

Mid-term Assessment Summary Report

Global Fund Breaking Down
Barriers Initiative

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FOREWORD

One of the most powerful lessons from the history of the fight against HIV is that success in confronting such a formidable disease cannot be achieved through bio-medical interventions alone. We must also confront the injustices that make some people especially vulnerable to the disease and unable to access the health services they need. The same is true for tuberculosis (TB), malaria, and other diseases, including COVID-19.

Despite significant progress, HIV and TB remain highly stigmatized. Legal and policy protections against discrimination based on HIV or TB status are weak or non-existent in many places. Harsh laws and policies against drug use and sex work, criminalization of same-sex intimacy and of HIV transmission, and deep-rooted gender inequalities continue to undermine access to health care. People in prisons are denied the level of care to which they have a right. As a result of such human rights violations, far too many people are left behind.

The Global Fund's *Breaking Down Barriers* initiative is a groundbreaking effort to confront these injustices. It translates into action the Global Fund's commitment to scale up comprehensive programs to remove human rights and gender-related barriers. Through *Breaking Down Barriers*, we have provided catalytic matching funds and technical support to drive development and implementation of country-owned national programs to address the injustices that continue to threaten progress against HIV, TB, and malaria.

This is all about putting into the hands of people affected by HIV, TB and malaria the knowledge and the skills to understand, demand and secure their health-related human rights. It is about enabling health care providers, police, prison officials, judges, and parliamentarians to provide supportive and effective services to all those most vulnerable to disease. It represents an unprecedented investment in health-related human rights. In the twenty countries in which we have implemented *Breaking Down Barriers*, investments in programs to reduce human rights-related barriers to health services increased from less than US\$9 million in the funding cycle before the initiative started (2014-16) to US\$78 million in the following cycle (2017-2019) and over \$130 million in the current funding cycle (2020-22). Particularly remarkable is how much countries participating in the initiative have increased investments in these programs from their main funding allocations in addition to the catalytic funding made available as part of *Breaking Down Barriers*.

The Global Fund is carefully documenting the progress achieved through *Breaking Down Barriers* in order to learn lessons and improve programming and outcomes. At the start of the initiative, we established baseline data for all twenty countries in terms covering the extent and nature of human rights and gender-related barriers, as well as already ongoing programs to address them. This report is an overview of the results of the *midterm* assessments of the activities supported by *Breaking Down Barriers*. It shows that countries involved in the initiative are making significant progress in developing and implementing comprehensive national responses to human rights- and gender-related barriers to health services.

To make progress on human rights and gender-related barriers there must be movement and action at both political and programmatic levels. *Breaking Down Barriers* has focused on both. It has united diverse stakeholders, including government, civil society and communities, behind efforts to confront injustices in national disease programs. It has reinvigorated support for key population-led organizations and their allies. It has brought together government and civil society in developing national plans for comprehensive human rights responses, with steering groups put in place to improve coordination and integration.

Equally exciting as the increased political commitment to health and human rights has been the concrete progress in translating human rights principles into scaled and practical programs that result in tangible improvements in people's lives. For example, we have seen significant programmatic gains in combating HIV- and TB-related stigma. As a co-convenor of the *Global Partnership to End All Forms of HIV-Related Stigma and Discrimination* the Global Fund is committed to taking action against stigma. This mid-term assessment report shows that *Breaking Down Barriers* has helped deliver results and build a robust platform for future progress.

Breaking Down Barriers has also enabled a significant expansion of programs to increase access to justice and to mobilize around changing harmful laws and policies. This aligns with the Global Fund's new Strategy, which commits us to leverage our voice and influence to challenge laws and policies that impede successful responses to HIV, TB and malaria. In the course of the midterm assessments summarized here, many civil society organizations noted that dedicated funding for legislative and policy advocacy was very rare before *Breaking Down Barriers* and was therefore especially highly valued. By supporting organizations led by key populations, the Global Fund enabled people with lived experience of unjust criminalization and abusive law enforcement to raise their voices in advocacy.

As of the time of writing, it has been over a year and sometimes longer, since many of the mid-term assessments were conducted. Programmatic progress is thus probably understated. End-term evaluations planned for late 2022 and the first six months of 2023 will capture four or five years of activity in the *Breaking Down Barriers* countries. We intend to conduct a more quantitative and in-depth assessment in some countries as part of this end-term exercise to gain an even more detailed picture of how the programs have worked, the problems they have encountered and the impact they have had in improving the health of the most marginalized.

We should have no illusions about the challenges involved in taking on such injustices. It takes time and determined effort to achieve changes in unjust laws or policies, or to shift discriminatory behaviors and practices, and these efforts often encounter significant resistance. There is still much more to do. Yet the *Breaking Down Barriers* experience demonstrates that, where there is sufficient funding and technical support, multiple stakeholders can be energized to combine and strengthen their efforts and as a result, can make real progress in removing long-standing barriers.

I hope the lessons and insights from the mid-term assessments presented here will inspire and inform future endeavors in this vital arena. For our part, the Global Fund, in line with our new Strategy, is committed to expanding and intensifying our support of interventions to address human rights and gender-related barriers to health services. This is critical to defeating HIV, TB and malaria, to building truly inclusive systems for health that leave no one behind, and to enabling everyone, everywhere to realizing their right to health and wellbeing.



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Executive Summary

The Breaking Down Barriers initiative of the Global Fund provides financial and technical support to 20 countries to remove human rights-related and gender-related barriers to HIV, tuberculosis (TB) and malaria services. Midterm assessments of this work were conducted in each of the 20 countries, about 1.5 to 2.5 years into the initiative (depending on the country), to examine progress made and to highlight effective program interventions.

The midterm assessments focused on the scale-up of internationally recognized programs and interventions that address stigma and discrimination, gender-based violence and discrimination, punitive laws and policies, abusive law enforcement practices, disrespectful treatment in health services, and inadequate services for people in prison. Seven HIV program areas were assessed in all twenty countries. Ten TB program areas were investigated in thirteen countries. Efforts to address human rights-related barriers to malaria services were assessed in two countries. The assessments scored programs on a 0-5 scale meant to reflect scale-up of the program and a qualitative sense of emerging impact of the interventions. Some countries were studied through desk reviews and a limited number of interviews with key informants; others were studied in greater depth with a wider range of interviews. Because of COVID 19, almost all assessments were carried out remotely.

All 20 countries saw expansion and improvements in HIV programming to address human rights-related barriers compared to baseline measures. On the 0-5 scale, the average improvement was 0.9. All countries where TB was investigated were also found to have made progress, with an average 0.6-point improvement on the 0-5 scale. This result was achieved despite COVID-19, which undermined TB programs directly in many countries as COVID caused intensified stigmatization of TB symptoms. In all 20 countries, costed national plans for comprehensive responses to human rights-related barriers were developed with the participation of a wide range of stakeholders, and adopted as country-owned plans or strategies. In most cases, these plans were based on information from the baseline studies of the *Breaking Down Barriers* initiative.

With respect to both HIV and TB, considerable progress was made in scaling up programs to reduce stigma and discrimination. Programs featured many forms of raising community awareness of the harms of stigma, as well as more targeted efforts such as eliminating stigma in health services. Stigma related to being a member of a key population was also confronted. Training of and engagement with health workers on a range of human rights and ethics issues faced in HIV and TB care were also markedly expanded in most countries. In addition to stigma, programs also focused on confidentiality of medical records and of TB or HIV status as part of engagement with health workers.

The midterm assessments found progress in improving access to justice, especially for criminalized key populations, as a means of enhancing access to HIV and TB services. Promoting rights literacy – ensuring that people with HIV and TB and key populations know their rights to be able to claim them – and mobilizing community-based paralegal and legal services advanced significantly in most countries. Improving police practices through training and other forms of engagement with police was also undertaken. Good training practices included enabling dialogue between key population members and police and providing pre-service as well as in-service police training. In most countries, advocacy was undertaken to repeal or reform laws and policies that impede health service access, especially for key populations. In a number of countries, data from community-led monitoring of human rights-related barriers to health services were captured in national-level internet-based platforms that enabled the tracking of the extent, type and disposition of cases of violations.

Efforts to ensure that HIV, TB and malaria programs address gender equality and gender-based violence were highlighted in the midterm reviews. Gender sensitivity was often featured in the content of training of law enforcement officers, parliamentarians and health workers. Many programs pursued empowerment of women's groups to know and claim their health rights and protect themselves from violence and other abuse. Programs for transgender persons remain insufficient, but several countries are making particular efforts at rights literacy and access to justice for this population.

A hallmark of the of *Breaking Down Barriers* initiative, as shown by the midterm assessments, has been the empowerment of people living with HIV and TB, TB survivors and other key populations. They have been mobilized as peer paralegals and as monitors of human rights violations. NGOs led by TB survivors have organized support groups for people with TB and their families. Some key population-led organizations have received significant financial and technical support for the first time.

The midterm assessments showed that there is much work to be done to raise awareness of human rights- and gender-related barriers to malaria services. Nonetheless, there is progress. There are efforts in national malaria plans and programs to ensure women are empowered to confront barriers to their participation in prevention and treatment efforts. The assessments found that existing community mobilization for delivery of malaria services may provide a base on which to identify excluded populations in the future.

The midterm reviews show that COVID-19 slowed the progress of the *Breaking Down Barriers* initiative in many countries. But they also chronicle the ways in which human rights-related work on HIV contributed to rights-based approaches to COVID-19. In a few countries, support was provided to community-based paralegals to address human rights violations occurring in COVID raids or lockdowns. Many innovative measures were undertaken to ensure that key populations would continue to receive services in spite of lockdowns or quarantines. In a number of countries, community awareness-raising focused on prevention of gender-based violence during lockdown periods.

Cross-cutting challenges in reducing human rights-related barriers were also highlighted in the midterm assessments. Many program managers cited the need for both dedicated funding and technical support to sustain rigorous monitoring and evaluation activities. The need for stronger links between access to justice activities, and health services was also raised. Persuading governments to take financial responsibility for human rights-related programs remains challenging in many countries, as does attracting a wider range of donors to support these programs.

The midterm assessments highlighted examples of interventions in all program areas that have been particularly successful or have exemplified programmatic lessons. It is hoped that these examples and lessons will continue to inform progress toward the continued scale-up toward comprehensive responses to human rights- and gender-related barriers to services.

Introduction

The Global Fund's *Breaking Down Barriers* program, launched in 2017, provides support to countries to scale up programs to remove human rights-related barriers to HIV, tuberculosis (TB) and malaria services. The goal of the program is to increase the effectiveness of Global Fund grants and ensure that health services reach those most affected. This report presents a summary of findings from midterm assessments conducted in 20 countries which sought to: (a) assess the countries' progress towards creating a supportive environment and putting in place comprehensive, quality programming to remove human rights-related barriers to HIV and TB services; (b) describe emerging evidence of impact of *Breaking Down Barriers*; and (c) inform future efforts and investment towards building a comprehensive response.

The theory of change for *Breaking Down Barriers* is based on evidence from the HIV and TB epidemics that human rights-related barriers to health services¹ increase vulnerability to infection and negatively affect access to, uptake of and retention in HIV and TB services, particularly for certain key and vulnerable populations. To effectively reduce these barriers, countries should implement – at appropriate scale and with high quality – a set of internationally-recognized, evidence-based, human rights and gender-related interventions.² This will in turn accelerate country progress towards national, regional and global HIV and TB targets. Efforts to remove rights-related barriers will also protect and enhance Global Fund investments and will strengthen health and community systems.

The midterm assessments captured countries' progress towards comprehensiveness in two ways: (1) a quantitative assessment of a country's progress towards comprehensive programs aimed at reducing rights-related barriers to services on a 0-5 scale (used for KPI reporting); and (2) qualitative information tracking programmatic implementation and emerging evidence of impact.

The goal of this summary report is not to duplicate the rich information provided in each country report but to provide an opportunity for the reader to look at broad trends across countries and to highlight key themes from the case studies identified as 'emerging evidence of impact'. The hope is that this quantitative and qualitative comparison will help orient individuals to the overall results of the project and which reports might be of interest to explore at greater depth.

Methods

The *Breaking Down Barriers* midterm assessment was designed with three tiers of evaluation associated with varying levels of review. These were labelled as in-depth, program and rapid assessments, and countries were designated to a specific level of review.

