

Baseline Assessment – Senegal

Scaling up Programs to Reduce Human Rights-Related Barriers to HIV Services

2019
Geneva, Switzerland

Disclaimer

Toward the operationalization of Strategic Objective 3(a) of the Global Fund Strategy, *Investing to End Epidemics, 2017-2022*, this paper was commissioned by the Global Fund to Fight AIDS, TB and Malaria and presents, as a working draft for reflection and discussion with country stakeholders and technical partners, findings of research relevant to reducing human rights-related barriers to HIV and TB services and implementing a comprehensive programmatic response to such barriers. The views expressed in this paper do not necessarily reflect the views of the Global Fund.

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Acronym List

ACI	Africa Consultants International
AIDS	Acquired Immune Deficiency Syndrome
AJS	Association des Juristes Sénégalaises
ART	Antiretroviral Therapy
CAT	United Nations Convention against Torture
CBO	Community-based Organization
CCM	Country Coordinating Mechanism
CCPR	Covenant on Civil and Political Rights
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEPIAD	Centre de prise en charge intégrée des addictions à Dakar
CERD	Convention on the Elimination of Racial Discrimination
CFLS	Comité Frontalier de Lutte contre le Sida
CIDA	Canadian International Development Agency
CNLS	Conseil National de Lutte contre le Sida
CSO	Civil Society Organization
CTA	Centre de Traitement Ambulatoire
DLSI	Division de Lutte contre le SIDA
FCFA	Franc Communauté Financière d'Afrique
FGD	Focus Group Discussion
FSW	Female Sex Worker
GBV	Gender-based violence
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
JHU	Johns Hopkins University
KP	Key Populations
KII	Key Informant Interview
LGBT	Lesbian, Gay, Bisexual, Transgender
MOH	Ministry of Health
MSM	Men who Have Sex with Men
NGO	Non-governmental organization
OHCHR	Office of the High Commissioner for Human Rights
OVC	Orphans and Vulnerable Children

PE	Peer Educator
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PNLS	Programme National de Lutte contre le SIDA
PMTCT	Prevention of Mother-to-Child Transmission
PreP	Pre-exposure Prophylaxis
PWID	People who Inject Drugs
SIDA	Le syndrome d'immunodéficience acquise (AIDS)
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
VCT	Voluntary HIV Counseling and Testing
WHO	World Health Organization

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Executive Summary

Introduction

Since the adoption of its strategy, *Investing to End Epidemics, 2017-2022*¹, the Global Fund to Fight AIDS, Tuberculosis and Malaria has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programs to remove human-rights related barriers in national responses to HIV, TB and malaria. It has done so because it recognizes that these programs are an essential means by which to increase the effectiveness of Global Fund grants. The programs increase uptake of and retention in health services and help to ensure that health services reach those most affected by the three diseases.

The Global Fund, governments, technical partners and other experts have recognized these programs as key components and critical enablers of the HIV response. These programs comprise: (a) stigma and discrimination reduction; (b) training for health care providers on human rights and medical ethics; (c) sensitization of law-makers and law enforcement agents; (d) reducing discrimination against women in the context of HIV; (e) legal literacy (“know your rights”); (f) legal services; and (g) monitoring and reforming laws, regulations and policies relating to HIV.²

Though the Global Fund will support all countries to increase investment in these programs so as to remove human rights-related barriers to services, the Global Fund is providing intensive support to 20 countries to enable them to put in place comprehensive programs aimed at significantly reducing these barriers.³ Based on criteria involving needs, opportunities, capacities and partnerships in country, Senegal has been selected as one of the countries to receive intensive support. This baseline assessment is the first component of the package of support to Senegal and is intended to provide the country with the data and analysis necessary to identify, apply for, and implement comprehensive programs to remove barriers to HIV services.

Programs to remove human rights-related barriers to services are *comprehensive* when the *right programs* are implemented *for the right people* in the *right combination* at the *right level of investment* to remove human rights-related barriers and increase access to HIV, TB and malaria services.⁴ This assessment: (a) establishes a baseline of human rights-related barriers to HIV services and existing programs to remove them; (b) sets out a costed comprehensive

¹ *The Global Fund Strategy 2017-2022: Investing to End Epidemics*. GF/B35/02

² See *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses*, Guidance Note, UNAIDS/JC2339E (English original, May 2012); ISBN: 978-92-9173-962-2. See also Global Fund Technical Brief *HIV, Human Rights and Gender Equality* Global Fund to Fight AIDS, TB and Malaria (April 2017) See also *Political Declarations on HIV/AIDS* (2011 and 2016)

³ *Ibid*, Key Performance Indicator 9.

⁴ This definition of “comprehensiveness » for the purpose of GF Key Performance Indicator 9 was developed with the Global Fund Human Rights Monitoring and Evaluation Technical Working Group.

program aimed at reducing these barriers; and (c) identifies next steps in putting this comprehensive program in place.

Methodology

In July 2017, the research team conducted a review of peer-reviewed and gray literature on the HIV response in Senegal. This was followed by in-country research that took place from December 2017 to February 2018. This research included 39 key informant interviews and 6 focus group discussions involving 50 representatives of key populations affected by HIV in the regions of Dakar, Saint-Louis, Kaolack, Kedougou, and Ziguinchor. The research team conducted these sessions with standard tools that were developed to be used across the twenty country assessments. An inception workshop was held with key stakeholders at the beginning of the data collection process to inform them of the assessment process and to consult with them on focus areas and key informants. This meeting was also used to fill any gaps in the literature review.

1. Summary of baseline findings: HIV

1.1 Key and vulnerable populations

The *Plan stratégique nationale de lutte contre le VIH/SIDA et les IST 2015-2017* from the Conseil National de Lutte contre le Sida (CNLS) currently describes populations key to the HIV epidemic in Senegal as men who have sex with men, female sex workers, and people who inject drugs. It describes populations vulnerable to HIV as mobile populations (truck drivers, fishermen, miners; the perceived risk factor for such mobile populations is procuring sex); women; prisoners; youth; and security forces (CNLS). The research confirmed these descriptions, and based on the epidemic in Senegal added transgender women as a key population for consideration, as well as people with disabilities and clients of sex workers as vulnerable populations. In accordance with Global Fund definitions of key populations, this assessment includes people living with HIV as a key population.

1. 2 Human rights-related Barriers to HIV services

The assessment identified the following as the most significant human rights-related barriers to HIV services:

- a) Stigma and discrimination based on HIV status and/or on membership in a key population are experienced in the community and at health facilities. Stigma in health facilities was most often experienced by men who have sex with men, female sex workers, transgender women, and people living with HIV.
- b) Legal and policy barriers relating to key populations are a major constraint to HIV prevention, specifically those affecting female sex workers, people who inject drugs, and men who have sex with men.

- c) Illegal police practices (e.g. harassment, extortion, violence) against key populations, particularly against female sex workers and arrests of registered sex workers, create widespread fear of police, making key populations harder to reach with services.

Other important barriers involve difficulty in accessing services due to:

- a) Poverty, which makes the additional costs, travel and time spent in seeking health services, barriers to those services
- b) Government stock-outs of antiretroviral drugs and viral load testing reagents, and
- c) Insufficient coverage of prevention programs for younger key populations, specifically young men who have sex with men and younger sex workers.

1.3 Programs to address human-rights barriers to HIV services – from existing programs to comprehensive programs

Based on the seven program areas (PA) described above, this section summarizes the existing or recent programs that have been implemented in Senegal to remove human rights-related barriers to services. This is followed by a summary description of elements of a comprehensive response.

PA 1: Programs to reduce stigma and discrimination

A number of civil society and community actors were concerned about the lack of specific and dedicated programs, resources, and a strategic plan, by which to directly address stigma and discrimination experienced by people living with HIV and other key populations. They pointed out that, in this context, those implementing other HIV programs/interventions often included communication activities and community mobilization against stigma and discrimination within these interventions. Thus, a number of programming areas currently exist in Senegal that either directly or indirectly reduce stigma and discrimination in the context of HIV. These include: (1) peer education and support for men who have sex with men, female sex workers, people living with HIV, people who inject drugs, and youth, (2) community mobilization and outreach throughout the country for key populations, except for transgender women; (3) engagement with community and religious leaders; (4) a program focused on inclusion of non-discrimination as part of institutional and workplace policies in employment; and (5) measurement of stigma through the *Stigma Index 2.0*.

The following describe efforts that should be made to expand existing programming and move towards comprehensive programming to remove stigma and discrimination. Though the ANCS supports many of the activities described below, there is a clear need to integrate reduction of stigma and discrimination into existing HIV prevention and treatment programs throughout Senegal and to extend the activities beyond the current focus on “priority” regions. More resources should also be provided to reach, strengthen and accompany key populations in the creation of associations, and the integration of national and regional networks.

- Implement routine measurement of HIV-related and key population-related stigma through the *People Living with HIV Stigma Index 2.0* every 3 to 5 years and in each region of Senegal.

- Expand coverage of peer-led discussion groups with key populations that focus on HIV prevention and transmission, human rights, stigma and discrimination, reproductive health, and living with HIV to all regions. This activity should be integrated within existing HIV prevention and treatment programs, and follow up/evaluation activities should be included.
- Leverage mobile technology and social media to create platform for peer-to-peer referral network among men who have sex with men to increase social cohesion, facilitate HIV prevention and treatment education, and reduce perceived and anticipated stigma.
- Support and strengthen existing key population networks to understand HIV-related and other forms of stigma and discrimination, measure these as experienced by their members, and mobilize around actions to reduce such stigma and discrimination.
- Support the integration of non-stigmatizing messages into TV and radio shows and other media through strengthening existing partnership with journalists, developing key messages and a strategic plan for integrating non-stigmatizing messages into existing media; strengthening capacity and current campaigns being conducted with youth; and supporting existing radio shows and television programs working in this area to build capacity.
- Integrate stigma/discrimination reduction discussion and activities into HIV prevention and treatment activities across the country for all key and vulnerable populations
- Develop national and local campaigns to educate people on HIV stigma and discrimination, so as to reduce it in communities, workplaces, health care settings and social services, through such means as integrating key messages into TV and radio shows and other media; educating journalists; strengthening current campaigns being conducted with youth; and expanding and strengthening existing radio shows and television programs working in this area.
- Support the re-establishment of Observatoire de la réponse au VIH/SIDA au Sénégal to coordinate discussion on HIV prevention and reduction of stigma and discrimination, document human rights violations and coordinate regular meetings between representatives of different stakeholders and key populations to continue discussion and strategy for HIV prevention and stigma reduction.
- Facilitate the development of organizational alliances with religious leaders that can create and disseminate messages supporting a more protective environment for key populations. Sensitize, train and engage traditional and religious leaders to help reduce stigma and discrimination against people living with HIV and other key populations.
- Develop and roll-out institutional and workplace policies in employment and educational settings that educate about HIV, prohibit HIV-related discrimination and provide for systems of redress.

PA 2: Programs to train health care workers on human rights and ethics related to HIV

Programs to reduce human rights-related barriers in the healthcare setting exist in Senegal, including stigma reduction training related to all key populations for health care providers and staff. It is proposed that these interventions be expanded and refined as follows, alongside the implementation of additional activities:

- Support periodic measurement of stigma and discrimination in health care settings

- Update, and where necessary develop, curriculum on human rights and medical ethics, including related laws, relevant to HIV. Integrate curriculum into *pre-service* medical education training.
- Roll out the training above as part of regular *continuing* education efforts, targeting health care facilities that deliver treatment to people living with HIV and other key populations.
- Implement stigma reduction training for current healthcare providers and administrative staff to improve services to key and vulnerable populations.
- Develop more specific guidelines regarding the disclosure of HIV test results to patients, their partners/spouses and families.
- Develop confidentiality guidelines and measures to operationalize them in clinics including sensitization training with health care providers, the importance of ensuring the safety of people living with HIV relating to disclosure of HIV status and means to monitor adherence to confidentiality policies.
- Establish clear guidelines for health care providers and social workers to provide information on confidentiality, informed consent and nondiscrimination as part of pre- and post-test counseling. Develop job aides and materials to be used as reminders for providing information on such rights, to be disseminated to health facilities. Conduct training on guidelines for health providers.
- Support civil society and key population associations to monitor quality of care and stigma and discrimination in health care settings, as part of patient support and retention efforts.
- Explore mechanisms by which to improve modalities of health care delivery so as to reduce lack of confidentiality, long waiting lines, stockout, etc.
- Support health care providers by developing non-discrimination policies for health care workers living with HIV, as well as safe working conditions through policies and programs to provide sufficient access to universal precautions.

PA 3: Programs to sensitize lawmakers and law enforcement agents

This program area includes: (1) sensitization training for lawmakers and law enforcement agents regarding the legal, health and human rights of key populations; and (2) training for prison staff regarding prevention, health care needs, and human rights of detainees at risk of or living with HIV. Existing programs in Senegal include dissemination of information regarding the relevant national laws and the implications for law enforcement, criminal and civil investigations, and court proceedings. It is proposed that these interventions be expanded and refined as follows, alongside the implementation of additional activities:

- Facilitate discussions, negotiations and joint activities among HIV service providers, beneficiaries of services (key and vulnerable populations), and police to address law enforcement practices that impede HIV prevention, treatment, care, and support efforts.
- Develop a curriculum and establish comprehensive law enforcement training program to support increased access to HIV prevention and treatment and remove problematic and illegal practices against key and vulnerable populations that act as barriers to services (harassment, extortion, arbitrary arrest, violence, rape). The curriculum should incorporate information on HIV transmission, stigma and discrimination experienced by key and vulnerable populations, and the negative impact of illegal police activity on

justice and on the HIV response. This curriculum should also include training around gender-based violence, intimate-partner violence, and gender discrimination more broadly. The training curriculum should also incorporate sessions on effectively implementing laws that protect key and vulnerable populations in Senegal.

- Implement training for prison personnel regarding the prevention, health care needs, legal rights, and human rights of detainees living with or at risk of HIV infection in order to provide adequate health care and security for those in detention.
- Coordinate and facilitate interaction between law enforcement and sex worker association leaders to monitor police practice and improve treatment of sex workers through identification of allies within the police department; facilitation and strengthening of communication between association leaders and law enforcement allies within each precinct; and conducting training with law enforcement allies on rights of sex workers, including rights associated with registration status.
- Improve coordination and outreach in partnership with health centers and associations of sex workers to facilitate registration of female sex workers.
- Implement information and sensitization sessions for the Ministry of Justice and Ministry of Interior, judges, prosecutors, lawyers through training on legal, health, and human rights aspects of HIV and on HIV-relevant national laws and the implications for enforcement, investigations, and court proceedings. These should be built on existing work done with CNLS and should be focused on existing themes.
- Building upon efforts to revise the legal framework supported by the Global Fund and UNDP, facilitate key populations' access to healthcare services through capacity building, developing tools, providing funding and conducting advocacy with community-based organizations, and implementing the recommendations stemming from the legal environment assessment. Additionally, provide support for the coordination and implementation of activities beyond the trainings conducted; and support training of government representatives to support sustainability.
- Scale up and regionally tailor services based on region-specific human rights related barriers.

PA 4: Programs to provide legal literacy (“know your rights”)

Legal literacy aims to improve knowledge of those living with or affected by HIV about human rights and national laws and policies relevant to HIV. Current programs in Senegal in this area include: (1) educational sessions for key populations to improve their legal and rights knowledge; (2) training civil society actors and health care providers on strategies regarding applications of legal knowledge to improve health and justice; and (3) documentation of rights violations cases in the context of HIV. It is proposed that these interventions be expanded and refined as follows, alongside the implementation of additional activities:

- Expand existing program on legal literacy being implemented with men who have sex with men to all key populations after adapting it to other key populations.
- Support and expand existing efforts in training and capacity-building to increase key populations' understanding of their rights and enable them to mobilize around those rights for purposes of advocacy and prevention of rights violations.
- Recruit, train and support peer human rights educators among community health outreach personnel working with people living with HIV and other key and vulnerable populations.

- Increase coverage of programs utilizing social media to conduct a campaign on legal rights relating to HIV for people living with HIV and other key and vulnerable populations. Strengthen partnerships with radio and social media programs currently working in HIV prevention and provide tools and messages for integration of legal rights into existing HIV prevention education including the expansion of such programs to more local radios.
- Scale up legal and rights literacy training for people with disabilities, beyond HIV priority regions, and with a focus on operational personnel working with these people as well as peer human rights educators.

PA 5: Programs to provide HIV-related legal services

Programs for HIV-related legal services can facilitate access to justice and redress in cases of HIV-related discrimination or other legal matters. Programs in Senegal and currently include: (1) legal aid offices that serve all key and vulnerable populations except transgender women; and (2) financial support for legal services targeted to female sex workers. It is proposed that these interventions be expanded and refined as follows, alongside the implementation of additional activities:

- Expand coverage of legal aid services to all regions in Senegal through recruiting, training and supporting peer paralegals for people living with HIV and for other key and vulnerable populations, including women and adolescent girls. These can be recruited from community health outreach workers providing prevention and treatment information.
- Develop comprehensive referral reference sheet for available HIV-related legal aid services, and training for regular updating. Disseminate referral sheet through clinics and key populations associations.
- Support sufficient lawyers willing to work with marginalized populations to provide supervision and support to peer paralegals.
- Establish referral and support hotline to provide support legal services and legal referrals. Disseminate number for hotline through HIV treatment facilities and key population association networks.

PA 6: Programs to monitor and reform laws, regulations and policies related to HIV

Laws, regulations and policies relating to HIV can negatively or positively impact the national HIV epidemic, as well as the lives and human rights of those living with and affected by HIV. Current programs in this area include: (1) advocacy aimed at legislators to improve the legal environment for key populations; and (2) evaluation of legal gaps for people living with disabilities. It is proposed that these interventions be expanded and refined as follows, alongside the implementation of additional activities:

- Support advocacy to include transgender women in the national definition of key populations and HIV-related programming.
- Conduct strategic session with CNLS to identify additional potential advocacy efforts. Support CNLS in working with a parliament commission to reduce human rights-related

barriers to HIV services for all key and vulnerable populations through technical assistance by civil society organizations.

- Re-establish national observatory mechanism so as to become fully functioning, operating with antenna in each region and able to monitor access to HIV services, as well as other HIV-related human rights barriers.
- Develop guidelines for health facilities to create a supportive environment for people living with disabilities, including integration into existing HIV services and outreach. Advocate for adoption of guidelines by CNLS. Review existing government facilities to assess the accessibility of facilities for individuals living with disabilities. Document accessibility and identify needs of each facility.
- Advocate for protective laws for sex workers to reduce violence experienced by this population.

PA 7: Programs to reduce discrimination against women and girls in the context of HIV

Programs to address gender inequality and gender-based violence as both causes and consequences of HIV infection should be supported in Senegal. Few existing interventions are specifically aimed at reducing discrimination against women and girls in the context of HIV, but this assessment found the following: (1) income-generating activities for female sex workers; (2) raising awareness at the community level about violence against women; (3) trainings for health providers and others to provide a comprehensive response to gender-based violence with specific modules on gender-based violence in the context of HIV; and (4) creation of gender policies and gender training activities by CNLS. It is proposed that these interventions be expanded and refined as follows, alongside the implementation of additional activities:

- Support existing and fully voluntary programs in revenue-generating activities and professional trainings to alleviate problems related to poverty in key populations.
- Support CNLS in updating gender policies through forming a working group and facilitating discussion for policy updates. Include capacity-building and technical assistance and coordination with gender focal point, and increased coverage of HIV-related gender training activities throughout the country.
- Support efforts with Ministry of Justice to ensure easier access to justice for women and increase awareness of and attention to practices and risks relating to female genital mutilation/cutting. Expand knowledge and training around a multi-dimensional and holistic Plan of Action to Eliminate Gender-Based Violence in which HIV-related aspects are included.
- Reinforce gender-based violence services, including relevant HIV components, in the health care system, through training on adherence to PEP guidelines and implementation for service providers. Adaptation of guidelines for trauma-informed care and development of tools for services providers

1.5 Program costing

In 2016 a total of around USD \$... was invested in Senegal to reduce human rights-related barriers to HIV services. Major funders and allocated amounts for reduction of human rights barriers to HIV services in 2016 were as follows:

Funding source	2016 allocation (USD)
Global Fund	447,317
USAID	196,139
Austrian Development Cooperation	2,708
Government of Luxembourg	2,651
Government of Senegal	5,904
Total	654,719

** Pending information on the funds allocated for reduction of human rights related barriers to HIV for 2015*

Although several funders stated that they were unable to provide exact figures for the amounts allocated to each program area, the assessment team calculated the likely split between program areas by acquiring expenditure data from the funded organizations and matching these to activities under each program area. This gave the following split of funding across program areas to remove human rights-related barriers to services:

HIV Human Rights Barriers Program Area	2016 (USD)
PA 1: Stigma and discrimination reduction for key populations	556,862
PA 2: Training for health care workers on human rights and medical ethics related to HIV	63,338
PA 3: Sensitization of law-makers and law enforcement agents	5,359
PA 4: Legal literacy (“know your rights”)	8,156
PA 5: HIV-related legal services	-
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	21,004
PA 7: Reducing discrimination against women in the context of HIV	-
PA8: Relevant activities but which cannot be classified elsewhere	-
Total	654,719

** We were unable to obtain details on funds allocated for reduction of human rights related barriers to HIV services for 2015.*

Estimated costs for the recommended interventions for the five-year comprehensive program are set out in the table on the following page. Detailed intervention areas and costs are set out in Appendix 3.

