Caritas, Save the Children, and Doctors Without Borders that support refugees in Egypt; “but usually the case is you go to health care services that Egyptians go to and receive some services for free, and for others, you pay a percentage of the cost”. It is the same for other organisations”. Hala mentioned that during the COVID-19 pandemic, these organisations remained operational, however, they had less funding. She gave the example of medications and said that “organisations will cover a lower percentage than before Corona”.

Hala also mentioned that during the pandemic all services in Egypt were offered online or through phone calls. “I believe that the quality of treatment dropped during Corona” she said. Hala also mentioned that it was harder to contact medical centres because they were not reachable due to the high demand of people calling on the phone.

Hala did not believe that there is much support to SRH services in Egypt. Elaborating on this point she said, “for example, as a refugee, we should have access to awareness sessions and health days organised for refugee women, but nothing like this happens. Not all the refugee population is educated, so awareness on SRHR issues is important. If a woman is aware of SRH issues she will be more aware of what to do”.
During the COVID-19 pandemic, Hala mentioned that “all the organisations and even the UNHCR reduced its budget”. Moreover, she noticed that there were shortages in medication and a reduction in services. Hala mentioned that organisations such as Caritas and the World Food Program (WFP) offered financial support to beneficiaries; “but in my case since the start of this year, funding stopped, because all the money goes to addressing Corona”. Hala made a complaint about this but did not receive any response.

Hala has a friend who is HIV positive and suffers from recurrent miscarriages, she said that she had two miscarriages, but the medical practitioners at the public hospitals refused to operate on her, and this was during the pandemic. For the third miscarriage, she went to a private hospital and was able to have the operation because she did not report her HIV status.

Hala also mentioned that during the pandemic, people testing for COVID-19 were cared for in the same hospital as where PLHIV would go to get their medication. She said, “the isolation centre for Corona is also in the same hospital as where COVID suspected cases go”. As for the medication for PLHIV, this remained available during Corona, “but the service provision was poor. People with HIV are already psychologically distressed because of their illness and fear of contracting the illness because they are at greater risk”.

Hala believed that it is very important to have awareness sessions on SRHR issues, saying, “when I know what is happening to me, it is better than when I don't know”. Hala also highlighted the importance of having medication at a reduced rate. For example, “some services like hormone testing are not available in public hospitals, so you have to pay for it in private hospitals”. Moreover, Hala also believed that sexual education should be provided in schools, “instead of being considered as shameful and forbidden to talk about”. There should be a preparedness plan, and budgeting allocated for emergency situations like Corona explained Hala. “But in our countries, everything stops during emergency situations”.

Recommendations

- Develop preparedness plans to ensure continuity of SRH services during pandemics and emergency situations. Plans should build robust response SRHR networks that are able to deliver services to remote and vulnerable populations without major delays.

- Increase investment in outreach and awareness campaigns targeting WiTD. Awareness activities should inform women of available sexual and reproductive health services and how to access them. Lack of awareness of services available to WiTD prevent them from seeking SRH services impacting their health.

- Awareness programs should develop differentiated modes of communication that are tailored to suit the needs of diverse women (for example, information for illiterate women could be provided by pharmacies or community networks instead of posters). Communication methods should be designed to be deployed promptly during pandemic and emergency situations.

- Outreach activities should capitalize on community networks to spread awareness and use peer-education as a tool to spread SRHR awareness in young populations and vulnerable women.

- Awareness programs should dedicate more resources towards women’s empowerment in relation to reproductive & sexual health decision-making. Young women should be aware of their SRHR and be given tools to aid them in controlling their sexual and reproductive health.

- Advocate for legal reforms to penalize health care professionals who deny SRH care for WiTD or discriminate against them in any way.

- Advocate for the expansion of comprehensive SRH services to unmarried and young women.

- Establish a central entity to coordinate between different organizations working on SRHR for WiTD, to avoid duplication, identify gaps in services, and optimize the use of resources.

- Integrate HIV and SRH services for WLHIV in primary health care facilities. This will ensure ease of access in emergency and pandemic situations and will minimize referrals. It will also increase the likelihood of having health providers who are trained on providing stigma free SRH services and are aware of the needs of WLHIV and women at risk.

- Scale-up training for SRH health workers to reduce stigma and provide quality care for WiTD. Trainings should develop sufficient knowledge and awareness among health providers to deal properly with diverse groups of women including WLHIV and women at risk of HIV infection, women from the LGBTQI+ community, sex workers, women who inject drugs and women with disabilities.

- Build on lessons learned from using online and remote SRH service delivery models and enhance them for emergency situations that might arise in the future.

- Surveys should be conducted to identify the exact needs of diverse groups of women. Many national surveys do not target diverse women populations, missing their SRHR needs.
3.2.2 JORDAN

Introduction

In 2015, the total population of Jordan was 9,531,712 million, with more than 4 million living in the governorate of Greater Amman. [95] It is estimated that around 49% of the population are females. [96] Jordanians account for 69.4% of the population, while non-Jordanians constitute 30.6% of the total population. In 2015, there were 1.3 million Syrians, 634,000 Palestinians, 636,000 Egyptians, 131,000 Iraqis, 31,000 Yemenis, and 23,000 Libyans living in Jordan. It is estimated that 2.7% of the population have “severe or absolute disability” (2.72% of males versus 2.64% of females), and around 11% of the total population over 5 (10.89% of males and 10.3% of females) have any degree of functional difficulties (simple to absolute inability to perform). [97]

In 2017, the cumulative number of HIV/AIDS cases registered was 1,408, including 383 Jordanians (this number is cumulative. It represents the total number of detected cases in Jordan since the 1980s). [98] During the beginning of 2020, the number of PLHIV in Jordan was 48,4. UNAIDS estimates the prevalence of HIV/AIDS in Jordan to be low, reaching less than 0.1% in adults aged 15 to 49. It estimates that around 37% of PLHIV and 61% of WLHIV over the age of 15 are on ART. HIV prevalence among SWs and MSM is estimated to be around 0.5% and 0.2% respectively. [100] Sexual contact is the main mode of HIV transmission in Jordan. It accounted for 71% of registered cases in 2012 and 2013 in Jordan. [101]

Situation of SRHR Services Prior to COVID-19 Pandemic

SRH services in Jordan are provided by a variety of organisations (see section on stakeholders and a description of services they offer). The table below details the availability of essential SRH services offered at primary health care facilities (PHC) in Jordan. [102]

<table>
<thead>
<tr>
<th>Services</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family planning</td>
<td>X</td>
</tr>
<tr>
<td>Antenatal care</td>
<td>X</td>
</tr>
<tr>
<td>Labour and delivery</td>
<td>X</td>
</tr>
<tr>
<td>Postnatal care</td>
<td>X</td>
</tr>
<tr>
<td>New-born and child health</td>
<td>X</td>
</tr>
<tr>
<td>Prevention of unsafe abortion and post abortion care</td>
<td>N/A</td>
</tr>
<tr>
<td>Emergency contraception</td>
<td>N/A</td>
</tr>
<tr>
<td>STI/RTI screening, diagnosis, and treatment</td>
<td>X</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>N/A</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>X (Diagnosis and treatment services)</td>
</tr>
<tr>
<td>Prevention and management of GBV</td>
<td>X (Management services)</td>
</tr>
<tr>
<td>Prevention and management of GBV</td>
<td>X (Diagnosis and treatment services)</td>
</tr>
</tbody>
</table>

The main entity responsible for SRH services is the Ministry of Health (MoH). It is worth noting, however, that in Jordan, SRH services are mostly restricted to reproductive health and family planning, as one key informant explained “in general, whether it was the Ministry of health or the royal medical services, there is no provision of a sexual reproductive health package. Sexual and reproductive health services are limited to reproductive health services” (KI, Jordan). The National Reproductive Health/Family Planning Strategy 2013-2017, provides a roadmap for implementing successful family planning in Jordan, to reach desired fertility rates, and does not cover sexual health. [103] . However, the 2020-2030 National Strategy for Reproductive and Sexual Health is under development. [104] Reproductive health services available typically include family planning services, antenatal, postnatal, labour and birth, GBV management, training and awareness raising, and to a limited extent, rape management. Access to emergency contraceptives is difficult and is not available in public hospitals or pharmacies. UN agencies and some NGOs provide emergency contraceptives to rape survivors, but this is mostly limited to refugee communities. Abortion is criminalised in Jordan, unless the pregnancy poses a threat to the pregnant woman’s life. [105]

During interviews, KIs explained that generally sexual health services are provided in private hospitals and clinics, but they are scattered and are not part of a whole SRH package. It was highlighted that there are no specialised institutions offering sexual health services, for things like, STI-related services or emergency provision of contraceptives. Testing for STIs is usually performed when a patient is referred by a physician and is not covered by a private health insurance in Jordan. Interviewees stressed that there needs to be more efforts dedicated to increasing awareness on STIs and providing women with methods of protection.

**Coverage and Quality of SRH Services**

The National Reproductive Health/Family Planning Strategy 2013-2017 recognises that an enabling policy environment for reproductive health services in Jordan remains a challenge, due to lack of financial resources and unsustainable donor support. The strategy acknowledges disparities in availability and quality of services, and degree of usage of family planning methods throughout Jordan. The strategy argues that there is space for the private sector (which includes NGOs, the Jordanian Association for Family Planning and Protection, UNRWA, and private sector clinics and hospitals) to expand its coverage and fill the gaps where the public sector is absent. However, it cites that lack of financial resources available for these organisations is a barrier. [106]

Similarly, KIs interviewed for this study discussed the geographic disparities in SRH service provision in Jordan, underlining how the coverage and availability of SRH services in Amman is better than other governorates. However, one KI believed that “needs are responded to more efficiently outside of Amman, due to the smaller scale of operation” (KI, Jordan). KIs mentioned that there is an issue of quality and accessibility of SRH services, especially in the South of Jordan. In addition, it was pointed out in interviews that adolescents and youth access to SRH services and information is limited. In general, the MoH was viewed as not doing enough to spread awareness on SRHR to different groups in Jordan.

A MR focal point reported that generally health centres do not provide awareness on disease prevention and solely focus on contraception for the purpose of family planning.

There is a lack of specialised SRH clinics designed to reach youth in Jordan primarily due to the assumption that they are not sexually active. [107] Furthermore, there are no linkages between SRH education and referral to services, and an absence of coordination between SRH health services and youth programs. [108] One study emphasised the importance of establishing youth friendly SRH services in Jordan to increase access. The study reported that youth indicated that unpleasant facilities, unprofessional conduct, and uninformed providers deterred them from seeking SRH services. [109]

Another issue highlighted by an interviewee was that the appropriate level of demand for SRH services in Jordan is not high enough, even with efforts dedicated towards creating awareness and information provision, stating “I think it’s weak [demand for SRH] and it’s limited to certain services, it does not clearly cover unmarried women and girls” (KI, Jordan). On the other hand, the KI underlined problems from the supply side, including lack of training for staff and capacity, in addition to the lack of full SRH packages. According to one KI, most organisations do not offer full SRH packages, noting that efforts are very scattered, and are mostly concentrated on providing information and awareness raising.

**SRH Services and Needs Related to WiTD**

Interview discussions highlighted the issue of access to SRH services by unmarried girls and women in Jordan. One KI described that when it comes to SRH services in the public sector “in general in Jordan, it is [SRH services] provided only for married women … when you go to Ministry of Health facilities, in any health centre, any service provider, there is the mother and child centre that provides only SRH services, but not the full package, and only for married women” (KI, Jordan). Screenings for breast cancer and cervical cancer were highlighted as unmet needs by a MR focal point, who mentioned that these services are usually expensive and not affordable to all WiTD.

Several entities provide SRH services for women refugees in Jordan including the United Nations Population Fund (UNFPA), the International Rescue Committee (IRC), UNRWA, and the International Medical Corps (IMC). Yet, Amiri et al. (2020) indicated that Syrian refugee women and girls experience many challenges to accessing SRH services. Barriers reported in the study included lack of knowledge and awareness of family planning services, inadequate STIs and HIV coverage, limited mobility and autonomy, lack of information on sexual and gender-based violence (SGBV), and cost of services. [110]

Targeted health services for WLHIV and women at risk of HIV infection in Jordan, are limited to what the MoH offer to PLHIV free of charge. The NAP is the main entity responsible for Jordan’s HIV response. It works in collaboration with government agencies and INGOs such as WHO, IOM, UNAIDS, and GFATM. NAP services include voluntary counselling and testing, prevention, treatment, and care including TB screenings for PLHIV. In addition, a hotline is available to provide counselling for KPs. [111] HIV testing is mandatory for blood donors, public sector employees before they get hired, people working in public and private hospitals, all army employees returning from the United Nations Peacekeeping Missions, people admitted to public treatment and rehabilitation centres for substance abuse, and foreigners who want to obtain a residency permit. [112] Foreigners who are found to have HIV/AIDS are deported to their country. [113]

According to interview findings, there are no specialised centres that offer SRH services to PLHIV and people at risk of HIV infection, nor is there any level of integration of HIV services with SRH care offered in health facilities in Jordan. NAP’s HIV related services are limited to testing and treatment and do not include special SRH packages for PLHIV and people at risk of HIV infection. Health facilities in Jordan also do not have referral systems for PLHIV who might need SRH care by trained health professionals. Discussions with KIs revealed that this can be attributed to a lack of interest in this population due to low prevalence rates, and therefore, the discussion has been more focused on STIs instead. Referring to this issue, one KI stated “they [people at the MoH] will say that we don’t have cases in Jordan, why do you talk about this issue?” (KI, Jordan). Meanwhile, another key informant explained “we don’t have this segment targeted in our SRH services, in my organisation and in general in Jordan. The interest of CBOs and NGOs was there before, in the 1990s until 2015, then the desire to target this segment of the population was not there... Targeting women at risk at a community level, is not easy” (KI, Jordan). Interviewees agreed that NGOs in Jordan do not develop programs targeting diverse women because of stigma and the sensitive cultural context. For example, the UNFPA does not have a specific program for SRHR and HIV, however it has some activities related to sensitisation and awareness on the SRH right of WiTD. Interview findings revealed that the MoH does not share data of PLHIV with SRH organisations in Jordan, making it difficult to target them. Interviewees stressed the importance of the recognition of these issues and the need for protocols for providing SRH for WLHIV and women at risk of HIV infection.

While access to health services is a right for all in Jordan, recognition of SRHR for LGBTQI+ community is absent. LGBTQI+ people face structural barriers to accessing health care due to discrimination and stigma. They are asked invasive questions by health providers, treated with disrespect and their privacy is not protected. As a result, many LGBTQI+ individuals are reluctant to seek health services. [114] One KI reported that cultural sensitivity around LGBTQI+ prevents their organisation from developing comprehensive programs targeting women from the LGBTQI+ community, noting that this has not changed during COVID-19. The interviewee stated “it is not about funding; it is about how to plan or start a program for them... it is an issue of human rights agenda in Jordan that is the concern of all agencies not only the UNFPA. Our approach doesn’t need to be conservative. However, we need to be very careful and not to deal with it alone, we need to involve our human rights office at the UN here as well as key UN agencies” (KI, Jordan).

According to interview discussions, transgender women are one of the most vulnerable categories of WiTD in Jordan. Transgender women face high stigmatisation, and their access to services is minimal. Since most SRH services focus on reproductive health, it is exclusionary of transgender and people living with HIV. One KI was of the opinion that none of the existing providers are welcoming or accepting of transgender people and PLHIV. Findings show that there is a need for concerted efforts to raise awareness around transgender women, and to ensure referral of transgender women to SRH psychological support services.

Forearms of Change Centre (Sawaed) is one of the main NGOs that provides services to women from the LGBTQI+ community, PLHIV, FSW, and PWID populations. The center offers services in an environment free of stigma and discrimination. However, according to their representative, their resources are limited, and their geographic reach is restricted. Forearms of Change Centre offers HIV testing and counselling services and refers cases that need SRH services to health centres (refer to section on stakeholders).

On the other hand, women living with disabilities are often ignored in SRHR policies and service provision. There is a lack of comprehensive SRHR coverage targeting PWDs, and service providers are not aware of their needs. In addition, health centres do not have appropriate facilities for PWDs. [115] Discussions with KIs highlighted the same issues, stressing that there are significant gaps in SRHR services for PWDs. Interviews revealed that there are some health centres that facilitate access for PWD, but not for all types of disabilities. One example of a program that considers the SRHR of PWDs, is a UNFPA program implemented in collaboration with the Higher Population Council and targeting PWDs. However, according to UNFPA’s representative, more work must be done in this area given the high percentage of disabled people in Jordan.

Stakeholders Involved

In Jordan, the MoH is the leading agency in the health sector. It is responsible for importing, storage, and distribution of contraceptives to their clinics and other organisations including UN Agencies. Health care providers in Jordan must comply by the reproductive health and family planning standards developed by the Health Accreditation Council. Reproductive health services in Jordan are provided by the following entities: [116,117]

Public Sector

1- **MoH**: covers 41% of demand for family planning services at its 20 hospitals and 444 health centres across Jordan. The services are offered free of charge for Jordanians and at a subsidised cost for non-Jordanians.

2- **Royal Medical Services (RMS)**: covers around 2.7% of demand for family planning services at its seven hospitals (RMS provides health insurance for 25% of Jordan’s population). It covers most areas in the country and provides free of charge services to members of the armed forces member including their families.

3- **University Hospitals**: cover around 0.5% of demand for family planning services.

Private Sector and NGOs

The private sector includes private hospitals, clinics, pharmacies, the Jordanian Association for Family Planning and Protection (JAFPP), UNRWA and other NGOs.

[117] Statistics and figures from 2012
[118] This list is not comprehensive, it reflects main organisations working in SRHR in Jordan and other organisations mentioned in interviews.
1- **JAFPP:** in 2012, it provided around 11% of family planning services (decreasing from 24% in 1997). JAFPP provide services through 17 health clinics that exist in all governorates except for Balqa, Tafileh, and Maan.

2- **UNRWA:** provides health services to around 1.1 million Palestinian refugees in Jordan, and 9.7% of its beneficiaries obtain modern family planning methods. UNRWA provides family planning services through 24 primary health care centres in Amman, Irbid, Zarqa, Balqa, Jerash and Aqaba.

3- **UNFPA:** supports integrated SRH services in Jordan through building the capacities of national institutions; comprehensive sexuality education and SRH education for youth; programs addressing gender-based violence; and child, early and forced marriages; as well as analysis on population dynamics and their links to reproductive rights, HIV and gender equality. [119,120]

4- **Institute for Family Health – Noor al Hussein Foundation (IFH):** provides comprehensive SRH care and clinical management of rape in 24 branches located in host communities and Syrian refugee camps. [121] Services include psychological and social health services, and GBV management.

5- **Forearms of Change Centre (Sawaed):** offers voluntary counselling and testing (VCT) for KPs (including MSM, FSW, IDUs, DUs) for STIs such as HIV/AIDS, and hepatitis B and C, in addition to providing awareness and education on HIV, STIs and GBV. The centre provides PSS and referrals to other services, and coordinates with hospitals and doctors to offer treatments to its beneficiaries. Other activities implemented by Forearms include outreach activities to LGBTQI+, trainings for peer educators on HIV and outreach, and case management for GBV survivors. [122]

6- **Jordan Health Aid Society (JHAS):** mostly provides reproductive health services to women at child-bearing age, as well as gynaecological services to post-menopausal women, targeting Syrians and vulnerable Jordanian women of low-socioeconomic status. Services include antenatal and postnatal health, labour and delivery, family planning, awareness on sexual rights, pregnancy, and GBV.

7- **IRC:** provides reproductive health care for Syrian refugees and vulnerable Jordanians through its static and mobile clinics. [123]

8- **IMC:** provides reproductive healthcare for Syrian refugees and vulnerable Jordanian host populations. [124]

The main donors in the areas of reproductive health and family planning in Jordan include USAID, the Japanese International Cooperation Agency (JICA), United Nations Population Fund (UNFPA), WHO, UNICEF, UNRWA, IPPF. [125]
Importance of SRH Services

When it comes to the importance of SRHR in Jordan, interviewees were of the opinion that, generally, reproductive health is prioritised. The National Reproductive Health/Family Planning Strategy was developed for 2013-2017, and no strategy was developed to cover 2018-2019. However, a strategy for 2020-2030 is under development with the support of UNFPA and other entities, which includes sexual health as well.