Mid-term Assessment Type	Countries		
Rapid	Benin Democratic Republic of Congo (rapid +)	Honduras Kenya Senegal	Sierra Leone Tunisia Uganda (rapid +)
Program	Botswana Cameroon Cote d'Ivoire	Indonesia Jamaica Kyrgyzstan	Mozambique Nepal Philippines
In-depth	Ghana	South Africa	Ukraine

All levels of assessment included a desk review of relevant program documents as well as other information on country and program contexts. Complementing this information, all levels of assessment included key informant interviews, the number of stakeholders interviewed varying by the level of assessment. Prior to the COVID-19 pandemic, in-depth assessments were envisioned to include a two-week in-country visit of the research team, and program assessments were to include a one-week trip for in-country data collection. Due to COVID-19, only the Ukraine in-depth assessment was able to include a field visit. The remainder of the midterm assessments were completed remotely. The timeline of mid-term assessments is provided below.

Country	Assessment Timeline
Ukraine	November 2019-January 2020
Philippines	November 2019-March 2020
Sierra Leone	December 2019- January 2020
Kyrgyzstan	May 2020-December 2020
Senegal	June 2020- October 2020
Côte d'Ivoire	July 2020-November 2020
Botswana	July 2020-December 2020
Mozambique	August 2020-February 2021
Jamaica	September 2020-December 2020
Cameroon	October 2020-December 2020
Benin	October 2020-August 2021

South Africa	November 2020- February 2021
Tunisia	November 2020-March 2021
Indonesia	November 2020-April 2021
Democratic Republic of the Congo	December 2020-April 2021
Nepal	January 2021- June 2021
Ghana	February 2021-March 2021
Honduras	June 2021-July 2021
Uganda	August 2021-October 2021
Kenya	June 2021-October 2021

Remote interviews with key informants were sought from principal recipients and sub-recipients of Global Fund grants, as well as other government, donor and civil society representatives. Semi-structured interview guides were used to steer the interviews, covering inquiry on scope, scale, sustainability, integration, and quality. Based upon the interviews, additional documents and data (both quantitative and qualitative) were requested from key informants, which fed into the analyses of the program areas for HIV, TB, and malaria.

Researchers used information from key informants as well as from program reports to identify progress towards comprehensive services, quality programs and the elimination of human rights-related barriers. This information was used both to calculate a scorecard for each disease – according to the methodology defined by Key Performance Indicator (KPI) 9 – and to describe program successes, challenges, gaps, and emerging evidence of impact.

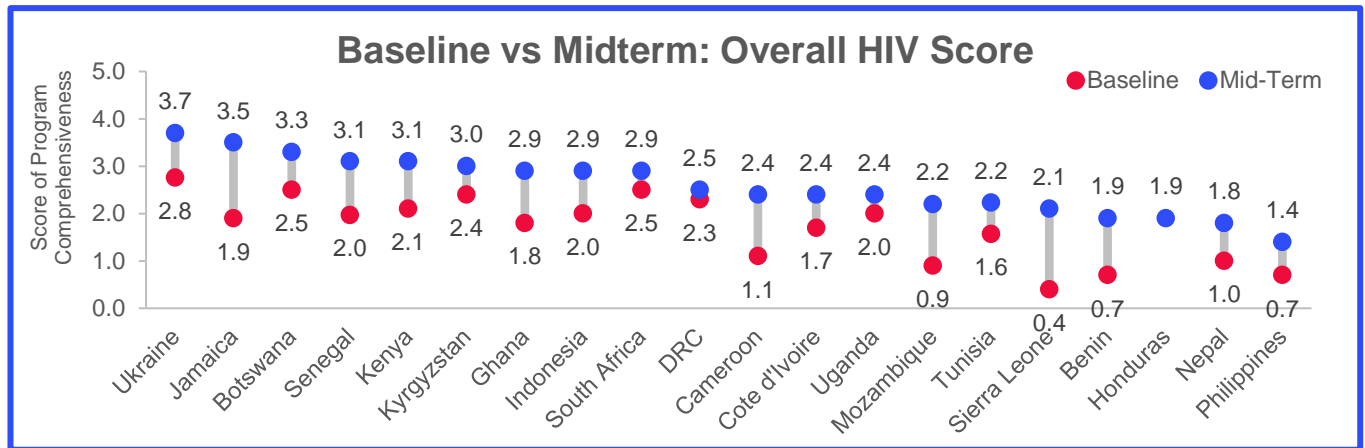
To calculate the scorecard, MTA country researchers independently scored each of the seven programs to reduce HIV-related human rights barriers and 10 programs to reduce TB-related human rights barriers, based on the geographic scale of each program area for each relevant key population, weighted equally (see table below) at midterm. In two countries, programs addressing rights barriers to malaria services were also assessed. Scores were compared and discussed among the research team to reach consensus.

Rating	Value	Definition
0	No programs present	No formal programs or activities identified.
1	One-off activities	Time-limited, pilot initiative.
2	Small scale	On-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching the targeted population. 2.0 Reaching <35% 2.3 Reaching between 35 - 65% of target populations 2.6 Reaching >65% of target populations
3	Operating at subnational level	Operating at subnational level (btw 20% to 50% national scale) 3.0 Reaching <35% 3.3 Reaching between 35 - 65% of target populations 3.6 Reaching >65% of target populations
4	Operating at national level	Operating at national level (>50% of national scale) 4.0 Reaching <35% 4.3 Reaching between 35 - 65% of target populations 4.6 Reaching >65% of target populations
5	At scale at national level (>90%)	At scale is defined as more than 90% of national scale, where relevant, and more than 90% of the population
Goal	Impact on services continuum	Impact on services continuum is defined as: a) Human rights programs at scale for all populations; and b) Plausible causal links between programs, reduced barriers to services and increased access to HIV/TB services.
N/A	Not applicable	Used when the indicator cannot be logically assessed (e.g., reducing discrimination against women programs for MSM).
* / Unk	Unable to assess	Used when it is impossible to determine a score based upon significant missing data (e.g., unavailable info from another donor).

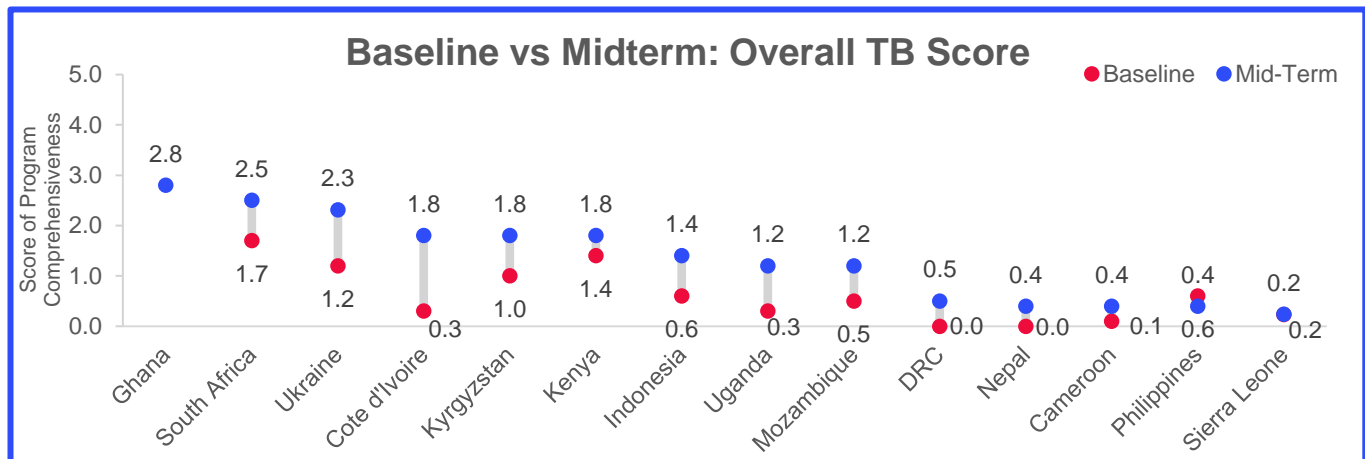
In addition to the challenges posed by conducting interviews remotely due to the COVID-19 pandemic, several additional limitations should be acknowledged. First, the scoring system above prioritizes national coverage. Among the 20 countries assessed, there are significant differences in geographic and population size, which results in more rapid scale-up in smaller countries. In addition, the defined scope and funding of activities in some countries were geographically limited, which similarly limited the ability of some countries to achieve the highest scores. Another limitation to comparability of progress across countries was that the timing of programs was not identical, with some countries receiving funds and implementing activities for a longer period of time since the baseline than others. In this regard, the term “midterm” applied to the assessment may be misleading. Measuring the implementation of integrated activities, for example, simultaneous training of health professionals in HIV- and TB- related rights concerns, was also, in some cases, a challenge, especially when implementing agencies emphasized one aspect of the training in their reports and interviews. The results from both the program scoring and the qualitative interviews should be understood as intended primarily to provide feedback and assist country programs in their planning of future activities.

Overall Scorecards for HIV and TB

All countries saw progress in removing human rights-related barriers to HIV services, with a mean increase of 0.9 points from baseline on the 0-5 scale.¹ However, even the top five scoring countries (Ukraine 3.7, Jamaica 3.5, Botswana 3.3, Senegal 3.1 and Kenya 3.1) are falling short of the scores that would represent a comprehensive response at a national level (above 4.0). Sierra Leone (+1.7), Jamaica (+1.6), Cameroon (+1.3) and Mozambique (+1.3) showed the greatest increase in scores.



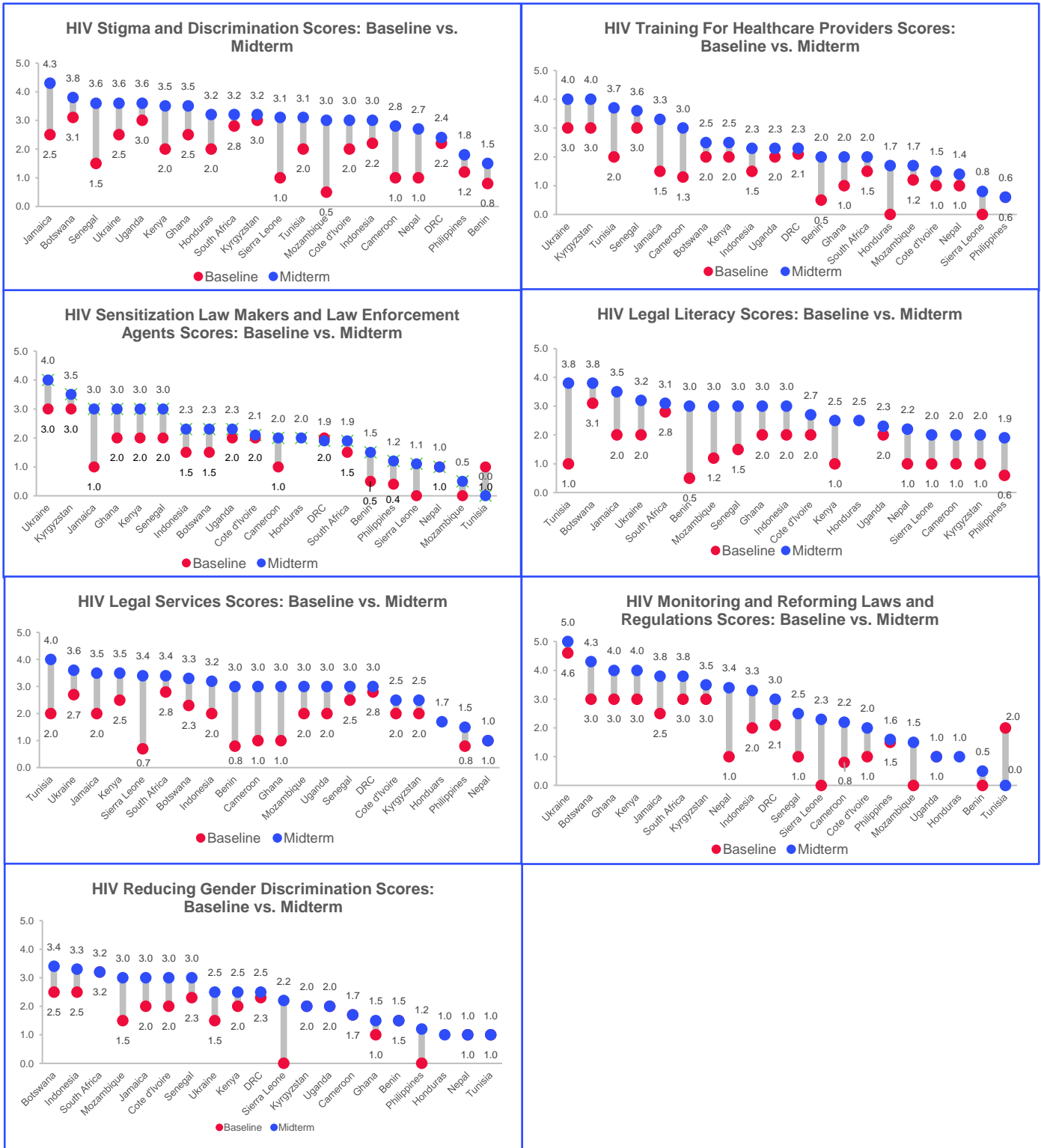
All countries surveyed also showed progress on TB programming.² The TB scores at midterm ranged from Ghana (2.8) to Sierra Leone (0.2), with an average increase from baseline of 0.6. For many countries, addressing human rights barriers to TB services entailed the development of new interventions, and the progress reported in the mid-term assessment reflects a rapid expansion. The greatest increase was seen in Ukraine (+1.1) and Côte d'Ivoire (+1.5).