The costing for the 5-year comprehensive program is set out in the following table:

HIV Human Rights Barriers Program Area	Total (USD)
PA 1: Stigma and discrimination reduction for key populations	1,145,399
PA 2: Training for health care workers on human rights and medical ethics related to HIV	1,474,701
PA 3: Sensitization of law-makers and law enforcement agents	199,402
PA 4: Legal literacy (“know your rights”)	344,066
PA 5: HIV-related legal services	281,509
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	343,978
PA 7: Reducing discrimination against women in the context of HIV	126,035
Total	4,937,039

***Including Program management, M&E and Research costs*

1.6 Priorities for scaling up towards comprehensive programs to reduce barriers to HIV services

There is an urgent need to improve stigma and discrimination within the health care facilities in order to improve uptake and quality of services for key and vulnerable populations. In this context, existing training curricula should be updated to improve trainings, both pre-service and in-service. Training on human rights and medical ethics should be rolled out to a majority of health care workers providing HIV-related treatment, as well as to key administrative personnel and management in the facilities. Such training should be implemented in priority districts where there are particular challenges with treatment and retention rates. To be able to evaluate these efforts, measurement of stigma and discrimination among health care personnel in some facilities should be conducted prior to the training and after. Linked with the scale-up of training activities, mid-term efforts should focus on developing and implementing appropriate monitoring tools for impact of training. Efforts in end years of implementation should focus on adapting training based on lessons learned from monitoring and evaluation. Programs should incorporate sustainability efforts through finalization of tools, curricula, and support mechanisms.

An additional priority is to expand legal literacy and legal services for key and vulnerable populations through the recruitment, training, supervision and support of peer human rights educators and peer paralegals for each key and vulnerable population. Peer educators and peer

paralegals can be recruited from existing community outreach health workers and/or mediators. The peer paralegals can be less in number but should have access to a few lawyers who will supervise and support them and are dedicated to serving marginalized populations. The work of these should not only be to support individual knowledge and legal needs but to help the networks and associations of the populations strategize and mobilize around concrete human rights and legal issues to improve their situation.

Other priorities include coordination and facilitation of relationships between law enforcement and sex worker association leaders to monitor police practice and improve treatment of sex workers; and development of organizational alliances with religious leaders toward the elaboration of messages that support a more protective environment for key populations; and the reestablishment of the Observatoire de la réponse au VIH/SIDA au Sénégal.

Though not necessarily to be supported by human rights funds but rather by key population and community strengthening funds, existing individual key population association networks should be supported and strengthened. This would contribute to the effectiveness of other programs recommended in this report. In particular, a priority would be to strengthen the engagement of transgender people. A first step would be to gather representative data on this population regarding the populations size, HIV prevalence, uptake of HIV prevention and treatment services; anticipated, perceived, and enacted stigma; and other barriers to accessing health services. These data should lead to advocacy for the expansion of services for transgender women based on their specific needs, and the inclusion of transgender women in the national definition of key populations. In the meantime, steps should be taken to incorporate transgender women into HIV programs. Following the inclusion of transgender women in the national definition of key populations, services should be adapted and expanded based on the specific needs of this population. Adaptation of key population service delivery methods should be considered based on acceptability by transgender women of these efforts.

1.7 Next Steps

Upon completion of this baseline assessment, the Global Fund will organize a multi-stakeholder meeting in Senegal where country stakeholders, technical partners and other donors will consider the findings and develop a five-year plan by which to fund and implement comprehensive programs to remove human rights-related barriers to services. In addition, the data in this report will be used as a baseline for subsequent reviews at mid-term and end-term during the period of the Global Fund strategy to assess the impact of scaled up programs in reducing human rights-related barriers to services. The Global Fund 2018-2020 grants include some of the recommended comprehensive programs, and the development of the human rights matching fund request will represent an opportunity for further prioritization and inclusion of key programs.

1. Baseline assessment - Senegal

1.1 Introduction

This report comprises the baseline assessment conducted in Senegal to support scaling up of programs to remove human rights-related barriers to HIV services. Since the adoption of its strategy, *Investing to End Epidemics, 2017-2022*, the Global Fund has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programs to remove human rights-related barriers in national responses to HIV, TB and malaria. This effort is grounded in Strategic Objective 3 which commits the Global Fund to: “introduce and scale up programs that remove human rights barriers to accessing HIV, TB and malaria service”; and, to “scale-up programs to support women and girls, including programs to advance sexual and reproductive health and rights and investing to reduce health inequities, including gender-related disparities.”⁵ The Global Fund recognizes that programs to remove human rights-related barriers are an essential means by which to increase the effectiveness of Global Fund grants as they help to ensure that health services reach those most affected by the three diseases. The Global Fund is working closely with countries, UNAIDS, WHO, UNDP, Stop TB, PEPFAR and other bilateral agencies and donors to operationalize this Strategic Objective.

Though the Global Fund will support all recipient countries to scale up programs to remove barriers to health services, it is providing intensive support in 20 countries in the context of corporate Key Performance Indicator (KPI) 9 – “Reduce human rights barriers to services: # of countries with comprehensive programs aimed at reducing human rights barriers to services in operation”. This KPI measures “the extent to which comprehensive programs are established to reduce human rights barriers to access with a focus on 15-20 priority countries”.⁶ Based on criteria that include needs, opportunities, capacities and partnerships in country, the Global Fund selected Senegal as one of the countries for intensive support to scale up programs to reduce barriers to services. This baseline assessment, focusing on HIV, is the first component of the package of support the country will receive.

The objectives of this assessment in Senegal are to: (a) establish a baseline of human rights-related barriers to HIV services and existing programs to remove them; (b) set out a costed, comprehensive program aimed at reducing these barriers; and (c) recommend next steps in putting this comprehensive program in place.

⁵ *The Global Fund Strategy 2017-2022: Investing to End Epidemics*. GF/B35/02

⁶ 2017-2022 Strategic Key Performance Indicator Framework, The Global Fund 35th Board Meeting, GF/B35/07a - Revision 1, April 2016

The program areas recognized by governments, UNAIDS and other technical partners as effective in removing human rights-related barriers to HIV services comprise: (a) stigma and discrimination reduction; (b) training for health care providers on human rights and medical ethics; (c) sensitization of law-makers and law enforcement agents; (d) reducing discrimination against women in the context of HIV; (e) legal literacy (“know your rights”); (f) legal services; and (g) monitoring and reforming laws, regulations and policies relating to HIV.⁷

Programs to remove human rights-related barriers to services are *comprehensive* when the *right programs* are implemented *for the right people* in the *right combination* under each of the program areas set out above, at the *right level of investment* to remove human rights-related barriers and increase access to HIV services.⁸

The findings of this baseline assessment will be used by national stakeholders, the Global Fund, technical partners and other donors to develop a five-year plan by which to fund and implement a comprehensive set of these programs to remove human rights-related barriers to HIV services in Senegal. Its data will also be used as the baseline against which will be measured the impact of the interventions put in place in subsequent reviews at mid-term and end-term during the current Global Fund Strategy period.

1.2 Methodology

Conceptual Framework

The conceptual framework for the baseline assessment is the following: (a) Depending on the country and local contexts, there exist human rights-related barriers to the full access to, uptake of and retention on HIV, TB and malaria services. (b) These human rights-related barriers are experienced by certain key and vulnerable populations who are most vulnerable to and affected by HIV, TB and malaria. (c) There are human rights-related program areas comprising several interventions and activities that are effective in removing these barriers. (d) If these interventions and activities are funded, implemented and taken to sufficient scale in country, they will remove, or at least significantly reduce, these barriers. (e) The removal of these barriers will increase access to, uptake of and retention in health services and thereby make the health services more effective in addressing the epidemics of HIV. (f) These programs to remove barriers also protect and enhance Global Fund investments, strengthen health systems and strengthen community systems.

Under this conceptual framework, the assessment in Senegal has identified:

- a) Human rights-related barriers to HIV services

⁷ See *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses*, Guidance Note, UNAIDS/JC2339E (English original, May 2012); ISBN: 978-92-9173-962-2. Governments committed to the implementation of these programs in the *Political Declarations on HIV/AIDS 2011 and 2016*. See also *Technical Briefs HIV, Human Rights and Gender Equality* Global Fund to Fight AIDS, TB and Malaria (April 2017); *Tuberculosis, Gender and Human Rights* Global Fund to Fight AIDS, TB and Malaria (April 2017)

⁸ This definition of “comprehensiveness » for the purpose of GF Key Performance Indicator 9 was developed with the Global Fund Human Rights Monitoring and Evaluation Technical Working Group.

- b) Key and vulnerable populations most affected by these barriers
- c) Existing programs to address these barriers; and
- d) A comprehensive set of programs to address these barriers most effectively.

Human rights-related barriers to HIV services were grouped under the following general categories: stigma and discrimination; punitive laws, policies, and practices; gender inequality and gender-based violence; and poverty and economic and social inequality.

Key populations have been defined as follows by the Global Fund:

- a) Epidemiologically, the group faces increased risk, vulnerability and/or burden with respect to at least one of the two diseases – due to a combination of biological, socioeconomic and structural factors;
- b) Access to relevant services is significantly lower for the group than for the rest of the population – meaning that dedicated efforts and strategic investments are required to expand coverage, equity and accessibility for such a group; and
- c) The group faces frequent human rights violations, systematic disenfranchisement, social and economic marginalization and/or criminalization – which increase vulnerability and risk and reduces access to essential services.⁹

Vulnerable populations are people who do not fit into the definition of key populations, but nevertheless are more vulnerable to HIV and its impact.¹⁰

The design, outcomes, and costs of existing programs to reduce these barriers were analyzed in terms of their scope and effectiveness. Based on this analysis, a comprehensive program to address human rights-related barriers at scale is described.

Steps in the assessment process:

- a) *Desk review* – A search to assess human rights-related barriers to HIV services in Senegal, key and vulnerable populations affected by these barriers and programs to address them was conducted using PubMed, Embase, and Web of Science to identify peer-reviewed literature. The publications section of local non-government organizations (NGOs) and community-based organizations (CBOs) working in Senegal in the HIV sector were also searched for relevant publications. In addition, searches were made in French. Emails seeking additional information on programs were sent to several NGOs working on HIV in Senegal to achieve a greater understanding of issues faced by their clients. Lastly, 14 phone or in-person interviews were conducted with representatives of the government, local and national NGOs, and key population networks. Finally, the legal and policy environment in Senegal was reviewed in the context of HIV.

⁹ The Global Fund to Fight AIDS, Tuberculosis and Malaria. *Key Populations Action Plan 2014-17*. Geneva

¹⁰ Greenall M, Kunii O, Thomson K, Bangert R and Nathan O (2017). Reaching vulnerable populations: lessons from the Global Fund to Fight AIDS, Tuberculosis and Malaria. *Bulletin of the World Health Organization* 2017; 95:159-161.

- b) *Preparation for in-country data collection* – From the desk review and initial consultations with stakeholders in Senegal, a list of key informants and populations for focus group discussions was developed for data collection in country. The data collection tools were written in English and translated into French. The data collection teams in-country were trained on the content and background of the questions contained in the data collection tools. Ethics approval was obtained from the Ministry of Health of Senegal. The Johns Hopkins School of Public Health Institutional Review Board determined this assessment to be exempt from “human subjects research” as identifiable information about subjects would not be collected, and the type of evaluation research being conducted did not result in the collection of personal experiences or information.
- c) *In-country work* – An inception meeting introduced the project to national stakeholders, explained the objectives of the baseline assessment and data collection procedures and summarized the findings of the desk review. This was followed by key informant interviews and focus group discussions with members of key and vulnerable populations in Dakar, St Louis, Ziguinchor, Kedougou, and Kaolack. A total of 39 key informant interviews were conducted, and 50 key population members participated in 6 focus groups.
- d) *Data collection* – Data were collected on the following areas:
- Human rights-related barriers to HIV services
 - Key and vulnerable populations most affected by these barriers
 - Programs and activities under the human rights program areas carried out presently or in the past that have been found through evaluation or through agreement by many key informants to be effective in reducing these barriers
 - Stated needs regarding comprehensive programs to address the most significant barriers for all groups most affected by these barriers
 - Funding of such programs (for 2016 financial year); and
 - Costing of effective¹¹ programs carried out presently or in the past.
- e) *Data analysis* – The in-country data were analyzed to explore agreement with or divergence from the desk review findings and to add data on barriers, programs, and affected populations missing from the desk review. This information, together with data on funding in 2016, was used to develop the Baseline Data Summary. Data on effective projects and on stated needs were combined to suggest the comprehensive programs to reduce human rights barriers to HIV services in Senegal.
- f) *Finalization and next steps* – Upon finalization, this assessment was provided to the Global Fund Secretariat for use as background in preparation of an in-country multi-stakeholder meeting to consider how best to scale up programs to reduce human rights barriers to HIV services in Senegal.

Costing methodology

Three sets of costing processes were undertaken for this assessment:

¹¹ Effectiveness is determined either by evaluation or by broad agreement among key informants that a program is/was effective.

First, all donors and funders who were discovered to have financed any activities in the human rights-related program areas for HIV were asked to supply details of the amount of funding provided and the program areas in which funding was provided; and, if possible, to state the type of activities and coverage of funded activities. This approach was largely successful in overall terms for HIV, in that most donors were able to state what program areas the funds were directed to, but they did not provide details regarding the funded activities or their reach.

Second, specific implementers were approached and information was gathered on costs involved in carrying out particular interventions. This process followed the Retrospective Costing Guidelines (available from Global Fund on request). The expenditure lists and donors for HIV are summarized in Annex 2. Individual costing sheets for services provided by each of the organizations were prepared.

Third, a prospective costing of the comprehensive program was carried out. The results of this process are provided in Annex 3. For each type of intervention, an intervention-level cost was assembled.

The unit costs for activities included in the prospective costing of the 5-year comprehensive response were premised on the unit cost of the budgetary sheet of the main HIV country proposal submitted to GFATM (under allocation). This costing was based on the practicing rates of the Principal Recipients (i.e. the standard unit costs for activities like training, counselling etc.).

These costs were used to construct calculation tables (see calculation tables in Annex 3). In these calculations, the number of services to be provided/people to be reached/trained were multiplied by the intervention-level cost to provide an annual cost for each activity. Annual costs are required because some activities only take place every few years, and others require capacity-building or other activities in the first year that are not needed in later years. Comment boxes to the right of each activity in these calculation tables show where the data came from to construct the calculation. These calculation tables were used to provide overall Program Area and Activity sub-activity budgets (Annex 3), for each of five years as well as a five-year total. These are the budgets that are used to construct the five-year totals provided at the end of this report.

Limitations

With regards to the retrospective costing, it should be noted that the tool for data collection was sent to a wide range of organizations, including networks of key and vulnerable populations, UN agencies (notably WHO, UNDP, UNAIDS), and NGOs involved in the national response to HIV. This often involved visiting these organizations repeatedly for orientations on the tool and follow-up, as well as telephone conversations. Many organizations were not willing to provide financial information, so the cost estimate of existing programs is likely an underestimate. Though unit costs for many outputs have been calculated, it was not possible for a number of activities, as it was extremely difficult to separate out the expenditures incurred for each of these activities because many headings including salary, utilities, transportations, and communications were shared by other interventions also. Moreover, many interventions also have multiple outputs at the same time.

2. Findings

2.1 Overview of epidemiological context and key and vulnerable populations

The Government of Senegal was among the first countries in sub-Saharan Africa to endorse and support early and broad access to antiretroviral therapy (ART) for people living with HIV (Méda et al. 1999). Senegal has been considered an example in the region due to its early response to HIV and moderate control of the HIV epidemic among the broader population. The HIV prevalence among adults of reproductive age in Senegal is estimated at 0.4% (0.4% - 0.5%). Approximately 41,000 people are estimated to be living with HIV (34 000 – 48,000), according to UNAIDS estimates (UNAIDS 2016). The estimated prevalence of HIV among women and girls in Senegal aged 15 years and older is 0.6% (0.5 – 0.7) with the prevalence among girls and young women ages 15-24 at 0.1% (<0.1 – 0.2) (UNAIDS 2017). However, a concentrated epidemic is observed in Senegal, as the burden of HIV disproportionately affects certain key populations.

The key populations most affected by HIV in Senegal include men who have sex with men, female sex workers, people who inject drugs, and transgender women. Vulnerable populations include young people, people with disabilities, prisoners, and clients of sex workers (including long-distance truck drivers, fisherman, miners, armed forces personnel). The *Plan stratégique nationale de lutte contre le VIH/SIDA et les IST 2015-2017* from the Conseil National de Lutte contre le Sida (CNLS) defines key populations as men who have sex with men, female sex workers, and people who inject drugs. It defines vulnerable populations as mobile populations (security force personnel, truck drivers, fishermen, miners), women, prisoners, youth and security forces (CNLS). This report includes people living with HIV as a key population.

Among men who have sex with men in Senegal, the annualized HIV incidence was estimated in 2013 at 16% (Drame et al. 2013). HIV prevalence has been estimated to be as high as 41.9% (Beyrer et al. 2012, Stahlman et al. 2016, UNAIDS 2016, Lyons et al. 2017, UNAIDS 2017). The estimated population size of men who have sex with men in Dakar was approximately 1,800 in 2015; however recent unpublished data has determined that this is an underestimate. (Baral 2017) Recent national estimates of men who have sex with men are approximately 9,300. (UNAIDS 2016) Men who have sex with men in Senegal have shown low uptake of services across the HIV care continuum, particularly in HIV testing. A 2017 study among men who have sex with men estimated that 13.2% of men who have sex with men study participants living with HIV were aware of their status (Lyons et al. 2017). Among those who were aware of their HIV status, 82.8% were receiving treatment, and among those receiving treatment, 63.6% were virally suppressed (Lyons et al. 2017). These data highlight the gap in testing and diagnoses among men who have sex with men in Senegal.

The size of the female sex worker population in Senegal was estimated at 4,200 in 2011 (World Health Organization 2011). However recent unpublished data has determined that this is an underestimate. (Baral 2017) Among female sex workers in Senegal, the HIV prevalence was estimated in 2013 to be over 20% (Papworth et al. 2013). However, recent estimates put the prevalence in sex workers at 5.3% (Lyons et al. 2017) suggesting there may be a decline in prevalence. Prevalence estimates can vary among age groups of female sex workers. Estimates from 2016 show 7.6% of female sex workers older than 25 years were seropositive compared to 3.3% of female sex workers under 25 years (UNAIDS 2016). Uptake of HIV testing, which includes receipt of test and knowledge of test results, among female sex workers in Senegal in a

12-month period was estimated at 66.4% in one study (Lyons et al. 2017). A recent study estimated that 55% of participants were aware of their HIV-positive status, and among those women, 68.2% had ever initiated ART (Lyons et al. 2017). Among female sex workers currently on ART, 66.7% had achieved viral suppression (Lyons et al. 2017).

With respect to people who inject drugs, the estimated population size of this group in Senegal is 1,300 (UNAIDS 2016), though it is likely that the size of this hidden population is underestimated. A study estimated the prevalence of HIV among people who inject drugs in Senegal at 10.2% (UNAIDS 2016). Sex differences have been observed in some prevalence estimates; for example, in one study, women who inject drugs were estimated to have a prevalence 21.8 percentage points higher than men who inject drugs (28.6% vs 6.8%) (UNAIDS 2016). Among people who inject drugs, over a given 12-month period 9.1% were tested for HIV and were aware of their results (UNAIDS 2016).

The estimated HIV prevalence among incarcerated people in Senegal is 2.0%, with a higher prevalence among women (4.7% vs 1.7% in men) (UNAIDS 2016). The prevalence is higher among incarcerated individuals who are less than 25 years old, with an estimate of 2.4% prevalence (UNAIDS 2016).

Data describing the HIV epidemic among transgender women in Senegal is limited. However, there are regional data inclusive of Senegal. Among aggregated data of transgender women in Burkina Faso, Côte d'Ivoire, the Gambia, Lesotho, Malawi, Senegal, Swaziland, and Togo, 77.9% had ever been tested for HIV, and 50.5% were tested in the last year (Poteat et al. 2017). Regionally, HIV prevalence among transgender women was higher than cis-gender men who have sex with men, with an estimated HIV prevalence of 25.4% compared (Ibid.). Recently, there are unpublished data that the burden of HIV is greater among transgender women in Senegal who have sex with men than of cisgender men who have sex with men. (Baral 2017) However, there is an urgent need to understand the HIV prevalence and HIV vulnerabilities among transgender women in Senegal with representative data.

2.2 Overview of the policy, political, and social context relevant to human rights-related barriers to HIV services

Protective laws (with challenges of enforcement)

Senegal has set forth several policies and laws that promote HIV care and treatment and reduce barriers to HIV services. However, assessment of the impact of these laws has been limited. The following laws, policies and strategies are relevant to key populations' access to and use of relevant services.

National policies/strategies include the following:

1. CNLS Strategic Plan to Combat HIV and AIDS 2014 – 2017. This plan targets vulnerable populations and highly affected regions including: Kolda, Sédhiou, Ziguinchor, Kédougou and Tambacounda.
2. The Initiative Sénégalaise d'Accès aux ARV (ISAARV). This initiative is a national program making antiretrovirals free of charge.
3. National Observatory for the Rights of Woman

- Convenes stakeholders with government ministries to research and analyze the situation of women.
 - Ensures the implementation, monitoring, control and evaluation of protective and safety measures to prevent and combat inequalities between men and women at all levels of life in society.
 - Formulates proposals and recommendations for legislative, regulatory and program reforms conducive to the development and promotion of economic, social and political rights in order to guarantee gender equity and reduce gender inequalities.
 - Carries out research and studies on the application of the law on gender equality.
 - Informs and disseminates, whenever necessary, the data required to comply with the provisions of the Act on Gender Equality and all those relating to the economic and social advancement of women.
4. National Strategy for Economic and Social Development (Poverty Reduction Strategy), includes three principles: (a) growth, productivity and wealth creation; (b) human capital, social protection and sustainable development; and (c) governance, institutions, peace and security.