Discussion with KIs highlighted repeatedly that SRH are not a priority in Jordan. This is evidenced by the National Reproductive/Family Planning Strategy and service packages offered at public and private institutions that exclude sexual health. And while sexual rights are part of a “long term discussion” (KI, Jordan), in the opinion of one interviewee “seniors at the MoH discuss sexual rights very conservatively as it will portray them as welcoming homosexuality”. The KI continued to explain that government officials refuse to acknowledge that the Jordanian culture is heterogeneous, that there are more people who have sex outside of marriage, and that there are gay people with SRH needs. As discussed earlier, SRH for WLHIV, women at risk of HIV infection, and LGBTQI+, is not a priority due to low HIV prevalence and cultural sensitivities.

Interview discussions highlighted the challenges related to funding HIV services in Jordan, underlining how private insurance does not cover HIV or other STIs, nor full packages of SRH services. Generally, insurance coverage mainly focuses on antenatal and postnatal care and delivery. Challenges in funding were cited to have affected the quality of HIV services offered at the level of the Ministry. For example, one KI stated that they considered the HIV program at the MoH as a very successful program, however when the funding stopped, the program significantly weakened. The key informant was referring to the GFATM grants to NAP for the period of 2004-2012. The MoH implemented a number of HIV prevention programs targeting populations at risk in Jordan in collaboration with CBOs and NGOs, under the grants. During the implementation period, the MoH undertook several activities including health education, prevention care and treatment of PLHIV and their families, HIV counselling, programs to reduce stigma, programs aimed at youth groups, and mass media campaigns, among other activities. [126] However, the implementation of these programs halted when funding stopped, and limited funding was available to implement HIV prevention activities, PMTCT programs, and harm reduction activities. [127] Moreover, the influx of refugees from neighbouring countries led to a shift of resources to refugee programs, which reduced the priority given to some health programs, including the NAP. [128]

Coordination and Referral Systems in Place

Interviewees commented that, in general, coordination between organisations working on SRHR is not strong. Jordan does not have a national coordination committee, and there are no regular meetings for stakeholders. Coordination meetings are usually convened by donors where different implementing NGOs and CBOs meet. Moreover, KIs pointed out that there is no national database for service providers. In general, it was noted that coordination is better inside refugee camps.

Organisations working in the SRH sector usually have referral systems to ensure access to services for WiTD. Examples mentioned during interview discussions included:

- UNFPA coordinates its work with other stakeholders working in refugee camps such as the UNHCR, IMC and IRC. The UNHCR is responsible for coordination between the organisations. There is a standard operating procedure used to organise the work of different providers, which includes a referral system. In addition, they have agreements with the public and private sector to refer complicated cases that require C-section deliveries. The UNFPA works with a variety of implementing partners, such as the MoH, the Ministry of Youth, the Ministry of Social Development (MoSD), the Higher Population Council, the National Council for Family Affairs, and the Jordan National Commission for Women, as well as coordinating with INGOs such as IRC, Care International, and Save the Children.
- JHAS refers rape and GBV cases to Noor Al Hussein Foundation (NHF).
- Institute for Family Health (IFH) refers GBV cases to the family protection department.
- Forearms of Change Centre coordinates with hospitals and doctors to provide SRH services to its beneficiaries.

### Challenges to Accessing Health Services

#### Stigma, Discrimination, Cultural Norms and Practices

One of the main challenges to accessing SRHR services for WiTD is stigma and discrimination. This barrier has been documented over and over in many studies and publications. The impact of stigma on WiTD’s access to SRH was mentioned repeatedly during interviews. Stigma impacts WLHIV in various ways and adds to their mental and physical burden. Women fear being stigmatised from their community and health care providers preventing them from seeking services. WiTD suffer from poor treatment by healthcare providers and denial of services. Moreover, fear of judgment and shame prevents women from reporting cases of domestic abuse.

Taboos surrounding sexuality is a key constraint, increasing the risk of SRH problems in women. Cultural and religious attitudes surrounding pre-marital sex disproportionately affect women more than men. As a result, unmarried women who are sexually active are reluctant to seek SRH services. Women who have sex outside of marriage are detained in some cases. Unmarried women are denied access to contraception through the public health system and to safe and legal abortion. Unmarried pregnant women are detained and prosecuted. Their children are removed from their custody and they are denied a legal and social identity. To register their children, women enter into unwanted or abusive marriages. [129]

Same-sex sexual relations are not criminalised under the Jordanian law. However, police use morality and public decency laws to target LGBTQI+ Jordanians. Transwomen are under the risk of being imprisoned under the Jordanian Penal Code for up to six months. Violence and discrimination against LGBTQI+ people are widespread in Jordan, in public and private spheres. Discriminatory language and policies towards LGBTQI+ people are continuously used by the Jordanian government and political parties. Media outlets perpetuate negative perceptions about LGBTQI+ people and disseminate negative homophobic and transphobic coverage. [130]

Abortion is only legal if there is a risk to the life or health of pregnant women; all other cases are criminalised, even in the cases of rape. Women who abort their babies without a valid medical reason can face imprisonment for a period of six months to three years. Access to safe abortion services for non-medical reasons is extremely difficult, exposes women to serious health implications, and entails high financial costs. [131]

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A KI was of the opinion that in comparison to the region, married women are more empowered when it comes to access to reproductive health in general, as evidenced by the rate of deliveries that take place in health facilities, and the low maternal mortality rate. However, this is not the case for all women. Power dynamics in the household strip women of control over their reproductive decisions and interferes with their access to SRH services. On this issue, interviewees commented that many married women in Jordan cannot leave the house without the permission of their husband or mother-in-law. Jordan has a male guardianship system that enables men to control women’s lives and gives them the authority to approve or reject a woman’s marriage. Women are also detained if their guardian reports that they are absent without permission. [132] In addition, certain practices such child marriage, undermines the SRHR of girls. According to the 2017-2018 Jordan Population and Family Health Survey (2017-2018 JPFHS), 5% of ever-married adolescent girls surveyed were either pregnant or have given birth in Jordan. [133]

**Violence Against Women**

Interview discussions highlighted violence against women as a significant barrier undermining women’s sexual and reproductive health. According to 2017-2018 JPFHS, 46% of ever-married women and 69% of men aged 15-49 believed that the husband is justified to beat his wife. Around 21% of women aged 15-49 experienced physical violence since they were 15, and 26% of ever-married women reported experiencing spousal violence whether it was physical, sexual or emotional. Perpetrators of physical violence against women are most commonly current husbands, followed by former husbands, brothers and fathers. [134]

An interviewee who serves on the National team for fighting against GBV highlighted the weak links between PWDs and GBV in Jordan stating that “There are no specific indicators or even no specific data collection around this issue” and “when I joined the team, I remember that it wasn’t even mentioned whether this woman who is subject to GBV had a disability or not. And we've added this in 2016” (KI, Jordan). Nevertheless, data linking people with disabilities and GBV is still underreported.

**Financial Challenges**

WiTD suffer from poverty and lack of resources, increasing their vulnerability and access to services. Cost of transportation is a common problem highlighted in the interviews that impacts access to SRH services for WiTD in Jordan, who are in many cases financially dependent on the men in their families.

**Knowledge and Attitudes Around HIV and STIs**

The National Reproductive Health/Family Planning Strategy 2013–2017 identified poor community culture, awareness and attitudes on reproductive health and family planning as a challenge for SRH in Jordan. [135] Interview discussions further indicated that health staff in Jordan lack necessary knowledge and skills to deal with and address the needs of WLHIV, women with disabilities, and women from the LGBTQI+ community.

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[134] Ibid
According to 2017-18 JPFHS, less than half of ever married men and women aged 15-49 know that using condoms can reduce risk of HIV infection. Moreover, 50% of ever-married women and 42% of men have knowledge of Mother-to-Child transmission (MTCT) of HIV, and about 25% know that the risk of MTCT can be reduced through medication. As for HIV testing, 27% ever-married women aged 15-49 and 40% of men know where to get tested for HIV. Levels of knowledge about STIs are much lower, as only one third of ever-married women have heard of STIs other than HIV. [136]

The National Reproductive Health/Family Planning Strategy outlines initiatives that the MoH conducted to raise awareness on family planning and reproductive health, [137] however, in the opinion of one KI, awareness done by the public sector is minimal. The KI expressed that while there are a lot of CBOs, NGOs and INGOs working on SRHR of women, they focus mostly on raising awareness. Despite these efforts, awareness on sexual and reproductive health and available services in Jordan is still lacking. [138,139],

In general, sexual and reproductive health education for young people in Jordan is limited due to cultural sensitivities, taboos around sex, and religious expectations that young people should abstain from sex until marriage. [140] One study revealed that young people's SRH knowledge is limited to maternal and child health, highlighting that young males have broader knowledge on the topic than young females. [141] Adolescents in Jordan do not have access to information about HIV and sexual health through schools. Sexual and reproductive health information in school curriculums is limited to basics of reproductive health, [142] which is often not properly discussed in classes and assigned as independent readings. Youth typically seek SRH information from social media outlets and friends, and refrain from openly seeking information out of fear of stigmatisation. [143] One initiative worthy of mentioning is UNFPA's program with the Royal Health Awareness Society, which focuses on improving awareness on adolescents and youth SRHR. The program includes training and awareness sessions to raise adolescents and youth knowledge on sexuality, building the capacity of parents to be more informed of adolescents' transitional period, creating comprehensive sexual education interventions within existing programs and awareness campaigns on youth SRHR and GBV. [144] The UNFPA also supports peer SRHR education for young people through the Y-Peer youth education network, as well as through collaboration with other entities such as Questscope, the Institute for Family Health, and the IRC. [145] Y-Peer in Jordan mobilised and trained 25,000 volunteers who raise awareness on SRHR in a youth-friendly manner in local communities. [146] However, according to one study, the extent of information presented in Y-Peer training sessions is limited by cultural sensitivities and taboos around sex topics. [147]
Situation of SRHR Services During the COVID-19 Pandemic

On March 16, 2020, the Jordanian government enacted the National Defence Law 13 of 1992 in response to the COVID-19 pandemic. Three days later, it declared a state of emergency. Under this state, the government imposed some of the strictest measures in the world to control the spread of COVID-19. All borders were closed, and a curfew was established where people were not allowed to leave their homes, except for medical staff, security forces and people working in essential services. After a few days, people were allowed to leave their houses to reach essential services only by foot. Social and religious gatherings and domestic travel was banned. Transportation services were halted, and only essential shops were allowed to function. All face-to-face educational activities were suspended and shifted to remote modalities. In addition, health services were only available for emergency and COVID-19 cases. By May 3rd, most of the restrictions were lifted, retaining a night curfew and allowing most economic activities to resume under strict safety guidelines. On September 8th, Jordan re-opened borders for commercial flights with testing and quarantine measures. After the second COVID-19 wave hit Jordan, the government re-instated a national lockdown on Fridays and curfews at night, and closed schools and universities until the end of the semester. Most restrictions were lifted in early 2021, but the rise in cases led the government to re-introduce restrictions in March 2021, including weekend lockdowns and evening curfews. The government fully reopened the economy in September 2021, with measures in place allowing more freedoms for vaccinated people. [148,149,150],

While the measures taken by the government at the beginning of the pandemic were successful in controlling the spread of the virus, they were not able to sustain the same level of control throughout the pandemic. On March 31, 2021, Jordan recorded the highest daily COVID-19 deaths of 111 people since the beginning of the pandemic. As of October 25, 2021, the number of cases in Jordan reached 851,41 - with 10,951 fatalities. The first phase of vaccination started on January 13, 2021, and as of October 20, 2021: 7,264,751 vaccine doses have been administered. [151,152],

The COVID-19 pandemic aggravated the pressure on existing weak social and economic structures in the country. The pandemic hit Jordan’s economy when it was already experiencing low growth rates, growing debt, and high unemployment rates. By the end of 2020, it is estimated that the Jordanian economy contracted by 1.6% and unemployment rates rose to 27.7% (in comparison to 19% in 2019). Unemployment amongst young people reached an unprecedented rate of 50% (rising from 40.6% in 2019) and female unemployment rose from 27% in 2019 to 32.8%. [153] Poverty is estimated to have increased by 38% among Jordanians and 18% among Syrian refugees when the pandemic first struck. [154]

[152] Ibid
In response to the economic impact of the COVID-19 pandemic, the National Aid Fund at the Ministry of Planning and International Cooperation (MOPIC) launched the Emergency Cash Transfer COVID-19 Response Project. The project targets vulnerable Jordanians, providing cash transfer to poor and near poor households in Jordan, including households of formal and informal workers. [155] Additionally, in 2021, the government announced a COVID-19 stimulus package to protect existing jobs, create employment for the youth and expand social welfare programs. [156]

SRHR Services and Needs Related to WiTD

Lockdowns and curfews imposed by the Jordanian government to limit the spread of COVID-19 significantly impacted access to social and health services, including reproductive health services. At the onset of the pandemic in 2020, the UNFPA reported that movement restrictions limited women’s access to health facilities including SRH services. [157] Critical services including contraception provision, STI treatment, and management of rape were reduced. Access by the youth was particularly affected in the lockdown period. Inadequate and lack of access to SRH services, was reported to have led to increased morbidity and mortality rates among mothers and babies. Health workers noted an increase in still births and serious pregnancy complications such as advanced Gestational Diabetes Mellitus (GDM) and Pregnancy Induced Hypertension (PIH). [158]

Interview discussions echoed these findings and revealed that the situation was particularly difficult in the first weeks of the pandemic when there was a total lockdown. During that period, SRH services were stopped, all health facilities were closed, except for hospitals which provided emergency services. After lockdown eased, and curfews were imposed, SRH services were allowed to operate, however, women had difficulty accessing them due to curfews and limited access to transportation. Moreover, it was reported that some service providers were reluctant to treat patients out of fear of getting infected. However, several KIs believed that disruptions in SRH services were mostly experienced in the first couple of months of the pandemic and that the level of services offered currently is slowly recovering to pre-pandemic status.

Interview findings also revealed that, like the rest of the world, the Jordanian government prioritised the COVID-19 response, and resources were diverted from health services including SRH to COVID-19 related measures. [159] Due to the urgency of COVID-19, many service providers focused their response on the pandemic, as funding was mainly directed to these activities.

[159] ibid
Pandemics and shocks impact women and men differently. They aggravate existing inequalities usually affecting women, young people, the elderly, PWDs, and LGBTQI+ people. KIs believed that issues of access for WiTD were probably exacerbated during COVID-19, as there was already a lack of services and information offered to these groups. KIs highlighted that WLHIV are amongst the most vulnerable populations that are affected by the state of the economy. KIs suggested that lockdowns impacted the mental health of women, increased their domestic burdens, and instigated GBV cases. A study conducted in the beginning of the pandemic, reported that women suffered from anxiety and stress, and experienced increased difficulty in accessing GBV and SRH services during lockdowns. The study also found that family planning and counselling services were affected, and that there was reduced access to SRH reporting. [161]

**Financial Challenges**

Interview findings highlighted the impact of the national economic crisis on the lives of WiTD. Interviewees discussed that the economic crisis induced by COVID-19 pandemic increased the vulnerability of WiTD, who suffered from loss of jobs, unemployment, and reduced income. The latter increased the demand for public health services as well, which might have affected their quality. High unemployment and the increase in poverty will “kill the national strategy which aims to have a small family size”, as one KI believed. A rapid assessment conducted by UN WOMEN in Azraq and Za’atari refugee camps and in communities across five governorates, reported that 52% of women indicated that they do not have enough money to buy enough food for two days for their household. [161]

**VAW**

Interview findings revealed that the COVID-19 pandemic increased the risk of VAW. Interviewees attributed this increase to women staying home with their perpetrators and the deteriorating economic conditions which increased family stress. This is confirmed by several studies conducted in Jordan. Women were confined in their homes with their perpetrators, with limited access to private phones, and lacked knowledge on how to access hotlines. Women and girls reported physical and emotional abuse, in addition to online sexual harassment and exploitation to a lesser degree. Furthermore, the closure of women and girls safe spaces during lockdown, meant that women lost access to social support and networks they relied on to cope with violence. [162] One study indicated that there was a drop of 68% in GBV reports during the first weeks of lockdown. [163] However, by October 2020, the Family Protection Department (FPD) reported an increase of 33% in domestic and GBV reports. The FPD reinforced response by establishing crisis teams and the fast deployment of women officers to support survivors. [164]

**Stakeholders Involved**

Findings from interviews revealed that organisations providing SRH for women were affected due to reduced technical and human capacity and limited access by beneficiaries to their services. Most organisations reported reduced demand for their services. For example:

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- An IFH representative stated that the impact of the pandemic is reflected in the number of beneficiaries served. In 2020, IFH was able to reach only 270,000 beneficiaries in comparison to 400,000 in 2019. However, the IFH representative confirmed that the numbers are recovering to pre-COVID-19 levels.
- Forearms of Change Centre (Sawaed) had to work in a reduced capacity, as the demand for their services decreased. The centre offered services online, but according to the organisation’s representative, providing PSS services was difficult over the phone due to the lack of privacy in the home. The representative noted that after the lockdown was lifted, there was an increase in SRHR needs, but the capacity and resources did not match the needs.
- A JHAS representative mentioned that demand for their services reduced during lockdowns, but later in the year, the demand increased, especially that economic repercussions of COVID-19 have made many people vulnerable and in need of free services. In addition, the JHAS representative stated that their capacity was reduced, as many of the staff got infected with COVID-19.

Several organisations lost their funding for some programs or had reduced financial support from donors. IFH, for example, had to halt their home visit program due to lack of funding and have not been able to bring it back in its entirety until now. JHAS on the other hand, experienced a 20-30% drop in their budget. Forearms of Change Centre (Sawaed) reported needing more financial resources to operate their mobile units.

Responses to mitigate COVID-19 impacts and ensure continuity of service provision included: [165]

- **Shifting delivery of services to online and remote modalities. For example:**
  - UNFPA operated hotlines for GBV case management and disseminating SRH messages to women focusing on family planning. [166]
  - IFH developed remote case management protocol, launched 10 national hotlines for GBV, and continued providing information on SRHR.
  - Forearms of Change Centre (Sawaed) offered hotline and online services such as PSS.
  - Forearms of Change Centre focused on awareness raising on safe sex as many of people started going into sex work due to financial challenges.

- **Organisations kept their essential SRH services. For example:**
  - IFH was granted permission to continue providing their clinical management of rape services, and the hotline dedicated to this service continued operating. After two weeks of lockdown, the organisation had the permission to operate its other SRH services.
  - During lockdown, JHAS was able to keep its services running and their staff working 24-7 in Za’atari camp to provide emergency services such as delivery and C-section delivery. JHAS developed a schedule for women to receive antenatal and postnatal services.
  - UNFPA prioritised continuity of essential SRH and GBV services such as emergency obstetric care and comprehensive SRH primary health services for refugees, and clinical management of rape. They mobilised youth and women networks to raise awareness about COVID-19. [167]
  - UNFPA funded by the government of Japan, launched a 300,000 USD project to support SRH services in Azraq camp during COVID-19, to offer integrated SRH and GBV services there. [168] In July 2020, the UNFPA also launched a mobile clinic program in seven governorates, to strengthen access to SRH, particularly for vulnerable women, respond to the impact of COVID-19 on these services, and address the gap in service provision in rural areas. The clinics provided SRH services including pregnancy tests, prenatal and postpartum care, gynaecological exams, STI screenings, health education, family planning, and referrals to social services. [169]

- **Other measures included mobilising community workers to deliver emergency medication and contraceptives for those in need during lockdown. For example:**
  - JHAS delivered family planning tools to women that needed them.
  - For special cases, IFH was able to reach to vulnerable women to provide them with contraceptives and hygienic kits.

[165] As reported by KIs during interviews and gathered from online sources
[167] Ibid
Importance of SRH Services

A UNFPA representative mentioned that when the pandemic started, a response plan was developed. The implementation of that response plan was assigned to MoH, and was coordinated through the national coordination platform, which included health development partners such as UNFPA, WHO, UNICEF, UNHCR, World Bank, EU and others. According to the representative, in the first draft submitted to the UNFPA, SRH services were not included. But upon their review, they were integrated in the response plan.