¹ In Honduras, not all baseline HIV program area scores were calculated, so there is not an overall baseline score.

² In Ghana, no TB baseline scores were calculated. In Sierra Leone, the baseline was 0.23 and midterm was 0.24. The graph displays values to one decimal point.

HIV Program Findings³



³ Scores with only a single dot and the same numerical value above and below the dot reflect a score that did not change. If there is no number below the dot, the country did not have a baseline score. Or, if both scores were 0.0, there is writing only above the dot. See individual country reports for more details.

The midterm assessment found considerable overall progress in breaking down human rights barriers to HIV care and treatment. In the context of a global pandemic that disrupted public health programs of every kind and diverted resources away from non-COVID-19 public health issues, this is an achievement worth celebrating.

Programs to address stigma and discrimination expanded in all countries. This included a range of different efforts, from social media campaigns, radio programs, and community dialogues to updating or implementing the HIV Stigma Index and anti-discrimination laws. Jamaica scored highest at midterm at 4.3, with programs reaching over 35% of target populations on the national level, and Benin scored lowest at 1.5, meaning activities remained one-off. Fifteen countries scored 3.0 or higher at midterm, which indicates programs operating at the subnational level or higher. The average increase was 1.2, with the greatest progress in Mozambique (+2.5), Senegal (+2.1) and Sierra Leone (+2.1). In Mozambique, this growth was credited largely to the Viva+ Project, which implemented community dialogues and radio programs to address stigma and discrimination in 11 provinces and 63 districts. Evaluators noted that Viva+ was gender-responsive with a focus on human rights violations experienced by women and girls. The radio programs also served to disseminate COVID-19 transmission information along with information on legal services. Efforts to address stigma and discrimination were often integrated with other programs, especially human rights training for health care workers and police as well as legal literacy and “know your rights” campaigns for key populations. These efforts often included input and leadership from key populations. For example, in Côte d’Ivoire, Alliance-CI has been reconceptualizing the “Looking In, Looking Out” (LILO) sensitization and training program (a stigma reduction initiative piloted by Frontline AIDS) and extending it to 60 health districts.³ In parallel, and in keeping with a recommendation from the baseline assessment, Alliance-CI has trained key population representatives as advocates and to serve as members of Community Advisory Boards (CAB) for key HIV services providers, to ensure that stigma and discrimination concerns are dealt with through dialogue between service providers and service users.

Botswana: Reducing Stigmatization of Key Populations

When community dialogue work began, many traditional chiefs were hostile to key populations (transgender and intersex people, men who have sex with men, sex workers), with some openly declaring that they did not want them in their communities. When organizations led by and representing key populations facilitated dialogues with traditional leaders to discuss issues related to human rights, harmful gender norms and gender-based violence, they observed how these conversations have helped break down barriers. One informant described the immediate impact: “By the time the traditional chiefs walked out the door, they had completely changed. The power of bringing people directly affected to represent issues caused... a real breakthrough.”

All countries also saw progress on training for healthcare providers, except the Philippines, whose programs remained at the level of limited one-off activities. The Philippines report noted that the only trainings were conducted by TLF Share and faced funding limitations. Ukraine and Kyrgyzstan scored highest at midterm at 4.0 (programs were at the national level but reaching under 35% of the target population). The average increase was 0.9, with the greatest increase in Jamaica (+1.8), Tunisia (+1.7), Honduras (+1.7) and Cameroon (+1.7). The midterm reports highlighted many successes in this area. In Botswana, in-service training of health care workers on human rights and patient-centered care has been led by civil society organizations, including key population-led organizations. Supported by the Global Fund, the Botswana Network on Ethics Law and HIV/AIDS (BONELA) trains health care workers in five districts on human rights and ethics, key populations, and recognizing and responding to gender-based violence. These “values clarification workshops” are meant to enable trained workers to sensitize their peers. Sisonke Botswana and BONELA also organize quarterly training of health care workers on sex work and human rights in four districts, supported by Aidsfonds. Similarly, in Kenya, the National AIDS and STIs Control Programme (NASCOP) trained more than 300 health care workers across 47 counties in a “training of trainers.” NASCOP also recently sought to address health care workers’ knowledge gap of HIV, the law and human rights violations via resources that were disseminated to workers in 10 “high stigma” counties. Several county-level initiatives to train community health volunteers are underway, with plans to scale up training of community health volunteers in every county. In Turkana and Meru Counties, for example, Kenya Red Cross Society has trained 1000 community health volunteers on human rights and HIV. With support from UNDP, the Kenya Legal & Ethical Issues Network on HIV and AIDS (KELIN) also trained 42 community health volunteers in 2020 to document human rights violations including among key populations.

Programs for training of lawmakers and law enforcement officers saw a wide range of scores. Ukraine scored the highest at midterm at 4.0, indicating programs operating at the national level, and Tunisia scored lowest with no programs. All but two countries reported positive progress, with an average increase of 0.6, with the greatest increase seen in Jamaica (+2.0). In Tunisia, trainings had been planned but were postponed as the police were mobilized for the state of emergency declared in the wake of the COVID-19 pandemic. It was noted by key populations in various countries that working with police was a significant issue that needed to be addressed, and that creating cultural shifts in police departments is a long-term goal that requires sustained efforts. This point is addressed more in the “Cross-Cutting Issues” section of this report. Many countries did see trainings with police implemented, which included input and engagement from key populations. For example, in Jamaica, more than 1,000 police officers were trained in 2019-2020 in protecting the human rights of PLHIV and key populations, including pre-service recruits at the national police academy and in-service trainings that reached regional and divisional leaders in addition to the rank and file. These programs were coordinated by the Enabling Environment and Human Rights Unit and led by a coalition of CSOs representing a diversity of constituents, including Jamaican AIDS Support for Life, Jamaicans for Justice, Equality for All, J FLAG, Eve for Life, Jamaican Community of Positive Women, Transwave, and others.

Sierra Leone: Changing Attitudes of the Police towards Harm Reduction

In December 2019, the Legal Aid Board and Social Linkages for Youth Development and Child Link (SLYDCL) organized a meeting with the police and key government officials on harm reduction interventions in the country, which resulted in a collective agreement from participants to support needle and syringe programs. Today, all of Sierra Leone's local unit commanders have been informed that SLYDCL is implementing a needle and syringe program. According to National HIV/AIDS Secretariat staff, "We now have police able to recognize people who work with injectors who distribute syringes and needles.... This is breaking ground."

Legal literacy showed significant progress and high scores at midterm across the countries. This progress is significant because it suggests a high level of community engagement with key populations. Ten countries scored a 3.0 or higher at midterm, which indicates programs at the subnational level (20-50% of the country's geographic area). The average increase was 1.2. The Philippines scored lowest at midterm, with a score of 1.9. Tunisia had the highest score of 3.8 as well as the greatest increase (+2.8) from baseline. It is also notable that Benin increased by 2.5 points, with the lowest baseline score of 0.5 to 3.0 at midterm. The Benin report notes the success of six legal assistants from Plan Benin who conducted 162 sessions with key populations between 2018 and 2020. A training module was also developed for transgender people who wanted to serve as peer educators on human rights concerns related to HIV prevention and treatment, with 68 people successfully completing the training. Many countries described programs' "one-stop-shop" for key populations to receive a wide range of care as well as legal literacy training in one location. In Côte d'Ivoire, the community center Marcory CASA was opened to offer holistic services to people who use drugs. Within the center, a multidisciplinary team made up of doctors, nurses, social workers, peer educators, and a lawyer work in close collaboration to provide an environment that is stigma-free and takes into account the specific needs of people who use drugs. All beneficiaries are sensitized on the themes of HIV, tuberculosis, and harm reduction. Similarly, in Indonesia, the 4 Pillars program implemented in 23 districts features one or more teams that include a paralegal, an anti-retroviral access specialist, an "enumerator" who assists the paralegal, and a focal point person to coordinate the team and facilitate engagement with the community.

Benin: Praise for Trainings of Health Care Providers

In Benin, one key informant noted that while stigma had previously been widespread, health structures now "know how to accommodate key populations and listen to them." *Plan Benin* said it had observed that several health facilities, including some regional public hospitals, have become particularly welcoming to key and vulnerable populations.

The scores for HIV legal services were also high at midterm and showed progress for all countries, with only three countries (the Philippines, Honduras and Nepal) scoring below 2.5. Tunisia scored highest at midterm, with a score of 4.0, and Sierra Leone reported the largest increase (+2.7). In Tunisia, the success was attributed to the spread in geographic coverage of community paralegals and the development of a digital referral platform for legal assistance and notifications of human rights violations related to HIV cases, which will also include a mapping of all governmental and non-governmental legal assistance services available for vulnerable populations in the country. The platform was launched in March 2021. Legal services and paralegal programs were often integrated with legal literacy and reform efforts as part of “one-stop shops” for key populations. For example, in Cameroon, the organization CAMNAFAW organizes legal aid clinics or “cafés juridiques” together with community-based organizations and at drop-in centers, often with participation of legal professionals. In the Democratic Republic of the Congo, the Center of Expertise in Human Rights and Criminology/Public Health (*Centre d’Expertise en Droits Humains et Criminologie/Santé Publique*, CEDHUC) has put in place legal clinics which provide legal, psychosocial and medical referral services to vulnerable groups, and implement awareness and capacity building activities on human rights related to HIV, gender, sexual violence, and sexual and reproductive health. According to the most recent data available, in 2018, more than 4,300 people had been trained or sensitized in 39 sites in Kinshasa. Regarding psychological and legal services, in 2020, they reported that 233 people benefited. More examples of legal services can be found in the “Emerging Evidence of Impact” section of this report.

The area of monitoring and reforming laws and regulations saw a wide range of scores at midterm, from 5.0 to no programs. The range is understandable, given the diverse political climates in which programs are operating. Ukraine received the highest possible score of 5.0, and the largest increase was seen in Nepal (+2.4) and Sierra Leone (+2.3). In Honduras, a coalition of civil society organizations has been working on developing an equality and equity law. The coalition includes a wide range of communities that experience human rights violations (including various LGBT groups, women’s rights organizations, sex worker groups and others). Coalitions were working on similar laws in Jamaica, Indonesia, and the Philippines. Despite this progress, key informants reported a need to do more, especially considering a rise in attacks against LGBTI activists during COVID-19. Tunisia was the only country to report a decrease in activities related to monitoring and reforming laws and regulations. This was due to the COVID-19 pandemic, and activities were planned for 2021.

Mozambique: Expanding Programming on Sexual and Reproductive Health and Gender Based Violence

The Viva+ project, supported by the Global Fund, reached 100,000 women, girls, transgender women, and men who have sex with men, with human rights education sessions that included modules focused on sexual and reproductive health and gender-based violence. This was hailed as a critical part of Mozambique’s broad and sustained efforts to reduce the disproportionate burden of HIV on young women and girls, including female sex workers.