National laws include the following:

1. Human rights-related provisions in the Constitution include:
 - Article 4: Any act of racial, ethnic or religious discrimination, as well as any regionalist propaganda, which may affect the internal security of the State or the integrity of the territory of the Republic, shall be punishable by law.
 - Article 7: All human beings are equal before the law.
 - Article 15: Men and women... have the right to possession and ownership of land.
 - Article 98: Treaties or agreements duly ratified or approved shall on publication take precedence over domestic laws, provided that each agreement or treaty is applied by the other party.
 - Title II (articles 7-25) enshrines Senegal's commitment to human rights.
2. Law No. 2010-03 on HIV/AIDS
 - Article 1: All healthcare providers must be trained to provide information on HIV and AIDS.
 - Article 2: All healthcare providers must make available information on modes of HIV transmission, prevention, and consequences of HIV infection. Prenatal counseling services must provide pregnant women with relevant information on HIV infection, access to voluntary testing and appropriate care. Doctors, pharmacists, dental surgeons and other healthcare providers must provide their patients with training to control the spread of HIV and AIDS.
 - Article 4: People living in prisons cannot be tested for HIV unless ordered by a judicial authority. The relevant ministries must provide necessary and relevant means of prevention in all penitentiary institutions and rehabilitation centers. The ministries concerned must make available to all penitentiary institutions and rehabilitation centers the means to ensure the protection of prisoners against all forms of violence, including sexual violence. Prison authorities must investigate

allegations of rape and other sexual violence in penal institutions and rehabilitation centers.

- Article 12: All screening centers, clinics or laboratories conducting HIV testing are required to provide free counseling services before and after each HIV test. Anyone 15 years of age or older has the right to be screened for HIV. For persons under 15 years of age who are unable to give their consent, the opinion of the parents or the legal representative is required. Compulsory testing is prohibited except at the request of the judicial authority. Any hindrance to voluntary HIV testing is punishable by law.
 - Article 16: Availability and free access to antiretroviral drugs should be provided to all people living with HIV, including children.
 - Article 19: People living with HIV in prisons and rehabilitation centers must be able to receive psychosocial and medical care.
 - Article 20: Except with the consent of the person concerned, no person shall have access to information relating to his or her serological status or to any other medical information concerning him. Any person with access to medical records, test results or medical information related to the identity and HIV status of people is prohibited from sharing this information.
 - Article 21: Any HIV test result is confidential and can only be returned by the person who is the subject of the test (or the legal representative of a minor or incapacitated adult who has undergone the test, or the competent authority which requested the test).
 - Article 29: No one may deny access to services provided in public or private health facilities or have his health care charged higher than normal due to his actual or suspected HIV serological status or professional activity.
 - Article 30: Discrimination against people living with HIV in prisons and rehabilitation centers is prohibited.
3. Law No. 2005-18 on reproductive health
 - Article 7: People living with HIV are entitled to special assistance, basic care and a guarantee of confidentiality.
 4. Convention on the rights of people living with handicaps (KII27)

Challenges of enforcement and other gaps:

While protective policies and laws are in place, challenges arise in enforcement and understanding. There is a need to sensitize lawyers and judges and ensure laws fully protect the confidentiality of people living with HIV and protect the human rights of all key populations.

A key informant reported that the Law no. 2010-03 on HIV is intended to be protective; however, in this person's view, is not adequately implemented due to judges who lack knowledge of this act. This law should be revised and legislators should be trained to understand the purpose of the act (KII21). Law no. 2010-03 has weaknesses for effectively upholding the human rights of key and vulnerable populations and is limited in its protections and scope. The

reluctance of some legislators to protect human rights of key populations is an additional barrier to reformation of stigmatizing policies and introduction of laws that could be protective of key and vulnerable populations. Existing social barriers towards key populations, including LGBT groups, hinder legislators from giving their opinions on such issues (KII24).

Disclosure of HIV status is a concern for people living with HIV in Senegal. A doctor is permitted under national law 2010-03 to disclose the HIV status of an HIV-positive person to his or her spouse or sexual partners if the person refuses to do so him- or herself after receiving appropriate support and counseling. The possibility of disclosure and potential for misunderstanding of the law leaves people living with HIV highly vulnerable to stigma in healthcare settings. A key informant remarked that a current challenge is the breach of confidentiality in cases such as outpatient visits to hospital by prisoners (KII17).

Political and social environment

The political and social environment related to same-sex relations and Article 319 of the penal code which criminalizes "unnatural" sex acts with persons of the same sex is politically sensitive and complex. NGOs and civil society organizations are working to provide services to men who have sex with men, and Government has been a key supportive partner in this effort. However, same- sex relations remain highly stigmatized, and discussions of rescinding the law are felt to be unproductive at this point (KII51).

Political and funding support for HIV response as described by key informants

Political and funding support for the HIV response was discussed with key informants for perceptions of the currently situation. The results represent the perspectives of individuals within specific institutions and may not reflect the situation in its entirety. Several key informants noted a decrease in funding in recent years for HIV programs and services generally (KII3 , KII4 , KII5). One key informant spoke of a decrease in financing that supports activities for people who inject drugs and the withdrawal of partners for this key population (KII12). Another key informant felt that current HIV responses do not prioritize prevention and sensitization activities (KII4). One key informant noted that the limited financing that exists is increasingly oriented towards addressing the human rights of key populations and their access to healthcare services (KII26). This appears to represent the need to address the disproportionate burden of HIV among key populations. Financing trends have shown priority for key populations despite decreases in overall funding. However, one key informant felt that there have been challenges in successfully implementing interventions related to the need to update existing recommendations for key populations programs (KII6). Implementers noted that the limited financing is a current obstacle to achieving the long-term objectives of their interventions. Establishing plans for routine follow-up with their financial partners could be an opportunity to address this issue (KII11).

One key informant felt that, given the multisectoral aspect of the fight against HIV/AIDS, the engagement of all key stakeholders in fundraising and development of guidance has to be considered for the needs of key and vulnerable populations (KII11). Another key informant felt that external funding in itself does not push the national government to make human rights issues a priority (KII16).

One key informant said that, from 2012-2017, the Country Coordinating Mechanism was involved in planning for programs for sensitization of lawmakers, monitoring and reform of laws, policies and regulations, evaluation and management of issues related to stigma and discrimination, training healthcare professionals in human rights, legal literacy, support for access to legal services, reducing gender discrimination and patient/community mobilization (KII14).

2.3 Human rights-related barriers to access, uptake, and retention of HIV services

The major human rights-related barriers identified through the literature review and in-country data collection include:

- a) Stigma and discrimination, based on HIV status alone and/or based on key population status, are experienced in the community and at health facilities (i.e. discriminatory practices in healthcare facilities, which are heightened for members of key and vulnerable populations).
- b) Legal and policy barriers relating to key populations are a major constraint to HIV prevention and treatment, specifically those affecting female sex workers, people who inject drugs, and men who have sex with men.
- c) There are illegal or abusive police practices against marginalized populations, particularly towards female sex workers, including arrests of registered sex workers. These police practices create lasting and widespread fear of police, making key populations even harder to reach with HIV services.

Other important barriers identified:

- d) Government stock-outs of antiretroviral drugs and viral load testing reagents, combined with poverty, make it difficult for vulnerable populations to access HIV care and treatment services.
- e) Coverage of prevention programs for younger key populations, specifically younger men who have sex with men and female sex workers, is limited.

Stigma and Discrimination

HIV-related stigma and discrimination

Stigma and discrimination due to HIV status were found to be key barriers to accessing HIV services in Senegal. Due to low national HIV prevalence and persistent HIV/AIDS-related stigma, seeking care and support services openly has been a barrier for people living with HIV in the past (Diouf 2007). Discrimination against people living with HIV was also accompanied by fear of disclosure and rejection, which has been found in the past to prevent many people living with HIV and those affected by HIV from seeking family support (Foley and Nguer 2010).

The location of HIV clinics and health facilities may deter people from seeking services for fear of becoming exposed as living with HIV. For example, in Matam, the facility where ART is provided is exposed to the public, and individuals may not feel comfortable seeking services there (FGD2). The outpatient facility in Kaolack is also distinct and isolated from other patient services, and patients' fear of others seeing them accessing HIV care has deterred people from going to this facility. The isolation of the facility reportedly contributed to why dozens of people were lost-to-follow up with their HIV care, according to a focus group of men who have sex with men in Kaolack (FGD1).

Service providers living with HIV also experience stigma and discrimination. For example, seropositive police officers are not sent on international missions, and candidates sitting for the police entrance exam are excluded if seropositive (KII13). Furthermore, health care providers who work with people living with HIV also report experiencing stigma due to their association with this key population (Baral 2017).

Key population-related stigma and discrimination

Members of key populations (other than people living with HIV) experience stigma and discrimination attributable to a key population group or characteristic. This stigma and discrimination also function as barriers to accessing HIV services in Senegal. One key informant pointed out that there is insufficient sensitization and willingness among decision-makers to consider the concerns of key populations, in particular men who have sex with men and female sex workers. More political will and attentiveness to these issues are needed among political decision-makers (KII20).

Anticipated, as well as actual, stigma have been challenging for both men who have sex with men as individuals and also within advocacy and rights groups, as openly identifying as a member of a key population comes with a high risk of, or fear of, violence and/or marginalization. Internalized stigma also remains a problem for men who have sex with men, who may forgo contact with peer educators since that would mean disclosing one's sexual orientation in a health facility (FGD5).

One focus group felt that in the region of Kaolack tolerance of men who have sex with men has improved compared to five years ago; however, stigmatization and discrimination are still present, particularly when accessing services at the outpatient unit (CTA) for management of HIV in Kaolack (FGD1). Another focus group of men who have sex with men in Dakar noted that, while access to healthcare facilities is becoming easier due to sensitization efforts aimed at healthcare professionals, men who have sex with men still face poor treatment from healthcare staff. Many men who have sex with men are unaware of the locations of healthcare services (FGD3).

Social media has become a tool for disclosing the sexual orientation of men who have sex with men (FGD5). People create fake Whatsapp or Facebook profiles to trick men who have sex with men into disclosing their sexual orientation and/or behavior (FGD5). While social media plays a role, blackmail of men who have sex with men extends beyond this domain and is a widespread phenomenon, according to focus group participants. Men who have sex with men threaten to disclose the sexual orientation/behaviors of others in exchange for sexual and/or monetary favors. This type of blackmail was noted to be often perpetrated by MSM police officers and MSM marabouts, local Muslim religious leaders, who may refuse to wear condoms as part of the blackmail (FGD1).

A focus group of men who have sex with men in Ziguinchor reported that people verbally harass them when they are walking on the street or in nightclubs, and that some members of MSM associations have lost their jobs because they are men who have sex with men. According to the participants of this focus group, stigmatization and discrimination experienced by men who have sex with men in this region has become worse than it was five years ago (FGD6).

A key informant noted that due to different levels of stigma it is easier for stakeholders to be engaged with key and vulnerable populations like people who inject drugs, prisoners, and truck drivers than it is for them to be engaged with men who have sex with men. She reported that leadership for men who have sex with men and transgender women needs to be strengthened (KII33).

Few data exist on the experience of stigma and discrimination among transgender women; however, regionally, transgender women experience higher levels of stigma and discrimination compared to cis-gender men who have sex with men. The limitation of data is an obstacle that was highlighted throughout the assessment. Many individuals identify themselves as transgender, but there does not appear to be a consensus definition of what transgender means among people who identify as transgender (KII24). In a focus group discussion with men have sex with men in Saint Louis, the existence of transgender women was mentioned, but the participants found this target group challenging to identify and often did not approve of transgender people being associated with cisgender men who have sex with men (FGD5).

The highly binary gender roles in Senegalese society make it difficult for transgender women to fit in, and they are stigmatized because of this. A transgender woman interviewed in Ziguinchor reported deep stigmatization from family members and in work environments. She reported that stigmatization, discrimination and various forms of violence are part of daily life and that society has become less tolerant in the past five years, despite the advocacy and sensitization work of organizations like ENDA Santé. She reported there is lack of support to create an organization of transgender people. She also said that a transgender mediator could help reduce wait times for specialized health services (KII37).

Stigma and discrimination against female sex workers persists, and female sex workers are not yet tolerated by society (KII19). Female sex workers report poor reception and gossip by some healthcare professionals within facilities. Female sex workers in a focus group in St Louis also reported feeling neglected by civil society actors, who they feel work almost exclusively with men who have sex with men in the region. Due to this perception, female sex workers may intentionally withhold information or otherwise act uncooperatively during organization activities (FGD4). There is a need to better understand the prevalence of stigma and impact of HIV and uptake of services among female sex workers in Senegal.

In addition, clandestine female sex workers are a difficult-to-reach population when trying to target sensitization efforts. A key informant noted there is a competitive rivalry among female sex workers that may hinder human rights efforts. For example, some female sex workers will disclose the HIV status of their colleagues (KII7).

As noted by a journalist interviewed, information disseminated about key populations, including men who have sex with men, female sex workers, people who inject drugs, and people living with HIV, remains sensationalist. He reported that journalists should treat information about HIV and key populations in a dispassionate manner (KII10). In the past, the media has been viewed as a deterrent for individuals to report human rights violations because reports of stigma

and discrimination have been used as opportunities by the media to reveal the HIV status of those coming forward (Open Society Foundations 2007).

People who inject drugs face stigma and discrimination, and some are rejected by their families (KII18). However, limited data exist on the experience of stigma affecting people who inject drugs.

Intersecting stigma

Intersecting stigma is a challenge for key populations in Senegal. Sexual behavior stigma, especially among female sex workers and men who have sex with men, often intersects with stigma related to HIV status or perceptions of HIV status. People with disabilities can be more stigmatized because of both their disability and their sexual orientation. Stigma and discrimination are acutely felt among gay youth with disabilities (KII33).

Stigma and discrimination in health care settings

Stigma and discrimination in healthcare settings were the most commonly cited barriers to accessing HIV services by key stakeholders in this assessment.

Interview results highlighted that, while the public health advocate and service providers in Senegal have pushed to create appropriate services for HIV, discrimination in healthcare settings remains a barrier to care. Vulnerable populations as defined in Senegal face legal and cultural barriers to health services. Discrimination comes from a range of actors from clinical providers to health facility administrative staff, who also may fear being labeled or stigmatized for providing services to key populations. Stigma around HIV impacts healthcare received, particularly for marginalized populations with already concentrated rates of HIV.

Men who have sex with men have been shown to experience significant levels of perceived, anticipated, and enacted stigma and discrimination relating to the health care setting. In a study among men who have sex with men, 17.7% feared seeking health services, and 15.3% reported avoiding seeking health services because they were worried someone might learn they have sex with men (Lyons et al. 2017). Among participants in one study, approximately 1.3% of men who have sex with men reported being denied services or being kept from receiving services because of having sex with men (Lyons et al. 2017). Additionally, 5.5% reported hearing a health care provider gossip or make discriminatory remarks about having sex with men, (Lyons et al. 2017), and 3.1% felt that they were mistreated in the health center (Lyons 2017).

Men who have sex with men avoid seeking services or openly identifying for fear of arrest or abuse (Conseil National de Lutte Contre le Sida 2005).

Similarly, female sex workers experience high levels of stigma related to the health care setting. Among female sex workers in a recent study, 21.9% reported fear of seeking health services, and 22% avoided seeking health services due to worry that someone may learn of their engagement in sex work (Lyons et al. 2017). In addition to anticipated stigma, the poor quality of service provision for female sex workers was noted as a key barrier. In an interview, a stakeholder explained that even when HIV services are available for female sex workers, their quality of service delivery and care is so poor that they are ultimately ineffective. Older literature has documented significant gaps in services for female sex workers and at-risk women who need care (Huygens 2001).

Women living with HIV face barriers to accessing reproductive health services. While women living with HIV have described wanting to have children, doctors have been hesitant to support

their decision to have children and provide insufficient or contradictory information on strategies to help them get pregnant and avoid possible risks associated with a pregnancy (Sow 2014).

One key informant stated that cultural determinants and factors that contribute to barriers to accessing health services are very difficult to change for key populations like men who have sex with men, people who inject drugs, female sex workers, and people with disabilities (KII2 2017). The key informant felt that respect for human rights is still unmet, and respect for human rights needs to be implemented in practice (KII2).

Gender equality and discrimination against women

Gender discrimination was identified as a barrier, especially in the context of sex workers and vulnerable women, as well as men who have sex with men. Social factors, such as divorce or financial strain, have been linked to initiation of sex work among women in Senegal and represent a level of vulnerability specific to women. However, there is a need to better understand the specific economic factors and vulnerabilities related to sex work in Senegal.

Gender inequalities experienced by women limit their ability to negotiate safe sex or medical care and the expenses associated with it. These inequalities extend to gender-based violence, which can lead to both direct biological risk of HIV as well as barriers to seeking health services.

Gender roles and their expectations for women play a role in HIV risk in Senegal. When women are expected to carry out more household chores, their time and ability to care for themselves or seek medical care may be more limited.

Additionally, past HIV programs have not successfully addressed women's economic and social vulnerability (Foley and Nguer 2010). Economic barriers were identified, including costs of transportation, fees associated with HIV diagnosis and treatment, lack of health care infrastructure and inadequate human resource capacity, prevention, care, and support activities (Open Society Foundation 2007).

Focus groups of men who have sex with men in Dakar and Kaolack believed that women have more access to healthcare services than men, because registered "female sex workers are supervised and directed" to healthcare while men who have sex with men are still stigmatized (FGD₁, FGD₃).

Punitive laws, policies, and practices

There are several laws and policies that negatively impact access to HIV services, as outlined below. While a number of laws related to sexual behavior exist, there is significant room left for interpretation and abuse.

- Article 319 of the penal code criminalizes "unnatural" sex acts with persons of the same sex. It does not define what an "unnatural" sex act is. Punishment is a prison term of one to five years and a fine of between 100,000 and 1,500,000 francs [approximately US\$187 - US\$2800]. If the act has been committed with a person under 21 years of age, the maximum penalty will always be incurred. Homosexuality is not an offence itself. However, Article 319 has been used to target people on the basis of their sexual orientation (Council 2013).
- Articles 318 to 327 legalize sex work in a highly regulated manner (Mgbako and Smith 2011). This law requires registration of sex workers and submission to mandatory bi-monthly STI and HIV testing. It also prohibits a number of sex work-related activities,

such as soliciting, aiding and abetting the practice of sex work, living off the profits of sex work, acting as an intermediary in the business of sex work, and impeding efforts to control, assist, and reeducate persons vulnerable to sex work.

- Article 109 criminalizes drug use, and states that those who illicitly buy, hold, or cultivate plants or substances classified as narcotic drugs or psychotropic substances, the small quantity of which makes it possible to consider that they are intended for their personal consumption, are subject to punishment. Potential punishments include: imprisonment of 2 months to 1 year and a fine equal to triple the value of drugs.

Several key events or laws have influenced access to justice and HIV services for key populations, as follows:

2008, Gay Marriage Case (Human Rights Watch 2010)

- In 2008, a Senegalese gossip magazine published photos from a party, claiming the people in the photos were homosexuals engaged in a “gay marriage” ceremony. Police arrested several of the men in the photos after public outcry against them. The men were released but suffered threats and attacks in the following months. Some of them fled the country, and some went into hiding in Senegal.

2008 Nine Homosexuals of Mbao Case (Human Rights Watch 2010)

- Police arrested nine men who were participating in an HIV/AIDS association, AIDES Senegal, carrying out education and outreach among men who have sex with men. These members were charged with engaging in homosexual conduct under Article 319 of the Criminal Code, and with forming a criminal association under Article 238. They were found guilty (in the absence of evidence of homosexual conduct) and sentenced to eight years in prison. The nine men were released in April 2009, and claim to have suffered loss of their livelihoods, families, and community. The case drew extensive media coverage, which lasted for months, with many conservative imams and other prominent leaders calling for the “destruction of homosexuals” in Senegal.

Law No. 2005-18 on reproductive health

- Article 16: Voluntary sexual transmission of HIV is defined as the transmission of HIV by unprotected sexual intercourse by a person knowing him/herself to be living with HIV. The definition of voluntary sexual transmission can include sexual acts that were the result of coercion, threat, violence, or surprise, as well sexual acts that were consensual.
- Article 17: Where the transfer [transmission] is the result of a voluntary sexual act, the partner who is a recognized first carrier shall be liable to imprisonment from two years to five years and a fine of 100,000 francs to 1,000,000 francs [approximately US\$187 – US\$1870]. When the transmission report is obtained as a result of rape, the penalties above are doubled. If the offense has been committed on a child under the age of 13 years or a person who is particularly vulnerable by reason of pregnancy, advanced age or medical condition resulting in physical or mental impairment, the maximum penalty is served.

Legal and structural barriers were identified for men who have sex with men in the context of criminalization of same-sex relations in Senegal (Open Society Foundation 2007, Foley and

Nguer 2010, Poteat et al. 2011, Drame et al. 2013). As discussed above, Article 319 of the penal code criminalizes sex acts with persons of the same sex. Documents and interviews during the assessment highlighted criminalization of same-sex behaviors as a barrier for uptake of HIV services and HIV programming (Human Rights Watch 2010, Human Rights Watch 2016). Several reports have detailed ways in which Article 319 has been used specifically to target men who have sex with men (UNHRC 2013). Moreover, this law has enabled an environment in which men who have sex with men face abuse by the police and the general public (Human Rights Watch 2016).

Senegal's National Strategic Plan on HIV/AIDS identified the criminalization of same-sex relationships as a major constraint to HIV prevention (CNLS 2014, CNLS 2015). Associations in Senegal for men who have sex with men provide supportive services, especially through HIV prevention activities. Legal and law enforcement barriers have had adverse impacts on HIV prevention efforts through several pathways, including: (1) instilling fear of arbitrary arrests and other human rights violations by police, which has led to membership attrition in these associations; (2) forcing geographic displacement of men who have sex with men, which in turn leads to lost contact between the association and its members and a reduction in health service attendance; (3) sanctioning the public "outing" of sexual and gender minority organizations that provide relevant referrals to HIV services, which has led to a negative impact of these association leaders' lives and property and the discontinuation of key services; and (4) forcing association leaders into hiding, which, among other things, further undermines referrals to or provisions of HIV-related services (Human Rights Watch 2016). Notably, in some circumstances in which discreetly functioning associations and their leaders have been exposed publicly, media outlets have played a role in this process, pointing to ways in which legal barriers and media practice act in synergy.