When COVID-19 pandemic hit, interview findings revealed that SRHR were not prioritised in terms of resource allocation. This is confirmed by the Higher Population Council report which specifies that the MoH did not consider SRHR services and GBV as priorities, and instead prioritised lifesaving services (such as emergencies and medication for chronic illnesses). Health care managers interviewed in this report stated that the Ministry of health did not provide medication for maternal complications. In addition, menstrual hygiene supplies were not provided. [170] An interviewee stated that a lot of CBOs disappeared, as they collapsed internally due to lack of emergency funds, noting that “Many of the NGOs and CSOs don’t have funds, as money coming from large donors go through the MoH, which has different pandemic response priorities compared to other long-term programs such as cancer screening and family planning. The government gather this money and give commitment to the donors to integrate Syrians, to offer them services, the same as Jordanians, we see most of the money going to Syrians [Syrian Refugees]” (KI, Jordan).
Referrals and Coordination

As for the impact of COVID-19 on the coordination between different stakeholders, interviewees mostly reported that coordination continued as it was before but shifted to online and remote modalities. For example, during the lockdown the UNFPA developed a new contingency plan for their working groups in line with different response sectors and conducted needs assessments. In the opinion of an interviewee, coordination after lockdown increased, stating “it was an opportunity between partners, and between different stakeholders to coordinate their efforts, and talk about this issue [COVID-19 pandemic and SRHR]” (KI, Jordan). Forearms of Change Centre coordinated with hospitals and doctors for women who need to give birth or were in need of medical services, and their representative reported this was affected due to lockdowns, as only emergency services were available.

WiTD Practices Related to SRHR during the COVID-19 Pandemic

When it comes to reproductive health, before the pandemic, around 37% of women aged 15-49 in Jordan used modern contraceptives, while 14% used traditional methods. According to the 2017-2018 JPFHS, 14% of women were estimated to have unmet family planning needs. When it comes to maternal health care, 98% of women aged 15-49 received antenatal care from a skilled health care provider at least once, and 98% delivered in a health facility (Two thirds of deliveries took place in public health facilities). The survey reported that 83% of women received a postnatal check-up within two days of delivery and 13% did not receive a postnatal check-up. [171]

During the COVID-19 pandemic, especially during the first months, KIs noted that WiTD were reluctant to access services to avoid crowded public facilities out of fear of COVID-19 infection. Some resorted to private health facilities, but many could not afford these options. A couple of KIs mentioned that they noticed an increase in unplanned pregnancies during the pandemic. This is confirmed by a study reporting that health care workers noticed an increased number of unplanned pregnancies among married women. [172] Some KIs stated that some women resorted to sex work due to losing their jobs and economic pressures.

Peer support, family networks and support from community-based organisations were highlighted during interviews as mechanisms that women relied on to cope with COVID-19 impacts on their mental health and SRH. Women resorted to remote and online services, which were more accessible to adolescent girls. [173] As for factors that enable WiTD to maintain healthy SRH practices, KIs believed that access to information during lockdown and curfews provided support for women and helped them in managing their sexual and reproductive health.

Recommendations

- Prioritise SRH and GBV services in pandemic and emergency responses. SRH and GBV services are vital to the mental and physical wellbeing of women and girls. SRH providers should be permitted to operate during pandemic and emergency situations with minimal disruptions. WiTD’s access to SRH services during emergency situations should be facilitated, in particular their access to contraceptives and safe delivery services.

- Strengthen innovative models of SRH delivery services that emerged out of the COVID-19 pandemic, including WhatsApp messaging, online sessions, and hotlines. Remote delivery models should address barriers to access faced by WiTD across geographical areas and age groups.

- Expand the role of mobile clinics to expand the coverage of SRH to remote and rural areas. In times of crisis, mobile units are critical to reach vulnerable women who face difficulties in accessing services (i.e. transportation issues, illness…etc.).

- Advocate for policy recognition of the SRHR of marginalised groups of WiTD, such as, unmarried women, young women, WLHIV and women at risk of HIV infection, women who inject drugs, women living with disabilities, and women from the LGBTQI+ community. Particularly, strong awareness and advocacy programs around SRHR of transgender women is needed. Transgender women experience high discrimination and are excluded from sexual health services. Efforts should ensure the establishment of strong referral systems for transgender women to access SRH services including PSS.

- Integrate comprehensive SRH service packages within the primary health care system, that is inclusive of WiTD such as WLHIV, women at risk of infection and women from the LGBTQI+ communities.

- Continue to advocate for women and girls’ rights. Gender inequalities created by socio-cultural norms, patriarchal systems, and discriminative policies, are exacerbated during emergency situations, leaving women more vulnerable and putting their lives at risk. Emergency response plans should have measures in place to ensure that inequalities are not aggravated. Linkages between SRH and GBV should be made clear in SRH policies and emergency response plans.

- Empower WiTD to demand their sexual and reproductive health rights and exercise them. Develop outreach programs that provide young women with reliable information on their basic reproductive and sexual health needs and equip them with tools that help them take control of their reproductive and sexual health choices.

- Advocate for the advancement of women's SRHR in Jordan including access to safe abortion services and emergency contraceptives.

- Develop youth-friendly sexual and reproductive health programs that are responsive to young women's needs and desires. SRH services should be available at public health care facilities and health professionals should be trained on youth-friendly service delivery.

- Advocate for the inclusion of comprehensive reproductive and sexual health education in school curricula and invest more in SRHR education and awareness campaigns for young people living in Jordan.

- Invest in youth leadership and SRH peer education programs. Activate the role of youth in their communities and build their capacities to deliver peer to peer education on SRH issues. Mobilize social media outlets and online platforms to strengthen peer to peer learning and amplify youth voices.

- Establish a national coordination committee for SRHR and create a national database for service providers and SRH programmes. Better coordination and reliable data are vital to strengthen referral systems and identify gaps in SRHR programmes in Jordan.

- Provide cash assistance to vulnerable WiTD in emergency situations to help them meet basic needs and alleviate economic pressures which have been linked to the increase of GBV cases during the pandemic in Jordan.

- Target issues of stigmatisation and discrimination in health care settings through desensitisation and training programs for healthcare professionals.
3.2.3 LEBANON

Context

Demographic Information
Lebanon's population reached 6,848,925 in 2018 of which 50.3% were males and 49.7% were females. Moreover, by January 2020, Lebanon hosted 910,000 registered refugees which made it the country with the highest number of refugees per capita. [174] There are also other refugees facing similar, if not greater challenges in the country, such as, for example, the 27,700 Palestinian refugees from Syria (PRS) and an estimated 180,000 pre-existing Palestinian refugees from Lebanon (PRL) living in 12 camps and 156 gatherings. Moreover, the total amount of funding Lebanon has received as part of the Lebanon Crisis Response Plan (LCRP) has reached US$ 5.64 billion since 2015. [175]

Findings of the Spring 2021 Lebanon Economic Monitor describe the current economic and financial crisis in the country as the top ten, and even possibly top three, most severe crisis episodes worldwide since the mid-nineteenth century. [176] Moreover, the worsening financial, economic, and political situation in Lebanon, coupled with the Beirut Blast in August 2020 and the COVID-19 pandemic, has had devastating implications for the country’s population, particularly those who are most vulnerable. These effects were highlighted in findings of a World Bank survey (2020), which showed that, for example, nearly one in three Lebanese became unemployed, and 61% of Syrian women and 46% of Syrian men reported losing their jobs because of COVID-19. Moreover, inflation has affected households' capacities to access food. Forty-one per cent (41%) of Lebanese respondents could not afford to stockpile food and the numbers are higher for Palestinians and more so for Syrians, reaching 44% and 64% respectively. [177]

HIV-Related Information
According to UNAIDS figures from 2020 there are 2,700 adults and children living with HIV[178] in Lebanon, and the prevalence rate for adults aged 15 to 49 is 0.1%. [179] In 2018, 2,600 out of the 2,700 PLHIV in Lebanon knew about their HIV status. As for the AIDS estimated deaths, it was 100 persons in 2019. [180] UNAIDS figures on Lebanon also show that 1,500 of PLHIV were on ART, 1,400 had suppressed viral loads, and the coverage of adults and children receiving ART was 60%.

As for data on KPs, population size estimates are 4,300 for SWs, 16,500 for MSMs, and 3,100 for PWIDs. [181]
SRHR Services and Needs Related to WiTD

The integration of GBV-SRH first took place through mainstreaming a GBV chapter into the Reproductive Health (RH) service delivery guidelines in 2009-2019, in addition to the later revisions that were made in the 2014-2016 guidelines. In 2013-2014 a training manual was also developed for health care providers on communicating with survivors of violence and training on it was rolled out to all health care providers. Other integration efforts of GBV-SRH included peer educators trained on RH and GBV issues and mainstreaming a GBV module in midwifery curricula at the St Joseph University, as well as distributing drugs[182] for women survivors of rape across 40 PHCs. [183]

The Syrian conflict and influx of refugees into the country is one of many factors impacting the country’s stability. In 2015, a committee was established by the MoPH and the UNHCR to coordinate and guide activities in collaboration with the Health Working Group. The Reproductive Health and SGBV sub-group are under this working group and is led by the UNFPA. [184] The MoPH, with the support of the UNFPA and the UNHCR focused on improving PHC services (including reproductive health services) for vulnerable Lebanese communities and Syrian refugees in the country. However, without a national reproductive health strategy, Lebanon will continue to face challenges in this area. Moreover, although coordination exists between the different stakeholders to support vulnerable Lebanese and Syrian refugee populations, the implementation of the Minimal Initial Service Package (MISP) for Sexual and Reproductive Health, and the provision of comprehensive SRH services has been limited. Several national and international NGOs are also involved in providing prevention and protection programs to support survivors of violence in Lebanon. These includes activities and services such as legal support, hotlines, protection and shelter provision, as well as medical and PSS support services for SGBV survivors. [185]

As for the needs of WiTD, all the KIs reported that this varied depending on various intersectional aspects that defined women such as age, sexuality, disability, etc. For example, explained a KI, “in the case of a woman that has sex with women, and has HIV, her needs are different”. The KI also gave the example of women with disabilities facing difficulties finding gynaecologists with beds that are accessible to persons with disabilities, “and if they are, they are usually in private gynaecologists clinics that are expensive”. Another KI working at Salama said that at one point there was also shortage of sanitary pads in the country, “which later became available but was very expensive”.

In the case of pre-natal care, 96% of women seek care when they are pregnant in Lebanon[186] , and 98% of births are attended by skilled staff[187] . However, when it comes to post-natal care, the rate drops to 50% claimed a KI. [188] One of the reasons for the low postnatal care practices is the lack of awareness of follow-up after giving birth, or where they can seek care for it reported the KI. There is also the issue of costs of visiting physicians and the aspect of prioritising the new-born care over the mother. A KI interviewed highlighted the importance of providing postnatal care for the mother and child equally. Moreover, she stated that even for those mothers who do receive post-natal care, “services such as mental health are not given… so there are huge gaps in the way services are provided and organised” (KI, AUB) As well as raising awareness of women on their bodies throughout the life course, men’s awareness about this is very low and needs to be raised as well.

[182] The type of drugs was not specified.
A study conducted in Lebanon identified three main barriers to accessing SRH services. [189] The first has to do with systems and process barriers related to accessing SRH services. Rather than being available in a more centralised and comprehensive manner, SRH services are provided by different service providers scattered around the country, which makes it difficult for women to receive comprehensive services (through one stop shop approach). Moreover, access to these services is particularly difficult for women who are vulnerable such as those with disabilities.

During an interview with a KI, the interviewee linked SRH needs to the rights of women in Lebanon. The KI believed that women’s rights are lacking on many aspects in the country, and gave the example of “rights for abortion, and for having a child without being married… the non-existence of these rights puts women at a disadvantage when talking about SRH” (See section below on Legal barriers). The KI also referred to major challenges in accessing SRH information, “which begins in schools”, due to issues such as religious laws and social taboos. Sex education in Lebanon was first addressed in 1995, when it was formally integrated into the curriculum and offered to eighth graders (12 to 14 years old). The curriculum was developed by UN agencies and various experts under the lead of the Educational Centre for Research and Development. However, it received major criticism from various religious leaders, and fearing pressure from them, the education minister later removed sexual education from school curricula. Since then, there have been efforts to re-establish it in the education system however, they have not been successful. [190,191],

There is also a significant difference in the way that unmarried and married women have access to SRH services, and this was reflected throughout the interviews with KIs. The struggle that unmarried women face to accessing SRH services and information is common across the MENA region. [192] These barriers are linked to religious, social, and legal issues. On the issue of barriers to accessing SRH services in Lebanon, a KI said, “there are a lot of problems, I don’t know where to start and where to finish, at every age, … and corner of life you would find a lot of barriers”.

Moreover, several KIs mentioned that SRHR is not on the agenda of policymakers and is usually pushed through the work of (I)NGOs “who mostly work on issues such as violence against women in Lebanon” (KI, CSO). Although some organisations work on SRH issues such as maternity and breastfeeding, there are other topics that remain in the background, such as, explained a KI, “the need for equitable access to contraception, SRH information, [and] SRH education at schools. There are a lot of gaps in our society” explained the KI. The interviewee described the health system in Lebanon as “very chopped,” and contributed this to the privatisation of the health system and lack of national guidelines and protocols to provide or integrate health care services in the country. The KI was of the opinion that, “if SRH and HIV programming was integrated into the health system, services would not have been as disrupted by pandemics such as COVID-19”.

Indeed, recent figures show that 70% of primary health care centres and 80% of hospitals in Lebanon are privatised. Moreover, the health care system is ‘fragmented’ as it is made up of complex public-private partnerships which involve many services providers and funding sources. According to Varoufakis the fragmented and privatised nature of Lebanon’s healthcare system makes it impossible to have preventative and curative care frames of social health, “let alone face a pandemic like COVID-19”.


Challenges to Accessing SRHR Services for WiTD
A survey distributed to 14 national stakeholders working on HIV and SRHR in Lebanon highlighted the importance of HIV services being integrated with SRH as one package. Key concerns challenging integration of HIV and SRHR had to do with institutions being unwilling to be trained and their poor M&E capacities. Survey findings also highlighted that SRH and HIV/VCT directors and supervisors identified the MoPH and the National Aids Control Program (NACP) respectively as their main partners. Moreover, according to interviews with 40 SRH services providers, the services most frequently provided was control/prevention of STIs (95%), followed by family planning (90%) and maternal, and new-born and child health (80%). Post-abortion care was also reported to be offered (47.5%) as well as prevention /management of GBV (at 30% of institutions). [194]

Other challenges reported during KIIs included the general lack of trust in SRH services “as some health facilities provide poorer quality services than others” explained a KI. Another factor reported is the distance and need for transportation to reach health care facilities, which can impede access to health services, particularly for women, who are often responsible for household responsibilities as well as those with disabilities. This is also particularly relevant, with the current fuel shortage that is causing further deterioration to what is described as the country’s ‘worst economic and monetary crisis in its history’. [195]

Other challenges particularly to Syrian refugee women’s access to SRH services include negative experiences with health care providers, and fear of being stopped by authorities on the way to health clinics because they lack proper legal documentation. Several studies also highlighted the lack of trained staff and health care workers as a deterrent to accessing SRH services, and particularly, regarding the availability of women health care workers (HCWs). [196] Moreover, Syrian refugee women often lack awareness of SRH services available to them, including those which are subsidised and free, and how to reach them. [197,198] Cultural issues also play a role in women’s access to SRH services. Women fear being replaced by another wife or of polygamy in the event where they negotiate use of contraception. [199,200] In the case of sexual violence survivors, they are also likely to refrain from reporting incidents because of fear of dishonouring the family or of honour crimes to take place. In other cases, women may be less inclined to receive SRH services because they are accompanied by their husbands or male family members. [201] Studies have also highlighted shortages in free SRH supplies at PHCs such as for prenatal vitamins and contraceptives. Moreover, shortages in preferred contraceptives among Syrian refugee women have been documented, which for many is injectable contraception. [202,203],

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During an interview with a KI, the interviewee reported that “there are people who don’t have a culture of awareness about having to go to the general practitioner for SRH purposes” (KI, CSO). The KI explained that some people do not have the knowledge of services that are available to them, and others are not aware of their SRH rights and needs. In the case of KPs, the KI reported that it is likely that “they are not aware of organisations that provide SRH services to them without discrimination” (KI, CSO).

Another KI believed that the primary challenge to accessing SRHR services has to do with culture followed by religion. Culture greatly affects women and girls in choosing where to get SRHR information from. The KI reported that often women “prefer asking their neighbour or relative on an issue rather than a medical expert.” Similarly, studies have shown that young people prefer to receive information about sexual and reproductive health issues from their parents rather than medical practitioners. [204]

During interviews with KIs, several described working on sexual health issues in Lebanon as challenging. For instance, a KI gave an example of work she had done in one of the more “liberal areas” of the country through the municipalities. She said that they were forbidden to carry out awareness sessions topics such as ‘irregular menstruation’ and ‘domestic violence’ through the municipality social media platforms (namely, Facebook). To address this challenge, the KI explained that they would change the topic of the session to more ‘acceptable’ headings such as “menstrual cycle during Corona”.

Legal Barriers

Lebanese laws create an additional barrier for access to health including HIV and SRH-related services and treatment among KPs through legislation that criminalises, or is interpreted as criminalising, of certain behaviours and practices. This criminalisation causes fear of arrest and incarceration among LGBTQI+, SWs, and PWID communities, and often prohibits them from reporting violations that they are subjected to, making them more vulnerable.

There is no specific law that criminalises homosexuality, however, Article 534 of the Lebanese Penal Code that criminalises sexual relations that “contradict the laws of nature” is often used by law enforcement to arrest and detain LGBTQI+ individuals. The financial burdens of accessing SRH services at PHCs is another factor affecting access particularly in the case of marginalised segments of the population.

In the case of sex work, it is illegal in Lebanon and several articles in the Penal Code explicitly criminalise the exchange of sex for money. The criminalisation of sex workers, as well as the various forms of stigma that they face, further challenges their situations and increases their risks to having their rights violated. Sex workers do not report crimes committed against them by clients and/or pimps to the police because they fear being arrested, or even experiencing further violations. Drug use is also criminalised in Lebanon, and people that are in possession of drugs are arrested and imprisoned. Moreover, women who are drug users are less likely to access SRH services in fear of being identified. [205]

At the legal and policy level, there are also various laws that discriminate against women and hinder their access to their sexual and reproductive health rights. For example, although rape and the use of violence to claim right to intercourse is criminalised in Lebanon, its interpretation by religious courts does not include its full implementation throughout the country. Moreover, according to Lebanon’s Penal Code, which dates to 1943, abortion is illegal. [206] Article 542 and 543 of the penal code stipulates that abortion is not considered a criminal act in the event where it is to protect a ‘woman’s honour’. However, the decision for abortion during such situations is by members of the family, rather than the woman. [207] During an interview with a KI, the interviewee reported that in situations where women need to access abortion services, “those who have access to NGOs who can advocate for them are better off than those who are not as resourceful and do not have such support.” Moreover, the KI explained that during COVID-19, health care professionals providing abortion services “are going to ask for more [money].” Which in turn, can contribute to risky practices such as unsafe abortions, particularly as the country is experiencing a severe economic crisis. However, the KI stated that there is very little data on women’s experiences to SRH services during COVID-19 and the multiple crisis that Lebanon is going through.