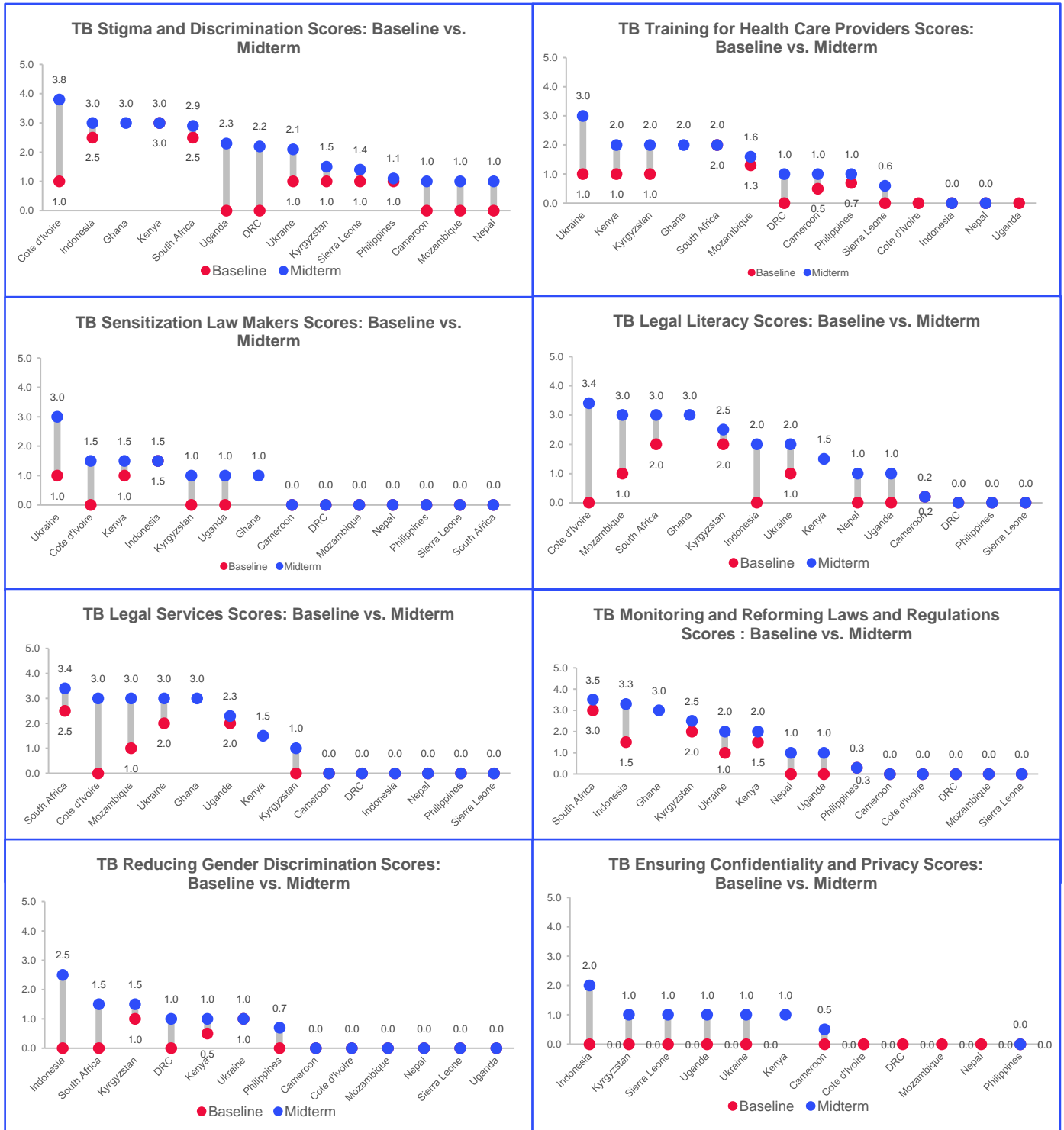
In the area of reducing gender discrimination, there was some notable progress but less than in other areas. Botswana scored highest at midterm at 3.4, indicating programs at the subnational level. Seven countries scored 3.0 or higher. The greatest increase was seen in Sierra Leone (+2.2). In Kyrgyzstan, community mobilization among the LGBTI population continued and expanded to include transgender sex workers. This is notable because many countries saw gaps in working with the transgender community. Two- or three-day training programs for sex workers were expanded to include trainees from all regions of Kyrgyzstan. Stakeholders interviewed in the country also reported that key population networks had developed positive relationships with the Republican (government) AIDS Center to address stigma and discrimination by medical doctors. In Mozambique, the Viva+ Project, an initiative to reduce HIV and gender-based violence against young women and girls, was implemented in 11 provinces and 63 districts. It includes two specific stigma and discrimination reduction activities: community dialogues and radio debates. The community dialogues seek to create safe and productive spaces for community discussion of barriers that key populations face in accessing health services. These dialogues are less formal than the legal literacy trainings also provided by Viva+ but play an important role in supporting those programs as they prepare community members, health officials and law enforcement to identify human rights violations encountered by women and girls, sex workers and other key populations and facilitate referrals to paralegals for resolution of conflicts and problems.

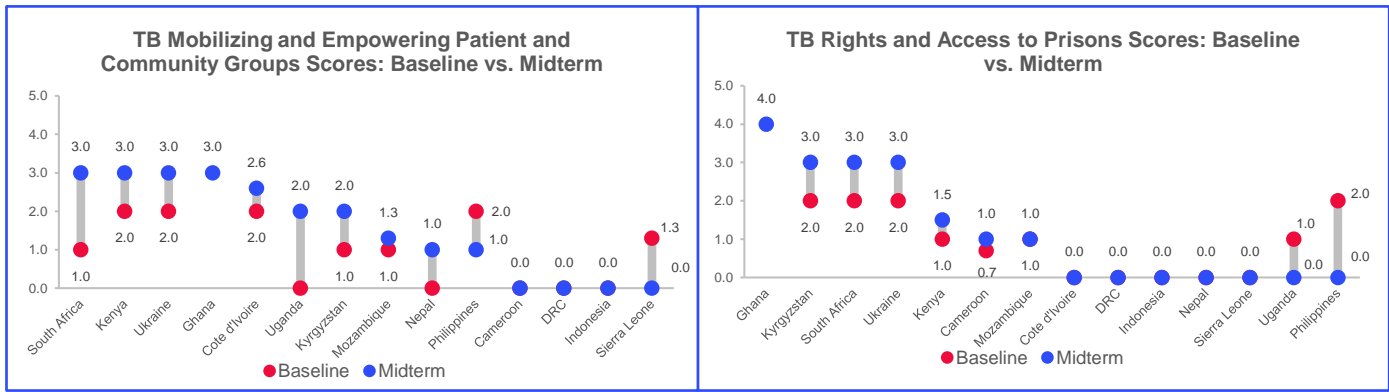
It is worth noting that across program areas, organizations created and strengthened gender-responsive models. As an example, Plan Benin has sought to mainstream a gender component into its work, integrating gender-based violence into its regular biannual consultations with local stakeholders in all 12 regions; it has also integrated gender-based violence into sensitization sessions with law enforcement and judicial officials. Many countries highlighted similar elements in their trainings. Benin also made promising progress in addressing barriers to services for transgender populations by developing a minimum package of services, which in addition to activities related to HIV prevention and treatment includes legal literacy, legal assistance, sensitization of law enforcement, and gender-based violence components. In Botswana, implementers noted that programs to reduce human rights-related barriers for sex workers and transgender people and campaigns to raise awareness of gender-based violence have increased in recent years.

Breaking Down Barriers has also strengthened services for survivors of gender-based and sexual violence. For example, in the Democratic Republic of Congo, the National Network of NGOs for Women's Development (*Réseau National des ONG pour le Développement de la Femme*, RENADEF) has been supporting 16 "listening centers" for the psychological care of survivors of sexual violence. From 2018 to June 2020, almost 2,000 survivors of sexual violence benefited from this service). RENADEF has also supported legal clinics, including one run by the Panzi Foundation, offering legal and judicial support for survivors of sexual violence and other key and vulnerable populations. Other countries, such as Côte d'Ivoire, Indonesia, Philippines and South Africa, highlighted the legal literacy and paralegal trainings offered to trans women, gay, bisexual and other men who have sex with men, and sex workers. There

have also been developments in programs for women living with HIV. For example, in Ghana the NGO Mothers to Mothers (m2m) launched a “mentor mothers” program in 2020, similar to ones it has implemented in other countries, to train women living with HIV to work with pregnant and postpartum women with a goal of elimination of vertical transmission of HIV and support for early child development of children born to women living with HIV.

TB Program Findings⁴





While scores for comprehensive scale up of TB programs to address human rights barriers were lower overall than HIV scores, in nearly every country and program area increases were noted. This was despite the fact that addressing human rights barriers for TB treatment was new and not always well understood in many countries. This progress is especially notable given the number of countries that had no programs at all at baseline (evidenced by a score of zero in specific program areas). Furthermore, TB programs were often integrated into existing programs on human rights and HIV. While this was part of the goal of the initiative, it is possible that the scores may be an underestimation of overall program reach, because it is difficult to assess scale in integrated efforts.

As with HIV, the impact of COVID-19 shifted priorities away from TB and other diseases. TB, in particular, may have been more affected, as TB diagnoses worldwide dramatically decreased, perhaps due to overwhelmed health systems and increased stigma of TB symptoms. As noted in the Ghana report, patients with TB were nervous to come forward because they feared their coughs would be misidentified as COVID-19. To respond to this, the Ghanaian NGO TB Voices Network produced an animated video to raise awareness of the need for people with symptoms of either disease to seek care without being stigmatized. The video reached an estimated 100,000 persons through social media.

Despite these challenges, there was notable growth across countries in programs that addressed stigma and discrimination related to TB. Côte d'Ivoire had the highest score for comprehensive TB programs addressing human rights-related barriers at midterm and the greatest increase. One aspect of their success was the programs implemented by COLTMER, the *Collectif des ONG de lutte contre la tuberculose et les autres maladies respiratoires* [Network of NGOs to fight tuberculosis and other respiratory diseases]. COLTMER activities include community counselors sensitizing patients and their immediate circles on self-stigma, stigma, and discrimination during home visits to patients for medical and social follow-up. All of the country's 113 health districts were covered by the program.⁴ Cameroon, Mozambique and Nepal had the lowest scores at midterm, but all increased from having no programs at baseline. Uganda also showed a significant increase. In Ukraine, it was noted that organizations that work

⁴ Scores with only a single dot and the same numerical value above and below the dot reflect a score that did not change. If there is no number below the orange dot, the country did not have a baseline score. If there is only a blue dot, there was no midterm score. Or, if both scores were 0.0, there is only writing above the dot. See individual country reports for more details.

primarily on HIV have increasingly integrated TB into many of their materials and activities to reduce stigma and discrimination for people living with HIV and people who use drugs. For example, FreeZone, an organization of former prisoners, has integrated TB into its stigma and discrimination reduction work with current and former prisoners as well as penitentiary personnel, but its collaboration with TB People, an NGO led by TB survivors, was apparently minimal.

Progress on trainings of health care providers on TB and human rights was more limited, with various countries showing no progress. Among countries showing progress, Ukraine stands out, with the highest score at midterm. While programs are not all institutionalized, TB People Ukraine is conducting TB-specific trainings for medical students (around 1200 students reached through lectures at 18 medical institutions in 12 regions as of December 2019), TB specialists and general practitioners (37 trainings with about 800 health workers in attendance as of December 2019). FreeZone conducted 30 trainings for penitentiary personnel in 2019 with stigma and discrimination related to TB integrated into the training modules. Three countries had not implemented any programs (Côte d'Ivoire, Indonesia and Nepal). However, the NGO NATA in Nepal did make progress in forming advocacy groups for TB patients in 5 districts of the country. NATA also convened 26 stakeholder meetings with DOTS center staff, civil society and local leaders, including district-level health authorities. These integrated activities and the engagement with health authorities pave the path for future work with health care providers.

Cameroon: Changing Attitudes among Government Officials

In Cameroon, *Breaking Down Barriers* was credited for accelerating the shift in recent years in government officials' attitudes, who are now willing to discuss and address key populations as part of the response to HIV and TB. As one person put it, the *Breaking Down Barriers* initiative "allows us to get different stakeholders to understand there is a link between health, access to justice, the right to education, etc., and that all these questions are interdependent...". One person noted, "key populations can be around the table now with national authorities. This is a big advance."