One study found that despite supposed constitutional protections for people who have same-sex relations, a stark rise in homophobia was observed beginning in 2008. This increase was accompanied by intensified violence against men who have sex with men (Niang 2009). Additionally, increases in levels of stigma and discrimination experienced by men who have sex with men were indicated at both community and family levels. The study referenced impacts of this increasing hostility including: decreased HIV programming for men who have sex with men, decreased reported condom use, decreased attendance at HIV testing services, and decreased access to healthcare services for men who have sex with men. Although NGOs in Senegal had developed interventions for men who have sex with men, the barriers that grew during this intensification of homophobia starting in 2008 after the publication of photos of a "gay marriage ceremony" limited implementation and uptake of interventions. Relatedly, this study recommended further involvement of civil society organizations in the HIV response to overcome these barriers and to create a safer environment for men who have sex with men in the country (Niang 2009).

Interviewees highlighted how criminalization of same-sex behavior prevented men who have sex with men from seeking assistance or health services. Laws around same-sex encounters also create barriers to promoting health for men who have sex with men. Stakeholders spoke about how legal illiteracy around human rights laws among key populations creates a barrier to exercising their legal rights. Many interview respondents spoke of how little advocacy there is to change laws, leaving harmful laws in place due to lack of political will to reform them. A key informant noted that refusal of some lawyers to defend members of key populations, such as men who have sex with men, is a constraint (KII26).

Legal barriers were also identified for female sex workers. Although commercial sex is legal in Senegal, strict regulations and registration requirements for female sex workers still present challenges. Registered female sex workers are required to participate in regular STI and HIV testing on a regular basis, and registration status is lost if not testing is not completed. Unregistered sex workers are harassed by law enforcement, which makes outreach difficult (Diouf 2007). Despite the need for support, few NGOs and CBOs were working with unregistered sex workers to provide outreach and HIV services (Open Society Foundation 2007). A representative of the Country Coordinating Mechanism reinforced that current laws and regulations that govern sex work do not address clandestine sex work (KII14). A key informant reported that the law on sex work is not up-to-date with current practices, and obeying current laws and regulations is a challenge for female sex workers considering barriers faced relating to registration (KII26). Female sex workers also noted the difficulty of the legal framework around the practice of sex work and the lack of respect for their human rights (FGD4).

Literature and interviews highlighted that the legal environment in Senegal inhibits prevention interventions for people who inject drugs (Human Rights Watch 2010, Poteat et al. 2011). Interviewees explained that criminalization of drug use prevented those populations from seeking help or care. Interviewees criticized the harsh punishments for drug consumers, which are as harsh as those for people who sell drug and do not consider the person's need for health services and support. Therefore, informants recommended that the law be amended to provide the consumer a non-jail punishment as an alternative to incarceration. A key informant explained that the criminalization of drug use ultimately stops people who use drugs from seeking help from health centers, and forces people who inject into hiding and out of range of supportive health services.(KII8) However, CEPIAD, a center that offers integrated care, treatment, and counselling services to people who inject drugs has shown to be accepted within this legal context.

Interviewees indicated that national policies in Senegal were not cohesive with the international conventions on human rights of which Senegal is a ratifying party, and ultimately people who inject drugs face human rights violations under Senegalese law, which influences their risk of HIV. Senegal has also ratified the UN drug conventions.

In its work with prisoners, Sida Services noted that they encounter legal barriers. An example of this is that they have experienced challenges in requesting and receiving permission to access prisons to carry out their interventions with prisoners (KII4).

According to a key informant, lack of respect for laws remains a key barrier to accessing services, in addition to stigmatization and self-esteem. Representatives from key and vulnerable populations need to be trained, sensitization needs to be done to create a favorable environment, and the capacity of key stakeholders needs to be strengthened (KII5).

In terms of overcoming these barriers, judges who are more open to new ideas, such as a softer application of penalties, may help to alleviate challenges. Additionally a more sensitized and respectful police force may help to overcome some of these barriers (KII10).

Focus group participants reported that human rights violations, unawareness of legal services and HIV law, and unfamiliarity of human rights are obstacles for men who have sex with men (FGD3) (FGD3).

Barriers for legal support and advocacy were mentioned during key informant interviews for other populations as well. A key informant noted that the Convention on the Rights of People with Disabilities has not yet been implemented (KII14).

Police harassment and abuse

Interviews highlighted that police target marginalized populations, undermining progress that has been made to promote human rights and destigmatize behavior among health care providers and public health stakeholders. A key informant noted that harassment and physical abuse by police forces, including arrests of men who have sex with men and female sex workers, are ongoing issues (KII15).

Prisoners remain handcuffed, accompanied by prison guards, during their medical appointments, a situation that compromises confidentiality between the health provider and patient, especially in the context of HIV (KII17). Additionally, prisoners may not want to discuss HIV risk behaviors and therefore could receive limited or inappropriate services.

Literature and interviews highlighted that criminal laws covering specific key populations can encourage violence perpetrated by police. An interviewee provided an example of how police abuse undermines health care services, as well as retention efforts, provided to men who have sex with men. He described that while the health care providers seek out men who have sex with men during the day to effectively provide them services, police also target men who have sex with men, forcing them further into hiding and reducing their trust of official systems that are supposed to protect them. When arrest, police harassment, and brutalization of men who have sex with men is normalized, retention in services becomes an increasing challenge.

There are also reports of failure by the police to respond to violence perpetrated against men who have sex with men by other individuals (AIDES Senegal 2015 , Human Rights Watch 2016). This provides an environment of impunity regarding perpetration of violence against men who have sex with men. Focus groups among men who have sex with men highlighted that they are treated poorly by police and are also subject to confiscation of property belonging to their associations (FGD1). They report being harassed in the streets simply because of assumptions about their sexual orientation and being “rounded up” after they were asked for their identity cards (FGD3). Moreover, some men who have sex with men report that others have been driven out of their apartments based on rumors of their sexual orientation (FGD5). Law enforcement officers reportedly abuse their power by handcuffing and publicly outing some men who have sex with men. Harassment and abuse by the police are frequent, according to men who have sex with men in Ziguinchor, and have increased over the past five years (FGD6).

Documents describe experiences of abuse that prevent the LGBT community from fully participating in society. One report highlighted the *de facto* criminalization of organizations providing supportive services to men who have sex with men by police as a particularly virulent, systematic barrier to health and HIV services (Human Rights Watch 2016). The report explained how members and leaders of LGBT associations (particularly MSM associations) have been investigated by police as though they were “organized criminal networks rather than community organizations working with the Senegalese Ministry of Health to fight the HIV epidemic heavily concentrated among men who have sex with men” (Human Rights Watch 2016).

While sex work is legal, respondents asserted that this legalization does not protect female sex workers, who are often assaulted or attacked by police. When faced with human rights violations

from police, victims lack information on where and how to seek support and report violations or abuse. In a focus group discussion, female sex workers reported blackmail by the police and abusive intrusion into their houses and on the street without providing reasons for their arrest (FGD4). Key informants reinforced that police harassment, including sexual and physical violence, towards female sex workers is an ongoing issue (KII35). Female sex workers reported that sex or money are sometimes used as compensation for release after arrests. They also reported that advocacy conducted with authorities has had a big impact in the reduction of arrests and cases of sexual and physical violence (FGD4).

Literature documents that unregistered sex workers are often arrested and harassed by police and harassed by their clients. Unregistered sex workers are at greater risk for arrest, detention, and blackmail because they do not have a registration card. However, both registered and unregistered sex workers report physical and sexual violence perpetrated by clients and police. (Open Society Foundation 2007) (Foley and Nguer 2010).

A key informant noted people who inject drugs also experience physical violence and bullying during arrest (KII18).

Sexual and physical violence

A report by Horizons/Population Council in collaboration with CNLS estimated that 37% of men who have sex with men had been forced to have sex in the last 12 months (Moreau 2002). Participants of a focus group discussion reported that two out of nine men who have sex with men in the focus group have been forced to have sex against their will, but that the situation is improving due to the existence of legal aid offices (FGD1). This happens among acquaintances in social circles, who threaten to disclose a man who has sex with men peer's HIV status if they do not engage in sexual activity (FGD3).

Several organizational reports present case data on legal and policy issues in Senegal that enable and perpetuate verbal and physical violence toward the LGBT communities in multiple regions of Senegal. Documents cite numerous cases of discrimination and violence, including unchecked/unenforced abuses where religious leaders have invested money to incite violence. The abuses reported include messages to “find and kill homosexuals,” instances in which media outlets have publicly “outed” LGBT individuals and organizations, and ongoing neglect of these forms of abuse by police (AIDES Senegal 2015, Human Rights Watch 2016). Men who have sex with men in Ziguinchor report that they have been victims of physical violence by their community and families and in their work places. These experiences of violence push men who have sex with men to leave the country in some cases (FGD6).

Given this backdrop of sanctioned violence, there is little recourse available to men who have sex with men. An interviewee explained that even if a man who has sex with men wished to seek justice in a court for inflicted violence, lawyers often refuse to take up their cases due to both discrimination and fear of experiencing stigma from the community for associating with such a case.

While sex work is legal in Senegal, the laws do not provide protection from physical or sexual violence for female sex workers. The director of a civil society organization explained that sex workers are highly vulnerable to violence due to their marginalization in Senegalese society and the overall social acceptance of violence against female sex workers.

Cultural norms

Stigma against men who have sex with men is still perpetuated by beliefs, values, and cultural norms, which limits participation in preventive and curative care (Ndiaye et al. 2011). Key informants reported that stigma and discrimination based on socio-cultural norms is still present for men who have sex with men, female sex workers, people who inject drugs, people living with HIV, and youth (KII3) (KII11). Interviews highlighted that culturally-based ideas about sexual orientation, drug use, and sex work create an environment of stigma, discrimination, and abuse, which allow human rights abuses against key populations to flourish..

Key informants spoke about how religion has been used to perpetuate stigma of key populations. Both Islam and Christianity have been used by individuals as reasons to discriminate against men who have sex with men, further marginalizing them within Senegal. Interviewees discussed ways in which religion has been used to limit conversations about the health of key populations. Religious leaders, who have the social capital to effectively advocate for key populations, have not done so, further isolating key populations and leaving them subject to stigma and discrimination. One interviewee mentioned how some religious discourse promotes discrimination on grounds of sexual orientation and gender identity.

A Ministry of Health official spoke of how HIV is stigmatizing in and of itself in Senegal. This interviewee discussed perceived associations of HIV with individual actions and marginalized groups, making it difficult to speak of HIV openly or get people appropriate treatment. Additionally, the interviewee discussed lack of knowledge about key populations as a significant challenge to supporting these populations.

Communication about HIV was a common theme in interviews. Respondents discussed how stigma prevents people from speaking about issues related to men who have sex with men, female sex workers, or people who inject drugs. This silence enabled rumors and misinformation to thrive.

Focus groups from a 2017 CNLS report described mixed community and family perceptions of people who use drugs. Some representatives of this group described long-term stigmatization and mistrust by family members even after they stopped using. Others described experiences with recovery through methadone treatment that enabled them to regain relationships and supportive connections with family members (Conseil National de Lutte Contre le Sida 2017).

Poverty and economic inequality

Poverty is an issue that affects people living with HIV. One focus group mentioned that people living with HIV pay for viral load testing out of pocket, which can be as much as 13,000 CFA [approximately US\$25]. Participants reported that this testing had been free in the past (FGD2). Female sex workers also report frequent difficulty affording transportation, purchasing medicines, and paying for laboratory tests (FGD4). A key informant noted that a large proportion of people with disabilities live in poverty, and basic social services are often not accessible to people with handicaps (KII27).

Focus group discussions highlighted that the lack of financial means among men who have sex with men pushes them to accept unprotected sex and engage in sex work, and that poverty in this population has not improved over time (FGD1). Men who have sex with men do not have stable financial resources to pay for healthcare services, one reason why they are often lost-to-

follow up in healthcare. Men who have sex with men who are not part of a MSM association are more affected by barriers to healthcare services than others who take part in associations (FGD5).

2.4 Programs to address barriers to HIV services – from existing programs to a comprehensive response

This section describes existing or recent programs in Senegal to reduce human rights-related barriers to services under the seven program areas described above.

Program Area 1: Stigma and discrimination reduction

The table below provides an overview of current programmatic efforts on stigma and discrimination reduction as well as a description of scale-up required for a comprehensive response. The content of the table is then further elaborated upon. In Senegal, the term “mediator” is used to describe in the context of the HIV response community actors who are from at least one key population and are trained in psychosocial support, leadership, and human rights. They are selected by their peers, and this choice is validated by the medical personnel. Mediators are the liaison between key populations and healthcare workers, and work closely with social workers to ensure access to a continuum of care. They also play a crucial role in assisting and orienting their peers based on their specific needs and mediating between key population members and their families in cases of conflict (personal and criminal).

Stigma and discrimination reduction for people living with HIV and other key and vulnerable populations							
Program (note that, in many of these programs, reduction of stigma and discrimination is only a small component of a broader HIV prevention or treatment effort – see 4th column)		Limitations					
Peer education and support		<p>While multiple peer education and support programs have been implemented across Senegal, many of these programs were limited in duration or scope and some are not currently operational. A major gap in peer education and support programs is current limited geographic coverage. There is a need for more mediators, as well as capacity-building of current mediators on the specific issues faced by key and vulnerable populations and follow up for participants. Capacity and materials for stigma reduction programs have been developed; however funding for scaling up these programs and integrating them into HIV prevention and treatment services is limited. At the time of this assessment, there was limited data available about the effectiveness or reach of many of the programs that have been implemented in Senegal in the past. No programs have been developed to provide targeted services for transgender women, despite the unique risks faced by these women and the high levels of stigma and discrimination they experience.</p>					
Implementer	Description	Population	Primary objective or component	# reached	Region	Time frame	Recommended scale-up
ENDA Santé	Peer-led discussion groups focused on HIV prevention and transmission, human rights, stigma and discrimination, reproductive health, and living with HIV and psycho-social management. This intervention is not currently operational.	MSM, FSW, PLHIV	Primary objective is reduction of stigma and discrimination	Kaolack, Fatick, Kaffrine: 300 FSW, 350 MSM in 2016-2017	Dakar, Mbour, Thies, Kaolack Fatick, Kaffine	2015 - 2017	<p>Integrate stigma reduction led by Enda Santé into existing HIV prevention and treatment programs.</p> <p>Utilize existing curriculum for peer led discussion groups and include modules on human and legal rights, self-esteem, resiliency, and mental health.</p>
ANCS	Peer discussion groups	MSM, FSW, PLHIV	Primary objective			2018 - present	<p>Increase human rights information and discussion as well as geographic coverage of peer discussion groups being led by ANCS, and support follow up activities.</p>
DLSI	Reducing stigmatization of FSW and improving respect for their rights in healthcare settings	FSW	Component			2012-2015	<p>Include discussion groups specifically for transgender individuals and their human rights</p>
AWA	Uses peer mediators to support social reintegration, access to healthcare, and reduction of self-stigma among female sex workers, including hidden female sex workers and those who inject drugs	FSW, PWID	Component				
CEPIAD	The main objective of CEPIAD is to provide a complete outpatient service to people dependent on psychoactive substances through	PWID	Component	1324 in Dakar, 400 in Mbour	Dakar, Mbour	Sept 2011-present	

	non-stigmatizing care. The center's approach combines reductions in risks and activities related to the empowerment of people who inject drugs (therapy, reintegration, convivial activities, auto support, etc.). The offer of service includes methadone, addictology, somatic and psychiatric dependencies treatments, Counselling and HIV and hepatitis testing, antiretroviral therapy, prevention and the treatment of STIs and tuberculosis, a needle exchange program as well as other activities.						Small demonstration tools should be included and provided to peer educators Utilize and build from existing capacity in implementing this intervention. Stigma and discrimination aspects of prevention programs should be adapted to target younger men who have sex with men, students, men who have sex with men who do not live with family, and populations living in Saint-Louis, Sédhiou, and Ziguinchor regions
National Youth Committee	The National Youth Committee has established youth bureaus in healthcare facilities and "bureaux d'écoute" in adolescent centers. The Committee collaborated with ASBEF, AJS, Siguil Jiguen Network, and the Association of young people for reproductive health (ANJSR) to make it so that youth and youth living with HIV are more involved in programs to fight HIV and create youth mobilizers.		Component				Approach used in this program should be reviewed to include sufficient reduction of stigma and discrimination and adapted to other key populations who lack access to healthcare services. The current challenges faced by the program are a need for more mediators, need to build capacity of current mediators on human rights as well as the reduction of health risks, and insufficient funding to cover all planned intervention activities
Sida Services	Support accessing healthcare; discussion groups; reintegration of youth in families and schools and stigma reduction.	MSM	Component	All MSM associations in Dakar	Entire country	2010-present	
Program		Limitations					
Community mobilization, outreach, and advocacy		There is a need for improved coordination between key population associations and across key population networks to improve capacity and progress in achieving initiatives. Transgender women and younger female sex workers have not generally been included in community mobilization, outreach, and advocacy efforts.					
Implementer	Description	Population	Primary objective or component	# reached	Region	Timeframe	Recommended scale-up

RNP+	Advocacy and mobilization of funding and resources for PLHIV and other key and vulnerable populations; dissemination of best practices including delegating power, joint decision-making, and visibility at meetings and in activities, which has increased the visibility of PLHIV and helped created a favorable environment	PLHIV	Component		14 regions		Setting up a coalition composed of civil society organizations and network representatives would be beneficial to facilitating collaboration and harmonizing efforts among the various actors. Strengthen partnership with AJS to build capacity and coordinate monthly meetings of members to discuss topics that touch on stigma, discrimination and other human rights aspects of the lives of FSW; build in programs specifically aiming to reach younger FSW.
And Sopékou	Advocacy, sensitization, discussion groups, and national advocacy campaigns with authorities to bring HIV prevention and treatment activities to FSW and reduce stigma related barriers to services.	FSW	Component				
ANCS	Intervention built capacity of local and community leaders to advocate for their needs, and prepared and sensitized legal authorities, security forces, care providers, and lawmakers to the needs and requests conveyed by community leaders. Overall, this program aims to reduce stigma and discrimination in health care services and improve the quality of care for men who have sex with men.	MSM	Primary objective				It is important to involve MSM leaders in discussions to identify obstacles when developing key messages and implementing advocacy activities This program should be expanded to Thies and Ziguinchor Build capacity of MSM leaders on stigma reduction and other human rights efforts in the development and dissemination of key advocacy messages.
Enda Santé	Conferences and workshops and distribution of documents with the goal of informing key actors about the vulnerabilities of men who have sex with men in Senegal	MSM	Component				
ANCS and Enda Santé	Mobile clinics aim to reach non-registered and hidden female sex workers and improved access to care.	FSW	Component				
ACI	Increasing awareness among MSM community to encourage their own engagement and participation in the HIV response. Encourages MSM to become key actors within decision-making and planning processes	MSM; PWID; youth; prisoners	Component			2009-present	

ACI	Advocacy activities for the HIV response, including mobilizing stakeholders for action. Programs aim to strengthen technical capacities and increase awareness to alleviate stigma and discrimination in the fight against HIV. Technical support role for other organizations		Component				
Handicap Form Educ	Support HIV testing implement social mobilization, and conduct sensitizations to reduce stigma through discussion groups and home visits; facilitate communication between healthcare workers and those who are deaf, mute, or may have visual or mental handicaps, developed inclusive box of images; standardized concepts in sign language related to HIV/AIDS	People with disabilities, PLHIV	Component				
CNLS	Creation of a watch committee for the respect of human rights of PLHIV and key populations; advocacy for the respect of the rights of key and vulnerable populations	All KPs except TG	Primary objective		All regions	Since 2006	
Sida Services	Improving community support for prisoners	Prisoners	Component			2013	
AMShE and AfriCASO	CNLS to discuss strategies to overcome legal and social barriers to access to health services through stigma reduction for vulnerable groups, including MSM. This workshop was attended by a variety of stakeholders, including representatives from the Ministry of Justice, the Ministry of Interior, and the media	MSM				2016	These meetings should take place on a regular basis to facilitate continued discussions, strategy development, and capacity building in the reduction of stigma and discrimination.
Program		Limitations					
Media campaigns, and social media, and mobile applications		While local radio and media outlets have been used to expose specific key population leaders and associations and to promote intensified stigmatization of key populations, few discussions emerged on ways in which large and small-scale media outlets have attempted to or have the potential to mobilize support for human rights among key populations. While information on planned or existing interventions using social media or mobile phone applications were not found through this assessment, these technologies have great potential to reach and engage					

		with key and vulnerable populations in Senegal, particularly men who have sex with men and there is now a budget line for this item in the current ANCS grant, though activities had not started at the writing of this report. Female sex workers in Senegal are noted to change phones, change numbers often; thus programs that rely on phone numbers tend to be challenging. Literacy among female sex workers is relatively low, therefore mobile applications requiring reading or writing may be difficult.					
<i>Implementer</i>	<i>Description</i>	<i>Population</i>	<i>Primary objective or component</i>	<i># reached</i>	<i>Region</i>	<i>Time frame</i>	<i>Recommended scale-up</i>
ANCS	Capacity building messages into TV and radio shows and other media through strengthening existing partnership with journalists, developing key messages and a strategic plan for integrating non-stigmatizing messages into existing media; strengthening current campaigns being conducted with youth; and supporting existing radio shows and television programs working in this area to build capacity.						
Program		Limitations					
Engagement with religious and community leaders, and celebrities		This assessment did not identify evaluations on how religious leaders and practitioners of traditional religious customs interact, do not interact, or have the potential to engage with members of key populations or their families around HIV needs and services.					
<i>Implementer</i>	<i>Description</i>	<i>Population</i>	<i>Primary objective or component</i>	<i># reached</i>	<i>Region</i>	<i>Time frame</i>	<i>Recommended scale-up</i>
Sida Services	A program focused on advocacy and referrals through imams to become more engaged in the fight against HIV and improve uptake of HIV services.		Component				Advocacy and capacity strengthening of imams is recommended to incorporate non-stigmatizing messages into sermons.
RNP+	Established religious representatives that serve as network focal points		Component				Leverage lessons learned on engagement and training with imams on reproductive health to conduct training on stigma reduction.
Medicos del Mundo		MSM, FSW, PWID				2013-present	
JAMRA	Mobilization and strengthening community systems: advocacy, training leaders at regional level on	MSM, FSW, PWID, PLHIV			Advocacy done in all regions;	Since 2012	Continue sensitization at places of worship.

	human rights, workshops, psychosocial support				support activities in Dakar only		
DLSI	Focus on traditional leaders, religious leaders, grassroots community organization to change their views of female sex workers	FSW				2015-2017	
Program		Limitations					
Measurement of stigma		Data on stigma and discrimination experienced by key and vulnerable populations is not being routinely collected in Senegal, which makes it difficult to assess the impact of the stigma and discrimination reduction efforts. There are limited data about the reach of the program implemented by AWA and the number of cases that have been documented through the program.					
Implementer	Description	Population		# reached	Region	Time frame	Recommended scale-up
RNP+	People Living with HIV Stigma Index 2.0						PLHIV Stigma Index should be administered every 3-5 years and should be expanded to cover all regions in Senegal.
AWA	Surveillance of FSW cases related to discrimination, violence, and stigmatization due to a service provider	FSW, PWID, youth' people with disabilities				Started in 2006 - collected every 3 years	

Current Programs

Peer education and support

The reduction of stigma and discrimination has often been a component (sometimes a small component) of peer education and support activities that have been undertaken in Senegal to improve access to HIV services. However, as peer education and support have been shown to be an effective way to reach marginalized people such as key populations, it may be an effective means by which build the capacity of key populations in the reduction of stigma and discrimination, including self stigma. Peer education generally consists of training members of key populations to engage their peers with services such as counseling around HIV risk reduction strategies, how to access HIV testing services or treatment for people living with HIV, and/or provision of information about HIV-related human rights. Additionally, programs often provide materials to participants such as condoms and lubricants and may serve as a vital link to health services such as HIV testing, treatment, and care for people living with HIV. Peer education and support programming in Senegal has been organized for people living with HIV, female sex workers, men who have sex with men, people who inject drugs, youth, and clients of sex workers located at fishing ports. Clearly these peer education and support programs offer low cost opportunities in which to integrate and scale up human rights knowledge and skills among key and vulnerable populations, including the reduction of stigma and discrimination.