Furthermore, according to articles 487 to 489 of the Lebanese Penal Code, if a woman commits adultery she can be sentenced to prison, whereas for men, they must be caught in an adulterous act inside their homes. Moreover, the sentence for women ranges from three months to two years, whereas for men it is between one month to one year. Women are also required to prove their innocence with a witness’s testimony, then can be found innocent based on the ‘presumtio innocentiae’. [208]

As for early and forced marriage, there is no legal minimum age to get married, and the government of Lebanon does not exercise civil marriages – however, it is accepted by law if undertaken abroad. In Lebanon, “religious courts define the marriage age based on confessions determined personal status law, and minimum age for marriage differ accordingly.”. [209] Hence, minimum marriage age can vary according to different courts from 14 to 17 years of age. In some cases, where women are younger than the sect’s official marriage age, religious courts may make an exception and allow the marriage to take place, upon receiving consent from the guardian and if she has reached mental/physical maturity. It should be noted that in some Islamic sects the marriage is permissible after a girl has reached nine years of age. [210]

### Stigma and Discrimination

Social stigma was mentioned during discussions with KIs and WITD as a barrier affecting access to SRHR services such as STIs and even reproductive services. This is particularly the case for WLHIV, because of cultural and religious taboos that are prevalent in Lebanon linking the transmission of HIV directly to sexual relationships, which increases stigma and discrimination towards them. [211]
Stigma is also existent among healthcare professionals in Lebanon and fear of being denied services is prevalent among WLHIV, leading them to avoid disclosing their status. Other KPs (such as SWs, IDUs and LGBTQI+ communities) also face stigma and discrimination when accessing general health care as well as SRHR services. Violations experienced within the healthcare sector by KPs can be disregarded as they are often considered lacking in credibility. [212]

Further marginalisation and vulnerability are experienced by transgender women who are in the process of changing their gender on national identification documents to conform to their physical appearance. Administrative violence is encountered among law enforcement and governmental officials at different levels. [213]

Stigma, discrimination, and sexism were believed to be the main barriers that prevented women from accessing SRH services. Elaborating on this point a KI explained that if a woman is not married, for example, and goes to a gynaecologist, it is possible they ask her if she is married, “the doctor assumes that she has never had sex before [if she is not married] and therefore may not recommend for her to do certain tests, so WiTD are always subjected to stigma, especially when it comes to their sexual health… in Lebanon and the Arab region in general”.

While the KI believed that the curriculum of nursing and medical schools in Lebanon are “very strong in clinical training [they are] not strong in the interpersonal aspect of the care, and for these specific groups you need to do capacity building for your staff, and also adjust the curriculum and incorporate within the curriculum these aspects” (KI, AUB) The KI reported that there are specific NGOs such as Marsa that have competent staff with such skills, “but again it depends on people’s knowledge of such NGOs and access to them” (KI, AUB).

Financial Barriers
Financial-related issues are a main barrier to accessing SRHR services among WLHIV and other KPs. They face a difficult time in securing work due to stigma and discrimination as well as pending legal issues, which contributes to their deprived situation and negatively affects efforts of trying to improve their quality of life. Gender orientation and stigmatising social norms for instance make it difficult for members of the LGBTQI+ community to secure employment. This inequality in employment opportunities becomes even further challenged when individuals face double and triple stigma if they happen to be living with HIV and/or engaged in sex work. Moreover, KPs already face challenges under normal circumstances, let alone the current protected and severe economic crisis that Lebanon is currently undergoing. Economic constraints also affected people’s ability to access medication. On this point a KI reported that “there are some cases of women choosing not to put IUDs because of economic reasons and then getting pregnant” (KI, Salama). At the level of organisations working on SRH, several KIs mentioned lack of funding as a challenge to the provision of SRH services, since it was not seen as a priority for donors and at a national level.

Stakeholders Involved
The health system in Lebanon is comprised of PHCs, hospitals, and ambulatory services/clinics that are managed by private, public, and NGOs or charities. Out of 950 PHCs spread around the country, 200 are governmental, managed by the MoPH (130) and the Ministry of Social Affairs (MoSA) (70) respectively. The rest are managed by religious or charitable institutions as well as thematic CSOs. Moreover, hospitals are predominantly private, and there are 28 out of 168 public hospitals. In terms of ambulatory services/clinics, private practice is dominant and there exists a concentration of healthcare services within large cities.101
As for access to HIV treatment, this is provided by the government free of charge, and is centralised within the NAP, which is located in the capital, Beirut. The NAP in Lebanon, which was established through a joint effort by the MoPH and the WHO, is the main entity for the HIV response. A wide range of HIV services exist in Lebanon, including prevention and VCT, to HIV treatment, care, and support. HIV awareness raising activities are prevalent in Lebanon and are conducted by the NAP at the national level, as well as by thematic CSOs. There are also a large number of CSOs working in the HIV field, in addition to LANA, which is a national network of CSOs working in HIV related fields. PLHIV also have an independent and registered organisation known as Vive Positif.

It is more difficult for national networks or organisations for sex workers and LGBTQI populations, to be established, probably as a result of their marginalisation and criminalisation. Institutional capacities among CSOs are quite varied, but it can be said that all of them engage in capacity building and training in an effort to improve. [214]

In the case of SRH services, a KI reported that Lebanon has a mix of providers; there are private hospitals and clinics, and there is the public sector, namely the MoPH and MoSA. When comparing between both government organisations, the KI explained that the former is responsible for providing SRHR services and the latter for offering SRHR trainings. There are also NGOs, many of whom manage PHCs, which are a network affiliated to the MoPH. The KI described these NGOs as having political motives which in turn determines their accessibility. On this point, the KI explained, “these NGOs are politically or religiously affiliated to the structural level, and the type of service depends on the type of affiliation, and that’s another layer of complication”. In addition to government and NGOs, there are also UN led SRHR programs such as those implemented by UNFPA, UNICEF, and WHO “these programmatic level interventions that affect the way SRH services are shaped, especially at the level of the public or NGO sector” explained the KI.

Meanwhile, a representative from the UNFPA reported that the Agency works at different levels; it provides support to government entities to institutionalise RH and GBV services within their facilities. It also works with legislations protocols, capacity development, service provision and awareness raising. UNFPA's target population is women in reproductive health; however, the agency makes sure that services are inclusive and that 'no one is left behind'. Moreover, targeting men is essential in UNFPA’s programming including those focusing on family planning and the paternal role.

There are also several public and private universities that promote SRH programs, and a few have integrated them into their curricula. During an interview with a KI working in AUB, maternal health was reported to be one of the topics provided at the Faculty of Health Sciences. The faculty has been established in the AUB for 60+ years as an independent public health school, which is important, as the KI explained, “because usually in the region, you find public health schools within medical schools. Having independence is important because it allows a public health approach to be followed.” In terms of resources on research at the faculty these are very limited. Awareness sessions on access to SRH services is also provided in schools through engagement between school focal points and NACP and NGOs. [215]

Various organisations in Lebanon, including NGOs and CSOs, work towards raising awareness on and preventing transmission of HIV within communities. These organisations also educate people about access to SRH services through the educational materials and prevention tools that are provided to them by the NACP. [216] CSOs working on SRH and particularly targeting KPs include entities such as Vivre Positif, Marsa, Salama and SIDC. During an interview with a KI, the interviewee reported that these are mostly CSOs, UN agencies, some international NGOs, but mostly local organisations. However, the local organisations are often working above their capacities.

In the case of the MoPH, the current situation in Lebanon is difficult, with the political and economic instability in the country, as well as health implications of COVID-19 on the population. The private sector is also an environment for SRH services for those who can afford it. A KI interviewed reported that organisations with local funding were most likely affected by the economic crisis in the country.

Other players engaged in SRHR and working with KPs include Lebanon Family Planning Association, Lebanese association for obstetrics and gynaecology, the Armenian Relief Cross in Lebanon, Helem (Lebanese Protection of Lesbian, Gay, Bisexual and transgender people), Oum el Nour (NGO working on drugs prevention) and Lebanese Council to Resist Violence Against Women.

**Referrals and Coordination**

UNFPA is the lead UN Agency responsible for responding to the GBV and SRH needs of people in Lebanon. The Agency collaborates with various stakeholders and sectors/clusters to ensure that quality in service provision and to mainstream GBV across sectors. In 2016-2017, the inter-agency implemented the “Guidelines for integrating GBV interventions” which allowed GBV to be mainstreamed within the work of SRH service providers. [217] Building on this, the UNFPA began prioritising models to integrate GBV into SRH service provision through, for example, integrating it into PHCs and mobile teams providing SRH services; integrating SRH in women and girls safe spaces; promoting partnership between GBV and SRH specialised organisations; and developing strong integrated referral pathways which include GBV and SRH partners. [218]

Coordination between organisations is, however, poor and often leads to duplicated efforts and unclear referral systems. [219] During an interview with a KI, the interviewee reported that NGOs working on HIV issues would benefit from connecting with other sectors so that HIV is streamlined across different thematic areas. The importance of expanding the circle of central partners working on HIV beyond those long-standing partners was also highlighted. The bigger problem with accessing SRHR services has to do with stigma surrounding sexuality, particularly in non-heterosexual and with women who are not married.

During an interview with a KI, the interviewee reported that the referral system in Lebanon was greatly affected by COVID-19 because resources were geared towards the pandemic and its effects. Moreover, the KI described referral systems in Lebanon as already very weak. While the private sector may provide referrals, this service is catered to those who can afford it. Moreover, although NGOs may also offer referrals, several KIs reported that it is completely lacking in the public sector. According to a KI interviewed, efforts were made by the MoPH to integrate mental health services into primary health care services, “and there was a pilot project taking place prior to COVID, but then during the crisis, resources were pooled into COVID mitigation and that was weakened.” The KI mentioned that there was a lot of effort to train staff, on issues including referrals as part of the pilot project, “but for PLHIV, that’s not at all integrated into primary health care services”.

Another KI representing a CSO providing SRH services in Lebanon reported carrying out screenings for GBV and referrals for case management. The organisation also has partnerships with labs so that beneficiaries can receive tests and scans needed at a discounted rate. Moreover, it is recently working in partnership with UNFPA to provide full coverage of fees for SRH-related laboratory tests (excluding paediatrics). It is also implementing a project funded by the Japanese Government targeting pregnant women. The pregnant beneficiaries are required to go through the whole process of care, “and once a beneficiary delivers, the organisation covers part of fees at the hospital as well” (KI, CSO).

Situation of SRHR Services During the COVID-19 Pandemic

Effects of COVID-19 on Access to Services
Several KIs interviewed reported that they continued providing services during COVID-19. However, changes in modalities of implementation were mentioned, as well as their adherence to the WHO protocols to prevent the spread of COVID-19. Regarding changes in modalities of implementation, organisations like SIDC reported providing online/remote awareness sessions, arranging visits to the centre by appointment and reducing the number of visitations, providing PPE equipment and material and implementing COVID-19 prevention measures, as well as stopping any physical outreach activities.

Other organisations like Marsa reported that, although the type of services they provided did not change, they had to stop working during the start of first lockdown for two months, because "we were not yet aware of the dangers of COVID-19". Marsa began operating normally since May, however, during the lockdown, services provided were only focused on emergency cases with the medical practitioners. In January 2021, there was another lockdown in the country, and Marsa closed as well, but when the lockdown was eased, the organisation gradually started operating and all staff were vaccinated. During the lockdown and closure Marsa focused on disseminating information via social media, and the KI reported experiencing a boom in their social media presence, which they are continuing to use. The KI reported that currently their work has become "more and more remote", due to multiple and accumulated challenges other than COVID-19, such as the fuel crisis and the severe economic depression.

As for the capacities of Marsa, during the year of 2020 and over the past two years, it was able to receive a high number of projects and their operations were reported to have grown. The KI mentioned being understaffed, however, they are in the process of recruiting and expanding. Similarly, other KIs mentioned being understaffed and overworked with limited resources constraining their ability to respond to the growing needs of beneficiaries.

Another KI representing a CSO reported that their beneficiaries started accessing services via telephone and online platforms during COVID-19. The organisation integrated digital channels to communicate with beneficiaries in order to overcome access challenges during the pandemic. Moreover, the KI reported there was a change in the perspectives of beneficiaries on reproductive health issues, and "people became more accepting to talk about them [on the phone]."

Meanwhile, a KI representing SIDC mentioned that during the full lockdown they were not able to carry out outreach activities, however, the organisation was able to open its clinic, because they have a dispensary certificate which positions them as a health care centre. SIDC made sure to take all the necessary precautions against COVID-19 infection, such as, for example, "purchasing sterilisation machines, placing a cover on the benches where people sit to be able to disinfect the seats, buying equipment needed to take the temperature of visitors, and SIDC also lowered the number of beneficiaries attending the centre". Visitations became by schedule and no more than three visitors were allowed at a time at the centre. The period of the counselling was also shortened, and calls were made via the hotline to check on the beneficiaries before they came to the centre.

The KI reported that doctors also closed their clinics during the full lockdown, so SIDC coordinated between them and the patients to make sure they received the needed care. “We did not close our doors for one day but reduced the hours of operation” explained the KI. When distributing the self-test for HIV they supported the person on video to make sure that they did it properly, “and they are directly supported if results are positive”.

SIDC’s services were also adapted for the beneficiaries. So, for example, the centre opened when beneficiaries came to receive their medication. The KI reported that even “NAP opened every day during COVID so there was no problem in the level of service delivery at the NAP and SIDC level.” The KI also explained that when the Beirut blast happened the NAP centre was damaged, and they had to relocate their offices. During this period, NAP delivered medication and a list of patients to SIDC, who became responsible for providing them with the needed services. Hence, coordination between SIDC and NAP ensured that patients did not experience disruptions in their treatment and care. The Beirut blast also destroyed many hospitals and affected the TB program which is closely linked to HIV.

Moreover, during COVID-19, there were reports that doctors were not receiving patients in their clinics, which affected KPs’ access to health services. To address this challenge, SIDC reported prioritising the needs of patients and making sure that those with critical needs were given appointments with doctors. Others that were not urgent were provided telemedicine care. The KI also reported that during COVID-19, UNFPA implemented a project in collaboration with the Syndicate of Social Workers to provide telemedicine for SRH. It was a project with family medicine doctors and the social worker contacted the families (pregnant women, girls, etc.) to raise awareness about SRH and COVID-19 and provide them with psychosocial support and referrals, as well as online access to a family doctor via telemedicine. On the 16th of March, SIDC started an online PSS network (including psychotherapists who are licenced and other mental health specialists) which provided support to their beneficiaries including sex workers, PLHIV and IDUs.

A KI explained that during COVID-19, many services became online, so staff needed to enhance their skills on online service provision. Moreover, materials were developed to fit the online modality which took time to develop, and “SIDC were learning by doing”. SIDC used online modalities to raise awareness on COVID-19 prevention measures and inform beneficiaries where to receive the needed services.

In the case of donors during COVID-19, in general, they were described as flexible and understanding to the complex and difficult context in which organisations were working in. On this point, a KI said that their donor “accepted SIDC’s shifting of activities to online modalities”. The KI also mentioned that changes in programming took time because “a lot of donor representatives left the country, and were requested to go back home, so adapting to COVID at a programmatic level took time”. Moreover, SIDC received donations during the Beirut Blast, “funds were used to change and scale services and extend reach but did not add new services that were not related to their vision or mission.”

There were also mention of some PHCs in Lebanon being equipped to deliver rape services for rape survivors during COVID-19 “but not all of them are functional”. Several PHCs were closed during the pandemic and others were damaged by the Beirut blast.

The changing context in Lebanon also led to changes in the priorities of service providers. For example, during an interview with a KI representing UNFPA, the Interviewee reported that the Agency had a plan for a complete program on STIs prior to COVID-19, however, “with the multiple crisis, the focus was on enhancing access to SRH services, including support to subsidisation of services”. The interviewee highlighted various challenges in Lebanon, such as, the economic crisis and people not being able to afford services, the migration of health care workers, and the movement to remote services where applicable.
With COVID-19, there were requests for information about the vaccination, so UNFPA had to consider the needs and priorities of people and adapt accordingly to meet the actual context and situation.

The KI reported that during COVID-19, UNFPA had specific interventions targeting LGBTQI communities to ensure that they received enhanced access to SRHR services. Within its programming, UNFPA also makes sure to target people with specific needs such as PwDs, migrant workers, and all residents in Lebanon including Lebanese, Syrians and others. During COVID-19, the KI said that UNFPA focused more on people with specific needs and nationalised groups, for example through medical mobile teams that can provide services with restricted mobility. The KI also mentioned working with organisations such as Salama, Marsa and SIDC to target LGBTQI and/or HIV communities. In 2019, UNFPA conducted a SRHR assessment in Lebanon. UNFPA developed specific guidelines on COVID-19 and pregnancy and the KI mentioned that they were the only ones in the region to start such an initiative. UNFPA also had training for service providers and ensured that there are protocols for severe cases and referral pathways and proper medical support for COVID-19 infected pregnant women, in addition to providing health care providers with PPEs, among other services. As with the other interviewees, the KI highlighted the need to consider the multiple crisis taking place in Lebanon to understand the needs and the context in Lebanon.

During COVID-19, UNFPA carried out different activities with communities, which included youth and women empowerment that were to a less extent implemented because of the restrictions on the mobility and other challenges arising in the country, such as the economic situation. UNFPA is also conducting an assessment about access to SRH services in Lebanon and preliminary findings show that many women were not accessing services and that they were prioritising other issues such as food. The data also shows a decrease in access to services during the start of COVID-19 due to aspects such as the lockdown and fear of contracting COVID. However, this was followed by an increase in access to services, but, the economic factor plays a role in this, and may reflect a shift in usage of services from private to public health care due to financial pressures.

During the Pandemic, a KI representing Salama reported that the organisation transferred its awareness sessions online. They distributed hygiene and dignity kits to KPs, “which became in great demand during COVID-19, because they were not available (pads, etc.)” explained the KI. The KI also mentioned that condoms became more expensive, and less accessible to people, particularly with the economic difficulties that many are facing in the country. Moreover, in general, interviews indicated a tendency for riskier behaviour among people in Lebanon. On this point, a KI explained that “it is possible for people to be more daring with their sex life, this is a coping mechanism with a lot of people in times of stress, it is possible for people to have multiple sex partners, use condoms less frequently, a higher probability for late diagnosis and health implications.”

There was also an increase in GBV, and according to reports from one of the organisations providing GBV support, during the first two months of the first lockdown (March – May 2020), “they received calls more than all of 2019 and they did not have any more space in the safe houses, and they could not allow more women because of the social distancing regulations.”

All the KIs interviewed highlighted the difficulty of isolating one crisis from the other in terms of its impact in Lebanon. As explained by a KI, “we cannot say that COVID-19 reduced services in Lebanon, there is also the issue of shortage of fuel, cash, security, and the Beirut blast, which as well as destroying Beirut, also damaged morals and mental health of people in Lebanon and those living outside of Lebanon who have family in the country”.

Similarly, when asked about the implications of COVID-19 on Lebanon, another KI described the country as a specific case because, “Lebanon is living multiple crisis together with COVID-19… so it’s very difficult to differentiate between the effect of COVID and other factors… like the economic collapse, the Beirut blast,”
the migration, the quick changes in our social context…”. The KI reported that looking at the macro level, Lebanon’s system is mainly privatised, and the role of the public sector in healthcare is lacking. The multiple crisis, “made that point clearer… that we don’t have a system that can… emerge through the crisis”.

One of the important things that happened during the COVID-19 pandemic, explained a KI, was the establishment of the National Committee for COVID and Pregnancy and Breast-Feeding Women, which acknowledges the need to look at these groups of women separately and follow global recommendations. Other than that, national efforts to focus on SRH were reported to have been insignificant despite the rise in violence against women during COVID-19 and the greater social burden of the lockdown on women compared to men. A KI highlighted the need for more research on this issue, saying “we probably haven’t discovered 10% of what that meant for women during the lockdown” (KI, AUB).

Another KI representing Salama reported that, while the quality of services they provided was not affected by COVID-19, they were required to stop operating several times because the location in which they were working became a COVID-19 hot spot. The KI mentioned that during the COVID-19 peak, they started making appointments by phone first, and made sure to follow all COVID-19 prevention precautions. They also began providing consultations on the phone and stopped carrying out outreach including in the schools and universities. Like other organisations, Salama started focusing on hygiene kits for beneficiaries, and continued to follow COVID-19 prevention measures until now. They also started providing awareness sessions on COVID-19. The KI mentioned that their services were more affected by the economic crisis in the country. It became harder to bring in medication, and both NAP and UNFPA were reported to have had a shortage of contraceptives, “and this is due to a global shortage because these are produced in China” explained the KI. The KI also reported that, with the COVID-19 pandemic and economic crisis, private medical care has become unaffordable for many, and more people are visiting their centres including those from host communities.