Progress in programs to sensitize lawmakers was also limited. Seven countries had not implemented any programs by midterm, but other countries showed significant gains, like Ukraine (+2.0) and Côte d'Ivoire (+1.5). Within Ukraine's parliament, a TB platform has about 40 members. Several members of parliament attended a TB conference organized by TB People Ukraine which provided a platform for discussion among parliamentarians, health workers and patients. Trainings for police on HIV also included a TB component. Côte d'Ivoire also saw a notable increase of programs compared to baseline. For example, Alliance CI provided a 3-day training session on HIV, TB and human rights to lawmakers (belonging to the social and security committees of the legislature, as well as members of the HIV and TB caucuses). There was also a concerted effort by various organizations in Côte d'Ivoire to train law enforcement in the protection and promotion of the human rights of people who use drugs, with a focus on TB.

This program has borne fruit as there appears to have been a reduction in the violation of human rights during raids on establishments where drugs are being consumed.

Legal services scores saw a wider range of progress. Although DRC, Philippines and Sierra Leone had not implemented any programs by midterm, Côte d'Ivoire saw considerable progress from the start of BDB, from no programs to a score of 3.0 at midterm. It was noted that about 20 of the 43 NGOs in the COLTMER network had applied the baseline recommendation of building a pool of expert TB patients to support others in managing their care. COLTMER has also been distributing the *Patients' Charter for Tuberculosis Care* to every new TB patient via all the diagnostic and treatment centers (DTCs) and anti-tuberculosis centers (ATCs) covering all the health districts.

The legal literacy area also saw a range of progress, with six countries showing little progress and others, such as South Africa, reporting great success. This work on TB legal literacy and legal services was often integrated into other programs to combat human rights barriers, as is recommended by the Global Fund. For example, in Kenya, KELIN trained 30 community health advocates from Mombasa, Nairobi, Kisumu, Homa Bay and Migori counties on TB, HIV and sexual and reproductive health rights, who then carried out community sensitization forums. With support from the Global Fund and in collaboration with various NGOs, 31 health care workers, 45 community health volunteers and 10 TB champions were trained on TB-related human rights and the law, TB identification, documentation, and reporting. Between May 2018 and May 2019, with funding from Stop TB Partnership, KELIN also worked in six informal settlements in Nairobi to increase knowledge on rights-based approaches to TB.

Democratic Republic of the Congo: Expanding Access to Justice

The Center of Expertise in Human Rights and Criminology/Public Health (*Centre d'Expertise en Droits Humains et Criminologie/Santé Publique* (CEDHUC)) has put in place legal clinics which provide legal, psychosocial and medical referral services to vulnerable groups, and implement awareness and capacity building activities on human rights related to HIV, gender, sexual violence, and sexual and reproductive health (SRH). In 2018, more than 4,300 people were trained or sensitized in 39 sites in Kinshasa. In 2020, 233 people benefited from psychological or legal services at the CEDHUC center.

Monitoring and reforming laws saw modest progress. One example from South Africa is the national policy proposed by TB Proof, which has advocated for better protections of community health workers and health care workers. They are supporting the finalization of a national policy on occupational health of health care workers and accompanying implementation guidelines. In Indonesia, organizations working with the Stop TB Partnership engaged in local and national advocacy to increase budget allocations for TB services. This work continues, and the Partnership has also undertaken significant advocacy efforts to build national political will for TB reduction and accountability for government action. These activities included promoting Indonesia's participation in international fora such as the United Nations High Level Meeting

(UNHLM) on TB in 2018 and hosting two side events during this convening with the Ministries of Health, Labour, Law and Human Rights and other relevant stakeholders. The Stop TB Partnership also helped secure Presidential Declarations in 2019 and 2020 that emphasized sustained commitment to eradication of TB, an intersectoral response, and a commitment to patient-centered, gender-responsive care based on human rights.⁵

Reducing gender-based discrimination also saw modest progress, with a highlight being again the work of the Stop TB Partnership in Indonesia, which wrote a report on the gender-related dimensions of TB in the country and began to develop a multi-sectoral response that involved the Ministries of Health, Female Empowerment and Law and Human Rights and development of gender equality indicators for monitoring and evaluation. The country's multi-year plan also recommends supporting the National Commission on Violence Against Women to strengthen programming related to the intersection of HIV, TB and gender-based violence.

Important progress was seen in expanding programs to ensure patient confidentiality and privacy. In Ukraine, the MTA found that confidentiality and privacy are integrated into the healthcare workers trainings, especially those conducted by TB People Ukraine. The declaration on the rights of people with TB, which TB People developed as a tool for legal literacy training of health workers, government officials, civil society actors and patients, contains strong provisions on confidentiality and privacy. Less progress was identified for scaling up programs to mobilize and empower patient groups. However, the South Africa assessment noted that various NGOs were working with patient groups. One example was the NGO TB Proof, which is run largely by former TB patients. They have organized support groups of TB patients, providing information to TB patients and their families on applying for TB social assistance grants. Another NGO, TB HIV Care, has conducted workshops on TB advocacy for community groups and other civil society organizations and has engaged civil society in consultations on TB advocacy priorities.

Increasing attention to TB rights in prisons was found to be extremely limited, with the greatest evidence for progress in this area coming from Ghana and Ukraine. In some cases, such as work by the organization FreeZone in Ukraine, efforts in this program area were delayed due to COVID-19.

Malaria Program Findings

For many countries, addressing human rights related barriers to malaria prevention and treatment is a new focus for programs that have traditionally focused on the widespread provision of bed nets and improving clinical treatment, with attention to women of childbearing age and children. As highlighted in the baseline reports, malaria is a disease that also has a disproportionate burden on those in poverty, including refugees and migrants who may be displaced from non-endemic to highly endemic areas and may be particularly vulnerable because they have little or no acquired immunity. Economic, linguistic, cultural and legal barriers may make it more challenging for these populations to access traditional means of prevention (e.g., insecticide-treated bed nets), chemoprevention (e.g., for pregnant women) or treatment.⁶

The midterm assessment examined Global Fund-supported programs that address rights-related barriers to malaria prevention and treatment in Uganda and Kenya, two countries with a significant malaria burden. For example, according to the United Nations High Commissioner for Refugees, 930,000 refugees are infected with malaria every year in Africa. Uganda hosted 1.3 million refugees and asylum-seekers in 2017, the vast majority fleeing war and human rights abuses in malaria-endemic South Sudan, the Democratic Republic of Congo and Burundi.⁷ In Kenya, more than 70% of the population live in areas endemic for malaria.⁸

Malaria Program Scores

Program areas	Uganda		Kenya	
	Baseline	Mid-term	Baseline	Mid-term
Reducing gender-related discrimination and harmful gender norms	0	1.0	*	0.5
Promoting meaningful participation of affected populations	1.0	1.0	0.5	1.5
Strengthening community systems for participation	1.0	2.0	*	2.0
Malaria programs in prisons and pre-trial detention	*	*	*	*
Improving access to services for underserved populations, including for refugees and others affected by emergencies	*	1.0	1.0	1.0
Overall score	0.7	1.3	0.8	1.3

Uganda

The midterm assessment in Uganda found that the concept of removing human rights-related barriers to malaria services is still new to many stakeholders in the country. While there are promising developments, including a strengthening of community health systems for the malaria response, concerted efforts are needed to raise awareness around the human rights-related elements for malaria.

The US President's Malaria Initiative's (PMI) activities in Uganda continue to integrate discussions of harmful gender norms in PMI's communications and behavior change strategy. Moreover, according to the National Malaria Control Program (NMCP) in the Ministry of Health, it has also been working to address gender norms.

As noted at baseline, the malaria response in Uganda uses village health teams to disseminate malaria-related communications and community mobilization for behavior change and to create demand for services. In 2018, Uganda launched a campaign aimed at having a malaria-free Uganda: Mass Action against Malaria (MAAM). In the same year, the UK-funded Strengthening Uganda's Response to Malaria (SURMa) 6-year project began to build community-level capacity to diagnose and treat malaria. MAAM is implemented in 17 districts, and SURMa in these 17 and 9 others. Each district has a task force comprised of technical and political stakeholder that is responsible for mobilizing communities and sensitizing them on malaria and other health issues. The SURMa project complements this effort by providing technical assistance to village health teams and community health workers.

While the MAAM campaign and SURMa project provide a promising framework for promoting the meaningful participation of affected populations, the midterm assessment was not able to collect information on the extent of the community mobilization work. Moreover, the midterm team echoes the concerns of the baseline assessment related to weak support for health facilities for mobile populations in Karamoja and in hard-to-reach mountainous areas.

At midterm, the NMCP reported that the adoption of Integrated Community Case Management (ICCM) – the training of selected community members in the skills required to diagnose, treat, and refer cases of diarrhea, malaria, and pneumonia -- was operating in 78 districts and helped strengthen health and community systems. ICCM targets children under 5 years old and relies entirely on village health teams. Since baseline, there have been trainings for frontline workers, as well as improvements in community reporting systems and supply chains. While this is a positive development in the overall malaria response, the MTA team was unable to fully assess the extent to which community health systems strengthening has improved meaningful participation in malaria programming.

The NMCP noted that there were two specific campaigns (one from 2017-18 and another from 2020-21) that distributed long-lasting insecticide-treated mosquito nets to refugee settlements in Uganda. These nets were also routinely distributed through antenatal care and immunization clinics for refugees. There was no information provided on how considerations of equity, non-

discrimination and other rights-related barriers might have been addressed by this work, nor was information available on efforts to address rights-related barriers to malaria services in prisons and other closed settings. However, activities to address human rights barriers to vector control in prisons are included in the final stage of funding, and the end-term assessment will seek to capture their results.

Kenya

Several promising developments in relation to malaria and human rights provide a strong foundation from which to develop and implement human rights programs. The *Kenya Malaria Strategy (KMS) 2019-2023* considers adherence to the principles of human rights, gender and equity as one of its guiding principles, and strives to ensure universal access to malaria interventions among all members of the community, including the “vulnerable, marginalized, and special groups.”⁹ A newly formed national technical working group on human rights and gender includes, for the first time, malaria stakeholders. And in 2021, the Kenya NGOs Alliance Against Malaria (KeNAAM) carried out a rapid mapping of malaria civil society organizations to inform the Malaria Matchbox Assessment scheduled to be undertaken later in 2021, and to build the capacity of those organizations to meaningfully engage in the assessment. 308 partners were identified that will form 15 clusters required for the Malaria Matchbox Assessment.

However, consistent with the findings at baseline, few programs were identified to address human rights-related barriers to malaria services, and commodities and service delivery remain the focus of most malaria programming, which key informants attributed to limited human rights expertise and resources. Nonetheless, malaria assessments have been carried out that include a focus on gender and human rights and have been used to inform the *Kenya Malaria Strategy 2019-2023*.

While the *Kenya Malaria Strategy 2019-2023* indicates that prisons are to be included in indoor residual spray campaigns and in malaria performance monitoring, diagnosis, and treatment efforts, people in prison and other places of detention continue to face challenges accessing malaria prevention and treatment services, such as bed nets, indoor residual spraying and malaria diagnostic tests and treatment. The National Malaria Program does not directly implement programs in prisons and only supports the prison department based on expressed needs. UNHCR has also distributed bed nets and insecticides in refugee camps, while the Kenyan government has provided people living with HIV free access to long-lasting insecticide-treated nets as part of the HIV Basic Care Package.

According to key informants, because malaria is not subject to stigma in the way that HIV and TB are, community health volunteers can engage in a broad range of activities including information and support around reproductive health and sanitation. However, a 2019 court ruling found that community health volunteers were not permitted to administer malaria testing, making community-led approaches to address malaria more difficult. The National Malaria Control Program has tried to comply with this court ruling by revising the curriculum for

community health volunteers to ensure there is quality assurance in diagnostics, safety guidelines, supervision, adequate training, and potential enrollment with regulatory bodies. Advocacy has also been undertaken to mobilize resources for adequate bed net access. A “Mass Net Distribution Campaign” by the Ministry of Health involves community sensitization, training of health care workers and volunteers, registration of households, and distribution at a fixed post.