Between 2015 and 2017, ENDA Santé implemented an intervention study that consisted of an integrated stigma mitigation intervention (Lyons et al. 2017). This was an intervention study that included a community intervention among men who have sex with men and female sex workers, targeting perceived and anticipated stigma with the aim of improving HIV prevention and treatment outcomes over 24 months. The community intervention was delivered using a peer-based approach and included 5 modules: HIV prevention and transmission; human rights; stigma and discrimination; reproductive health; and living with HIV. Topics include HIV transmission, prevention and risk-reduction techniques; definitions of human rights and rights issues in the MSM and FSW communities; and methods for identifying and responding to stigma and discrimination, stress management, and self-esteem. This intervention showed improved HIV prevention and treatment outcomes over 24 months and reductions in perceived and anticipated stigma. The dissemination meeting of this study demonstrated that representatives of key populations, partner NGOs, Division de Lutte contre le SIDA (DLSI), CNLS, and others were supportive of the results, and were interested in incorporating lessons learned into the national strategic plan. This intervention ended in 2017. However, there is capacity within ENDA Santé to advise or implement this intervention as a program.

Alliance Nationale des Communautés pour la Santé (ANCS) has recently started implementing peer discussion groups with key populations, with the primary objective of this program focused around stigma reduction. However, limited evidence and information was available on this activity at the time of this review. Some key opportunities were identified which included the need for geographic expansion of activities. Additionally, the program currently has limited support for follow up activities for the peer discussion groups and supporting these activities could potentially improve the impact.

The Division de lutte contre le SIDA (DLSI) works nationally to promote behavior change, to increase screening rates for HIV and STIs, and to make healthcare services more accessible for men who have sex with men and female sex workers. A program organized by DLSI aimed at

reducing the stigmatization of female sex workers and improving respect for their rights in healthcare settings. This stigma reduction was a component of the broader program. A key informant noted that there is a need to integrate community leaders within the intervention and hold a knowledge-sharing workshop with religious leaders, men who have sex with men, the press, and healthcare service providers (KII50).

AWA is a national organization that implements programming, organizational financing, sensitization activities, advocacy and mediation related to respect for human rights. One program organized by AWA uses peer mediators to support social reintegration, access to healthcare, and reduction of stigma among female sex workers, including hidden female sex workers and those who inject drugs (KII35, KII39). Thus, stigma reduction is a component of their broader program.

The Centre de prise en charge intégrée des addictions à Dakar (CEPIAD) at Fann Hospital in Dakar has led a program since 2011, which has the main objective of providing a complete outpatient service to people dependent on psychoactive substances while respecting their human rights. The center's approach combines reductions in risks and activities related to the empowerment of people who inject drugs (therapy, reintegration, convivial activities, auto support, etc.). The offer of service includes methadone, addictology, somatic and psychiatric dependencies treatments, counselling and HIV and hepatitis testing, antiretroviral therapy, prevention and the treatment of STIs and tuberculosis, a needle exchange program as well as other activities. Broadly this program aims to provide non-stigmatizing care of people who inject drugs through advocacy and care management in Dakar and Mbour, including the trainings of people who have formerly injected drugs as mediators in the intervention (KII43). A key informant noted that the intervention has facilitated access to healthcare services among beneficiaries and could be replicated for other key populations who lack access to healthcare services (KII38). Another key informant noted that ideal coverage would extend to Thies and Ziguinchor as well (KII43).

One component of the program is to reduce stigma of people who inject drugs to facilitate their reintegration into their families and communities. The current challenges faced by the program are insufficient mediators, insufficient capacity of current mediators, and insufficient funding to cover all planned intervention activities (KII38). This program provides a good opportunity to integrate and scale up activities, skills and knowledge among people who use drugs to reduce stigma and discrimination.

From 2010 to 2016, the National Youth Committee provided training of peer educators, testing services, sensitization activities, and condom distribution in all regions of Senegal. Stigma reduction is one component of the program. The Committee established youth bureaus in healthcare facilities and "bureaux d'écoute" in adolescent centers, in collaboration with the Association Sénégalaise Pour le Bien-Etre Familial (ASBEF), AJS, Siguil Jigguen Network, and the Association of young people for reproductive health (ANJSR). The objectives of the program were to create youth mobilizers, to reduce stigma among youth, and encourage youth and youth living with HIV to be more involved in programs to address HIV.

Sida Services has implemented a program since 2010 that aims to teach men who have sex with men about human rights and improve their access to healthcare through discussion groups, resilience of youth, and provision of support to access healthcare. Stigma reduction is one component of this program. Sida Services also conducted activities to improve community

support for prisoners, though no data were available regarding their specific activities at the time of this assessment.

Limitations/Challenges

The above paragraphs have described peer education and support programs that had the reduction of stigma and discrimination as one, often small, component. Not only were these broader programs not dedicated to the reduction of stigma and discrimination, they also were limited in duration and scope regarding their primary objectives. At the time of this assessment, there was limited data available about the effectiveness or reach of many of the programs that have been implemented in Senegal in the past.

To the degree these programs are effective in reaching and engaging key and vulnerable populations they provide a potential opportunity to scale up the reduction of stigmas and discrimination and other human rights activities. This could be accomplished by training and recruiting additional mediators on the human rights issues faced by these populations and using them not only to provide prevention and treatment information but also human rights information, as discussed below in legal literacy. Capacity and materials for stigma reduction programs have been developed; however, funding for scaling up these programs and integrating them into HIV prevention and treatment services is limited.

This assessment also notes that no programs have been developed to provide targeted services, including those addressing their human rights, for transgender women, despite the unique risks faced by these women and the high levels of stigma and discrimination they experience.

Community mobilization, outreach, and advocacy

Community mobilization efforts are designed to sensitize community members and other stakeholders to issues faced by people living with HIV and other key and vulnerable populations, and to advocate for programming, policies and legal provisions that reduce the experience of stigma and discrimination in these populations. Civil society in Senegal has been engaged in discussions with programmatic and association partners regarding issues faced by men who have sex with men, female sex workers and people who inject drugs and the reduction of stigma and discrimination faced by key populations. However, one key informant noted that these efforts have been hampered by a lack of domestic funding (KII16).

RNP+ is a national network composed of several associations in the 14 regions of Senegal that engages in advocacy and mobilization of funding and resources for people living with HIV and key and vulnerable populations. Some of the effective practices of RNP+ have included the delegation of power and joint decision-making among member organizations, and activities that increase the visibility of people living with HIV and have helped to create a more favorable environment (KII28). Stigma reduction is a component of their broader program.

And Sopékou is a female sex worker association founded in 2008 that engages in advocacy, and organizes sensitization activities, discussion groups, and national advocacy campaigns with authorities to bring HIV prevention and treatment activities to female sex workers. A representative of the program noted difficulties such as providing programming for female sex workers younger than 21 and struggling to follow up with female sex workers for healthcare services due to the frequency with which they move. And Sopékou includes a team and network of trained female sex workers who often provide support to other organizations and institutions

conducting activities in stigma reduction. For example, And Sopékou partners with organizations like the Association des Juristes Sénégalaises (AJS) to convene monthly meetings of members to discuss topics that touch on the lives of female sex workers (KII29).

Africa Consultants International (ACI) engages in advocacy activities for the HIV response, including mobilizing stakeholders for action. These program components aim to strengthen technical capacities and to increase awareness to alleviate HIV-related stigma and discrimination. ACI also plays a technical support role for other organizations (KII8). Since 2009, in reaction to a wave of persecution against men who have sex with men in the country, the organization has played an active role in organizing activities to reduce the isolation of key populations and recognize their human rights. Activities include capacity-building of MSM leaders in advocacy techniques and organization of advocacy activities with religious leaders. ACI found that involving MSM leaders in the development and dissemination of key advocacy messages was the most effective approach. It is important to involve MSM leaders to identify obstacles when developing key messages and implementing advocacy activities (KII40).

ANCS has implemented a community-based program to provide sexual and reproductive health, HIV and STI prevention, and health services tailored to the needs of men who have sex with men since about 2012. The ANCS intervention built the capacity of local and community leaders to advocate for their needs, and prepared and sensitized legal authorities, security forces, care providers, and lawmakers to the needs and requests conveyed by community leaders. Overall, this program aims to reduce stigma and discrimination in health care services and improve the quality of care for men who have sex with men. The intervention placed a strong emphasis on inclusion of community groups for men who have sex with men, who participated in decision-making, program design, and community mobilization (Dia 2014). In a summary of this intervention, it was discussed how incorporating and focusing on the voices of men who have sex with men has the potential to create more effective programming and increase the agency of target populations (Dia 2014). An intervention was led by ANCS and coordinated with leaders of two men who have sex with men organizations to develop strategies for reducing STI risk among men who have sex with men, which were implemented in each of their respective zones (ELIHoS 2010).

A program organized by ENDA Santé included conferences and workshops and distribution of documents with the goal of informing key actors about the vulnerabilities of men who have sex with men in Senegal (ELIHoS 2010). Stigma reduction was a component of the program objectives. An evaluation of these combined interventions conducted in 2010 found that they were successful in training leaders of associations for men who have sex with men by strengthening their management skills and increasing knowledge around safe sex behaviors, which they can then share with their peers. While the interventions have trained an increasing number of providers on provision of care for men who have sex with men, the evaluation noted that this population is still highly stigmatized, even within health facilities. This evaluation found that few interventions focus on transforming the cultural environment through advocacy and that technical strategies to address stigma and discrimination remain weak.

Mobile clinics run by ANCS and ENDA Santé have helped to reach non-registered and hidden female sex workers and improved access to care for female sex workers (Dia, 2014). ANCS and its partners have helped the Ministry of Health in its policies around access to health and preventive services by increasing the demand for adapted services and reducing constraints associated with accessing services, including lack of information for patients, stoppages in care,

costs of transport, economic and psychological issues, and stigmatization. Stigma reduction is a component of the program. Targeted outreach and advocacy efforts to policymakers, healthcare providers and lawmakers resulted in better care for registered and non-registered female sex workers through reduction of discrimination. Problems encountered included difficulties maintaining the focus of the program and suboptimal PMTCT, care and treatment for female sex workers living with HIV (Dia 2014). Strategies for HIV prevention and care targeted to sex workers have remained largely the same over time, despite changes that have taken place, such as the growing numbers of young people involved in sex work. There is also no formal legal and judicial assistance mechanism for sex workers whose rights have been violated (Dia, 2014). Programs should be holistic in nature, reflect the needs expressed by sex workers themselves, and have human rights as their focus.

Handicap Form Educ organizes HIV prevention activities among people with any kind of disability. They work with people living with disabilities to get tested, implement social mobilization, and conduct sensitizations through discussion groups and home visits. Stigma reduction is a component of their intervention. This program supports HIV testing and social mobilization and conducts sensitizations to reduce stigma through discussion groups and home visits; facilitates communication between healthcare workers and those who are deaf, mute, or may have visual or mental handicaps, and develops an inclusive box of images and standardized concepts in sign language related to HIV/AIDS.

Limitations/Challenges

Associations for key populations, especially men who have sex with men are active in Senegal. However, there is a need for coordination between associations and across key population networks to improve capacity and progress in achieving initiatives. Additionally, transgender women and younger female sex workers have not generally been included in community mobilization, outreach, and advocacy efforts. These associations of key populations provide opportunities into which can be integrated and scaled up support, capacity building and activities to reduce stigma and discrimination and carry out other human rights activities.

Media campaigns, social media, and mobile applications

Media campaigns can be used a strategy to influence national policy and community norms around HIV-related stigma and discrimination experienced by people living with HIV and other key and vulnerable populations. In Senegal, a strong partnership exists between institutions working with key populations and the media. One of example of this partnership was the organization of roundtable discussions in 2010 with journalists following the arrest of 9 members of the AIDES association, to discuss depictions of homosexuality in the media. This workshop included the organization of a committee tasked with developing a strategic framework to promote tolerance and support for men who have sex with men and other vulnerable populations. However, while journalists are engaging in work to reduce stigma and discrimination of key populations in the media, a key informant noted that journalists who support this kind of work are stigmatized and discriminated against themselves in the places where they work (KII9).

Media interventions have been included in the Global Fund's Africa Regional HIV Grant for Removing Legal Barriers to access, and data from this initiative may be particularly helpful in guiding additional expansions of this type of programmatic effort.

ANCS organizes a yearly capacity building workshop with journalists, TV show hosts, religious leaders on how to cover HIV-related topics, particularly when key populations are involved. The focus of these workshops is the use of non-stigmatizing language. However, there remains a need to integrate non-stigmatizing messages into shows on TV and radio as this is not currently in their implementation plans. There is also a need to expand coverage of media campaigns to rural areas where there are few to no interventions.

In February 2016, AMSHeR and AfriCASO held a workshop at CNLS to discuss strategies to overcome legal and social barriers to accessing health services for vulnerable groups, including men who have sex with men. This workshop was attended by a variety of stakeholders, including representatives from the Ministry of Justice, the Ministry of Interior, and the media. Stigma reduction was a component of this workshop.

Limitations/Challenges

While local radio and media outlets have been used to expose specific key population leaders and associations and to promote intensified stigmatization of key populations, few discussions emerged on ways in which large and small-scale media outlets have attempted to or have the potential to mobilize support for human rights among key populations.

Program implementation details were not available on interventions using social media or mobile phone applications. However, these technologies have potential to reach and engage with key and vulnerable populations in Senegal, particularly men who have sex with men. Men who have sex with men seem to use mobile applications more frequently, and their literacy levels are generally higher than those of female sex workers. However, men who have sex with men may have concerns about anonymity when engaging in social media and mobile applications and it would therefore be important to build in robust security features into any programming using these technologies. Theatre testing of a web-based intervention aimed at reducing individual stigma, and improving social cohesion was conducted through the HP2 study (Lyons et al. 2017). Although results are not yet available, preliminary results showed that web-based platforms are more acceptable among young men who have sex with men; and that there is a need to diversify the content of a web intervention beyond the topic of HIV and stigma. It also be noted that the preferred social media applications change quickly with this population. (Baral 2017)

Female sex workers in Senegal are noted to change phones and change numbers often, and programs relying on phone numbers tend to be challenging. (Baral 2017) Literacy among female sex workers is relatively low, therefore a mobile application requiring reading or writing may be difficult.

Engagement with religious and community leaders, and celebrities

Religion is an important factor in the trajectory of stigma and discrimination reduction in Senegal. Religious leaders such as imams, marabouts, and Christian leaders, as well as practitioners of traditional religious customs, are involved in shaping values in Senegalese communities. Traditional healers are also sought for assistance with health issues. Due to their important position in Senegalese society, religious and community leaders can be extremely effective in the development of strategies to reduce the HIV-related stigma and discrimination experienced by people living with HIV and other key and vulnerable populations.

A program implemented by Sida Services has encouraged imams to become more engaged in the fight against HIV. They have found that advocacy and referrals through imams greatly facilitate access and uptake of healthcare services. Engagement and support of religious leaders may help to reduce stigma among HIV and key populations. A key informant noted that beneficiaries were involved in the entire process of implementing, monitoring and evaluating the different programs and interventions (KII42).

JAMRA has implemented programs to train leaders at the regional level on human rights since 2012 in partnership with ANCS, CNLS, Plan International, World Vision, and the Inter-Ministerial Committee against Drugs (CILCD). A key informant reported that the organization's largest success from this program was a greater involvement of religious leaders in advocacy work, an area that could be expanded upon in future interventions (KII48).

RNP+ has recently established religious representatives that serve as network focal points.

Medicos del Mundo conducts occasional activities among some religious leaders who are potential allies for advocacy. Medicos del Mundo's activities focused on stigmatization and discrimination reduction regarding the stigmatization of men who have sex with men, female sex workers, communities of people who inject drugs, and the treatment of information by media professionals (KII23).

DLSI has also been involved with engaging with traditional leaders, religious leaders and grassroots community organizations to reduce stigma towards female sex workers.

Limitations/Challenges

This assessment did not find comprehensive reviews of how religious leaders and practitioners of traditional religious customs interact, do not interact, or have the potential to engage with members of key populations or their families around HIV needs and services. Some efforts for stigma reduction through working with imams were noted; however limited information was available on the details of these efforts. Additionally, some documents provided examples of religious leaders who perpetuate stigma and violence toward marginalized groups.

Measurement of stigma

The *PLHIV Stigma Index* is a process that was developed by and for people living with HIV to generate data for advocacy and empower communities to advocate for their rights using the data. The *People Living with HIV Stigma Index* in Senegal was conducted in 2012 in Dakar, Saint Louis, Ziguinchor, and Kaolack. This assessment and report was conducted by the National Network of Associations of People Living with HIV in Senegal (RNP+) in partnership with the Regional Center for Research and Training of the National University Hospital Center of Fann (CRCF) as part of an international initiative developed by GNP+, IPPF, ICW, and UNAIDS.

The *PLHIV Stigma Index 2.0* was piloted in two regions in Senegal in 2017 by Johns Hopkins University and ENDA Santé. This updated tool aims to assess the empirical utility of an improved stigma measurement index in detecting the causes, extent, manifestation and impact on care service uptake, of stigma and discrimination experienced by people living with HIV in Senegal. This updated tool also aimed to measure both stigma attributable to HIV status and also stigma attributable to key population status and sexual behaviors.

AWA has also implemented a program since 2006 that documents cases related to discrimination, violence, and stigmatization from service providers reported by female sex workers.

Limitations/Challenges

The most recent *People Living with HIV Stigma Index* was conducted in 2012 and covered only four regions of Senegal. Data on other key and vulnerable populations is not being routinely collected in Senegal, which makes it difficult to assess the impact of the stigma and discrimination reduction efforts. There is limited data about the reach of the program implemented by AWA and the number of cases that have been documented through the program.

Moving to more comprehensive programming

With regard to programs aimed at reducing stigma and discrimination against people living with HIV or people at risk of HIV infection, it is proposed that these interventions be expanded and refined as follows, alongside the implementation of additional activities:

- Expand peer-led discussion groups of key populations that would meet on a regular basis and focus on the reduction of stigma and discrimination and human rights, as well as HIV prevention and transmission, reproductive health, and living with HIV. This activity aims to build capacity of key populations to reduce stigma and discrimination in communities and in health care settings as well as increase uptake of HIV prevention and treatment services. This intervention should be integrated within existing HIV prevention and treatment programs under the current national prevention and treatment strategy. A curriculum has been developed and could be adapted to other key populations as needed. In addition to specific strategies to reduce stigma and discrimination, the curriculum could be expanded to include modules on self-esteem, resiliency, as well as mental health. It is recommended to establish discussion groups specifically for transgender individuals. It is recommended to utilize and expand existing capacity to implement this intervention. For peer discussion groups planned for ANCS, it is recommended to increase geographic coverage, and support follow up activities.
- Support and strengthen existing individual key population association networks and facilitate coordination and capacity strengthening among key population networks to engage in activities to reduce stigma and discrimination. Coordinate regular meetings to facilitate sharing and capacity-building between networks of key populations on these activities. Although key populations groups vary greatly from each other, working to recognize similar barriers, and identify similar messaging for advocacy could help to increase impact of efforts.
- Support national and local campaigns to reduce stigma and discrimination affecting people living with HIV and other key and vulnerable populations. This should include the incorporation of stigma and discrimination reduction messaging into existing HIV related educational and awareness campaigns. It is recommended to involve community leaders, people living with HIV and potentially celebrities in this process. It is also recommended to use TV and radio shows, and other media in these campaigns against stigma and discrimination. Through strengthening existing partnership with journalists, develop key messages and strategic plan for integrating non-stigmatizing messages into existing media. Strengthen current campaigns being conducted with youth and adapt to

broader the population. Support existing radio shows and television programs working in this area to build capacity. This activity aims to decrease stigma and discrimination from the community toward people living with HIV. It is recommended to utilize existing journalist and media allies to strategize and implement activities. It is also recommended to expand coverage to rural areas.