Common Practices During the COVID-19 Pandemic

In terms of accessing services, women in general do not prioritise their health, whether they are married or single. In the case of transgender women, the stigma they face is high, many do not feel safe walking in the streets during the day. So, for trans women their situation is much more challenging, and they are at greater risk of violence. If they are on hormone therapy, they will need specific kinds of services and the endocrinologists that provide these services are usually not accessible, most do not have experience with hormone therapy and are few. There is also a lack of education within the healthcare sector on the needs of transgender people. A KI reported that a lot of transgender women had to resort to transactional sex during COVID-19 to cover their basic needs. Moreover, transgender women were particularly affected by the Beirut blast, because of the difficulty of finding landlords that would accept to rent out places to them. Furthermore, a KI explained that in “situations where a woman does not have food, or shelter, it is unlikely that she will focus on her SRH needs, unless she is in pain.” Moreover, in the case of abortion, as long as it is illegal to have this, there is also the opportunity to exploit women in need of this service. With the reduced access to condoms, it is likely that women practiced unsafe sex and were therefore at greater risk to unwanted pregnancies and STIs reported a KI. Indeed, the literature highlights how lockdown measures led to major disruptions in the supply of contraception on a global level. [220]

Like many KIs, an interviewee working in academia emphasised the multiple crisis Lebanon is going through and the difficulty to differentiate and “pinpoint which changes have contributed to health systems in the country, and which are emerging as a consequence of all these factors together”.

Factors Enabling WiTD to Maintain Healthy SRHR Practices

During an interview with a KI, the interviewee highlighted the poor role of the public sector in healthcare. Moreover, the crisis in Lebanon, including COVID-19 and other events that took place in the country, highlighted the fragility of the country’s health system, and its inability to cope with crisis situations. COVID-19 and other multiple crisis that took place also showed how people with resources were better able to cope, whereas those with less resources were left out. Another key factor that enabled WiTD to maintain healthy SRHR practices was the support provided by peer educators who were the link between CSOs and KPs during the pandemic.

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Sabirah is a 44-year-old Lebanese woman with a physical disability. Sabirah has been living in a rented place for eight years with a family of six persons. She is currently going through a divorce with her Egyptian husband who is in jail. Sabirah said that she did not want to marry but was forced to because of her physical disability and “lack of options” available to her. The woman was physically abused by her husband and his family. She said that he married three other women and that she decided to leave him after too much abuse from her husband and his family.

Sabirah suffers from a leg and back disability due to a war injury. She was very grateful for the support provided to her by an organisation she has known for 14 years. She said, “the organisation helps women who do not have work, those who are divorced and want to have custody of their children”. She was introduced to the organisation through word of mouth from people like her.

Sabirah has an 8-year-old daughter and a 7-year-old son. Her husband placed her children in a convent, after she left him. She now knows nothing about them, not even the convent that they are in. She said that even if she did know, the convent would not permit her to see them.

Sabirah left her husband six years ago but wants to officially file a divorce against him. However, her husband requested $350 from her to accept the divorce. She went to a religious agent, who requested $100 for the divorce, but she does not have the amount to cover this. The woman said that she is looking for someone to help her to go through a divorce, and that “this is the most important thing for me”.

Sabirah mentioned using contraceptives when performing sexual relationships “before or after COVID”. However, she said her clients prefer having sex without a condom. “I would ask for 50,000 LL but he will say I will give you 100,000LL without a condom. If the skin does not touch the skin, he will not enjoy it”. She said that she would try and negotiate with the client, saying that it is for protection from diseases, and from spreading diseases to your wife and children. But he would respond saying he is ‘clean’ and she would inform him that the FSWs may not be, and he would say “no I know them”. Sabirah claimed that she would refuse clients if they do not accept use of condoms.

Sabirah experiences a lot of discrimination because of her physical disability. She reported being refused public transportation services because of her disability.

When asked about the availability of condoms, Sabirah reported that there are projects where condoms are distributed. “But now in the current situation it has become expensive, but before it was around 1,500 LL for one pack, now the most recent purchase I had of a pack of three condoms, it was around 75,000LL... from that day I stopped getting them and going out with anyone”. Sabirah said that this rise happened after Corona, “before one could afford to get them, but now no”. Sabirah mentioned that FSWs usually get the condoms from the pharmacy and that there is one close to her, but “now people [clients] are not even going to get condoms, the client tells me, it’s expensive now, let’s do it without one”.

On the availability of SRH services Sabirah said that these are not available in Lebanon “before and after COVID... But now everything is expensive”. Comparing her situation with other FSWs, the woman said that other younger FSWs request up “500,000 LL for an hour and in a hotel, not in the street and so on, for a small sexual act, and when I would ask the client for the same thing, the client would say no, you have a limp and the other FSW is young”. Sabirah mentioned that FSWs work with the dollar, and that “when the Dollar falls, they increase the price”. She also said that she increased her rate to 150,000LL but does not receive any clients.

In cases where the FSW gets pregnant, Sabirah said that they would go through abortions. She knew that they are forbidden in Lebanon, saying “a woman that does this can go to jail”. Sabirah heard from others before Corona, that there are medication women can take when pregnant “you take a pill, and you will get a miscarriage”. She said that this pill is available in the pharmacy but does not know how expensive it is.

Sabirah mentioned that there was a time during Corona when people could not get any medication, “not for children nor adults, it was not available in the pharmacy, and one could not get it without a medical slip from a doctor... but the condoms are never out of supply, even during Corona, one can always get it”.

The story of Sabirah
Sabirah reported only going once to the doctor during Corona because her toe got infected. She also suffers from kidney pain but is unable to go to the doctor because she does not have the financial means to cover her treatment. The woman said that when commuting to get treatment for her toe, she faced challenges because of her disability as well as the costs of transportation.

Since the start of Corona, Sabirah said she has always been wearing the mask, even though when she is around people and clients, they do not wear the mask; “the clients ask me to remove it, saying that there is no Corona” said Sabirah. She also mentioned that the FSWs have the masks “but they do not wear them, they say that there is no Corona. And they are right because there is no Corona, it is an exaggerating issue, it is just a flu, but I don’t know why people are exaggerating. I heard that people are dying from the vaccination…” Sabirah was never infected with Corona nor was anyone in the household she was living in. Moreover, she is not vaccinated nor are the people in her household.

Sabirah said that access to health care services became more difficult now, “if you don’t pay you don’t enter the hospital, you will die, and they will not treat you unless you pay”.

Sabirah also mentioned experiencing beatings by some of her clients. She saw a person who had beaten her the other day and warned her FSW friends about him. She said, “the women are strong and can fight with these kinds of men, but I can't because of my leg. There are cases where the clients steal my money, or sometimes when I perform sexual activity and then the man refuses to pay me because he does not ejaculate”.

Sabirah finds support from other FSWs. For example, she said she once fainted while walking with a FSW friend, because she had not eaten all day. The woman gave her food to eat after hearing that. Sabirah also finds support from some clients who are kind to her. She gave an example of one ‘well off client’ who would give her food and money for transportation.

Sabirah wants to save money to use for issuing a passport as she wants to travel abroad. She said that to do that she would need a civil registration extract, proof of residence, and a certification of criminal background. However, when issuing a certification of criminal background, Sabirah said, “if one committed a crime, the person would go to prison”.

Sabirah went to prison twice for sex work. “One of the clients I went with turned out to be an undercover policeman and this was before Corona” said Sabirah. Sabirah mentioned unjustly going to prison twice for the same offense, the first time for a month, and the second time for three months. After that Sabirah became scared of getting a certification of criminal background, fearing interrogation by the police, and finding out that she is a sex worker. Sabirah said that her mental health is deteriorated, “I’ve had enough of doing this work, I want to travel abroad to Turkey, they take care of people like me there, they give women a salary and shelter”.

To avoid getting caught by undercover police Sabirah only goes with people she knows. She once went into a car and the person started asking her many questions, so she got scared, and asked him to stop the car and went off. For her, it is more difficult to escape undercover police, compared to other FSWs, because “they run away but with me I cannot because of my leg”. Sabirah also recently heard that police are attacking FSWs with sticks. Sabirah said that to protect themselves from the police, “the FSW would perform sexual activities with him, and he will cover for her. And most of these people do not use condoms”. She heard of several cases where women contracted STIs, “these are usually gypsy women who stand in the streets, they will not spend money for it”. Sabira said that those women who get STIs do not even seek treatment.

Sabirah said that before Corona there were opportunities for women to work as cleaners. “But now because of Corona, this is not possible”.

As for the community centres, Sabirah described them as “places women could go to and meet other women and learn vocations, and even work as a cleaner. But now this is not possible because of corona’. Sabirah mentioned taking part in awareness sessions where they would inform FSWs of STIs and then distribute condoms. “But now because of Corona there are no more of these activities”. Sabirah only knows of such centres in Beirut.
Sabirah does not have family support. Her parents died and she is not close with her siblings. In fact, “her parents and siblings never treated her well”. Sabirah does not have friends either, except for the people she lives with.

She regularly gets tested for HIV at Dar al Amal, and always gets negative results. The location of the centre where she does the test is in Beirut, and it is far from her residence. Moreover, she does not know of any other places where she can do the HIV test. The last time she went there was around three months ago. She said she finds it hard to commute to the place, especially because of Corona, “the centre would be closed when I get there, and it is difficult for me to get there on time because of the difficulty of transportation”. She is thinking of going this week to do a test and said that she does not need to do an appointment and can just drop in to do it, which is convenient. “But there are no women there like before Corona”. Sabirah said that she would wait for five or ten minutes and then get her results. She found the test easy. “But if there is a place where I can go closer to me, that would be better for me”. Sabirah mentioned that the doctors in her area do not provide quality care, and that her financial situation does not even allow her to get medical treatment.

Recommendations

- Having cell crisis in the communities is an important mechanism to convey messages across the communities. Moreover, involving local communities, empowering them, and ensuring that they have ownership of interventions is important to make sure that services continue.

- Allocate resources for outreach activities during times of emergency to ensure that those who are most marginalised are reached. The role of peer educators is critical for this purpose. As important is the need to ensure that peer educators are protected and provided the needed resources and capacities to perform their roles and responsibilities during emergency situations.

- Interventions in Lebanon need to ensure that beneficiaries can be assisted in a tangible manner, because of the current extremely poor situation in the country and stand-alone awareness raising is not sufficient.

- With regards to donors, more support is needed from them to CSOs and for them to be more open to recurrent and long-term funding of organisations, rather than “starting with new CSOs from scratch”.

- On a policy level advocacy towards rethinking the policy against abortion and for it to be allowed during cases such as rape or when detrimental to the health of the mother and/or child.

- Advocate for the development of national policies and strategies that adopt comprehensive human rights approach to SRH.
3.2.4 MOROCCO

Introduction

Demographic Information

The total population of Morocco in 2020 reached 36,910,558 (18,316,887 were male and 18,593,671 or 50.375% are female. [221] The literacy rate for people aged 15 and above in Morocco is 74% (65% for adult females and 83% for males) of the same age group. Literacy rates for youth (15-24) males and females is much higher reaching 98% and 97% respectively. [222] Despite the improved fertility (2.346 births per women) and education rates over the past several years, only 22% of females aged 15 and above are economically active. [223]

HIV-Related Information

According to UNAIDS figures, HIV incidence per 1000 population (adults 15 – 49) is 0.02% in Morocco. Of the 22,000 adults and children living with HIV in the country, 9,300 are women aged 15 and above. The majority of HIV cases (65%) are in Souss Massa, Marrakech-Safi and Casablanca-Settat. Moreover, there are certain cities of Morocco that have higher rates of HIV, namely, Marrakech (5.7%), Casablanca (9%), Nador (13.2%), and Tetouan (7.1%). Moreover, in 2018, Morocco ranked 180th out of a sample of 189 countries in terms of female labour force participation (FLEP). [224]

The HIV prevalence rate of women aged 15 to 49 is <0.1, which is like the male ratio. As for newly infected HIV cases for adults aged 15 and above, it is <1000. In terms of gender ratios, newly infected HIV cases is <200 for women and <500 for men aged 15 and above. [225] According to a study conducted by the Ministry of Health in Morocco, 70% of women with HIV/AIDS have been infected by their husbands. [226]

Of the 22,000 people living with HIV, 18000 (81%) know of their HIV status; 17,000 (76%) are living with HIV and are on ART (83% women and 68% men); and 15000 (70%) are living with HIV and have viral loads. Late HIV diagnosis [with the initial CD4 cell count <200 cells/ mm3] is 48% (43% for adult females and 51% for adult males). As for late HIV diagnosis [with the initial CD4 cell count <350 cells/ mm3], it is 71% (68% for adult females and 72% for adult males). [227]

In Morocco, deaths due to AIDS among adults aged 15 and over is <500, with a female to male ratio of <200 and <500 respectively. The percentage change in new HIV infections and deaths since 2010 is -52 and -53 respectively and the prevalence and mortality ratios are 3.30 and 1.58 respectively. [228]

Regarding mother-to-child transmission data for Morocco, the coverage of pregnant women who receive ART for the PMTCT is 54%. More specifically, 228 pregnant women received ART for PMTCT and <500 pregnant women need ART for PMTCT. The final vertical transmission rate including during breastfeeding is 18 and new HIV infected averted due to PMTCT is <100, with 5500 HIV exposed children who are uninfected. [229]
As for key population figures in Morocco, the table below provides an overview of the population size estimates of sex workers, men who have sex with men, people who inject drugs, and prisoners (See table 4). The table indicates that commercial sex workers are the largest of all KPs in Morocco, which includes around 85,000 FSWs and 850,000 clients based on figures from 2013.

<table>
<thead>
<tr>
<th>Key population</th>
<th>Population size estimates (No.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex workers</td>
<td>72000</td>
</tr>
<tr>
<td>Men who have sex with men</td>
<td>42000</td>
</tr>
<tr>
<td>People who inject drugs</td>
<td>1200</td>
</tr>
<tr>
<td>Prisoners</td>
<td>85000</td>
</tr>
</tbody>
</table>

HIV prevalence among sex workers is 1.7% and the HIV testing and status awareness of this KP is 44.4%. Around 61% of sex workers use condoms in Morocco, and coverage of HIV prevention programmes in the country is 54.9%. In the case of MSMS, HIV prevalence rate is 4.9%, and HIV testing, and status awareness is 54.9%. Moreover, 57.7% of MSMS use condom and 6% have active syphilis. As for the coverage of HIV prevention programmes, it is 53.3%. As for people who inject drugs, HIV prevalence among this KP is 7.1%, and HIV-testing and status awareness is 36.1%. Condom usage among PIDs is 44.6% and safe injecting practices is 92.1%. The coverage of HIV programmes in Morocco is 45.4%. Moreover, 100 needles and syringes are distributed per person who injects drugs, and coverage of opioid substitution therapy is 33.4%. As for HIV prevalence among prisoners, it is 0.4% and 157 prisoners receive opioid substitution therapy. Furthermore, 631 people receive pre-exposure prophylaxis (PrEP). [230]

Stigma and discrimination are key factors that disable the ability of KPs to access health services. In fact, in Morocco, 23.4% of sex workers, 7.6% of MSMS, and 29.9% of PIDs avoid health care because of stigma and discrimination. [231]

In the case of data on gender and HIV related issues, the prevalence of recent intimate partner violence among women aged 15-49 is 22.2%. This data disaggregated by age groups is not available. 22.22% of young people aged 15-24 know about HIV preventions, and the knowledge among women is less than men, reaching 19.82% and 24.66% respectively. [232]

### Situation of SRHR Services Prior to the COVID-19 Pandemic

#### Situation of SRHR Services and Needs Related to WiTD

In Morocco, national policies concerned with reproductive and maternal health have gone through several enhancements. For example, safe motherhood and family planning units were established in primary health care (PHCs) facilities in the 1980s, and emphasis was placed on the rights of people to access reproductive maternal health (RMH) since the 1990s. The table below shows a list of essential sexual and reproductive health services offered at PHCs in Morocco. [233]

#### Table 5: Essential sexual and reproductive health services offered at PHCs

<table>
<thead>
<tr>
<th>Service</th>
<th>Morocco</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family planning</td>
<td>X</td>
</tr>
<tr>
<td>Antenatal care</td>
<td>X</td>
</tr>
<tr>
<td>Labour and delivery</td>
<td>X</td>
</tr>
<tr>
<td>Postnatal care</td>
<td>X</td>
</tr>
<tr>
<td>New-born and child health</td>
<td>X</td>
</tr>
<tr>
<td>Prevention of unsafe abortion and post abortion care</td>
<td>X</td>
</tr>
<tr>
<td>Emergency contraception</td>
<td>X</td>
</tr>
<tr>
<td>STI/RTI screening, diagnosis and treatment</td>
<td></td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>X</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>X</td>
</tr>
<tr>
<td>Prevention and management of GBV</td>
<td></td>
</tr>
</tbody>
</table>

While SRHR services are generally available to a significant number of women and are accessible to them, services are not comprehensive. There is a high level of inequities in access to services by geographic area and socioeconomic groups. During an interview with a KI, the interviewee highlighted that the availability of psychological services is very limited in Morocco, due to limited geographic coverage, as well as the high costs of consultations. Meanwhile, another focal point mentioned significant improvements in coverage of SRHR services in the country and referred to a network of health care facilities established, which included PHCs, hospitals and private clinics in rural and urban areas of the country to improve people’s access to the needed medical and emergency care (FP1, Morocco).

In the case of family planning and safe motherhood, interventions were implemented that focused on prioritising this issue between 2000 and 2007, and a national health action plan was developed between 2008 and 2012 that involved all departments of the Ministry of Health (MoH). The action plan emphasised reproductive and maternal health (RMH) packages and delivery of RMH services. This included the development of the national reproductive health strategy in 2011, which emphasised the importance of rights to and integration of RH components. A national health strategy that emphasised SRH and universal health coverage was first developed between 2008 and 2012 and later accelerated between 2012 and 2016. Moreover, in 2018 the strategy emphasised a continuum of SRH care and UHC through 2025. The National Health Plan 2025 also aims to address fragmentation and non-convergence of SRH programmes within the health benefits package (HBP). Maternal health was included in this plan as a national priority, as well as its integration with the SRH package. Efforts focus on harmonising Morocco’s political and technical plans, re-consolidating joint partnership activities, and encouraging civil society organisations and the community engagement to enhance the health and well-being of women in Morocco. [234]

A study conducted on SRHR services in the MENA region highlighted that measures to address new-born and maternal mortality in Morocco included expanding coverage of comprehensive prenatal, obstetric, postpartum and new-born care, as well as access to effective contraception, and recruitment or training of skilled birth attendants. As for measures applied with regards to the SRHR of adolescents in Morocco, these included raising the minimum age of marriage, expanding girls’ secondary school enrolment or retention, providing school-based sexuality education.