On the whole, key informants observed that the level at which Kenya’s malaria programs have come to embrace human rights and gender in programming is encouraging. Additionally, the engagement and representation of malaria-affected communities across decision-making platforms has continued to bring positive change in human rights programming, though community-led organizations need to be adequately resourced to participate and there remains a gap in coordination of programs and inadequate monitoring and evaluation systems.

Impact of COVID-19

The significant progress made across HIV, TB and malaria programs should be considered within the context of the devastating challenges of two years of the COVID-19 pandemic. Starting in early 2020, the pandemic impacted all aspects of life across the globe. Many countries included in *Breaking Down Barriers* reported programs halting or significantly decreasing their work due to the pandemic. Others shifted to online and telehealth models where possible. In the context of lockdowns and increased isolation, communities across the globe witnessed an increase in human rights violations and gender-based violence. It should be noted that some of the groundwork laid by HIV, TB, and malaria programs also helped improve the pandemic response and respond to human rights violations. The following are examples from a few countries of adaptations made in response to the pandemic. As noted in the Global Fund's guidance on human rights in the time of COVID-19, a rights-based and gender-responsive approach is the best way to respond to COVID-19.¹⁰

Many stakeholders, across all countries included in *Breaking Down Barriers*, described creative and innovative adaptations to the challenges of the pandemic, from virtual programming and added sanitation precautions to expanded mental health services for staff and program beneficiaries. It is important to note that the midterm assessments occurred between 2019 and 2021. It is therefore difficult to make comparisons between countries as to their approaches to the COVID-19, because some assessments were in the early days of the pandemic and others after over a year. However, the impact of COVID-19 on programs will be closely examined in the end-term assessment.

In Jamaica, CSOs applied telehealth sessions as an alternative to in-person clinical care. They also mobilized funds to pay for taxis for individuals at high risk of COVID to access clinical care instead of taking crowded public transportation. In Indonesia, a Global Fund-supported emergency call service was developed for people to receive psychological support. The Indonesian government also agreed to the emergency release of 30,000 vulnerable prisoners, including people who use drugs, to prevent them and others from getting COVID-19. Similarly, in Kenya, the Ministry of Health and county governments adapted to COVID-19 by using virtual platforms, extending drug collection schedules, implementing measures to allow patients already on treatment to continue collecting their drugs, and arranging for health care workers to deliver medicines to people's homes (and exempting some workers from movement restrictions to deliver essential services to households in need).¹¹ The National AIDS and STI Control Programme (NAS COP) and implementing partners and donors worked to ensure the continuity of key population service delivery during the pandemic. NAS COP created technical guidance on issues ranging from setting up virtual coordination platforms and capacity building of service providers on HIV in the context of COVID-19, to advocacy efforts to raise resources so that service providers, including key population-led outreach workers, have personal protective equipment (PPE) and sanitizer. Mobile dispensing services for people who use drugs were also established to enhance service delivery along with the formation of virtual psychosocial support

groups and hotlines to respond to incidents of violence and facilitate distribution of food baskets to the vulnerable.¹²

In some cases, organizations working on TB and HIV took on stigma and treatment issues related to COVID-19. For example, in Botswana, BONELA prepared a series of COVID-19 policy briefs, touching on issues ranging from COVID-19-related stigma to COVID-19 and gender-based violence — the latter in collaboration with Sisonke Botswana. Similarly, in South Africa, the NGOs TB HIV Care and TB Proof, recognizing the risk from COVID-19, advocated for better support and protection for community health workers (CHW). TB HIV Care conducted rallies in support of the rights of CHWs and in 2020 established a solidarity “care fund” to mobilize resources for personal protective equipment (PPE), psychosocial services and other support for these workers. In Uganda with Global Fund support, the Human Rights Awareness Promotion Forum’s (HRAPF) work addressed violations of human rights resulting from COVID-19-related lockdowns, providing stipends to over 80 paralegals across Uganda and, in 2020 alone, supporting 1,000 cases. HRAPF was also able to file litigation to support the rights of LGBT persons who were arrested during COVID-19 raids.

Ghana provided an interesting example of human rights programming in the context of COVID-19. The Ghana-West Africa Program to Combat AIDS and STI (WAPCAS) mobilized many of the partners already active in the implementation of the Human Rights Strategic Plan to be part of a rights-based response to COVID 19 that included raising awareness of stigma and other human rights concerns and monitoring and following up on COVID-19-related human rights violations. Information materials disseminated through social media and radio messages were meant to inform people about COVID-19 and avert discrimination, gender-based violence and other abuses. Messaging included information on access to legal services and advice should the need arise. These activities resulted in multiple queries from the public to the legal and public health experts mobilized for this purpose. In addition, WAPCAS organized food assistance for people living with HIV and TB and key populations, reaching over 8000 persons. WAPCAS judged these activities to be helpful in keeping COVID-19-related fears from undermining health services for marginalized persons more broadly.

Cross-Cutting Issues

The Global Fund has outlined guidance for what constitutes quality programming.¹³ The guidance emphasizes that programs should strive to:

- 1) Align with the national plan for disease response;
- 2) Utilize existing sources of information;
- 3) Be integrated into existing prevention, treatment, key population programming, and community outreach services;
- 4) Combine different programs to maximize impact in one location;
- 5) Avoid duplication/gaps;
- 6) Avoid one-off programs;
- 7) Build capacity and sustainability;
- 8) Recognize and address the context of beneficiaries;
- 9) Use local capacity to build on good existing programs;
- 10) Be gender-responsive;
- 11) Address safety and security; and
- 12) Build in monitoring and evaluation, focusing on access to services.

With these points in a mind, the midterm assessment found several common themes related to progress and challenges among countries in *Breaking Down Barriers* as they sought to improve the quality of HIV and TB programs serving key and vulnerable populations.

Quality

A central issue for almost every country was monitoring and evaluation. Many stakeholders mentioned limited funding and capacity as challenges to efforts made to improve data collection necessary for ongoing evaluation of program impact. In some countries, the midterm assessment highlighted the lack of clear indicators by program implementers and in some cases, such as South Africa, sporadic data collection impacted the ability to assess current progress in *Breaking Down Barriers*.

Some countries (such as Côte d'Ivoire, Tunisia, Senegal, and Honduras) reported gaps in programs for certain key populations, such as transgender people, women, and male sex workers. In Senegal, for example, the midterm assessment team noted a need to pay greater attention to young people and women among key populations, as well as people in prison. Transgender people are not included in the current National Strategic Plan against AIDS, and the baseline assessment identified gaps in the provisions of services for transgender women.

In a similar vein, researchers in a few countries highlighted a need to increase integration into or linkage with prevention and treatment services and key population programming, whenever possible. For example, in Indonesia, the 4 Pillars program for paralegal workers was judged to need better coordination with the Ministry of Health on trainings of health care workers. Similarly, the police sensitization intervention at Jakarta Central Station was identified as not connected enough with the paralegal services provided in that location. Geographic limitations are also an issue in Indonesia, Sierra Leone, and other countries, where programs remain clustered in one central area with limited access to the rest of the population. This was both due to general limitations of HIV programs in countries like Indonesia, where the geography poses a barrier to access, and an issue of clustered investment in other countries like Sierra Leone.

Many countries mentioned a need for institutionalization of the trainings for healthcare workers and police into ongoing required training, including pre-service training. There were concerns that the trainings would not be sustained after the Global Fund, in part due to funding and in part due to a lack of commitment from the government. In addition, where there was training, there were some concerns that the training had not been linked to accountability mechanisms. For example, in Kyrgyzstan, the midterm assessment noted that accountability mechanisms that proved to be effective in the past, such as strategic litigation, have been discontinued and that new mechanisms, such as Trust Councils or the Council to Defend Rights of Vulnerable Populations at the Ombudsman's Office, have not been developed enough to be effective in holding officials accountable for serious and systemic human rights violations. The end-term assessment may be able to assess if this problem continues or has been addressed.

Political Will

Some of the midterm assessments also highlighted the need for governments to take on more ownership and provide political leadership for health and human rights programming. In certain cases, such as Nepal, larger political instability has made it difficult to create lasting commitments from government officials. For example, several midterm assessments discussed the need for the government to take more leadership in institutionalizing sensitization efforts with health care workers. However, some countries, like Ukraine, noted progress, for example, on city-level initiatives to adapt human rights policies.

Reflective of the challenge of changing laws, regardless of some level of political will, a number of mid-term assessments noted the continued presence of laws that discriminate against key populations, such as laws that criminalize same-sex intimacy and restrictions on harm reduction programs for people who inject drugs. These laws make it difficult for key populations to safely access services. The reports from Botswana and Ghana, among others, noted the need for greater political will to address this issue. In Botswana, key informants described a lack of strong leadership on the part of government stakeholders to address and remove barriers, even within the Ministry of Health and Wellness. At the same time, the Botswana Court of Appeals did uphold the ruling that decriminalized same-sex intimacy. In Ghana, stakeholders noted that the backlash against LGBTQ people is an urgent human rights crisis and a profound threat to

the national HIV response. While outreach activities to this population have been able to continue to some degree, it is a significant barrier to both health and human rights that LGBTQ outreach workers should have to have a network of safe houses or that training on a system of reporting human rights violations was delayed because of the backlash around LGBTQ rights.

Financial Sustainability for Programs to Remove Human Rights Barriers

Many midterm assessment reports noted concern about sustainability of programs to remove human rights-related barriers because of reliance on external funding for these programs. A number of donors to these programs were noted -- including PEPFAR/USAID, UN agencies, the European Union, the Open Society Foundations and AIDS Fonds -- though in many countries the Global Fund was the only or the most prominent supporter of these programs.

In addition to sustainability concerns, there were also issues of programs being siloed because of a lack of coordination between funders and competing priorities, making it unclear which funds could support ongoing human rights initiatives. *Breaking Down Barriers* was identified as a leader in creating better coordination. In a few countries, key informants stated that donors became potentially more open to funding human rights programs because of the leadership of the Global Fund.

Kyrgyzstan: Leveraging Donor Support

In Kyrgyzstan, it was noted that the Global Fund's leadership has made other donors more open to funding human rights programs. As one informant stated: "We've supported human rights work in Kyrgyzstan for a long time, but our work has a narrow focus. Due to *Breaking Down Barriers* we can extend our work onto health issues much further in terms of how long we can continue our support and in terms of how many issues we would be willing to cover."

Technical and other Partnerships

Besides the Global Fund, UNAIDS was the primary partner mentioned in most countries. The UNDP, USAID/PEPFAR, UNFPA, UN Women, and the European Union were also discussed. For example, in Ukraine, UNAIDS has played a role as convenor and technical assistance provider at every stage of the process. UNDP also recognized the synergies between the initiative and its own work on the legal environment and developed a focus on working with cities that have been significantly impacted by HIV and TB to address human rights-related barriers. This work resulted in the above-mentioned city-level human rights strategies in Dnipro, Kyiv, and Odessa.

The Global Partnership to Eliminate All Forms of HIV-Related Stigma and Discrimination, convened by the Global Fund, was also mentioned as an important source of support since 2020. For example, in Jamaica, the Global Partnership represents a sustained commitment in

this area and incorporates funding from other donors such as PEPFAR. The engagement of the Office of the Public Defender and the Ministry of Labour in the Partnership also lends important multisectoral support for Jamaica's HIV response.

The Stop TB Partnership was mentioned as a technical partner in several countries (Kenya, Mozambique, the Philippines, South Africa, Uganda, Ukraine). Activities supported with technical guidance from Stop TB included social media and awareness campaigns, a pilot program for reporting discrimination in health care settings in Mozambique, and a legal and policy assessment for a gender-sensitive TB response in the Philippines.

Other examples of work undertaken by partners in *Breaking Down Barriers* countries include: In Jamaica, USAID and PEPFAR support law and policy reform efforts along with its primary focus on clinical activities. UNFPA provides support for developing and implementing the National Trans and Gender Non-Conforming Health Strategy. The European Union provides important support for women and girls through its Spotlight program that focuses on sexual and reproductive rights and reducing gender-based violence. In Indonesia, UNAIDS led the preparation of a position paper identifying programmatic gaps in the HIV response that urges increased government action to ensure sustainability of human rights programs for key populations. UN Women provides technical assistance to many women-led organizations to increase their capacity for participation in Global Fund programming initiatives and supports implementation of programs to combat gender-based violence and discrimination. Importantly, UNDP has also prepared a report on HIV, human rights and gender and has committed to supporting the HIV sector to use SP4N- LAPOR.