- Provide support for a working group to coordinate discussion on reduction of stigma and discrimination and coordinate regular meetings between representatives of different stakeholders and key populations to continue discussion and strategy for HIV stigma reduction. This activity aims to increase coordination between stakeholders, government actors, implementers, and key populations; and increase involvement of key populations in decision-making for activities involving reduction of stigma and discrimination. It is recommended to utilize and build from previous workshops and meetings held to establish more sustained group of stakeholders.
- Engage and sensitize religious and traditional leaders to understand issues of HIV-related stigma and discrimination and work against these in communities. Facilitate the development of organizational alliances with religious leaders that can create and disseminate religious messages supporting a more protective environment for key populations. This will include the identification of allies among religious leaders; facilitation of dialogues and coalitions between religious leaders and established organizations working to improve access to services for key and vulnerable populations; convening of strategy sessions with religious leaders to determine the best messaging and approach for reaching other religious leaders; and organization of a guided discussion with a broader group of religious leaders, directed by the identified allies within the religious community. These activities aim to reduce stigma among religious leaders, increase their understanding and support of the needs of key populations, and disseminate this through their religious networks. It is recommended that these activities be framed as community health initially, and then slowly expanded into discussion about HIV and stigma, discrimination and violence faced by people living with HIV, women and other key and vulnerable populations.
- Include non-discrimination as part of institutional and workplace policies in employment and educational settings through advocacy for development of workplace and educational policies and development of guidelines on stigma reduction for the workplace, which could be adapted to different industries. It is recommended to work with networks of people living with HIV to develop document.
- Support the re-establishment of Observatoire de la réponse au VIH/SIDA au Sénégal to coordinate discussion on HIV prevention and reduction of stigma and discrimination and coordinate regular meetings between representatives of different stakeholders and key populations to continue discussion and strategy for HIV prevention and stigma reduction
- Implement routine measurement of HIV and key-population related stigma through the People Living with HIV Stigma Index 2.0 every 3 to 5 years and in each region of Senegal. It is recommended to conduct the assessment in every region in Senegal.
- Utilize mobile applications to share HIV anti-discrimination messages, as well as HIV educational games, stories, and information. The aim of the application is to increase peer to peer referrals and social cohesion; decrease stigma and improve uptake of services. Privacy and security for group should be a priority.

Program Area 2: Training of health care providers on HIV-related human rights & medical ethics
The table below provides an overview of current programmatic efforts on training health care providers on HIV-related human rights and medical ethics as well as recommendations for scale-up. The content of the table is then further elaborated upon.

Program			Limitations			
Stigma reduction training for health care providers and staff			<p>Several training programs have been implemented for healthcare providers regarding HIV-related human rights, medical ethics, and clinical service delivery. However, further structural, health system-wide interventions are needed to effectively address stigma and discrimination and other human rights and ethical abuses in the health care setting.</p> <p>There is also need to integrate training on human rights, medical ethics, and improvement of service delivery to key populations into medical professional training, as health care providers receive limited training on these topics during their standardized education.</p> <p>Training specific to service provision and care for transgender individuals does not currently exist.</p> <p>While there have been several models of trainings for individual health care providers on stigma and discrimination, ethics and service provision, no systematic training of health care administrators or health care staff has been implemented in the country.</p> <p>Accountability mechanisms for healthcare providers to document maintenance of patient confidentiality, provision of high-quality treatment, and support for increasing attendance and uptake of services by key and vulnerable populations are currently limited.</p> <p>There are no programs with the aim to reduce stigma experienced by health care workers who serve key populations or are living with HIV themselves.</p> <p>A lack of collaboration between actors and limited financial resources has posed a challenge for those working within this program area.</p>			
Implementer	Description	Population targeted	# reached	Region(s)	Time frame	Recommended scale-up
DLSI	Training of healthcare professionals to effectively care for MSM, identification of facilitators within target population	MSM, PLHIV		All regions through health districts	2003-present /Round 9: 2011-2015	Sensitization training of healthcare providers has increased the frequency of medical visits among key and vulnerable populations, which demonstrates that these trainings should be scaled up to target more health care professionals.
DLSI	Building capacity of healthcare professionals to take care of FSW without discrimination	FSW, healthcare professionals			2012-2014	To improve dissemination of key messages and exchanges, small groups were recommended to be integrated into sensitization activities at the Outpatient Unit in Ziguinchor to make programs
AWA	Training on self-esteem, human rights, rights to healthcare services	FSW, PWID, PLHIV, healthcare providers				

ENDA Santé	Training health workers to improve the clinical and social competency of the providers in addressing the needs of men who have sex with men and female sex workers	MSM, FSW, PLHIV, healthcare providers				more participatory and interactive, which could be scaled up and potentially integrated into other programming.
ENDA Santé	Conducting capacity-building sessions on human rights and health for healthcare professionals (who work with PLHIV, MSM, FSW, and PWID)	Healthcare professionals (who work with PLHIV, MSM, FSW, PWID)				
Outpatient Unit, Ziguinchor	Reducing stigma within healthcare settings: Sensitization activities for key actors and training of service providers on human rights to improve access to healthcare services among key populations	MSM, FSW, transgender, PWID, PLHIV, people with disabilities, prisoners, police and law enforcement; healthcare professionals		Municipality of Ziguinchor	2013-present	
Outpatient Unit, Ziguinchor	Training sessions with healthcare service providers	MSM, PWID, PLHIV, people with disabilities, healthcare professionals			2015-2017	
Medicos del Mundo	Strengthening capacity of healthcare providers on human rights	MSM, FSW, PWID, PLHIV			2013-present	
UNDP	Capacity building of healthcare providers on human rights: prompting healthcare providers to identify target key populations and LGBT and provide them with sound and adequate healthcare services	MSM, FSW, PWID, PLHIV, healthcare service providers, paralegals	50 beneficiaries trained	Dakar, Thies, Saint Louis, Mbour, Louga, Ziguinchor, Kaolack	2016-2018	
AJS	Strong collaboration with women medical doctors for caring for victims of abuse and sexual violence; Training and sensitization of healthcare providers on human rights issues	MSM, FSW, PLHIV youth, people with disabilities; police, law enforcement		Dakar, Ziguinchor, Kolda, Thies, Kaolack	Since 1974	

And Sopékou – ENDA Santé, AJS, and RNP+	Conducted training with all regional medical officers of Senegal on neglect experienced by female sex workers by healthcare providers and the high levels of stigma and discrimination female sex workers face	Healthcare professionals	14 regional medical officers	9 regions	2016-2017	
ANCS	Capacity building, training, sensitization of healthcare providers	Healthcare providers		All regions	Over 5 years (since 2012?)	
Handicap International	Strengthening health systems/Monitoring and evaluation: training healthcare service providers on inclusion of people with disabilities	PLHIV, people with disabilities, healthcare professionals	500	Ziguinchor, Dakar	2017-2019	
JAMRA	Development of support and referral guideline financed by UNDP/CNLS that facilitates access to healthcare services to better manage human dignity; conducted advocacy activities with key stakeholders	PWID, PLHIV, religious leaders		2010-2012		

Current Programs

Stigma reduction training for health care providers and staff

Several systematic training programs for healthcare providers have been implemented in Senegal. However, a key informant emphasized that training for healthcare professionals should include a stronger focus on human rights issues (KII19). The focus group of men who have sex with men reported that advocacy with key actors and healthcare service providers on human rights contributes to the reduction of stigmatization and discrimination of men who have sex with men (FGD5).

As part of the integrated stigma mitigation intervention implemented by ENDA Santé, a clinical intervention was conducted with the objective of reducing enacted stigma and alleviating barriers to care experienced by key populations in the healthcare setting. ENDA Santé implemented a training program for healthcare providers aimed at improving their clinical and social competency in addressing the needs of men who have sex with men and female sex workers. The training is based on a curriculum by the Global Forum on MSM & HIV (MSMGF) and Johns Hopkins and informed by Karnataka Health Promotion Trust. Each module includes tips for the facilitator, group activities, case studies, pre- and post-assessment questions, pre-reading assignments, and additional readings. Topics of the training include sex, sexuality, and sexual health; mental health promotion; overcoming barriers; creating a friendlier environment; health implications of sexual practices; assessing health status; evidence-based interventions; clinical care for HIV and other sexually transmitted infections; gender-based violence; and reproductive health. Preliminary evaluations suggest an improvement of knowledge among those who attended the training. (Baral 2017) ENDA Santé also conducts capacity-building sessions on human rights and health for healthcare professionals who work with men who have sex with men, female sex workers, people who inject drugs, and people living with HIV (KII16). This intervention has ended. However, materials and lessons learned should be used for the implementation of any additional training.

The Outpatient Unit in Ziguinchor conducted training sessions with healthcare service providers to demonstrate the negative influence of stigmatization, discrimination, and breaches of confidentiality on key populations such as men who have sex with men and people living with HIV. A key informant reported that this intervention became a necessity because a significant number of individuals were lost to follow-up as a result of having experienced stigma in the healthcare setting. According to a key informant, the clinic staff noticed that men who have sex with men and people living with HIV seem to feel more at ease in the healthcare setting because of this intervention (KII21). In addition to training for healthcare providers, the Outpatient Unit in Ziguinchor also conducts sensitization activities for other key actors regarding human rights as they relate to the access of healthcare services by key and vulnerable populations.

Having noted that female sex workers were avoiding healthcare facilities due to the experience of stigma, And Sopékou (in collaboration with ENDA Santé, AJS, and RNP+) organized training sessions with 14 regional medical officers in nine regions of Senegal regarding the neglect of female sex workers by healthcare providers and the high levels of stigma and discrimination that female sex workers face. The program also advocated for the decentralization of female sex worker health records to health posts. The project, in partnership with ENDA Santé, AJS, and RNP+ involved regional medical officers and the regional medical officer of Dakar, who sent a

memorandum to all health districts in the region. The organization trained 30 female sex workers to conduct the activity in several regions (KII29).

FEVE, implemented by ENDA Sante in Senegal, is an intervention that takes place in Senegal, Guinea, and Gambia mentoring health service providers in HIV prevention, care and treatment of key populations, and assessment of STI management among men who have sex with men. Three new providers were trained in Dakar, although the program focused mainly on populations at the borders between the three countries, to address risks related to population mobility. It is unclear how many of the participating clinics were in Senegal. Providers were also given additional training on gender sensitivity and specific needs of key populations for HIV care. This post-training supervision was helpful to reinforce key messages from the initial training, as well as to collect feedback from the providers on their experiences implementing the lessons.

ANCS has for over five years been committed to addressing stigma and discrimination against key and vulnerable populations in the healthcare context and in training healthcare providers to respect HIV-related human rights and medical ethics. This program has involved capacity building, training, and sensitization in all regions of Senegal, with the partnership of administrative and health authorities. Lack of collaboration between actors and limited financial resources have been challenges, but reinforcing existing collaborations and resources for implementing this intervention have helped to overcome these obstacles. Actors feel they have ownership and direct involvement in the process of implementing the intervention, and this has been coupled with a strong system of monitoring and evaluation (KII46).

Acknowledging some of the difficulties that people who are deaf, mute, or have visual or mental handicaps may encounter within the healthcare context, Handicap Form Educ and ANCS developed a visual guide to facilitate communication between healthcare workers and these patients. They developed this guide in collaboration with lawyers, communications professionals, and graphic designers. Standardized concepts in sign language related to HIV have also been developed through this collaboration. While these services may be useful, mobility and logistics for patients remain key challenges and barriers to service (KII27). These activities aim to reduce stigma and discrimination in the health care setting, and improve accessibility of services among people with disabilities.

Handicap International has implemented a program since 2017 to train healthcare service providers to improve the accessibility of people with disabilities to healthcare structures. Leaders of organizations for people with disabilities and people living with HIV have been involved from the conception of the project through implementation (KII49). A representative of Handicap International highlighted that there are already a large number of tools that can be used for advocacy activities targeting people with disabilities, including the existence of strategies within the *Convention on the Rights of Persons with Disabilities*, the existence of UNAIDS strategies that include all people living with disabilities among the twelve priority population groups, and the existence of the “equal opportunities map” tool in Senegal (KII2). A key informant reported that Handicap International is training civil society actors and healthcare service providers on discrimination related to disabilities and legal obstacles for people with disabilities in Dakar. The project has also helped people with disabilities access locations of healthcare services, including ramp construction at facilities to improve physical access, and has established the VIH/Handicap platform (KII49).

AWA, AJS, DLSI, and Medicos del Mundo also organize sensitization activities to educate healthcare service providers about human rights, though limited details were available on the content of these trainings at the time of this assessment (KII39). AWA provides training for healthcare providers on self-esteem, human rights, and rights to healthcare services. AJS has collaborated with female medical doctors in the care and support of survivors of abuse and sexual violence and has organized training and sensitization activities for healthcare providers on human rights issues in five regions of Senegal (KII25). DLSI conducts trainings with healthcare professionals at the district level, focusing on more effective and comprehensive clinical management of men who have sex with men and female sex workers, including respect of patient confidentiality (KII50). The program focusing on men who have sex with men has been implemented from 2003 to present, and the program focusing on female sex workers was implemented from 2012 to 2014. Medicos del Mundo has implemented programming from 2013 to the present that focuses on strengthening the capacity of healthcare providers on human rights pertaining to men who have sex with men, female sex workers, people who inject drugs, and people living with HIV.

Limitations and challenges

While several training programs have been implemented for healthcare providers regarding HIV-related stigma and discrimination, human rights, medical ethics, and clinical service delivery, there are needed more structural, health system-wide interventions to effectively address stigma and discrimination in the health care setting. There is also a need to integrate training on stigma and discrimination, medical ethics, and quality service delivery into medical professional training, as health care providers receive limited training on these topics during their standardized education. One area of service delivery that needs focus would be training specific to service provision and care for transgender individuals, which was not found in any of the trainings programs described above. A key informant noted that there should be a strategic inclusion of human rights teaching into all national training and education system levels for ensuring sound success of interventions (KII 18). While there have been several models of trainings for individual health care providers on stigma and discrimination, ethics and service provision, no systematic training of health care administrators or health care regulators has been implemented in the country.

In addition to stigmatization experienced by key populations in the health care context, health care providers and other service providers who work with key populations, especially men who have sex with men, experience stigma and discrimination in the workplace. However, no stigma reduction programs exist with the aim to reduce stigma experienced by this workforce, including those who might be living with HIV themselves.

Accountability mechanisms for healthcare providers to document maintenance of patient confidentiality, provision of high-quality treatment, and support for increasing attendance and uptake of services by key and vulnerable populations are currently limited. Additionally, a lack of collaboration between actors and limited financial resources has posed a challenge for those working within this program area.

Moving to more comprehensive programming

Programs to reduce human rights-related barriers in the healthcare setting exist in Senegal. However, there is need for standardization of trainings, increased coverage of training, and support for improved adherence to guidelines. It is proposed that these interventions be expanded and refined as follows, alongside the implementation of additional activities:

- Introduce standardized training on human rights and medical ethics (as related to key and vulnerable populations) in pre-service medical and healthcare education. Promote and standardize national medical professional training to include human rights and ethics curricula on issues faced, and needs of key and vulnerable populations, as well as more specific guidelines on the disclosure of HIV test results to patients, their partners/spouses and families. This activity aims to increase knowledge among health care providers of patient rights and issues faced by key and vulnerable populations that block access to services; and to decrease inappropriate disclosure of HIV status by health care providers. This activity should be done in collaboration with the Ministry of Health and Ministry of Higher Education, medical and nursing schools.
- Develop confidentiality guidelines and measures in clinics and sensitization training of health care providers on importance of confidentiality and safety. Review confidentiality guidelines and establish best practices, and conduct training with health care providers and staff on confidentiality. New guidelines should be disseminated, and processes put in place to increase adherence to these policies. This activity aims to increased adherence to confidentiality by service providers; and increase uptake of services by key populations.
- Provide support to health care providers and social workers to provide information of relevant rights and laws relating to HIV status as part of the pre- and post-test counseling.
- Implement stigma reduction training for current healthcare providers and staff to improve services to key and vulnerable populations. Finalize and adapt existing curriculum developed for integrated stigma mitigation intervention; develop supportive tools for health care provider and staff training; and conduct regular trainings with health care providers and staff. It is recommended to utilize existing curriculum; and that training should be informed by results from the *Stigma Index 2.0* conducted in 2017.
- Establish programs by which NGOs and CBOs monitor quality of care and health care delivery at key facilities as part of patient support activities. This would involve training-of-trainers on such monitoring and mediation between patients and health care facilities. Monitoring should be done in a non-adversarial manner to support patients to receive and health care facilities to deliver supportive, friendly and non-discriminatory health care.
- Explore potential mechanisms for coordination among medical and legal institutions to reduce healthcare-specific barriers and increase accountability of healthcare providers in maintaining patient confidentiality, providing non-discriminatory and supportive treatment, and in playing a general role in increasing attendance and uptake of services.

Program Area 3: Sensitization of law-makers and law enforcement agents

The table below provides an overview of current programmatic efforts related to sensitization of law-makers and law enforcement agents, as well as recommendations for scale-up. The content of the table is then further elaborated upon.

Program		Limitations				
<i>Sensitization of police & law enforcement</i>		<p>Violence, perpetrated by community members or by the police and experienced by key populations, is prevalent and often occurs with impunity.</p> <p>Violence and lack of protection of men who have sex with men has driven migration of these populations to neighboring countries.</p> <p>There is lack of regional programs that consider the local context in their programming, such as those areas where individuals are more likely to migrate to escape human rights violations.</p> <p>While sex work is legal in Senegal for registered workers, the laws do not provide protection of female sex workers.</p> <p>Sex workers experience violence and blackmail by law enforcement agents, even when the sex workers are registered.</p> <p>Treatment and actions regarding sex workers are left to the discretion of law enforcement.</p>				
Implementer	Description	Population	# Reached	Region	Time frame	Recommended scale-up
ENDA Santé	Collaboration with law enforcement on human rights issues of arrested KPs	MSM, FSW		Reported by St. Louis office	2010-2017	<p>Allies should be identified in law enforcement and partnerships/activities between FSW associations and law enforcement should be strengthened.</p> <p>Programs need to be adapted to the regional context to provide more effective services.</p> <p>There is a need for clear protections of sex workers under the law, improved treatment of sex workers by law enforcement, and more structural interventions to improve law</p>
ANCS	Trainings on transformational leadership and human rights; advocacy	Deputies, security and defense forces, elected officials		All regions	5+ years (since 2012?)	
Outpatient Unit in Ziguinchor	Meetings with police regarding human rights	Unknown				
CEPIAD	National plan to revise legislation and train law enforcement; involve social workers; program to address punitive practices, harassment by police, stigma, and discrimination	PWID, FSW			2016-2017	
UNDP	Conducted three meetings on human rights issues	Police, members of the military, & law enforcement			2016-2017	
Radio Oxyjeunes	Program to address stigmatization and discrimination, harassment and abuse by the police	MSM; FSW; PWID; PLHIV; youth			December 2017	

						enforcement practices more broadly.
Program		Limitations				
Sensitization sessions for government actors		There remains a deficit of advocacy and sensitization among decision-makers to consider the concerns of key populations, especially men who have sex with men and female sex workers. No efforts to engage and coordinate with traditional leaders with sensitization programming were found through this assessment.				
Implementer	Description	Population targeted	# Reached	Region(s)	Time frame	Recommended scale-up
ENDA Santé	Global Fund – training on the Prostitution Control Act	FSW	1600 beneficiaries	All regions	2015- 2016	Recommend a human rights component in the training curricula.
ENDA Santé	Regional project to build capacity and develop training tools, advocacy and provision of funding to CBOs, evaluation of legal framework, sensitization and advocacy activities for legislators	All key and vulnerable populations, members of parliament, jurists, lawyers, law enforcement officers		All regions	2016- 2018	
CNLS	Elaboration and promulgation of the law on HIV in coordination with members of parliament; sharing workshops to consider limits of the HIV law	All key populations, except transgender		All regions with a focus on regions in the south east where there is a higher HIV prevalence	Since 2010	
AWA	Sensitization of law enforcement personnel: provides sensitization on to how to support FSWs living with HIV who are in jail; trains lawyers on health issues like HIV/AIDS	FSW, PWID, PLHIV, lawyers, military, law enforcement, legislators		9 regions	2007-present	

Ministry of Interior	Advocacy activities carried out to promote human rights of KPs by individuals in the Ministry.					
AJS	Sensitization of lawyers: working session with lawyers regarding human rights for standardization and better care of specific problems of key and vulnerable populations	MSM, FSW, PLHIV, youth, people with disabilities, prisoners, women and children		Dakar, Thies, Kaolack, Ziguinchor, Kolda	Since 1974	
Association des Jeunes Avocats	Promoting a course that includes the respect for agreements signed by Senegal to protect human rights. Sensitizing judges to take human dignity into account when passing verdicts	MSM, FSW, PWID, PLHIV, transgender women				
ACI	Communication, training, and advocacy with legal administration	MSM, FSW, PWID, PLHIV, police, law enforcement	16 MSM leaders	Ziguinchor, Thies, Kaolack, Kolda, Kédougou, Dakar, Kaffrine, Sedhiou	2011- 2014	
ACI	Training and creation of legal plans composed of operational plans to coordinate actions in response to HIV; creation of multisectoral management system	MSM, FSW, PWID, PLHIV, civil society		Dakar	2011- 2014	
CEPIAD	Collaboration with CIDL coordinator who works as an ally among legal authorities; legal meetings with different actors to foster a favorable legal environment for PWID	PWID			2016- 2017	
JAMRA	Stigma and discrimination reduction through sensitization and advocacy activities	PWID, PLHIV, religious leaders			2010-2012	
Medicos del Mundo	Advocacy activities with parliamentarians who are members	MSM, FSW, PWID, PLHIV			2013-present	

	of the commission in charge of law in national parliament, judges, and law enforcement officers					
Program		Limitations				
<i>Training for prison personnel</i>		There is a need for improved and increased training in prisons. Prisons are interested in implementing programming; however, there is an insufficient number of health professionals and financial resources. (KII4).				
Implementer	Description	Population targeted	# Reached	Region(s)	Timeframe	Recommended scale-up
Sida Services	Sensitization of prisoners & prison authorities on stigma & discrimination reduction & addressing punitive practices, laws, and policies	People with disabilities, prisoners			2013- 2015	Increase tools and capacity building for staff within provisions.
Ministry of Justice	Conducts screenings, staff trainings, advocacy workshops, and sensitization with prisoners & prison staff	Prisoners, Prison staff				

Current Programs

Sensitization of police and law enforcement agents

Several training and sensitization efforts have been implemented in Senegal to train law enforcement agents on HIV-related human rights of key and vulnerable populations. However, there have been no systematic and sustained efforts to implement programming on a national scale or to evaluate the impact of trainings.