SRH figures show that there are 72.6 maternal deaths per 100,000 live births in Morocco, with the main causes of maternal death being haemorrhage (33%), hypertensive disorders (18%), infection (8%) and uterine rupture (7%). The most common causes of death during pregnancy are fistula, reproductive tract infections and infertility. While there has been a decrease in maternal mortality rates by over 30% in the past five years, 73% of maternal deaths could have been prevented. [235] In a report published by the UNFPA, findings showed that the first sexual intercourse for boys is 16.5 and for girls it is 17.8. Young girls and boys are more likely to practice several risky behaviours because they do not have sufficient information about SRH services. In Morocco, around 7.9% of girls aged 15 to 24 who have had sex have had unwanted pregnancies and 60% of young boys engage with sex workers with 25% of them never using condoms. The consequences of young people’s poor sexual education and lack of access to reproductive health services are more serious with existing gender inequalities, which allow for gender-based violence to persist and prevent women and girls from claiming their SRH rights. [236] As for figures on violence against women, a study conducted by the Moroccan Family Planning Association and the Asian Pacific Resource and Research Centre for Women highlighted that 62.8% women in Morocco aged 18 to 64 were victims of some type of violence and 48% of women of the same age group were victims of psychological abuse during the period of the study. [237] Another study highlighted that 22.6% of women in Morocco have experienced sexual violence, and the rates are double in urban areas of the country compared to those in rural locations. [238] Moreover, the study also highlighted that women and girls face challenges to accessing quality and dignified SRH care services. [239]

Furthermore, no less than 10 percent of women never marry in Morocco and more than 50% of married women use modern methods of contraceptives. As for figures relevant to early marriage, in 2019, Moroccan courts approved 25,920 child marriages and 98% of these requests come from rural areas of the country. Although the legal age of marriage is 18 years, the Family Code law still accepts marriage of minors with the consent of the judge. [240] Abortion is also illegal under the Moroccan Penal Code -unless it is done to save the life of the woman or preserve physical health-, and it is estimated that there are 130,000 to 150,000 illegal abortions carried out each year in the country. [241]

Over the past ten years, the Ministry of Health has shown great interest in improving access to contraceptives, particularly among poorer segments of the female population who are in rural areas of the country. [242] Although condoms are the most used contraceptives by WLHIV and are promoted by health care providers, there is a general lack of awareness of safer sex practices and inconsistent usage of condoms during sexual interaction. Moreover, 10% of women have unmet family planning needs. [243] Barriers to contraception usage during sex are associated to social, cultural and structural factors. For example, the dominant role that men play within relationships prevented WLHIV from using condoms. Other factors include inability to purchase condoms, lack of awareness on the efficacy of contraceptives and the fear of disclosing one’s HIV status. [244]

Findings of a study conducted on 72 WLHIV in Morocco highlighted that up to 50% of WLHIV sampled preferred sexual abstinence and up to 25% felt a decrease in sexual desire. Moreover, there was an increase in sexual disorders among the WLHIV, from 7% and 69% among pre and post HIV diagnosis. The WLHIV believed that the painful intercourse they experienced was due to the “antiretroviral therapy, experience of sexual violence, denial of their HIV diagnosis by self and others, and fear of becoming pregnant”. [245]

In the case of maternal health, health care usage is low in Morocco and even lower after childbirth. Moreover, finding of a study conducted on SRH services in the MENA region showed that 50% of women who did not seek antenatal care when pregnant, did so because they did not have a complaint. The generally low rate of antenatal care is partly linked to pregnant women’s poor awareness of the importance of medical care. Antenatal visits are important because they allow for screenings to take place for sexually transmitted infections, and treatment of pregnancy related illnesses such as (pregnancy induced hypertension). Antenatal visits also provide an opportunity for women to be educated about health diets as well as being given supplements to avoid nutrient deficiencies. Postnatal care is even lower than antenatal care in Morocco. It is important because it allows for the identification and treatment of childbirth-related injuries and illnesses, promoting breastfeeding and raising awareness to couples on family planning issues and spacing of births.

Moreover, skilled attendance at childbirth in urban areas is 85%, whereas in rural parts of the country it is 40%. As for abortion, which is prohibited in Morocco, post abortion care is offered as part of government health care services. In the case of STIs, very few studies are carried out on this topic and the little data available indicates that the prevalence of STIs in the country is greater than expected. In Morocco, it is estimated that 600,000 STIs occur annually. [246]

According to a study conducted on SRHR, Morocco was reported to have the most advanced sexual health programmes in the region as well as the most organised HIV surveillance system. [247] The HIV-related services available in the country include VCT centres with broad national coverage; mobile testing centres for HIV; HIV/STI surveillance system; and mandatory HIV testing for military recruiting.

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As for interviews with KIs, there were mixed reports on views regarding the level of prioritisation of SRH at a national level in Morocco. Although a KI described SRHR as a national priority, she believed that “the availability and affordability of these services at the national level is not enough, and nor do they cover the needs of the whole population” (FP2, Morocco). Meanwhile, another KI believed that the national politics in the country does not consider the issue of SRH as important as other health domains, however “there are efforts, improvements and enhancement in terms of service provision”. The interviewee believed that a key issue is that SRHR service provision is standardised and dependent on the donor priorities. The KI went on to explain, “yes there is a tremendous improvement in terms of women living with HIV but there is a need to study more the situation of these women” (KII, Morocco). Another KI mentioned that all partners working to support PLHIV are providing a minimum package of sexual and reproductive services (KII, Morocco).

Challenges to Accessing SRHR Services for WiTD

**Legal Barriers**

In terms of challenges to accessing SRHR services, the biggest challenge for key populations such as female sex workers and women who inject drugs has to do with legal issues and the penalisation of these KPs. These laws foster a climate of violence against KPs and put them at greater risk of vulnerability. More specifically these laws relate to: [248]

- Sex-work which is not punishable as such, however, soliciting may result in one month to one year of imprisonment, in addition to a fine of $21,000 USD. [249]
- Drug use of any kind is punishable by 12 months of imprisonment. In addition, the law and legal practice also allows criminal charges to be imposed on persons carrying any amount of drug no matter what the quantity or purpose. There are cases when the judge proposes therapeutic injunction rather than severe punishment, however, this is not usually the case, most likely due to the lack of knowledge on drug detoxification available in Morocco.

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Social Barriers

Like many Arab countries, SRH services are considered to be services for married women for religious reasons. Hence, accessing these services is more difficult for those who are under 18 or not married and they are excluded from health care. In addition to facing such challenges, stigma and discrimination of key populations such as transgender women, female sex workers, female drug users and women living with HIV also challenges and discourages women belonging to KP groups from accessing SRH services. According to a baseline study conducted by Frontline AIDS in 2019, stigma and discrimination in the streets by public servants and healthcare workers, and particularly with law enforcement discourages KPs such as transgender women from accessing health care services. [250]

During an interview with a KI, the interviewee explained that barriers to SRHR services are related to a combination of factors including the availability of resources, cultural issues, and the existing health system. The KI said that “women in Morocco still face discrimination and stigmatisation when accessing health services, despite all partners’ efforts in responding to this issue. In addition, there is a lack of health services in many areas of the country” (KI1, Morocco). Moreover, women’s sexual life is still considered taboo in many areas in the country. Cultural traditions and norms stigmatise women in their diversity; “women are not allowed to speak about HIV in Morocco, the cultural improvement is still low at this point” explained the KI (KI1, Morocco).

Another FP believed that young women and adolescent girls are particularly vulnerable when it comes to accessing SRHR. In addition to the taboo associated with SRHR for this particular age group, there is also the issue of confidentiality that is lacking when they are provided these services. On this point the FP elaborated saying “they are not allowed to speak and to express their needs and their privacy is not respected. They cannot attend any doctor's appointment or have the HIV test without their parents or caregivers” (FP2, Morocco). Indeed, the law does not allow medical treatment (including HIV testing) of minors, without a parent or guardian. [251,252], Moreover, the issue of family honour can place the life of young women and adolescent girls at risk if their parents find out that they are infected with sexually transmitted infections.

Violence Against KPs

Findings of the baseline study [253] also indicated that KPs – and particularly transgender women - were exposed to violence and threats from law enforcement officers as well as the general public. During a FGD with FSWs in Morocco, which was carried out as part of the Frontline AIDS baseline study, the FSW reported experiencing sexual violence with clients, mentioning the following as barriers to accessing HIV services:

- Stigma from police officers and healthcare providers, particularly for transgender people
- Criminalisation of homosexuality
- Violence and threats of violence from customers, people in the streets
- Sex customers refusing to pay; intimidating instead or threatening with violence
- Sexual abuses from the police; police officers asking for free sex in exchange of not being arrested
- When arrested, raping in police stations by police officers.

The criminalisation of sex work makes it difficult for female sex workers to report cases of violence (from clients and the public). Moreover, the FGD findings highlighted that KPs exposure to violence with negative health outcomes such as HIV/AIDS and STIs and self-stigma and psychological trauma. [254]
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Lack of Socio-economic Opportunities
Findings of the Baseline study also highlighted that the lack of job opportunities or income-generating activities was a main challenge for KPs to access HIV treatment, prevention and retain in care. Because of the difficulty of securing livelihoods, KPs are likely to resort to transactional sex to secure a living, and their power to negotiate condom use is limited which can increase their risk of exposure to HIV and other STIs. Commercial sex work is also a criminal offence in Morocco, which in turn places them at greater risk to being exposed to violence and penalisation.

Challenges in accessing income can also affect KPs access to healthcare services. Gender discrimination enforced by patriarchal norms further challenges women KPs from accessing health services. For example, factors such as restricted mobility, their reproductive role, and the barriers to financial independence are all factors that make it more difficult for them to access health services.

Gender Discrimination
In Morocco, Article 19 of the 2011 Constitution proclames gender equality and willingness of the state to protect it; however, the criminal code (article 290 of the criminal code) states that sexual relations outside marriage is punishable to a year in prison. Moreover, the NSP to fight HIV/AIDS 2017–2021 does not stipulate those services should be tailored according to the particular needs of WIDs. According to findings of the Frontline AIDS baseline study, KIs described this as a “double discrimination that women KPs faced when receiving services”. The report mentioned the lack of waiting rooms for women with children at centres and clinics for PWID as an example to highlight this. Discussions with KIs also reported that the conservative and religious environment in Morocco reinforced patriarchal conceptions on sexual relations and gender roles, as well as ‘unwritten laws’ that, for example, refused a sexual life for women out of marriage, which in turn further consolidates the stigma towards KPs, particularly SWs.

Service Delivery Barriers
According to findings of a bio-behavioural study targeting female SWs in 2016 in Agadir, Marrakech, Casablanca, Rabat, Fez and Tanger, the presence of syphilis was higher (13.3%-21.4%) compared to HIV (average prevalence of 1.3%) in all the cities. Moreover, in the case of PWID, viral Hepatitis C (VHC) is more prevalent - 45.4% in Tetouan, 71.9% in Nador and 74.5% in Tanger - than HIV (8% average prevalence in the mentioned localities). [255]

KIs interviewed in the Frontline baseline study highlighted a lack of awareness of STIs among KPs. Moreover, routine screening for STIs is not carried out for PLHIV and KPs. ALCS-run centres conduct regular tests on HIV and STIs, as well as colposcopy. However, they are not considered as HIV or KP related services, so they are not provided in ART areas in government-run clinics.

Stakeholders Involved

In Morocco, the main sectors of the country's health care system are the public, private non-profit and the private for-profit sectors. The public sector comprises of a network of health care facilities that include PHCs, a hospital network (HN), an integrated network of medical emergency care and a network of medical social institutions. Health care provision and outreach was improved through the country's investment in broadening the number of PHC services in both urban and rural areas of the country, including medical offices, pharmacies, dental clinics hospitals and private clinics, in addition to tertiary university teaching hospitals. [256]

The MoH has been successful in strengthening primary and secondary health care services by providing SRH care coverage along the continuum of care, and by targeting preventable maternal and child deaths. All these health interventions have led to a reduction in the maternal mortality ratio (MMR) by 35% between 2010 and 2016, falling from 112 to 72.6 per 100 000 live births. [257] In 2018, the neonatal mortality rate was 13.58 per thousand live births; the rate of contraceptive use was 70.8%; the rate of antenatal health care coverage was 88.5%; and 86.6% of births were attended by skilled health personnel.

Another organisation known as ARROW works with the Morocco Family Planning Association to better understand effects of religious fundamentalism in challenging the achievement of universal access to SRHR. Their work focuses on researching abortion practices and the influence of religion on the availability of safe abortion services in Morocco. [258]

As for stakeholders involved in HIV interventions in Morocco, there are different components within the MoH that manage reproductive health and HIV programming. The MoH has partnered with several organisations such as UNICEF, GFATM, UNFPA, UNAIDS and WHO to implement SRH and HIV programmes, with each partnership having specific priority areas. For example, UNAIDS focuses on technical support, UNFPA on the development of RH policy and GBV interventions and UNICEF on paediatric HIV and PMTCT. [259]

Describing the partners that are working with WiTD in Morocco, a key informant (KI) explained that a diverse network of operational local and international organisations and institutions exist. At the institutional / government services and departments there are:

- The Ministry of Public Health
- Women and children's health management cells
- National human rights organisations focusing on women’s and minorities' rights
- Units at the level of courts that receive and accompanies women.

In addition to the other organisations working with people living with HIV, there are also women's associations. A KI reported that “major actors and players are supporting women globally and large civil society movements exist in Morocco” (KI1, Morocco).

Meanwhile, during discussions with a WiTD, she highlighted the important role that civil societies play in support to WiTD, including WLHIV. She said,

“They accompany, refer, listen, and support women in many sectors. For me, the role of civil society is very important, as we see, the government is not able to be involved in all domains and support women in all sectors” (WiTD, Morocco).

[259] https://www.who.int/reproductivehealth/topics/linkages/RASmorocco.pdf?ua=1
Another FP reported that non-governmental organisations and medical centres specialised in sexual and reproductive issues are the principal parties providing SRHR services to women. However, the KI believed that there is a need to raise the awareness of staff at medical centres so that they do not stigmatise and discriminate against WLHIV, and that this should be the role of NGOs. Moreover, the KI reported that the MoH is focusing on strengthening health care services in Morocco by increasing SRHR care coverage for women in Morocco and ensuring structured involvement from different stakeholders including national security agencies, the Human Rights Council, and national and international organisations.

**Referral Systems and Coordination**

In Morocco, ART can be accessed through 8 service points distributed throughout the country. Two are at the university hospitals and six in the regional hospitals. There are plans to create greater service points to increase access to ART among PLHIV. [260]

Action plans are also developed between the MoH and its partners to implement HIV related interventions, which can create challenges regarding coordination between the different stakeholders. However, addressing such coordination challenges may be achieved through the integration of partner interventions into the overall MoH plan. The GFATM projects support such integration, such as through the PMTCT expansion, the universal precaution interventions, integrated RH and HIV for school health clubs and support provided to NGOs. [261]

In the case of SRH, reproductive health programmes targeting adolescents are the responsibility of population and health education sector. Population education was established in Morocco after the 1974 International Conference on Population and Development (ICPD) in Bucharest and the set-up of the population education coordinating body made up of the Moroccan Family Planning Association (AMPF) and the ministries of the Interior; Public Health; Employment and Social Affairs; Education; and Youth and Sports. In addition, a national school health program has been developed by the Ministry of Public Health which aims to provide basic health services to students. The Ministry of Youth and Sports also implements sexual health education program through summer camps, sports clubs, youth centres in poorer neighbourhoods and vocational training centres, as well as homes for delinquent youth. The program focuses on STIs and disease prevention among other issues. The Ministry of Youth and Sports also provides RH sessions to adolescents in their homes. [262]

In fact, Morocco was the first country in the MENA region to integrate population education into its national high school science curriculum. The MoE implements this curriculum, which talks about human reproduction, contraception and STIs. Various outreach and advocacy activities are also carried out by the Ministry of Public Health that have to do with reproductive health, these included activities by the UNFPA, AMPF, ALCS and INSAF, which target WLHIV. [263]

[261] https://www.who.int/reproductivehealth/topics/linkages/RASmorocco.pdf?ua=1
Situation of SRHR Services During the COVID-19 Pandemic

Effects of COVID-19 on Access to Services
The effects of the COVID-19 Pandemic on access to services was reported during various discussions with WiTD and key informants. For example, a FP working at ALCS reported that the lockdown, movement restrictions, and the implementation of curfews undoubtedly impeded patients’ access to HIV services, in fact “many patients faced delays in their medical treatment for up to… 12 months” (FP1, Morocco). The FP also mentioned that as well as the delays in care, “some WLHIV avoided going for medical care because they feared getting infected with COVID-19” (FP1, Morocco). Furthermore, the increased economic difficulties faced during COVID-19 made it difficult for KPs and particularly women to access services.

The FP also highlighted the impact of COVID-19 on the available funding for organisations working to support KPs in addressing their health needs. External funding decreased and the interests of donors focused more on COVID-19. ALCS, however, did not face major challenges in terms of financial and technical capacities during the pandemic. In fact, the FP reported that more resources were mobilised during Pandemic and activities introduced to address the changing needs of KPs. “We were the only organisation in Morocco that provided thousands of food parcels and medications to respond to the basic needs of the population” explained the FP. However, there were cases where staff became infected with COVID-19.

The FP also mentioned that activities were reduced at the start of the Pandemic due to aspects such as the national lockdown and social distance regulations. The FP explained that ALCS worked in limited attendance in sessions between 10-15 women, “while before the pandemic the number reached 40 women per session” (FP1, Morocco). ALCS clinics were also opened with a very limited number of patients received, and “only positive cases with an emergency issue were able to access the clinic for a consultation with a prior appointment”. The FP believed that the economic challenges that arose due to COVID-19 had a greater impact on KPs than issues related to their health and rights. The FP also mentioned that ALCS team continued to work during the Pandemic, and new team members were recruited to support KPs in the new context, however, there were cases where team members became infected.

ALCS also adapted to the current context by using new technologies to respond to the situation. Activities were carried out remotely during COVID-19, and information was provided to beneficiaries by phone. A hotline was also set up to receive patients’ requests and the organisation’s medical teams were distributed between hospitals to follow up on the patients’ files, especially new cases that tested positive. “Cases were provided with necessary preventive information, testing and support so that they can be familiar with the whole process” explained an FP (FP1, Morocco). ALCS also experienced a shortage of stock in lubricants, and cases in need of condoms were referred to the nearest medical clinics. Hospitals were also closed during the initial stages of the Pandemic. Nevertheless, “ALCS team contacted new positive HIV cases on a daily basis to explain and follow up on their treatment plan from A to Z” (FP2, Morocco). Other effects mentioned by KIs included the rise of domestic violence towards women and KPs as well as the increased restrictions on women’s movement. On this point a FP explained that the COVID-19 outbreak has put women and girls at risk of domestic violence and patrimonial abuse.

However, with the roll out of vaccinations in Morocco, the FP explained that movement became more possible. In fact, ALCS worked closely and in direct partnership with the MoH and other organisations in the country to provide WLHIV with the necessary treatment and information.

Another KI working at Global Fund believed that the Pandemic affected the already limited services available to KPs. The KI highlighted the importance of maintaining communication with KPs during the Pandemic because they are amongst the most vulnerable in a population and they are likely to be most affected. Moreover, the KI believed that in the case of women, “whenever there is deterioration in the social and economic situation, they are the first key populations that got affected” (KI2, Morocco). The KI believed that programs implemented by Global Fund did not target the primary needs of women who came about during the pandemic. A clear strategy was lacking on how to ensure women’s economic
independence during the pandemic, as many lost their jobs or were unable to work during the lockdown. Moreover, the KI reported that women were at greater risk to exploitation and violence during the Pandemic and safe places should be available and sustainable rather than relying on donor’s to be maintained. The KI emphasised the need to strategize for similar situations that may arise in the future and document learnings (KI2, Morocco).

Meanwhile, during discussions with a WiTD, the interviewee highlighted that while the services were still available, accessibility and quality of services deteriorated. She said, “with the pandemic, consultations were not available, visiting doctors and organisations was not easy and activities were limited” (WiTD, Morocco).

Referrals and Coordination
The majority of interviewees reported that COVID-19 pandemic affected coordination between partners. During discussions with a FP, the interviewee reported large scale coordination between the different partners was imperative during the pandemic “as most of the services were closed and beneficiaries were not able to access them” (FP2, Morocco).

One KI mentioned that each organisation had a specific role to respond to the COVID-19 crisis, however, some were forced to “close down their activities because they were not able to mobilise resources” (KI1, Morocco). Another KI believed coordination between organisations working to support women’s SRHR needs during the Pandemic was poor, and that duplication of activities existed (KI2, Morocco). Meanwhile, an FP reported that coordination increased during the COVID-19, which was necessary and cases at risk were prioritised. “All partners worked together to improve responsiveness, performance and to create a positive impact” explained an FP (FP1, Morocco).

Another KI highlighted the importance of partners at the regional level to collaborate together and discuss how to reduce the burden of the Pandemic on the region, and for each partner to focus on their specific sectors (KI2, Morocco). Another KI also mentioned that ALCS developed a services mapping of associations and service providers working on HIV, which also includes partners working on SRHR. The purpose of this mapping is to identify services provided by the different providers and in the different regions for beneficiaries to refer to. The KI believed that while some partners are active and responsive, others are less so.

During an interview with a KI at ALCS, the interviewee reported that a referral system exists between partners. This system was described as participatory, “where all partners coordinate together to increase the effectiveness of the services provided and to support solutions to the existing gaps”. Elaborating on this point, the KI explained, “if ALCS cannot deliver the service to the patient or some of these services are not available, ALCS refers the patient to other service providers, track, follow up and monitor the referral to make sure that the patient receives the requested service”. The KI also mentioned that coordination meetings take place almost every month between many sectors and organisations to maintain strong communication lines between partners especially during the remote work that took place during the COVID-19 pandemic.