Community Engagement and Support for Community Organizations

Overall, there were many positive examples of community engagement, as have been highlighted in other sections of this report (see: program area scores and "Emerging Evidence of Impact").

Many midterm assessments noted the need for more support for community organizations. In some cases, stakeholders reported that funding has prioritized more established organizations instead of emerging organizations that may be more grassroots-level and led by key populations. In Cameroon, for example, they noted that community organizations were treated more as implementers than as strategic partners and sometimes lost ownership over programming when larger organizations became involved. In Honduras, stakeholders noted the need to increase community organizations' capacity, particularly for project management and financial administration.

Emerging Evidence of Impact

Legal Services

In most of the BDB program countries, funding was provided for the training and support of paralegal workers. These were often peer paralegals – that is, people living with HIV reaching out to others living with HIV, sex workers reaching out to their peers, etc. Paralegals in these programs may be charged with legal literacy sensitization for their “clients”, help in navigating legal or judicial processes, and referral to a lawyer when needed. Discrimination and exclusion from access to prevention and treatment services are often the central problems paralegals help to address, but for criminalized key populations they may also help in informing people of their rights when searched or arrested by police, the nature of possible criminal charges, and when they may need a criminal lawyer.

In **Mozambique**, for example, paralegal programs have expanded significantly in recent years, with three NGOs training and deploying paralegals in 11 provinces under Project Viva+. In addition to achieving successes in supporting people excluded from health services, paralegals in the Tete district helped secure the release of 45 sex workers, who were detained by a community safety council for possession of condoms. The NGO Namati, which has pioneered programs working with paralegals and health advocates in Mozambique,¹⁴ is one of the key organizations supporting the trainings. Namati has also opened a training center that will allow civil society groups from across the country, working on diverse health issues, to send representatives to be trained as paralegals. Namati is working to integrate legal literacy and paralegal programs with the work of village health committees and other structures that can improve accountability of health services to everyone in the community.

Paralegal programs can also be used to support specific groups at high risk for human rights abuses. For example, in **Senegal**, since the start of BDB initiative, 118 sex worker paralegals from across the country have been trained with the support of the Global Fund, the Foundation for a Just Society (FJS) and Mama Cash. These trainings were implemented by the NGO And Soppeku. During the trainings, paralegals received legal information relevant to sex workers (sex work-related legislation, sexual violence, civil status, etc.), and were trained to document rights violations and understand the challenges of the current legal environment, including interactions with police. Sex workers who interacted with the paralegals reported that the service helped them to know when and how to lodge criminal or civil complaints, including for such matters as discriminatory treatment in health services or extortion and other abuse by police, as well as civil matters such as vital registration. Sex workers also reported that the intervention raised awareness among law enforcement authorities about legal and illegal policing practices related to sex work and among health care providers on respectful practices. In addition, sex workers said that the capacity to stand up against discrimination and other human rights violations, and possibly to obtain justice, had reduced self-stigma and improved self-esteem.

In **Ghana**, the organization Women in Law and Development in Africa (WiLDAF) pursued both broad community-based legal literacy trainings and more in-depth training of 88 persons living with HIV, sex workers, MSM and former TB patients as paralegals. WiLDAF also supported Ghanaian NGOs working with key populations in community-level consultations to sensitize key population members, peer educators, case managers and other outreach workers on human rights and how to report abuses and use the legal system. In 2020, WILDAF followed up with refresher training for 324 paralegals and peer educators, including 223 women in sex work, 3 persons from TB Voice (an organization of TB survivors), 64 men who have sex with men, and 34 persons from the Ministry of Health. Despite periods of restricted movement due to COVID-19 in 2020, paralegals were active in identifying cases that were referred to legal services or otherwise resolved, including 78 involving men who have sex with men and 70 involving sex workers.

In the **Democratic Republic of the Congo** in 2018, the Center of Expertise in Human Rights and Criminology/Public Health (CEDHUC) provided technical support to community organizations and the Ministry of Justice to build the capacities of their members and constituents on human rights, gender, and sexual and reproductive health linked to HIV. Among those reached were magistrates, police officers, lawyers, healthcare providers, prison staff, journalists, political administrative authorities, human rights activists, and members of key populations. In addition, the program supported 34 legal clinics, which since 2018 have provided legal services to over 3,500 survivors of sexual violence, resulting in almost 1,200 judgments providing redress to survivors. The activities of CEDHUC were estimated to significantly improve reporting of rape cases to the authorities rather than settlements between families, which were felt to undercut justice and redress for survivors and to be less likely to reduce gender-based violence-related stigma.

Addressing Criminalization

The reform of punitive laws, policies and regulations that contribute to discriminatory practices is critical to reducing stigma and discrimination and increasing access across the HIV care continuum and is possible even in countries with long records of discrimination and rights abuses against key populations.

Efforts to reform these punitive legal landscapes clearly has benefits not only for health care access but for many other areas of well-being for key populations such as the LGBTI community, sex workers, people who inject drugs, and people living with HIV (PLHIV). Below are summaries of a few countries with significant progress in this area.

Botswana: Laying the groundwork for the Botswana High Court to decriminalize same-sex intimacy

LEGABIBO (Lesbians, Gays & Bisexuals of Botswana) is Botswana's longest-running human rights organization seeking to promote the human rights of the LGBTI community. With legal support from the Southern Africa Litigation Centre, LEGABIBO played a key role as *amicus*

curiae in the case that challenged the constitutionality of sections 164(a), 164(c), 165 and 167 of the Botswana Penal Code criminalizing same-sex intimacy between consenting adults.¹⁵ LEGABIBO filed evidence describing the impact of criminalization on LGBTI mental health, experiences of violence, and access to health care services. In June 2019, the High Court of Botswana unanimously declared that sections 164 and 165 were unconstitutional as they contravened fundamental rights enshrined in the Constitution, and also clarified that sexual acts taking place in private would not amount to gross indecency under section 167.¹⁶ This ruling came 16 years after the Court of Appeal upheld the criminalization of same-sex intimacy and marked a significant turning point for LGBTI rights in Botswana.¹⁷

In its decision, the High Court noted that the evidence before it — submitted by LEGABIBO — demonstrated that the aforementioned sections constituted examples of structural stigma, and the criminalization of consensual adult same-sex intimacy subjected LGBTI persons in Botswana to violence and hampered their access to health care, “thus making it hard for them to access vital messages about safe sexual conduct, essential in the age of HIV/AIDS.”¹⁸ As the Court stated, this evidence was pivotal, and justified a departure from the previous Court of Appeal decision.¹⁹ Already, the impact of the decision is being felt. Key informants have described more positive public discourse and media reporting of LGBTI communities and less overt stigma and discrimination against LGBTI persons, including from health care workers and law enforcement. The decision has also mitigated the risk LGBTI people feel in asserting their rights. Police, traditional leaders, health care facilities and government establishments are also more willing to engage with LGBTI organizations in the country, facilitating critical dialogue.

Indonesia: Collaborative civil society advocacy to oppose regressive Penal Code amendments

In September 2019, the Indonesian government introduced amendments to its *Penal Code* that violate many human rights of key populations, including amendments that criminalize extramarital sexual intimacy,²⁰ effectively criminalizing sex work and — by virtue of the prohibition on same-sex marriage — all same-sex sexual intimacy.²¹ The proposed penalty for this offence is imprisonment ranging from six months to one year.²² Another amendment prohibiting the “promotion” of contraception would result in decreased access to vital reproductive health care information, while the proposed inclusion of drug offences in the Penal Code (which are already regulated under Indonesia’s *Narcotics Act*) would further perpetuate the criminalization of people who use drugs.²³

Global Fund support had helped to catalyze and strengthen discourse regarding human rights, HIV and key populations among civil society organizations, altering the political landscape and facilitating joint advocacy. The Indonesian AIDS Coalition and LBH Masyarakat (LBHM), a community legal aid institute that works closely with marginalized communities, was among the organizations that rallied against the bill,²⁴ and LBHM lawyers partook in a civil society-led social media campaign, organized press conferences and engaged media, lobbied parliamentarians, and organized marches outside of Parliament in response to the

amendments.²⁵ LBHM also met with and mobilized other civil society organizations working on issues affected by the bill, and underscored the risks the new *Penal Code* would pose for key populations. Thousands of demonstrators took to the streets, resulting in the largest student movement in Indonesia since 1998.²⁶ As a result of this advocacy, voting on the amendments has been postponed, although the amendments have not been abandoned.

Kyrgyzstan: Mitigating Effects of Punitive Laws

Many key informants noted that negative effects of the 2017 Criminal Code and 2017 Code of Misdemeanors were largely averted because of the timely community-based monitoring of the implementation of these Codes. Community groups quickly alerted law enforcement officials and political leadership about the negative impact that the draconian fines could have on human rights of people who use drugs and their access to health services. This resulted in law enforcement moderating the fines they imposed on people who use drugs. Community-based monitoring conducted by sex workers groups remain a key source of information on law enforcement corruption and instances of interference by law enforcement officials in the delivery of health services for key affected populations. All informants noted that the *Breaking Down Barriers* initiative lifted issues of human rights and non-discrimination to the appropriate level of importance in all segments of the dialogue between the state and civil society. This is especially valuable for Kyrgyzstan at a time when conservative and anti-human rights movements gain momentum and may threaten human rights accomplishments. According to one key informant *“when everyone starts talking about human rights seriously and professionally, even the most stubborn bureaucrat has to change to match the environment ...”*

Anti-Discrimination Laws

Jamaica: Strengthening Advocacy for Law and Policy Reform

Jamaica’s robust civil society continues its long-term struggle for human rights. Perpetuated by the Offenses Against the Person Act that criminalizes sodomy, a virulent anti-LBTI bigotry pervades the culture. Key stakeholders report that the BDB initiative has catalyzed national human rights advocacy, promoted the development of new strategies, and increased levels of participation from a broad range of constituent organizations. With support from UNAIDS, the European Union, Ministry of Health, and the Office of the Public Defender, Jamaica has made notable progress in advocacy for legal reform. Recognizing that new strategies are called for, HIV-focused CSOs are broadening their work against stigma and discrimination to include organizations of people with disabilities, Rastafarians and other religious minorities, reproductive rights groups, churches, and others. HIV-focused CSOs published a Joint Civil Society Advocacy Plan that outlines specific strategic targets for law and policy reform in multiple sectors- health, employment, education, reproductive rights-- and identifies key civil society and government partners for each initiative. The Office of the Public Defender (OPD), Jamaicans for Justice (JFJ) and JASL prepared a policy paper and drafted anti-stigma and discrimination legislation that expanded the framework for defining human rights protections

beyond HIV and LGBT to all sectors. Key stakeholders report that passage of the bill is an attainable goal. JFJ and OPD also collaborated on a paper in support of creating a National Human Rights Institution. The passage of such laws and the National Human Rights Institution could significantly reduce discrimination and barriers for health care access for key populations.

Philippines: Collaborative Civil Society Advocacy on a Rights-based HIV Law

Passing a human rights-based law and implementing rules and regulations that guides the national HIV response is an immense achievement, and one that was nine years in the making. Supported by the work of ACHIEVE and working closely with the Department of Health and the Philippines National AIDS Council (PNAC), the Network to Stop AIDS Philippines - a coalition of more than 27 civil society organizations - helped craft a comprehensive bill that not only provides a legal and accountability framework for the government's HIV response but also removed serious human rights-related barriers for key populations. The Law's public health approach to drug use also provides opportunities for dialogue with local government units and law enforcement for the potential of harm reduction responses. Under the HIV Law, passed in July 2018, PNAC is to act as manager for implementation of its provisions and to closely coordinate this work with the Commission on Human Rights and the Department of Justice. This mandate affords a promising opportunity to align the HIV Law with PNAC's development of the *Comprehensive Action Plan to Address Barriers in Accessing HIV Services* and maximize coordination and strategic planning on human rights.

Utilizing protections afforded by the HIV Law, civil society groups have already challenged discriminatory laws and policies. For example, TLF Share challenged the policies of the Insurance Commission that required people living with HIV to demonstrate low viral load and meet other health criteria to qualify for coverage under the national health insurance program. Joined by the Commission on Human Rights and the Department of Justice, TLF Share successfully convinced the Insurance Commission to withdraw these barriers that were impermissible under the HIV law.