ENDA Santé works with police and gendarmerie and advises them on how to manage human rights issues that affect key populations (KII20). During a dialogue with non-governmental organizations, CNLS, and female sex workers, it was concluded that there was a need to address the challenge that law enforcement officers, lawyers, and female sex workers themselves do not know about the Prostitution Control Act. ENDA Santé had a program in 2015-2016 to educate and train female sex workers and law enforcement officers on the Act, which reached 1600 beneficiaries nationally. Female sex workers were involved in the development of modules for training manuals based on their knowledge and experience. A key informant noted that the involvement of law enforcement officers in the development of the program would be more useful for the next iteration of the program (KII50).

Since April 2006, ANCS has coordinated multiple interventions in Senegal and has expanded them to reach more female sex workers throughout the country. For more than five years, ANCS has been conducting trainings on transformational leadership and human rights and engaging in advocacy throughout the country, targeting legislators and personnel of the national directorate of the police (DNPN). ANCS organized face-to-face meetings between police and female sex workers at various police stations. Police officers and the relevant law enforcement officials committed to calling upon ANCS as a mediator in cases involving female sex workers. Involving the decentralized police precincts was a key success of this program (KII46).

The Outpatient Unit in Ziguinchor and UNDP have both been involved in sensitization efforts with the police, but data regarding the reach of these efforts were limited at the time of this assessment. A key informant noted that the Outpatient Unit in Ziguinchor has conducted meetings with law enforcement officers and parliamentarians on human rights issues, but that more efforts are needed (KII21). Additionally, UNDP conducted three meetings in 2016-2017 with the police, members of the military, and other law enforcement agents regarding human rights.

Limitations and Challenges

Violence at the hands of community members and police and experienced by key populations is prevalent and often occurs with impunity. There is a need for improved protection of key populations against such violence. Violence and lack of protection of men who have sex with men have driven these populations to migrate to neighboring countries. Participants of a focus group of men who have sex with men conducted in Saint Louis raised the issue of men who have sex with men migrating to Mauritania, where they felt the environment was more favorable and where men who have sex with men who engage in sex work are able to make more money; however, they reported that a prohibition of condoms in Mauritania increases the HIV and STD prevalence among men who have sex with men (FGD5). There is lack of regional programs that consider the local context in their programming, such as where individuals are more likely to migrate to escape human rights violations.

While sex work is legal in Senegal, the laws do not provide protection of female sex workers. Sex workers experience violence and blackmail by police, even when the sex workers are registered. Treatment and actions regarding sex workers are left to the discretion of police and

gendarmerie. There is a need for clear protections of sex workers under the law, improved treatment of sex workers by law enforcement, and more structural interventions to improve law enforcement practices more broadly.

ANCS training and coordinating with police officers experience some challenges in sustainability due to high turnover of police personnel. Therefore, such activities need to be carried out regularly.

Sensitization sessions for government actors

Several programs have been organized to provide information and sensitization sessions for members of Parliament, personnel of Ministries of Justice and Interior, judges, lawyers, and religious leaders on the legal, health, and human rights aspects of HIV and on relevant HIV-related national laws. However, there has been no systematic effort to disseminate information at all levels, and there is limited data on the reach of many of these sensitization efforts.

Since 2010, the CNLS has coordinated with members of Parliament to conduct dissemination workshops to promulgate information regarding the HIV-related laws in Senegal. These workshops have been organized in all regions in Senegal, with a focus on regions in the southeast, which have a higher prevalence of HIV. According to one key informant, the CNLS has been conducting knowledge sharing workshops with key stakeholders such as lawyers, armed forces, and program implementers with involvement of targeted beneficiaries since 2009 (KII5).

In August 2016, ENDA Santé organized a workshop and professional development summit to bring multiple stakeholders together to discuss the legal obstacles of key populations to accessing HIV care. Fifty participants attended the workshop, representing national governments, UN organizations, and civil society (ENDA Santé, Africaso, UN Women, OHCHR, and UNDP) from 10 African countries, including Senegal. The goals of the workshop were threefold: discuss the state of the epidemic and the role of a human rights approach; increase understanding around the legal barriers to public health goals; and build capacity to address laws and policies that limit the ability of HIV and TB programs to reach key populations. Through this workshop, actors from Senegal created a roadmap for addressing human rights-related barriers to HIV services in country. The roadmap included six activities focused on sensitizing law makers and leaders in other sectors to HIV-related human rights, setting up an “influential group” in the Senegalese Parliament to “assure transition and continuity” between legislative election cycles, training of parliamentarians on human rights leadership and approaches; involving journalists and religious leaders through advocacy sessions, which would include identifying champions among them and including them from the start of the process; and rereading laws to identify issues that create barriers to health services for key populations (Santé and UNDP 2016).

Under the revised legal framework developed by the Global Fund and UNDP for facilitating key populations’ access to healthcare services capacity building has taken place within civil society organizations and the lead for this activity relating to parliamentarians, Enda Santé. This work is conducted through capacity building, developing tools, providing funding and conducting advocacy with community-based organizations, and conducting an evaluation of the legal framework.

A project implemented by AWA aims to inform legislators on the [legal] texts related to sex work, to improve their understanding of the current HIV context for sex workers, and push legislators to revisit laws according to the current context of sex work. Their successes so far have included discussions exchanged with the President of 11th legislative commission in charge

of health issues and a presentation on different interventions at the Social, Economic, and Environmental Council. The revision of laws and their adoption will enhance the protection of people who inject drugs and help them to access healthcare services more easily (KII39).

Within the Ministry of Interior, advocacy activities are carried out by agents of the Ministry to encourage respect of the human rights of key populations by individuals who work within the Ministry. The duration of these activities is set by the convention established by the CNLS and the Ministry of Interior (KII13).

The Association des Juristes Sénégalaises (AJS) conducts HIV-related activities and assists key populations and vulnerable groups. The organization sensitizes legislators through workshops and trainings on the importance of legal reform, respect for human rights, and stigma and discrimination based on gender. The organization is also a consultative body for the president of Senegal (KII25).

The Association des Jeunes Avocats is championing a course that includes the respect for agreements signed by Senegal to protect human rights. The organization is advocating for judges to take human dignity into account when passing verdicts (KII26).

ACI, Medicos del Mundo, ANCS, and CEPIAD also implement sensitization activities with government actors within Senegal. From 2011-2014, ACI conducted communication, training and advocacy efforts with the legal administration. Medicos del Mundo conducted advocacy activities with parliamentarians who are members of the commissions in charge of law in the national Parliament, judges, and law enforcement officers. The efforts coordinated by ANCS described in the previous section include work with legislators to improve their knowledge of human rights and legislation on human rights. CEPIAD, in collaboration with the CIDL coordinator who works as an ally among legal authorities, conducts meetings with legal stakeholders to foster a favorable legal environment for people who inject drugs.

Limitations and Challenges

There remains a deficit of advocacy and sensitization among decision-makers to consider the concerns of key populations, especially men who have sex with men and female sex workers. (KII20). Young people have suggested implementing initiatives that sensitize legislators, but one key informant suggested that the local context is not yet ready to accommodate them (KII18). No efforts to engage and coordinate with traditional leaders with sensitization programming were found through this assessment.

Under the revised legal framework developed by Global Fund and UNDP for facilitating key populations' access to healthcare services, capacity building has taken place within civil society organizations and by the lead for this activity relating to parliamentarians, Enda Santé. However, there is a need to build on the work and trainings that have been conducted. There is an opportunity to convene groups at the national level to strategize activity implementation. Support should be provided for the coordination and implementation of follow-up activities. Currently, there is a need for capacity-building among government representatives to support sustainability.

Training for prison personnel

Activities aimed at training prison personnel on the prevention, health care needs and human rights of detainees living with or at risk of HIV infection are currently limited in Senegal. However, a key informant noted that there is willingness among the prison administration staff to collaborate on interventions. (KII24) Another key informant mentioned that prison administration staff should be coached on respect of human rights with training sessions that

bring together multiple sectors, including prison guards, social service administrators, and nurses (KII24).

The one active program targeting prison personnel is implemented through the medical/social services sector within the Ministry of Justice. This program conducts screenings, staff trainings, advocacy workshops, and sensitization sessions, working with both prisoners and prison staff. They aim to achieve the “three 90s” goal within prison settings, fight against stigmatization, and respect the human rights of prisoners (KII17).

From 2013 to 2015, Sida Services implemented sensitization activities with prison authorities and prisoners to reduce stigma and discrimination, and to address punitive practices, law, and policies.

Limitations and Challenges

There is a need for improved and increased training in prisons. Prisons appear to be interested in implementing programming; however, there is an insufficient number of health professionals and financial resources. (KII4).

Moving to more comprehensive programming

The expansion of high-impact training for key actors on human rights barriers faced by each population of interest was highlighted as necessary to achieve the long-term enforcement of human rights for key and vulnerable populations in Senegal. For example, although workshops and other training mechanisms have been initiated by several organizations, the CNLS recommended that this type of training be expanded and embedded through strategic partnerships between government agencies, human rights associations, universities, and other partner agencies. Paralegals constitute an additionally important group of actors to train and mobilize in order to structure more effective responses to widespread human rights abuses towards key and vulnerable populations.

Additionally, CNLS recommended the organization of regular dialogue sessions between representatives of populations of interest and healthcare providers, security and police forces, the media, and members of the religious sector to discuss issues related to HIV, human rights and gender-based violence.

Another encompassing theme that emerged throughout this assessment was the need for consistent dialogue between members of key and vulnerable populations and organizational decision-makers. Interviews with key populations representatives demonstrated that these efforts remain essential to grounding recommendations, programs, services and evaluations in the daily realities faced by members of key populations. In focus group discussions, key population representatives, in particular, discussed the importance of understanding their experiences and perceptions of marginalization in organizations and institutions designed to help them. Although focus groups highlighted this programming need for key populations, in particular, it is recommended that institutions and programs seek the participation of members from each population that they serve before and during the development of policies and services.

It is proposed that the following interventions be expanded and refined:

- Facilitate discussions, negotiations and joint activities among HIV service providers, those who access services, and police to sensitize police to the human rights and health needs of key and vulnerable populations; address law enforcement practices that impede HIV prevention, treatment, care, and support efforts; reduce human rights abuses against key and vulnerable populations; and improve service provision to key

populations. This will include establishing local working groups of leaders, allies within each sector, and members of key populations to meet on a regular basis; using the working groups to help identify areas for improvement and share knowledge of respective sectors and its relationship with the other sectors; and determine priorities and methods for improvement.

- Develop a curriculum and establish a comprehensive law enforcement training program on interacting with key and vulnerable populations. The curriculum should incorporate information to increase knowledge of HIV transmission; disseminate information regarding stigma, discrimination and other human rights abuses experienced by key and vulnerable populations; the impact of HIV in cases of sexual violence; and sensitization to the negative consequences of illegal police activity on justice and on the HIV response. This curriculum should also include training around gender-based violence, intimate-partner violence, and gender discrimination more broadly. These activities aim to increase law enforcement knowledge of HIV-related harms of domestic violence; and increase the will of law enforcement communities to respond to domestic violence. The training curriculum should also incorporate sessions explaining the importance of understanding and effectively implementing laws that protect key and vulnerable populations in Senegal. Trainings should be administered in a series of sessions over a prolonged period of time, as stand-alone trainings are not recommended. It is recommended to utilize existing tools developed by Enda Santé. The role of police training academies in cascading knowledge and skills to the lower levels of the police force is critical.
- Scale up training for prison personnel regarding the prevention, health care needs and human rights of detainees living with or at risk of HIV infection. This activity aims to improve treatment of incarcerated individuals; decrease stigma, discrimination and violence against incarcerated individuals; and improve knowledge of HIV prevention by prison staff. There appears to be willingness among the prison administration staff to collaborate on interventions. There is also interest by prisons that are receiving the implemented programs; however, there is an insufficient number of health professionals and financial resources.
- Coordinate and facilitate the relationship between law enforcement and sex worker association leaders to monitor police practice and improve treatment of sex workers. This will include identification and development of allies or “friendly police” in the police department; facilitation and strengthening of communication between association leaders and law enforcement allies within each precinct; conducting training with ally law enforcement agents on legal rights of female sex workers and rights associated with registration status; supporting joint activities between police and sex workers; and developing a monitoring system and communication between associations and law enforcement allies to report instances of abuse. These activities aim to improved capacity of law enforcement agents; reduce harassment, extortion arbitrary arrests and violence against sex workers; and improve recognition of registration status.
- Improve coordination and outreach in partnership with health centers and associations of sex workers to facilitate voluntary registration of female sex workers when such registration is desired. Activities include coordination and outreach through female sex worker associations to support sex workers who wish to register; development of systems for associations to share guidance and check lists for maintaining registration status; training on legal, health and human rights aspects of HIV and on relevant national laws

and the implications for enforcement, investigations and court proceedings. These activities aim to increase registration status among female sex workers who wish to be registered; and improve knowledge of stigma and discrimination relating to female sex workers. It is recommended to work with health facilities to coordinate testing services to more easily adhere to testing requirements and maintain registration status.

- Implement information and sensitization sessions for the Ministry of Justice and Ministry of Interior, judges, prosecutors, lawyers through training on legal, health, and human rights aspects of HIV and on relevant national laws and the implications for enforcement, investigations, and court proceedings.
- Support utilization of the revised legal framework developed by the Global Fund and UNDP for facilitating key populations' access to healthcare services through capacity building, developing tools, providing funding and conducting advocacy with community-based organizations, and conducting an evaluation of the legal framework. This approach should improve coordination of activity implementation, process, and outcome identification
- Advocate for HIV focal person within the Ministry of Justice to help facilitate efforts to address current obstacles (KII13 2017).

Program Area 4: Legal literacy (“know your rights”)

The table below provides an overview of current programmatic efforts related to legal literacy (“know your rights”) as well as recommendations for scale-up. The content of the table is then further elaborated upon.

Program		Limitations				
<i>Community mobilization and education</i>		<p>Legal/human rights literacy, including knowledge of patients' rights, among key and vulnerable populations is overall low.</p> <p>There is currently little focus on people living with HIV in legal literacy programming in Senegal.</p> <p>Legal literacy and adherence to laws is a particular challenge with health care providers due to limited training and resources.</p> <p>Legal literacy activities have been limited to community mobilization and education efforts. Activities focusing on peer outreach, telephone hotlines, or awareness-raising media campaigns were not found through this assessment, though these approaches have been found to be effective in other contexts.</p>				
Implementer	Description	Population	# Reached	Region(s)	Time frame	Recommended scale-up
ENDA Santé	Educational sessions on human rights	MSM, FSW, PWID, PLHIV				<p>Expand existing program on legal literacy being implemented nationally with men who have sex with men to all key populations. Adapt program to other key populations; review and refine tools used for program; and expand program.</p> <p>Develop curriculum on legal and patients' rights related to human rights and HIV.</p> <p>Support and expand existing efforts in training and capacity building, including those funded from the 2018-2020 GF grants, to increase key populations understanding of their rights and prevent cases of rights violations. Leverage key population associations to increase coverage of trainings and dissemination of information.</p>
AIDES Senegal	<i>Tagategbe</i> involves advocacy, capacity building, and documenting cases of violence. Aims to make MSM aware of laws & legal rights	MSM, PLHIV	"Not quantifiable"	National	2016-2019	
ACI	Legal literacy	MSM, FSW, youth, prisoners			2009-present	
AJS	Sensitization of key and vulnerable populations on human rights issues for better identification of problems as well as guidance for the legal aid providers for better management of any human rights violations	MSM, FSW, PLHIV, youth			Since 1974	
And Sopékou	Mama Cash: teach FSW about their rights	FSW	100 discussion groups with 10 FSW ea.	Dakar	2016-2017	
ANCS	Training and capacity-building to increase key population understanding of their rights and prevent cases of rights violations; legal literacy	MSM, FSW, PWID, PLHIV, youth, people with disabilities, prisoners, truck drivers, fishermen, gold miners, police, military, law enforcement		All regions	Over 5 years (since 2012?)	

Current Programs

Community Mobilization and Education

Most legal literacy activities reviewed in this assessment focused on community mobilization and education, with specific programs that target men who have sex with men and female sex workers and several efforts that serve key and vulnerable populations more broadly. While many of these activities reach key and vulnerable populations, few efforts have been made to reach people living with HIV with targeted legal literacy services. Nor were there sufficient efforts to develop and disseminate patients' rights materials or deploy peer human rights educators among key and vulnerable populations.

A 2012 survey conducted by RNP+ measured legal knowledge among a sample of people living with HIV in 4 regions of Senegal (Réseau National des Associations de PVVIH du Sénégal (RNP+), 2012). In the study, 55% of respondents indicated that they were aware of Senegal's national law 2010-03 on HIV/AIDS (RNP+, 2012). Furthermore, very few people living with HIV who reported having experienced human rights violations indicated that they had sought recourse. Given the low reported recognition of the national law on HIV/AIDS, the report recommended that the CNLS widely publicize the law through flyers, posters, leaflets, and other media. Sensitization of all levels of society on the stigma faced by people living with HIV, information about human rights literacy, legal redress mechanisms, access to legal services, and the inclusion of people living with HIV in future policy development on HIV may help to alleviate stigma and discrimination experienced by people living with HIV. In disseminating the protective aspects of national law 2010-03 on HIV/AIDS, it will be important to consider and address the provisions of the law that need to be clarified in terms of how they are implemented. For example, as described above, a doctor is permitted under national law 2010-03 to disclose the HIV status of an HIV-positive person to his or her spouse or sexual partners if the person refuses to do so him or herself after receiving appropriate support and counseling. There are also provisions regarding the intentional transmission of HIV. If not well understood, these provisions could lead to misapplication with resulting harm to people living with HIV.

Tagategbe is a three-year program implemented by AIDES Senegal that targets two intervention areas at the national level: reducing stigma and discrimination among key populations and legal literacy. The program was instituted to address the social and quality of life needs of men who have sex with men through a human rights-based, holistic HIV program. The program has seen strong involvement of regional associations of men who have sex with men who are learning to successfully manage implementation of the project on their own. A key informant noted that future success of the project will require that all regions are involved in strengthening associations of men who have sex with men and in raising awareness among stakeholders and the general public (KII53).

The fieldwork revealed that many female sex workers are not aware of their rights and are afraid of getting into trouble with the law. To address these issues, And Sopekou, a local NGO, held trainings with female sex workers throughout Dakar in 2016 and 2017 to teach them about their rights and laws related to sex work. Trainings and workshops, conducted in partnership with Mama Cash and AJS, provided legal information to participants, including the concept that access to healthcare is a right. Female sex workers were involved in the planning, implementation, monitoring and evaluation of the program and sex workers themselves were able to train their peers. Through this program, 100 discussion groups were convened with 10 sex workers each, reaching approximately 1000 female sex workers. The impact was not measured. One key informant suggested that this program could be disseminated to regional health posts in the future (KII29).

To facilitate the identification of human rights violations, AJS also coordinates sensitization of men who have sex with men, female sex workers, people living with HIV and youth on HIV-related human rights issues. In cases of human rights violations, AJS guides key and vulnerable populations towards their legal aid offices where they can provide these persons with legal services. In addition to other programming efforts described above, ENDA Santé, ACI, and ANCS are involved in legal literacy efforts for key and vulnerable populations. ENDA Santé conducts educational sessions on human rights among men who have sex with men, female sex workers, people who inject drugs, and people living with HIV. ACI provides legal literacy programming among men who have sex with men, female sex workers, youth and prisoners. ANCS provides legal literacy training and capacity building to increase key populations' understanding of their rights to prevent cases of human rights violations. Legal literacy activities organized by ANCS reach men who have sex with men, female sex workers, people who inject drugs, youth, people with disabilities, prisoners, truck drivers, fisherman, gold miners, police, military and law enforcement.

Limitations/Challenges

Legal and human right literacy, including knowledge of patients' rights, among key and vulnerable populations is overall low. There is currently little focus on people living with HIV in legal literacy/patients' rights programming in Senegal. Legal literacy, adherence to laws and patients' rights is a particular challenge among health care providers due to limited training and resources. Legal literacy activities have been limited to community mobilization and education efforts. Activities focusing on peer outreach/peer human rights educators, telephone hotlines, or awareness-raising media campaigns were not found through this assessment. One key informant noted a lack of specific programs on HIV and human rights in the context of migration, which could be addressed by ensuring that migration issues are considered in the strategic plan and in programs. Advocacy programs and sensitization efforts could target regional decision-makers (KII20).