Common Practices During the COVID-19 Pandemic
During a discussion with an FP, the interviewee explained that the main modality used to support women to access SRH services was by visiting them at their workplace and raising their awareness on ways to protect themselves from STIs and access HIV care and treatment. These visits also helped them identify their needs and any sexual problems that they might have. The FP explained that “usually, during these check-up visits, the team provides awareness sessions and preventive measures with the detection of positive cases to be referred to the appropriate treatment” (FP2 Morocco). However, such practices changed during the COVID-19 pandemic, and check-up visits as well as visits from women to the centres dropped.
Another FP described the common practices of women to access SRHR services as follows:
• Attending check-up and follow-up appointments for STIs and HIV cases.
• Attending awareness sessions on SRHR issues including gender-based violence and sexual and reproductive health and rights
• Practicing proper hygiene and safe methods when it comes to sexual activities
• Practicing safe pregnancy and delivery for women who are living with HIV
• Receiving maternal and child services.

The FP at ALCS reported that these practices did not change during the pandemic and ALCS centres were open to receive urgent cases. A team was also allocated to call beneficiaries and follow up closely with them. Meanwhile, hospitals were only opened for urgent cases.

During an interview with a WiTD, the interviewee explained that "Like many women, I have a yearly test for pap smear. Women living with HIV should have this test every year, in addition to using contraceptives and taking vitamins, as well as receiving regular information on practices to ensure a safe sexual relationship" (WiTD, F1, Morocco). The interviewee said that practices changed during the pandemic and accessing testing and even consultations was not possible. The interviewee also highlighted facing an issue with stock in vitamins. Another WiTD interviewed said that she took care of her sexual health by “respecting her doctor’s appointments, taking all the necessary medication and vitamins”. In general, the WiTD interviewed did only visit clinics when they had problems or needed to be tested. Moreover, visiting private clinics was a challenge for them due to high costs of consultations. During the pandemic, closure of pharmacies and hospitals, increased financial difficulties faced by many, and fear of getting Coronavirus, further discouraged them to attend to their SRHR needs.

Factors that Enabled WiTD to Maintain Healthy SRHR Practices During COVID-19
During discussions with an FP, the interviewee believed that free of charge service provision was a key factor that enabled WiTD to maintain healthy SRHR practices during COVID-19. The awareness raising and continued follow-up provided by organisations to ensure that the needs of KPs were addressed was also a key factor that ensure they were able to maintain healthy SRHR practices during COVID.
Rose is a Moroccan woman living in Casablanca. After completing her secondary schooling (Thanawi), Rose was involved in an arranged marriage by her parents at the age of 17. Her father decided to marry her off because she got along better with male friends than females; “I found the character of boys better than girls, so my father thought it was better for me to get married”. This was the first of Rose's three marriages. She chose to leave previous husbands because, “I was not willing to accept issues that would degrade women”.

Rose's first marriage took place when she was 17 years old and her husband was 28; she said, “he was working in information engineering, and I saw him as an old person because I was much younger than him”. One day Rose and her husband went out to a café, and one of her male friends from school came up to her while they were seated to say hello to her. The husband got jealous, and they divorced after three months of marriage. She said, “When I divorced him, the paper said divorce before intercourse”. So, she was still a virgin, which was an important issue for her and her family that improves her prospects of potential future marriage.

Her second marriage took place shortly after her divorce, when she was 17 years and a few months. Rose was introduced to another young 23-year-old man who was a friend of her friend. Rose said, “in times when a woman is divorced, she needs care and someone to be nice to her, and I found this in him”. They dated for two months, and one day, he convinced her to go on a trip with him and her friends, during which, he gave her a pill to take. Rose did not know what the pill was, and just remembered waking up the next day after taking it, and “my lower part was all blood… when I wanted to stand up my legs were heavy and I didn't know what happened”. Her boyfriend was very happy that she was a virgin and promised to ask for her hand from her father.

However, her friend who had gone with her sent her father a message informing him that his daughter is no longer a virgin. Receiving the message, her father asked her to return home, and go with her mother to do a virginity test. Rose informed her mother of everything that happened on the way. When her parents found out, she said “my father didn't tell me to leave the house, but I didn't want to see ‘his look towards me’; the shame I felt on that day is indescribable”.

Rose decided to leave her family’s house saying, “this was the worst day of my life, because when you leave the house, be sure that you leave to the wolves, and everyone wants to take from you!”. When she left, she rang her boyfriend who refused to speak to her and blocked her number. At this shock, Rose said “I decided to do things I never did, like smoking, and other things”. She stayed homeless for six months until her father asked her to return home.

Returning to her family, she decided to veil herself and turn to religion. Rose was later approached by another man for marriage. Her father informed her that she needs to let him know about her virginity status prior to their marriage. Rose informed him, and the man accepted to marry her saying “if you want someone, conceal their sins”. They married for a year, however, a while after their marriage, Rose said, “he started cursing and blaming her for the things that happened to her”. Rose divorced him a year later and went back to her family.

Rose later met Turkish man on Facebook, and decided to marry him because, she said “in my family, they find a divorced woman as something shameful, so I just wanted to leave”. She travelled to Turkey to live with him and found out that he had two daughters who were as old as her. She could not cope with her husband's daughters and left him after a year and a half.

When she came back to her family in Morocco, Rose decided to remove her veil and return to smoking and taking drugs because “I was devastated”. She got addicted to cocaine “until I almost saw death”. Rose got into a relationship with a man who was also addicted to drugs and got pregnant from him. Rose said, “I didn’t know until I was three months pregnant. At three months the doctor said you cannot get an abortion. So I told my parents. During that time, I had to do tests, and that was when I found out I was HIV+.”
To this day, Rose claims that she does not know how she contracted the disease; “I don’t know exactly how I got the virus, if it is from sexual intercourse, or from the cocaine, because when we took it there was a lot of blood, and we were not careful”. Rose had never heard about the virus before contracting it. The man who had impregnated her did not contact her and his mother refused to let her see him.

When Rose did the blood test to see if she was pregnant, she found out about her HIV status. Rose said that the doctor informed her about her HIV status, and consoled her, encouraging her to look at it as any other chronic disease. She told her to begin her medication and “hopefully things will be fine”.

“When I first found out it was a huge shock for me” said Rose, “but I read about it, and my family were very supportive towards me. It was also a shock for them at first, and then they said thank God that you are okay”. So, Rose took the medication regularly and then did another test after six months. From the day I found out about my illness, I started praying and became closer to God and sought help from my family so that the illness would not get over me” she said.

Rose did not let her illness destroy her morale and would read up on the internet about it to “see if there are any new medications”. She also attended awareness sessions and appreciated that the facilitators would talk about the illness in a positive manner without looking at it as a deadly and grave matter.

She said that when she heard about the experiences of others, she realised that she was in a better off situation than many. Rose mentioned that she is part of a WhatsApp group for PLHIV. One 20-year-old girl said that she contracted HIV from her boyfriend, and did not tell her family about it, she even must hide the medication from them and “suffers in silence”.

Rose's daughter is 1.5 years old and her first test for HIV was negative. She did the second test and is waiting for the results.

Rose emphasised on the importance of having a supportive family to help her go through her illness.

During Corona, Rose said that she continued following up with her doctor and taking the medication. She said that there were three months of lockdown, but after that the lockdown lessened, and Rose claimed that “Corona only affected me a bit”. Rose said, “I heard that when a person’s immunity is weak, they are at greater risk of getting Corona, so I avoided going out completely. I took the two vaccines”. Moreover, when she went to get her medication, NAP would give her enough stock for 7-8 months, “and this was really good” she said. Whenever she felt tired, she would call her doctor, and the doctor would consult her. The doctor also gave her an appointment to do blood tests every six months.
Rose said that during Corona, the hospital she usually went to for her HIV treatment and care closed for a bit. She said, “I rang my doctor one day and wanted to go to the hospital, but the doctor told me the hospital is now specifically for Corona cases, and that I have to get medication from another hospital that was farther away from where I lived”. Rose always wore the mask when she went out and said that she would purchase them from the pharmacy. “Initially, when corona started, the masks were expensive, but later on their price became normal,” said Rose.

Rose delivered during COVID. Recounting her experience, she said that at the day of her delivery she had a bad experience. She said, “when I gave the hospital my papers, when they saw I had HIV, they started talking about me in a bad way, but the problem is they are not even doctors, they are nurses”. Rose's water broke at the hospital, and her pants became wet, but she said, “I was not in pain, but at the hospitals like these you have to look like you are in pain to deliver”. One of the nurses told her to go home because she said she was not ready for the delivery. The nurse was rude to her because she had the virus and told her ‘Go look for the guy who impregnated you’. So, she left the hospital crying. Rose went home and the next day she was in severe pain. When she went to the hospital, the doctor said that she was supposed to give birth yesterday.

Rose stayed in the hospital for three days and said that the nurses took care of her. She said the doctor gave her daughter a serum during delivery “and after that he told me that my daughter must take the serum for three years and a half on a daily basis”. Although, initially, Rose was supposed to have a natural delivery, because of the complications she experienced, she had a caesarean instead.

Rose said that the hospital remained open during Corona, “it has a zone specifically for PLHIV, it is the hospital that is far from her residence”. She said that government hospitals are always open. In Morocco, this is the only hospital where people with HIV come to get the medication, so it is always full,” said Rose.

When asked about organisations supporting PLHIV, Rose said that ALCS is the main entity that provides this and that she does not know of any others. “At first I didn’t know about ALCS. I would go to my doctor and by chance the FP was there, then we started talking and she asked me to visit the centre”. Rose was happy with the centre's services, however, “this year, there is nothing at all and there was no communication with PLHIV”. Rose said that during the peak period of Corona, “ALCS would call us, but now no one is calling at all, and during the Eid they would distribute financial aid to single mothers, but … the support stopped after corona”. Rose believed that ALCS was very useful because she received financial support from them and felt that this reduced the burden that she placed on her family, “I was very grateful for this”.

Rose mentioned, that the thing that bothered her during Corona, was that she could not go to the hospital she usually goes to for treatment, because “it became for Corona only, and if you go to the other hospital, you go in the morning and come back in the evening. It’s far and there is a lot of people there”. Two months ago however, her doctor rang her and told her that she could go and do her tests at the hospital close to her.

Rose was happy with her doctor, claiming that she had initially seen her as a friend, “because she is young, and I told her all my secrets and when I spoke to her she is not the type of person that would get shocked at things”.

Rose believed that in emergency situations like Corona, it would be useful to have a call centre that would deal with all the issues of PLHIV, and to give them consultation on phone on what to do. She also suggested that PLHIV be provided a stock of medication sufficient for a year rather than 8 months, “so that one can be at psychological ease”. Interestingly in terms of gender dynamics, Rose felt more comfortable with the male doctors “because the females are judgemental”.
Recommendations

- Provide stigma free and non-discriminatory care for pregnant women, particularly those living with HIV, before and after pregnancy.

- Strengthen reproductive health services for women and also improve access to general health services for women as well.

- Improve women's access to information, job opportunities, and work in terms of quality and accessibility. An integrated systematic strategy should be developed to ensure women's empowerment and to improve their autonomy.

- All organisations and networks working and serving KPs and WiTD develop a common strategy of intervention. The idea is not only to prepare reports and studies but to physically meet to discuss a common strategy. The meeting should develop a statement about the COVID situation and women's positions during the pandemic to be addressed to donors, UN Agencies, institutions, and ministries.

- Improve safety and psychological wellbeing for women by providing more psychological support for people living with HIV. People who are HIV positive, experience psychological problems and they need regular mental health screening. They experience discrimination and social isolation most of the time and they always worry about their quality of life and issues such as their health. They have the right to benefit from appropriate psychological services such as individual sessions, peer support groups, and others.

- Mainstream legislation to protect the rights of people living with HIV. In the area of law, improvements should be made to protect human rights and contribute towards the Global AIDS targets 2025 and the SDGs. [264]

- Increase women's financial independence by maintaining employment initiatives and increasing activities focusing on job skills. National plans should contribute to creating jobs and long-term income-generating opportunities for vulnerable women so these women will be able to improve their livelihoods and manage their financial income.

- Ensure services' sustainability especially those related to financial support "An initiative was created by the government during the pandemic. The initiative supports financial income for vulnerable unemployed groups including women. They are supported by 80 Euros, but unfortunately, these services were limited to 3 months and the pandemic is still ongoing ". The government should ensure long-term services for women to avoid further degradation and to maintain critical sustainability for services.

- Address specific needs among women and girls living with HIV so as to ensure women access and protection of basic rights and their freedom to live in safety and dignity.

- Increase advocacy with the government to endorse new strategies and policies that support:
  - Women's access to education, to increase investment in women's educational opportunities. Education generates positive outcomes for the health of young women and adolescent girls. Learning achievement and continuation in education help women to develop to their full potential and putting them on a path for success in their life especially for women living in rural areas and deserts.
  - Financial resources for women for long terms. Stimulate government to foster income-generating opportunities and employment for women and to create cash-based assistance programs.
  - Security and protection for women to improve access to sexual and reproductive health and rights. Security forces and police should support relevant partners to reach more people in need. In addition, they should ensure community protection and security and should decrease the use of violence against this community.

[264] See: https://www.avert.org/global-hiv-targets
3.2.5 TUNISIA

Introduction

Demographic Information
As of 2021, Tunisia has a population of 11,811,335 inhabitants. [265] Tunisia has supported a successful family planning program that has reduced the population growth rate to just over 1% per annum, contributing to Tunisia’s economic and social stability. [266] In 2020, Tunisia’s female population amounted to approximately 5.96 million, while the male population amounted to approximately 5.86 million inhabitants. [267] Tunisia’s population is comprised of the following ethnic groups: Arab 98%, European 1%, Jewish and other 1%. [268] In 2014, adult literacy rate for Tunisia was 79%. Adult literacy rate of Tunisia increased from 74.3% in 2004 to 79% in 2014 growing at an average annual rate of 1.05%. [269] Education is given a high priority and accounts for 6% of GNP. [270] A basic education for children between the ages of 6 and 16 has been compulsory since 1991. [271]

HIV-Related Information
Figures from 2020 point to the fact that there were 4,500 adults and children across Tunisia living with HIV. [272] Of these individuals, people living with HIV who know their status constitute 2,300 individuals, with 1,400 of the 2,300 receiving ART (antiretroviral therapy). [273] Presently, 54% of pregnant women are covered for PMTCT, with the final vertical transmission rate including during breastfeeding at 27.6% as of 2020. [274] Early infant diagnosis stands at 20%, with new HIV infections averted due to PMTCT at 100%. [275] Other estimates on HIV prevalence include: 9.1% among MSM and 6% among people who inject drugs. [276]

SRHR Services to WiTD in Tunisia
According to the UNFPA, life expectancy in Tunisia is growing, maternal and new-born mortality are down, and contraceptive prevalence continued to increase. [277] Tunisia is also the only country in the MENA region that permits women by law to have abortions for social reasons. The law legalising abortion was first instated in the country in 1965. It legalised abortion, however, on the condition that it be carried out by a medical practitioner in a hospital or clinic, and that the woman be in her first trimester of pregnancy. Moreover, the law required the couple to have a minimum of five children, and the woman parents need to submit a request for this. The law was later updated in 1973, stating that a woman can get an abortion

[268] See: https://minorityrights.org/country/tunisia/
[269] See: https://knoema.com/atlas/Tunisia/topics/Education/Literacy/Adult-literate-rate
free of charge, irrespective of whether she is married or not, or the number of children she has within the first three months of pregnancy. In the case of minors, however, they are required to obtain consent from their parents or legal guardians to access abortion services in a public health care facility. Although these regulations apply to all medical practice, they are not as strictly followed in private health care institutions. [278]

Nevertheless, while the law states that women can get abortions irrespective of their marital state, cases have been reported of unmarried women having to show consent from “their husbands” to undergo abortions. In the case of minors who are raped, they are usually brought to the hospitals by their parents and requested to go through an abortion in secret to avoid being shamed. However, in the case of minors, they are not allowed to get abortions without a police investigation of their case, making the rape and abortion an official matter. [279]

Progress in the areas of SRHR remains unequal between rural and more developed regions. [280] Despite the fact that Tunisia is generally regarded as a “pioneer” in the MENA region in the areas of women’s status and the provision of women’s rights, including SRHR, studies and testimonies have pointed to a number of ongoing barriers that remain unaddressed. A deep dive into the extent to which reproductive rights have been integrated into the country’s larger reproductive health policy, the gaps in implementing such policies, as well as the influence of such policies on gender empowerment highlights that progress has been “slow” in terms of incorporating reproductive rights into the national reproductive health policy. [281] Moreover, the implementation of such policies have failed to incorporate regional inequalities in the accessibility and availability of reproductive health services, the poor quality of maternal health care services, and documented discriminatory practices. [282]

Since 1994, women’s reproductive health indicators in Tunisia have shown significant improvements. [283] By 2012, the unmet need for contraception was as low as 7%. [284] Moreover, skilled delivery attendance increased from 76.3% in 1990 to 97.6% in 2013, [285] and the maternal mortality ratio declined from 91% per 100,000 live births in 1990 to 46% per 100,000 in 2013. [286] However, according to a 2010 shadow report submitted to the CEDAW Committee by Tunisia’s Democratic Women’s Association

[284] Ibid
[285] Ibid
Women in Tunisia continue to be exposed to frequent violations in the areas of their sexual and reproductive rights, including discrimination against unmarried women (particularly those with HIV), virginity testing and other discriminatory religious practices, as well as the ongoing criminalisation of homosexuality.[287] As a KI from Tunisia puts it: “Civil society organisations are the ones who provide SRHR services for women in their diversity in Tunisia. Most of the beneficiaries refuse to access public health institutions in the country because of discrimination, stigmatisation, intolerance, and lack of respect” (KI1, Tunisia). On the issue of discrimination, another KI from Tunisia also elaborates, “Stigmatisation and discrimination especially for women living with HIV is the main barrier. Women refuse to reach these centres because they face discrimination once they share their situation. They are the main victims once they get these services. Women living with HIV face the main barriers to access these services and solutions should be found for these women at the community level” (KI2, Tunisia). By 2016, Tunisia had undergone a political transition characterised by renewed aspirations for democracy and improved human rights standards at the national level. Throughout the transitional period that followed, women’s rights, particularly their SRHR, remained one of the most contested issues in this new phase of the country’s political history prompting the need for a gender-sensitive human rights-based analysis of Tunisia’s reproductive health policy.

Stakeholders Involved

Along with pertinent Ministries (such as the Ministry of Health and the Ministry of Women, Family and Children), a number of UN Agencies, international non-governmental organisations and local non-governmental organisations have led on SRHR across Tunisia – in many cases carrying out much more work than the government itself. As one KI from Tunisia puts it:

“The government’s efforts in this domain are very limited and they are not involved in the provision of sexual and reproductive health services in the country. What is implemented by the government is nothing compared to the services implemented by the civil society. It has been many years without any improvement in terms of sexual and reproductive health in Tunisia, giving that the public health services are deteriorating more and hospitals are failing and that was noticed clearly during the pandemic” (KI1, Tunisia).

She elaborates: “[…] Sexual and reproductive health services are mostly maintained by civil society organisations. It is one of our strategic objectives. We emphasize on the importance of sexuality and women leadership through our interventions and activities, particularly in terms of prevention, awareness, guidance, and training. SRHR are very important for us while it is considered secondary for the government.” (KI1, Tunisia)

Operating in Tunisia since 1974, the UNFPA continues to extend reproductive health services, especially in remote rural areas, and ensures the right of all people to access information and care.[288] For the UN agency, youth and adolescents constitute a central focus, and it continues to involve pertinent government and civil society bodies in the development of targeted services to this population group, as well as in development planning.[289] In 2018, thirteen Tunisian NGOs assembled to discuss the theme: “Let’s mobilise against the disengagement of the Tunisian

[288] Ibid
[289] Ibid
[290] Ibid
The organisations included the Tunisian Association of Women Democrats (ATFD), Tawhida, Association of Tunisian Women for Research and Development (AFTURD), Association Beity, Association for the Defence of Individual Freedoms (ADLI), Tunisian League of Human Rights, Association of Reproductive Health, ATL/MST/AIDS, Association of Positive Prevention, Mawjoudin, Damj, Tunisian Association for the Defence of the Right to Health, and Ness and Shouf. [291]

Stakeholders at the civil society level continue to stress the lack of knowledge of ‘sexual rights’ in Tunisian law. [292] While this right is often assumed to constitute part of the discussion on ‘reproductive and sexual health’, this excludes sexual rights from the right to health, and also excludes many factions of the population. [293] An order issued by the country’s Ministry of Health requires reporting on pregnancies and births outside marriage and access to HIV treatment. [294] This order excludes members of the LGBTQI+ community, as reported in the results of a 2018 survey of the LGBTQI+ community undertaken by local NGOs Damj, Chouf and Mawjoudin. [295] The study highlighted that more than half of the respondents either do not visit a physician, or do not do medical tests because of fear of discrimination or abuse by medical staff in connection with their practices or their gender identity. [296] As a KI from Tunisia puts it, there is an overall lack of targeting women from gender minorities:

“Women in all diversity do not have the same needs, some needs are common to all women such as prevention tools, sexual independence, and financial autonomy but these are not the same always. For example, I cannot mobilise LGBT women and provide them with training on contraception, or women who need to change their sex and put them with other women” (KI3, Tunisia).