Ukraine: Changing National Conversations

Recent years have seen significant shifts in national conversations in Ukraine about LGBTI people, sex work, and drug policy. While this has not yet led to structural changes such as the decriminalization of sex work and drug use-related activities, or to the legalization of same-sex marriage, a mature, open national conversation about these topics is likely to lead to a reduction in stigma and discrimination and to empower communities and is a necessary steppingstone for policy and legislative shifts.

Ukraine did make progress by removing a discriminatory provision on IVF for women living with HIV. Following an advocacy campaign by several community organization and implementers, Ukraine's Ministry of Health changed a legal provision in one of its regulations that banned women living with HIV from being able to access in vitro fertilization if they have an

undetectable viral load. This legal change facilitates acceptance of women living with HIV in both the healthcare system and broader society.

Ukraine also repealed a ban on adoptions for people living with HIV, based on a discrimination claim filed by a person living with HIV in Odessa. The court overturned a Ministry of Health order that barred people living with HIV from adopting children in October 2019.

Legal Landscape around Harm Reduction Programs

Mozambique: Mafalala Harm Reduction Pilot Project

Begun in September 2017, Médecins Sans Frontières (MSF) and the civil society organization UNIDOS have worked alongside the Ministry of Health, National Aids Council (CNCS) and Cabinet for Drug Prevention (GCPCD), to implement a harm reduction pilot project for people who use drugs (PWUD) in the Mafalala neighborhood of Maputo. The initiative is organized around a drop-in center for PWUD, which provides a comprehensive harm reduction package, including needle & syringe programming (NSP); opioid substitution treatment (OST) with methadone; TB screening; and HIV, HBV, and HCV testing. In addition, peer outreach workers provide information, safer injection kits, condoms and HIV testing in the district, and refer individuals for services and care.

The project worked with the city's drug commission to get buy-in and support for a local exemption to laws criminalizing needle and syringe distribution. A community committee has built support among local residents and sensitized local and national police officials to protect clients and advocates from arrest. In programming designed to reduce gender discrimination, women-only days at the DIC have helped to reach women who use and inject drugs and provide tailored services to them in a safer environment.

Based upon the lessons of the project, the CNCS developed information on working with PWUD for their Standard Operating Procedures for Key Populations manual and a Harm Reduction Plan.²⁷ Mozambique included specific funding in its 2020 funding request to expand harm reduction services to 3 other provinces in Mozambique: Maputo Province, Sofala and Nampula, while taking over the Maputo City intervention by September 2021. The proposal extends the model of person-centered, low-threshold and non-judgmental harm reduction services within a context of an enabling legal environment and community-based, peer-led interventions.

Sierra Leone: Social Linkages for Youth Development and Child Link

With support from the Global Fund, in 2019, Sierra Leone established its first needle and syringe exchange program. Recognizing the importance of harm reduction to prevent an “explosive epidemic of HIV” among people who inject drugs, Social Linkages for Youth Development and Child Link (SLYDCL) sought to include police from the inception in its efforts to implement a needle and syringe program and to cultivate a good working relationship with them. In 2018, SLYDCL was among those presenting the findings of a harm reduction

assessment to the Sierra Leone police management board, during which Sierra Leone's Inspector General of Police expressed the need for police to support a needle and syringe program and requested collaboration with the National HIV/AIDS Secretariat to develop a harm reduction curriculum for police. That year, the National HIV/AIDS Secretariat also sponsored a study tour of Kenyan harm reduction programs in which SLYDCL and Sierra Leone police participated.

Today, all of Sierra Leone's local unit commanders have been informed that SLYDCL is implementing a needle and syringe program. According to National HIV/AIDS Secretariat staff, "We now have police able to recognize people who work with injectors who distribute syringes and needles.... This is breaking ground."

Ukraine: Removal of identification requirement for users of state harm reduction services

As part of the 20-50-80 transition, the Ukrainian government is increasingly funding harm reduction services that were previously funded by the Global Fund and other external donors. During negotiations about this transition in 2019 it became clear that under government regulations, all users of these services would be required to register using passport information. Community organizations strongly objected to this arrangement, arguing that most clients would stop using harm reduction services and that, as a result, needle-sharing and HIV infections would grow. Advocacy by these organizations, alongside the Global Fund, ultimately led to the government replacing the identification requirement with a different process which allows tracking of unique users of services without disclosing their identity. While this has not led to increased uptake of HIV prevention by people who use drugs, it has likely prevented a significant decline in the use of these services.

Working with Police

Ghana

Breaking Down Barriers enabled revitalization of work with police in Ghana that had begun years before with the engagement of high-level police in an effort to reduce police abuse of sex workers. Beginning in 2019, the Global Fund-supported NGO WAPCAS oversaw a revised training manual and new rounds of general training, training of regional commanders, and training of trainers among police officers. In addition, following an appeal by WAPCAS, the Ghana Police Service inspector General and the Police Management Board, a high-level decision-making body in GPS, agreed to the formation of a Police Technical Working Group (PTWG) to include WAPCAS and other civil society representatives with representatives of the police training academies, the police hospital, the special GPS unit on domestic violence, and the GPS HIV unit. The PTWG has a mandate to oversee training on and implementation of rights-based practices of the police.

South Africa

In South Africa, the sex worker-led organizations SWEAT and Sisonke had long expressed concern about abusive policing of sex workers. On behalf of SWEAT, in 2009 the NGO Women's Legal Centre brought a lawsuit that resulted in an order for the police in greater Cape Town to stop the practice of detaining sex workers without charge; detained sex workers often experienced extortion and other abuse at the hands of police.²⁸ But concerns remained about continuing police abuse of sex workers around the country. In 2016 the NGO Sonke Gender Justice, working with SWEAT and Sisonke, conducted a national survey of sex workers on their experiences of policing, which revealed a persistent problem of abuses, including rape, extortion, and arbitrary arrest.

In consultation with key population organizations and other experts, a training program called the Dignity, Diversity and Policing (DDP) was developed and piloted with the Dutch NGO COC and the South Africa Police Service (SAPS) in 2017. Training sessions included the active participation of key population representatives, for which many SAPS officers expressed appreciation in the post-training feedback. COC did not have funding to continue the training; BDB catalytic funding enabled it to proceed, though expansion to a significant percentage of the over 150,000 SAPS officers remains a challenge.

In the same period, SWEAT, Sisonke and Sonke Gender Justice consulted with key population groups and other NGO allies, academic experts, and policing and security experts and eventually decided to create the "Positive Policing Partnership" (PPP). PPP was conceived as a platform for bringing together police, key populations, other civil society and government representatives to talk about ways in which all parties could work together to improve police practices.²⁹ A 2019 PPP event in Cape Town resulted in a wide-ranging discussion that included key population members and some police who had been exposed to the DDP training.³⁰

A series of consultations involving the police and other stakeholders was organized in 2020 to explore best practices in multisectoral responses to violence and other abuses faced by women and key populations. They included the NPA, SAPS, civil society organizations including key population-led groups, health workers, social service providers and survivors of sexual violence and other human rights abuses. They took place through the Thuthuzela Care Centres (TCC), facilities found throughout South Africa that are meant to be "one-stop shops" for survivors of sexual violence.

Groups representing the concerns of people who use drugs have also engaged with the police. The Step Up Project of the NGO TB-HIV Care, which provides drug-related harm reduction services in a number of cities, has worked to sensitize police to the importance of health services for people who use drugs. The Community Oriented Substance Use Program (COSUP) in Tshwane (Pretoria), which provides harm reduction services at 17 sites in the city, has had regular workshops with the police and other forms of interaction, including through sports teams.³¹

Dialogues with Community Members around Stigma

Botswana: Community dialogues with Dikgosi

A potent area of work to address stigma and discrimination that has expanded is “community dialogues” with traditional leaders, or *Dikgosi*, at *Kgotlas* (local community meetings) and before *Ntlo ya Dikgosi* (the governing body of chiefs). When community dialogue work began, many traditional chiefs were hostile to key populations, with some openly declaring that they did not want key populations in their communities. Yet key population-led and civil society organizations, including those that represent transgender and intersex people, men who have sex with men and sex workers, have facilitated dialogues with traditional leaders to discuss issues related to key populations, human rights, harmful gender norms and gender-based violence, and observed how these intimate conversations have helped break down barriers.

Côte d’Ivoire: Centre Solidarité et Action Sociale (CSAS).

The midterm assessment identified CSAS as an example of success because of the comprehensive set of services it provides to PLHIV and their families, with many important activities to remove human rights-related barriers to services introduced or developed since the start of the BDB initiative. To name a few, since 2020, in Bouaké and Khorogo, the “Support programme for women” (“Projet d’accompagnement des femmes”), aiming to address family-level stigma toward women living with HIV, has been taking place. If a spouse or partner reacts adversely when the woman discloses her HIV status, CSAS assists with the use of mediation, a community instrument considered more sustainable than formal legal proceedings. CSAS also continued its legal literacy program, with the organization of a large thematic meeting on the law, and the rights and responsibilities of PLHIV and their families, which gathered approximately 150 PLHIV. Finally, committed to its integrated people-centered health approach, an MSM peer educator has been part of CSAS’ team since the second semester of 2019. This is a step towards implementing programs to remove human rights-related barriers to services in a gender responsive/transformational manner.

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¹ The main categories of human rights and gender-related barriers to HIV and TB services include: stigma and discrimination, including within the provision of health services; punitive laws, policies, and practices; gender inequality and gender-based violence; poverty and socio-economic inequality; and harmful working conditions and exploitation (mainly for TB).

² For HIV and TB: stigma and discrimination reduction; training for health care providers on human rights and medical ethics; sensitization of lawmakers and law enforcement agents; legal literacy (“know your rights”); legal services; monitoring and reforming laws, regulations and policies relating to the 3 diseases; reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity. Additional programs for TB: mobilizing and empowering patient and community groups; ensuring privacy and confidentiality; interventions in prisons and other closed settings; reducing gender-related barriers to TB services (TB).

³ The number of health districts has varied over recent years. At the time of the baseline assessment, there were 79 districts in the country; in many areas of the multi-year plan, activities to reduce human rights-related barriers to services were anticipated solely for 60 districts; as of late 2020, there appear to be 113 defined health districts.

⁴ See Endnote 4: At the time of the midterm report, there appeared to be 113 health districts in the country.

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¹³ https://www.theglobalfund.org/media/9729/crg_programstoremovehumanrightsgenderbarriers_guide_en.pdf

¹⁴ Feinglass E, Gomes N, Maru V. Transforming policy into justice: the role of health advocates in Mozambique. Health and human rights. 2016 Dec;18(2):233.

¹⁵ Section 164: “Any person who – (a) has carnal knowledge of any person against the order of nature; [...] or (c) permits a male person to have carnal knowledge of him or her against the order of nature; is guilty of an offence and is liable to imprisonment for a term not exceeding seven years.”

Section 165: “Any person who attempts to commit any of the offences specified in section 164 is guilty of an offence and is liable to imprisonment term not exceeding five years.”

Section 167: “Any person who, whether in public or private, commits any act of gross indecency with another person, or procures another person to commit any act of gross indecency with him or her, or attempts to procure

the commission of any such act by any person with himself or herself or with another person, whether in public or private, is guilty of an offence.”

¹⁶ *Letsweletse Motshidiemang v. Attorney General*; LEGABIBO (Amicus Curiae) MAHGB- 000591-16 (High Court 2019).

¹⁷ *Kanane v. The State* [2003] (2) BLR 67 (CA).

¹⁸ *Letsweletse Motshidiemang v. Attorney General*; LEGABIBO (Amicus Curiae) MAHGB- 000591-16 (High Court 2019), paras. 134 and 135.

¹⁹ *Ibid*, para. 171: “In the Kanane case, the Court of Appeal stated that as at that time (2003), the impugned provisions were not discriminatory to gay men, on account of the factual and legal matrix presented in the case. What is presented before this court is fundamentally different from the Kanane case. Before this court, expert evidence has been adduced to prove the case, whereas there was no such evidence in the Kanane case.”

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³⁰ Sonke Gender Justice and PPP, *op.cit*.

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