The Government and the GFATM grant are the main entities funding the NASP in Tunisia. Projects implemented related to HIV/AIDS prevention in the country are financially supported by the GFATM. As for the CCM, it was established in 2005 and its purpose is to coordinate programs that are funded by the GFATM. Moreover, it works to ensure that activities of stakeholders (particularly CSOs) continue, since their programs are GFATM funded.

According to a baseline study conducted by Frontline AIDS in 2019, there is a need for greater engagement of CSOs to impact health policies in Tunisia.

The study highlighted the need for CSOs to have a minimum level of expertise in advocacy at a political level in order to ensure a continuation of activities, influence decision making, integrate innovative approaches, and monitor the HIV response in the country. The Baseline study also indicated a lack of CSOs working on HIV to ensure adequate coverage across the country. Moreover, variances were also reported in the capacities of these CSOs, and the quality of services provided. The need to strengthen their knowledge on HIV was highlighted and their capacities to improve programming based on evidence-based data.
SRHR Services Before and During the COVID-19 Pandemic

Since the country’s independence, Tunisia has developed accessible and free reproductive health services. [297] At the government level, reproductive and health services are made readily available within the structures of the National Family and Population Office (ONFP) in the country’s twenty-four governorates, in a number of university hospitals, as well as in smaller local health centres across the country. [298] Both contraception and abortion services are additionally provided in the public and private sectors alike. [299] However, in the last decade, SRHR services have experienced challenges and declines in several indicators such as the contraceptive prevalence and abortion rates according to multiple reports – particularly in the public sector. [300]

Across the last twenty years, Tunisia’s economic policy has yielded nationwide budget cuts, including on abortion services. [301] As one KI from Tunisia puts it:

“Sexual and reproductive health in Tunisia was only limited to family planning and contraception, there was a shortage in funds in the last years. Meanwhile, we are facing an improvement in these services by going forward to provide testing, screening for cases, feminine preservatives, sexual and reproductive rights, access to screening and care” (KI2, Tunisia).

Abortion services have since been replaced by what laid the foundation for some public sector doctors mobilizing to prevent access to abortion on grounds of “conscientious objection,” as a way to refuse provision of abortion care. [302] The Tunisian Association of Democratic Women (ATFD) has expressed concern about the Ministry of Health’s inaction, and insists that if conscientious objection is an individual right for practicing doctors, then there is also an obligation to refer women to doctors providing abortion without restrictions. [303]

It has also been reported that in a number of hospitals and university hospital centres, abortion is no longer a free service, which largely excludes women from lower socio-economic backgrounds who are unable to pay. [304]

The ATFD subsequently cautioned that this led to the witnessed decrease in contraceptive prevalence from 63.5% in 2006, to less than 60% in 2016, and an increase in the fertility rate from 2% in 2007 to 2.4% in 2017.[305]

The emergence of the COVID-19 pandemic swiftly altered the pre-existing global sexual and reproductive health environment. [306] The provision of contraceptives and their availability, as well as a range of sexual health and maternal health services were severely impacted.[307] As a KI from Tunisia puts it:

[298] Ibid
[299] Ibid
[301] Ibid
[303] Ibid
[304] Ibid
[307] Ibid
“Before the pandemic, and after the pandemic, there is a shortage in stock and medication and unfortunately during the pandemic the shortage in stock increase until today” (KI3, Tunisia).

As per the Policy Brief “Gender and Crisis of COVID-19 in Tunisia: Challenges and Recommendations” published by UN Women in 2021, women’s access to sexual and reproductive health has also been impacted by the lockdown, with 50% of women who participated in the study stating that they had difficulty accessing family planning support. [308] Alongside many intersectional areas of concern regarding the situation for women during the COVID-19, the deterioration in quality and access to sexual and reproductive health services in Tunisia in recent years has only been exacerbated according to the report. [309]

With priority being given to establishing and cementing COVID-19 care channels, the lack of personal protective equipment (PPE), particularly during the pandemic’s early stages, coupled with the overall lack of clear guidelines about the manner to implement the Ministry of Health’s decision to stop non-emergency consultations and elective surgeries, led to the closure of several National Office for Family and Population branches and basic health centres. [310] Consequently, the 50% of women who needed family planning services, and in need of renewing their supplies encountered little-to-no access to these forms of care. [311]

The curfew and general confinement across Tunisia, as well as the fear of contamination created additional difficulties for women to access services, especially for childbirth and other reproductive health emergencies and the risk of increased home births with women. [312] Voluntary interruption of pregnancy has not been possible for several women according to a number of reports as well. [313]

On April 24, 2020, Tunisia’s Ministry of Health issued Circular 23/2020 ordering the reopening of elective procedures in the public and private sectors with special mention for prenatal consultations, maternal and childcare and sexual and reproductive health services. [314] Child deliveries have also taken a major hit during COVID-19. A survey conducted by the Tawhida Bechickh Association with the Midwives Association of Tunisia reported that 126 midwives confirmed that 50% of SRHR services either been reduced or halted altogether. [315] According to CIVICUS, access to sexual and reproductive health services was also affected because women could not get out and seek these services for fear of the virus. [316]
Recommendations

Despite the fact that Tunisia has made significant steps toward incorporating SRHR into its reproductive health policies at the national level, a number of inadequacies remain present in the policy implementation and the adoption of meaningful actions to achieve gender equality. Moreover, analysing policy through a human rights lens remains a pivotal component towards ensuring tangible improvements in the areas of women's access to SRHR. Realities such as the denial of legal abortion as well as discriminatory attitudes must be addressed, along with ensuring that health professionals’ training be improved in order to ensure that their delivery of reproductive health services meets human rights standards and principles. One of the main gaps in the implementation of Tunisia's SRHR policy remains the inequity across regions in terms of the accessibility and availability of these services.[317] Moving from this reality, the reduction of regional inequities in women's access to SRHR necessitates addressing their root causes such as infrastructure inequalities, poverty, and other forms of social and political marginalisation. The process of advancing reproductive rights must subsequently be framed within larger human rights and social justice frameworks by the Tunisian government and civil society actors. This is especially relevant in Tunisia's current political context, whereby the “new” 2014 Constitution overtly protects the right to health and outlines the state's obligation to enforce women's rights and to protect women from violence and discrimination. [318] Moving from the aforementioned reality, it is pivotal that the Tunisian government ensure women's access to sexual and reproductive health services and reopen all basic health centres and hospital services as well as ensure the availability of contraceptives in pharmacies and in public and private facilities including emergency contraception despite the ongoing challenges of COVID-19 and budget cuts.

Other recommendations include:

1. The need for the creation of a national community to observe and follow up on the sustainability of SRHR services,
2. The development of a national platform that includes all stakeholders providing services for women in all diversity (WiTD),
3. The establishment of a national committee (or body) to observe and follow up on discrimination and violence for women who tested positive, as well as
4. The establishment of an evaluation strategy that outlines a clear action plan and way forward (KI3, Tunisia).

Another recommendation stemming from the fieldwork conducted for the purpose of this study, includes the need for the establishment of a national federation to respond to HIV/AIDS, which is constituted of civil society actors.

[317] Ibid
[319] KI3, Tunisia.
4. Conclusion

As with the rest of the world, Egypt, Jordan, Lebanon, Morocco and Tunisia experienced disruptions in health care delivery. In all five countries, organisations resorted to remote delivery models to ensure continuity of service provision during the pandemic. However, this did not ensure universal access to services by women, as many do not have internet connectivity or the required devices. Across all countries, findings reveal the need to improve collaboration and partnerships between organisations to enhance access of WiTD to SRH services. Interviews revealed the need for strengthening referral systems to better respond to emergency situations such as COVID-19 and having a robust contingency plan to ensure continuity of services. Furthermore, findings highlight the critical role peer educators play in the design, implementation, monitoring and evaluation of SRHR interventions targeting WiTD. Therefore, it is essential to foster an enabling environment to aid the development of capable peer educators who can take leading roles in SRHR delivery especially in emergency situations. Barriers to accessing SRH services across countries include stigmatisation and discrimination against WLHIV and key populations, issues of PLHIV’s access to medications, and GBV – all of which were aggravated during the pandemic. In addition, lack of integrated HIV and SRH services in all countries, increased difficulty of access. It is evident that changing attitudes and behaviours is an important part of addressing barriers to accessing SRHR services.

Findings from Egypt, reveal that COVID-19 measures imposed to control the spread of the virus, resulted in severe disruptions in the health system and a large reduction of SRH services. Health care facilities were overwhelmed with COVID-19 cases, and access to SRH services was severely restricted. Public health facilities and private pharmacies had shortages in some types of family planning methods. WiTD had limited or no access to family planning services and SRH care and incurred financial burdens in some cases in order to get care at private facilities. Testing for WLHIV became difficult and irregular, and some women experienced shortages in their medication. PLHIV were afraid to get their medication, as the government dedicated fever hospitals which dispense ART as testing centres for COVID-19. Outreach and awareness activities were also affected; however, most were delivered via online and remote modalities. In addition, findings indicate that some common challenges impacting WiTD’s access to SRH services such as stigma and discrimination persisted, while others such violence against women were exacerbated. Different organisations offering SRH services to women in Egypt reported reduced technical and financial capacity to deliver services during the pandemic. Organisations adapted in different ways to ensure continuity of services, such as shifting their services and activities to online and remote models, establishing online support groups, providing financial and material assistance to women and facilitating WiTD’s access to SRH services during lockdowns and curfews.

During the pandemic, women avoided seeking face to face SRH care due to fear of COVID-19 infection. Most women relied on remote and online SRH services. Some women resorted to health facilities near their houses to avoid taking public transportation or going to public health facilities they perceived as unsafe. WLHIV supported each other through sharing medication and online support groups. Due to shortages in some contraceptives, some women had to stop using them and others changed their methods. Findings show that community-based organisations and NGOs played an important role in providing support to women through remote SRH services and financial assistance.

Jordan imposed some of the strictest measures in the world to control the spread of COVID-19. Findings from Jordan show that lockdowns and curfews imposed significantly impacted access to social and health services, including reproductive health services. The Jordanian government prioritised COVID-19 response, and resources were diverted from health services including SRH to COVID-19 related measures. Movement restrictions limited women’s access to health facilities, and critical services including contraception provision, STI treatment and management of rape were reduced. The disruption on SRH services was the highest during the first lockdown, when all health facilities were closed, except for hospitals which provided emergency services.
Due to the economic repercussions of the pandemic, WiTD suffered from loss of jobs, unemployment and reduced incomes. In addition, findings reveal that the pandemic increased the risk of violence against women, due to women staying home with their perpetrators and deteriorated economic conditions. Organisations providing SRH for women were affected due to reduced technical and human capacity and limited access by beneficiaries to their services. Organisations adapted by shifting delivery of services to online and remote modalities, keeping essential services running, and some mobilised community workers to deliver emergency medication and contraceptives for those in need during lockdown. Coordination between organisations continued as it was before the pandemic but shifted to online and remote models.

Findings reveal that during the first months of the pandemic, WiTD were reluctant to access services to avoid crowded public facilities out of fear of COVID-19 infection. Some resorted to private health facilities, but many could not afford this option. Women accessed online SRH services and relied on peer support, family networks and support from community-based organisations to cope with COVID-19 impacts on their mental health and SRH.

**Findings from Lebanon** reveal that the impact of the pandemic is entangled with other crises in Lebanon such as the economic crisis, political instability and the Beirut blast. Therefore, it is difficult to isolate the impact of COVID-19 on SRH service delivery from other factors. Before COVID-19, due to the economic crisis, Lebanon had issues with access to essential medication, contraceptives, and hygiene products, and there were more restrictions on women during labour and childbirth. The Beirut blast resulted in the destruction of many hospitals in addition to the NAP building. Furthermore, interviews highlighted that the influx of Syrian refugees to Lebanon before the pandemic led to prioritising maternal health and family planning services for this group. Nevertheless, KIs reported that due to prioritisation of COVID-19 response, especially in the first phase of the pandemic, a number of disruptions happened in SRH service delivery. Reported impacts include reduced cancer check-ups and screening tests for women, shortage of sanitary pads, and decreased access to contraceptives. It was reported that due to fear of contracting COVID-19, people were reluctant to seek medical care, and that PLHIV were unable to reach their infectious diseases physicians. In addition, interviews highlighted issues of stigma, lack of privacy and disrespectful treatment that some patients experienced. Findings also indicate an increase in domestic abuse and violence against women.

Several organisations reported that they continued offering SRH services during COVID-19, however, organisations adapted their delivery methods. Adaptations reported include, delivering activities remotely, reducing number of visitations at centres and stopping physical outreach activities. Other organisations like Marsa had to stop their operations during the first lockdown, however, they were able to resume after restrictions eased.

As for common SRH practices of WiTD, findings show that women in general do not prioritise their health. Transgender women face issues with accessing hormone therapy, and that there is a lack of knowledge about the needs of transwomen in the health sector. KIs reported that transgender women face high stigma and don’t feel safe in Lebanon. During the pandemic, a lot of transgender women had to resort to transactional sex to secure basic livelihoods. Interview discussions revealed that, as a result of the pandemic, it is likely that women practiced unsafe sex and were therefore at greater risk to unwanted pregnancies and STIs.

**Findings from Morocco** show that during the pandemic, access to SRH services was restricted and their quality deteriorated. Women experienced delays in receiving care and financial difficulties limited their ability to reach health care providers. Funding for most organisations working to support key populations in receiving SRH care decreased as the interests of donors focused more on COVID-19. Organizations had to reduce the scope of their activities during the pandemic due to COVID-19 related restrictions and lack of resources. They adapted by delivering some of their services and activities remotely. Interviews highlight that domestic violence increased due to limitations on women’s movement. In addition, findings show that coordination between organisations in Morocco is generally strong and a participatory referral system exists. However, coordination was affected due to the COVID-19 pandemic, and some duplication in activities occurred.
Moreover, the focal point from Morocco reported that common SRH practices for WiTD during the pandemic did not change and their centres were open for urgent cases. However, a WiTD interviewed indicated that some practices changed during the pandemic such as accessing testing and consultations. WiTD sought health care only when they had issues and reported that visiting private clinics was a challenge for them due to high costs.

**Findings from Tunisia** indicate that during the pandemic, the country had increased issues in medication supply, which it already had before COVID-19. In addition, the pandemic aggravated the deterioration in quality and access to sexual and reproductive health services in Tunisia. Due to lockdown restrictions and priority being given to COVID-19 response, several family and population branches and basic health centres were closed. Women had difficulty in accessing family planning methods and SRH services, especially for childbirth and other reproductive health emergencies. Moreover, women reported difficulties in accessing abortion services.
## 5. Annexes

### 5.1 Annex 1: Advocacy Plan

#### 1 INCEPTION PHASE

1.1 Scoping meeting

1.2 Document review

1.3 Submit first draft of Inception report

1.4 Revision of inception report based on feedback Mena Rosa

1.5 Submission of final draft

### 2 DESK AND FIELD RESEARCH

2.1 Logistical preparations for field research

2.2 Desk review and secondary data analysis

2.3 Individual interviews (for all 5 countries)

### 3 FINAL ANALYSIS + REPORTING

3.1 Analysis and writing of first draft

3.2 Submit first draft of the report

3.3 Submit advocacy plan

3.4 Conduct validation workshop

3.5 Amendments to report based on MENA Rosa comments and validation workshop feedback

3.6 Submission of final report

3.7 General Open webinar + Presentation

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5.4 Annex 4: Ethical Protocol

Good ethical practice is key to the credibility of any research. The gathering of legitimate and appropriate data as well as a key element of data collection in sensitive contexts or topic areas depends on the execution of research in an ethical manner. When working with vulnerable people, an ethical protocol is important to ensure the safety, security of participants as well as their protection from any emotional or physical harm, discrimination or abuse. This protocol will guide the execution of this baseline evaluation in an ethical manner.

**Data and Participant Confidentiality and Anonymity**

1. Data and participant confidentiality and anonymity will be maintained at all times.
2. Individual data will not be shared outside of the research team.
3. The contributions of individual participants will not be named in any document.
4. All quotes will be anonymised.
5. Datasets will be shared within the evaluation and MENA Rosa teams only.
6. Participants will be informed of the anonymity and confidentiality of their participation in the research prior to consent.
7. Participants will be informed that their participation is voluntary, and should they wish to withdraw from the research at any time, they are free to do so with no risk of repercussion or negative impact on themselves or their families.

**Team Member Training**

1. Training of team members in ethical practice will be the responsibility of the lead consultant and will be completed prior to starting work on this study.
2. Team members will be provided with disability sensitivity training as part of the ethical briefing & training.
3. Team members will be expected to engage in ethical practice at all times.
4. If a team member or fieldworker is found to be breaching the terms of contract, relevant to this ethical protocol they will be dismissed from their duties.

**Inclusive Practice**

1. Where possible, all participants will be given the opportunity to participate in their vernacular language.
2. Where required special needs facilitators and fieldworkers will be included in the research team to support people with disabilities.
3. Focus on women in their diversity will be placed as women and girls are the main beneficiaries of the project.
4. No eligible person will be discriminated on because of factors such as age, gender and disability.

**Duty of Care and informed consent**

1. Participants will be required to sign the same register to indicate that they give informed consent to participate in the relevant activity. This can be done using a pseudonym or initials.
2. Participants displaying signs of distress will not be expected to continue in the research activity & will be referred to a project partner for support and further referral into appropriate channels for help.
3. Participants disclosing incidences of abuse, discrimination or trauma will be referred to the relevant project partner for support and referral to services in line with national or regional systems and protocols.
Key Informant (KI) Participation Ethics

1. Key informants will not be made party to any confidential or program-related documentation, information or confidentially disclosed detail about the project or any project participants.
2. Key informants will be assured of the confidentiality of their responses and participation in the study.
3. No key informant will be identified by name, just organization, gender and country or region.

5.5 Annex 5: Consent Forms

You are being invited to participate in this interview. Please read this brief intro and take time to consider the information before deciding whether to take part.

MENA Rosa would like to invite you to take part in this SRHR Assessment in the MENA region. The interview will include questions regarding SRHR services related to Women in their Diversity (WiTD) before the COVID-19 pandemic. It will also include questions on Sexual and Reproductive Health and Rights (SRHR) practices before and during the COVID-19 pandemic and assess how these practices changed during said pandemic on regional level.

Your opinion and input is extremely valuable and will enable us to understand the situation from your point of view. You do not have to take part in this interview. If you decide to take part, you can change your mind at any time. This interview is anonymous and any information you share is confidential. Your name will be removed from interview and all data collected will be kept securely. The interview will be recorded and transcribed only if you give your permission. The interview will last between 1 ½ - 2 hours, depending on how much you would like to say. During the interview, you are free not to answer any questions that you choose. You can also leave at any time without giving a reason.

The information collected will be written up as part of a study report for MENA Rosa. Findings may be presented at conferences, written up in journal articles or policy reports.

If you agree to take part in this interview, please provide your consent below. Thank you for considering taking part in this survey. If at any time you have any complaints that you would like to discuss, please contact:

Name: Taline Torikian
Position: Project Coordinator, MENA Rosa
Contact Details: Tel: 00961 1 480714, Mob: 00961 3 969370, Email: admin@menarosa.me

- I understand that taking part is voluntary and that I am free to withdraw my consent from taking part at any time
- I agree to the interview being audio recorded
- I agree that any information collected about me in this interview including the taped transcript, to be used in the study for MENA Rosa in anonymous form
- I consent to taking part in the interview

Name of participant or initials if preferred ______________