Moving to more comprehensive programming

According to the key informant interviewed from Handicap International, there should be a broader vision that uses systematic community approaches that are focused not only on HIV but also work alongside community and social leaders through consistent sensitization about respect for human rights. Innovative programs, using new technologies targeting adolescents such as RAES, should be implemented. Integrated approaches to address HIV are needed, rather than individual approaches (KII2).

It is proposed that the interventions described above be expanded and refined as follows, alongside the implementation of additional activities:

- Support networks of key and vulnerable populations to develop accessible curricula on legal and human rights literacy as well as patient rights' for each key population whose realities and legal challenges will differ.
- Expand existing program on legal literacy being implemented nationally with men who have sex with men to all key populations. Using curricula developed above train trainers/peer human rights educators among representatives of key populations and support them to disseminate legal/human rights/patients' rights literacy among their peers and to develop strategies by which to mobilize around these laws/rights for

advocacy on needed change. Leverage associations of key and vulnerable populations to increase coverage of trainings and dissemination of information.

- Utilize social media to conduct a campaign on human rights/legal rights relating to HIV. Strengthen partnerships with radio and social media programs currently working in HIV prevention and provide tools and messages for integration of legal rights into HIV prevention education.
- Scale up training of civil society actors and healthcare service providers on methods for providing a more supportive environment and patients' rights for people with disabilities.

Program Area 5: HIV-related legal services

The table below provides an overview of current programmatic efforts on HIV-related legal services as well as recommendations for scale-up. The content of the table is then further elaborated upon.

Program		Limitations				
<i>Legal advice and representation</i>		There are existing services for key populations, however there is a need for an increased workforce and scale-up of services.				
Implementer	Description	Population targeted	# Reached	Region(s)	Timeframe	Recommended scale-up
AJS	Provision of legal services	MSM, FSW, PLHIV, youth, women and children		Dakar, Kaolack, Kolda, Thies, Ziguinchor	Since 1974	Expand coverage of legal aid offices services established in all regions in Senegal.
CNLS	Boutique de droits, which was a legal aid office in communities serving key and vulnerable populations	MSM, FSW, PWID, PLHIV, youth, people with disabilities, prisoners, truck drivers, fishermen, miners			2013-2014	Build capacity by training existing legal aid workers, and recruit, train, support and supervise peer paralegals among key and vulnerable populations.
ANCS	Implementation of legal advice offices	MSM, FSW, PWID, PLHIV, youth, people with disabilities, prisoners, truck drivers, fishermen, gold miners		All regions	Over 5 years (since 2012?)	
ENDA Santé	Legal services for key populations during trial	MSM, FSW				
Program		Limitations				

<i>Legal information and referrals</i>		<p>There were no programs found through this assessment to engage religious or traditional leaders and traditional legal systems to change harmful traditional norms and to resolve disputes.</p> <p>Major obstacles to legal service effectiveness in human rights cases include lack of documentation of instances of discrimination against people living with HIV and other key populations and the absence of a formal mechanism for individuals to report experiences of stigma or discrimination.</p>				
Implementer	Description	Population targeted	# Reached	Region(s)	Timeframe	Recommended scale-up
Outpatient Unit, Ziguinchor	Collaboration with legal aid office for accompanying KPs to defend their rights	MSM, FSW, PWID, PLHIV			Since 2012	Develop comprehensive referral reference sheet for available HIV-related legal aid services. Disseminate referral sheet through clinics and key populations associations.
AWA (with ANCS & Plan International)	Supporting access to legal services – covering honorarium fees and covering drug costs for FSW victims	FSW, PLHIV, youth		9 regions	2007-present	Scale up paralegal support and access to pro bono lawyers for key populations who, due to poverty and economic vulnerability, are unable to cover costs of legal services or to make bail if they have been imprisoned.

Current Programs

Legal advice and representation

There are several programs in Senegal that provide legal services to key and vulnerable populations, including people living with HIV. However, a representative from CNLS reported that there is still a lot of work to be done, such as improving access to services at legal aid offices among key populations (KII5).

AJS, in the five regions where it has established legal aid offices (Dakar, Kaolack, Kolda, Thies, and Ziguinchor), provides legal consultation, does petition writing services, and hires lawyers to accompany victims of human rights violations. The organization's legal aid offices meet the needs of individuals who were afraid to access legal services and individuals who lacked the means to hire legal services (KII25). These legal aid offices are located in communities that serve key and vulnerable populations, including men who have sex with men, female sex workers, people who inject drugs, people living with HIV, youth, people with disabilities, prisoners, truck drivers, fishermen and miners. *Boutiques de droits* are the legal clinics set up by AJS and its civil society partners. Each clinic has a lawyer, and paralegals belonging to at least one key population (often mediators) who offer information and guidance on laws, legal proceedings, and paperwork. It is recommended that the geographic coverage of these services be expanded and that the *boutiques de droits* collaborate with the national/regional observatories to track and document cases of human rights violations.

In addition to the services described above, Edna Santé provides legal services for men who have sex with men and female sex workers.

The Rights Kiosk Project aimed to enable women to know what tools they had at their disposal to fight violence and discrimination (CEDAW 2015).

Limitations and Challenges

Though there are existing services for key populations, there is a need for an increased workforce and scale-up of services.

Legal information, referrals, and financial support for legal fees

In addition to programming that provides legal advice and representation, there are several programs that provide legal information, referrals, and financial support for legal fees (but not legal advice or representation) to key and vulnerable populations.

The Outpatient Unit in Ziguinchor provides medical support to people living with HIV and men who have sex with men, as well as responding to their socio-economic, legal, and nutritional needs. It collaborates with the legal aid office of the AJS. At the community level, the activities of the Ziguinchor Outpatient Unit are run by civil society organizations, which “allowed for a favorable environment (KII21).”

The program run by AWA in partnership with ANCS and Plan International works to address the issues of abusive and arbitrary arrest of female sex workers and many female sex workers' lack of funds to be released from jails. The program supports access to legal services by covering honorarium fees and covering drug costs for female sex workers who have been victims. Female

sex workers have been involved in the decision-making structure, program development, and implementation process of the program, which has contributed to its success (KII39).

Limitations/Challenges

There were no programs found through this assessment to engage religious or traditional leaders and traditional legal systems to address stigma and discrimination, change harmful traditional norms and to resolve disputes in communities. Major obstacles to legal service effectiveness in human rights cases include lack of documentation of instances of discrimination against people living with HIV and other key populations and the absence of a formal mechanism for individuals to report experiences of stigma or discrimination.

Moving to more comprehensive programming

HIV-related legal services can facilitate access to justice and redress in cases of HIV-related discrimination or other legal matters. It is proposed that these interventions be expanded and refined as follows, alongside the implementation of additional activities:

- Expand coverage of legal aid offices services established in all regions in Senegal. Build capacity by training existing legal aid workers, and by training a cadre of peer paralegals for each key and vulnerable population. Peer paralegals should be frontline providers of legal support (dispute resolution, dealing with complaints of stigma discrimination, will writing, custody and property-disputes, etc) with access to a much smaller number of lawyers to supervise them and provide legal support in difficult cases.
- Develop comprehensive referral reference sheet for available HIV-related legal aid services. Disseminate referral sheet through clinics and key populations associations.
- Scale up supportive services to cover legal fees or access to *pro bono* lawyers for key populations who, due to poverty and economic vulnerability, are unable to cover costs of legal services or to make bail if they have been imprisoned.
- Establish referral or support hotline to provide support services and legal referrals. Disseminate number for hotline through HIV treatment facilities and key population association networks.

Program Area 6: Monitoring and reforming laws, regulations, and policies relating to HIV

The table below provides an overview of current programmatic efforts related to monitoring and reforming laws, regulations, and policies relating to HIV as well as recommendations for scale-up. The content of the table is then further elaborated upon.

Description		Limitations			
Engagement of government actors in the reform of laws, regulations, and policies related to HIV so they support, and not hinder, access to HIV and health services		According to some key informants, the current political context is not conducive for revision of laws relating to men who have sex with men.			
Implementer	Description	Population	Region(s)	Timeframe	Recommended scale-up
CNLS	Working with a parliament commission in charge of health laws and stakeholders who lobby for legal reform				Support CNLS in providing evidence and advocacy support for reforming current laws which prohibit the distribution of condoms to prisoners, and revision of law to enable adolescents younger than 15 to independently access HIV testing and treatment Advocacy/strategizing for legal reforms and protection against discrimination and violence with regard LGBT, as well as capacity strengthening for government actors in this area Sensitization with leaders and authority figures should be conducted so that they better understand the issues and eventually advocate for legal reform.
ANCS	Advocacy activities, capacity building, sensitization	MSM, FSW, PWID, PLHIV, parliamentarians, program managers	All regions	Over 5 years (since 2012?)	
AWA	Advocacy activities focusing on decision-makers, legislators for adjusting laws according to current context; customized experience sharing workshop	FSW, PWID, PLHIV, youth, people with disabilities, miners, police, members of the military, and law enforcement, members of parliament and decision-makers	9 regions	Since 2007	
ENDA Santé	Advocacy focusing on concerned key stakeholders to improve consideration of key populations' rights	MSM, FSW, PWID, PLHIV			
Program	Description	Limitations			
	Formal review or evaluation of laws and law enforcement practices to see whether they impact the national response to HIV positively or negatively, as well as the lives and human rights of those living with and affected by HIV	There is limited involvement of people living with disabilities in developing public policies; their involvement would mean both representation of this population and inclusion of their expertise.			

Implementer	Description	Population targeted	Region(s)	Timeframe	Recommended scale-up
UNDP	Legal environment assessment with parliamentarians; capacity building around HIV and human rights	MSM, FSW, PWID, PLHIV, transgender, parliamentarians	Dakar	2016-2018	Currently undergoing execution process and parliamentarians are becoming aware of existing gaps in HIV Control Act
Handicap International	Legal evaluation: evaluation of legal gaps and advocacy	PLHIV, people with disabilities	Dakar	2017-2019	
ANCS	Comité de veille et d'alerte for laws on HIV, which responds to human rights violations of key and vulnerable populations				
ENDA Santé	Strengthen evidence-based legal reforms, strengthen access to justice and enforcement of supportive laws and policies, improve regional and national mechanisms to prevent and address human rights violations, and strengthen the capacity of regional non-governmental organizations				

Current Programs

This assessment demonstrated ways in which legal barriers such as the presence of punitive laws or the lack of enforcement of protective laws perpetuate or facilitate violence and police abuse toward key populations. These barriers affect multiple points in the HIV prevention/treatment cascade. Several large-scale projects have been initiated to address these overarching barriers to HIV prevention and treatment in Senegal. The Global Fund's Africa Regional HIV Grant for Removing Legal Barriers to Access is a significant systematic intervention targeting legal and policy reforms, access to justice, structural mechanisms to prevent human rights violations, and capacity-building of key stakeholders (UNDP 2015). Additionally, other programs have focused on specific projects aligned with Global Fund interventions, such as efforts to engage government actors in legal reform activities and setting up monitoring systems to improve legal action, accountability, and the national response in cases of human rights violations.

Advocacy to engage government actors in legal reform efforts

CNLS is working with a parliamentary commission in charge of health laws and stakeholders who lobby for legal reform. This commission aims to reduce human rights-related barriers to HIV services for key and vulnerable populations (KII5). CNLS is working to change the law on HIV, noting that the current law has limits. For example, current laws do not allow for the distribution of condoms to prisoners. CNLS also aims to revise the law to enable adolescents younger than 15 to access HIV testing, prevention and treatment independently (KII47).

To address the issue of non-inclusion of access to justice and healthcare services among key and vulnerable populations, UNDP, in partnership with ENDA Santé, UNICEF, and the UN High Commissioner for Human Rights, is working with parliamentarians, judges, and prison administration staff to revise legal texts and build capacity of these sectors (KII24).

According to a representative from the Ministry of Justice, there is a “multi-sector-based fight against discrimination,” but revision of laws could make them more flexible. He noted there is positive involvement from stakeholders on this issue, which is reflected through the attendance of all key actors during workshops. There is a strong engagement of religious and other actors who contribute to the HIV response and respect of human rights. There has been increasing accessibility in prisons, availability, and engagement in programs. The Minister of Justice has been personally engaged in all HIV response-related activities within prisons. An event he considered a best practice was a hearing with the Minister of Justice, the HIV focal person in the Ministry of Justice, and the national executive secretary of CNLS to promote partnership, share activity packages, and discuss the role of Ministry of Justice in the HIV response at prisons (KII17).

ANCS, AWA, and ENDA Santé are also involved in advocacy efforts in Senegal to encourage government actors to engage in legal reform activities, though limited data were available on the specific activities or reach of these programs at the time of this assessment. ANCS organizes programming to ensure the conformity of Senegalese laws regarding HIV with international law and practice and to ensure that these laws are applied correctly. AWA engages in advocacy activities that focus on decision-makers and legislators, and is aimed at adjusting laws to the current context. This work has been complemented by a customized experience-sharing workshop. ENDA Santé engages in advocacy efforts focusing on key stakeholders to improve the consideration of key populations' rights.

Limitations/Challenges

One key informant remarked that the national context is not yet ready for programs focusing on monitoring or reform of laws, especially those relating to same sex behaviors. Because of this, this KI recommended that it is necessary to continue with sensitization that targets leaders and authority figures so that they better understand the issue (KII8 2017).

Review and evaluation of laws and law enforcement practices

As part of the Global Fund's Africa Regional HIV Grant for Removing Legal Barriers to Access, an initiative has been developed to strengthen the legal and policy environment to reduce the impact of HIV on key populations in ten countries in Africa, including Senegal. UNDP is the principal recipient for the grant, and ENDA Santé is leading the work in Senegal. This project aims to strengthen evidence-based legal reforms, strengthen access to justice and enforcement of supportive laws and policies, improve regional and national mechanisms to prevent and address human rights violations, and strengthen the capacity of regional non-governmental organizations (UNDP 2015). This project targets men who have sex with men, sex workers, transgender individuals, people who inject drugs, prisoners, and people living with HIV. The project will also benefit vulnerable populations, including migrants, women and girls.

Under this program, ENDA Santé has organized a national action planning meeting, regional trainings for parliamentarians, a national advocacy campaign targeting the media, key populations and CSOs, and the development of training tools for key stakeholders and media and policy briefs (Ferguson et al. 2017). Baseline and end-line assessments of this project were conducted by the Program on Global Health and Human Rights at the University of Southern California, however, these assessments were not available at the time this report was drafted (Ferguson et al. 2017).

In 2013, a four-year project dedicated to strengthening the capacity of locally-based LGBT advocacy groups was rolled out in Senegal, with the goal of contributing to building LGBT leadership across Francophone Africa. With funding from the European Commission, the Francophone LGBT Advocates Initiative (FLAI), focused on building networks and training LGBT community groups to track, document, and communicate information about human rights abuses against LGBT communities within their countries (AMSHeR). This project was implemented by AMSHeR. In Senegal, FLAI trained the Senegalese AIDS Association on data collection, analysis, reporting, security, and documentation of human rights violations against LGBT populations and communities. Based on this training, the Senegalese AIDS Association collected reports and interviews on human rights abuses against the LGBT community in Senegal, with the goal of creating a database of information and communicating the results. AIDES Sénégal published findings from this activity to both collect abuses and publicize the epidemic of violence. The findings include narratives of men who have sex with men living with HIV as well as issues around stigmatization and fear of disclosure of HIV status to family (AIDES Senegal 2015).

Handicap International, in partnership with AJS, is studying the application of the *Disability Rights Convention* for people with handicaps, identifying gaps in existing laws, ensuring that the legal rights of people with disabilities are better protected. They are conducting a bio-behavioral study to identify obstacles that limit access to healthcare services among people with disabilities (KII49). The representative interviewed from Handicap Form Educ noted that there

is insufficient involvement of people living with disabilities in developing public policies, and their involvement would mean both representation of this population and inclusion of their expertise. For example, the built environment does not account for those with physical disabilities and accessibility issues that some people with disabilities encounter need to be considered (KII27).

From 2016-2018, UNDP conducted training-of-trainers on documentation and data analysis on cases of human rights abuse and strengthening of the capacity of associations to ensure effective coordination and collaboration to better identify the target group and provide adequate care to key populations. The most effective approach has been the organization of interactive community dialogue, which focused on sharing information on human rights and generating recommendations accordingly (KII24).

ANCS participates in the Comité de veille et d'alerte for laws on HIV. One representative interviewed noted strong mobilization of the Comité every time key or vulnerable populations are abused (KII46). According to ANCS, the *Comité de veille et d'alerte* is led by CNLS, ENDA, ANCS, AWA, RNP+ and other key populations networks. This committee aims to mediate between law enforcement (police and agents at the Interior Ministry) and key populations in cases of conflict or severe abuse, and discuss issues related to key populations. However, it appears that the committee is barely functional and meetings are not held regularly.

A key informant noted that the legal framework in Senegal, as in other African countries, is binding as it relates to healthcare services for HIV. ENDA Santé, in partnership with the Global Fund and UNDP, are interested to analyze and revise the legal framework for facilitating access of key populations to healthcare services through capacity building, developing tools, providing funding to and conducting advocacy with community-based organizations, and conducting an evaluation of the legal framework (KII51).

Though primarily focused on monitoring international HIV funding in Senegal, the Observatoire de la Réponse au VIH/SIDA au Sénégal also provides overall monitoring of the national response to HIV in the country. The Observatoire was established to provide systematic management of international HIV funds and ensure the involvement of civil society organizations in the national HIV response. ANCS and four other major national NGOs initially came together to support this effort, which led to the establishment of the Observatoire as a permanent monitoring body of Senegal's HIV response. The committee makes efforts to regularly incorporate input from representative of organizations of men who have sex with men, sex workers, and other key populations (Alliance 2014). However, according to ANCS, the Ministry of Health, and other key actorsthe *Observatoire* is no longer functional.

Limitations/Challenges

There is limited involvement of key and vulnerable populations, and specifically people living with disabilities, in developing public policies, as well as in monitoring and reforming them. Their involvement would mean both representation of these populations and inclusion of their expertise.

Moving to more comprehensive programming

Laws, regulations and policies relating to HIV can negatively or positively impact a national HIV epidemic, as well as the lives and human rights of those living with and affected by HIV. Programs in this area aim to monitor and reform laws, regulations and policies so they support,

not hinder, access to HIV and health services. It is proposed that these interventions be expanded and refined as follows, alongside the implementation of additional activities:

- Support CNLS in working with a parliamentary commission to reduce human rights-related barriers to HIV services for all key and vulnerable populations.
- Scale-up the activities begun under the Global Fund’s Africa Regional HIV Grant for Removing Legal Barriers to Access to continue and support legal and policy reforms, access to justice, structural mechanisms to prevent human rights violations, and capacity-building of key stakeholders.
- Re-establish the national observatory mechanism to monitor access to HIV services and human rights barriers.
- Develop guidelines for health facilities to create a supportive environment for people living with disabilities in HIV services. Advocate for adoption of guidelines on disabilities and HIV by CNLS. Review existing government facilities to assess the accessibility of facilities for people living with disabilities. Document accessibility and identify needs of each facility.
- Advocate for protective laws for sex workers to reduce violence experienced by this population.
- Support advocacy to include transgender women in the national definition of key populations and HIV-related programming.
- Conduct strategic session with CNLS to identify additional potential advocacy efforts.

Program Area 7: Reducing discrimination against women in the context of HIV

The table below provides an overview of current programmatic efforts related to the reduction of discrimination against women in the context of HIV as well as recommendations for scale-up. The content of the table is then further elaborated upon.

Description		Limitations			
Programs to reduce harmful gender norms and traditional practices that put women, girls, men and boys at risk of HIV infection, including capacity development of civil society groups working for women's rights and gender equality					
Implementer	Description	Population	Region(s)	Timeframe	Recommended scale-up
AJS	Community-level sensitization about violence and abuse against women; awareness march about the burden related to human rights violence and disrespect			Since 1974	Reinforce human rights training and sensitization of staff providing gender-based violence services in the health care system. Incorporate human rights training in trauma informed care.
ANCS	Capacity building	Men and women generally	All regions	Over 20 years	
ENDA Santé	GF program that involves addressing HIV while taking gender issues into account	FSW		2010-2017	
CNLS	Reduction of stigma and discrimination against women: advocacy, training, sensitization	FSW, youth, people with disabilities, prisoners, fishermen, miners, police, military, law enforcement	All regions	Since 2004	
USAID/Senegal	Conducted a gender assessment to identify gender issues and address gender inequalities in their programming				
Description		Limitations			
Strengthening the legal and policy environment to ensure that laws protect women and girls from gender inequality and violence					
Implementer	Description	Population	Region(s)	Timeframe	Recommended scale-up

CNLS	Creation of gender policies with the development of a guide for integrating gender programs; implementation of a gender focal point; gender training activities	All key and vulnerable populations	All regions	Since 2010	Provide technical assistance to support CNLS program in updating gender policies, capacity building and coordination with regard to inclusion of women's and girls' rights information, training and skills-building, and increased coverage of gender training activities with human rights integrated throughout the country.
Ministry of Justice – Gender Policy Cell	In the Ministry of Justice, aims to ensure easier access to justice for women.				Provide technical assistance to support efforts with Ministry of Justice to ensure easier access to justice for women with regard to gender-based discrimination, child marriage, property grabbing, gender-based violence including female genital mutilation/cutting and other harmful gender norms. Expand knowledge and training around the multi-dimensional and holistic Plan of Action to Eliminate Gender-Based Violence.

Current Programs

Programs seeking to reduce harmful gender norms and gender-based violence

Capacity-building programs by ANCS have resulted in the training of women's associations, and the organization has promoted female condoms and health services follow-up. The representative interviewed noted that given the low social status of women, it is important to create a framework of consultations with women and better involve women in the intervention decision-making process to empower them (KII46).

In 2010, USAID-Senegal mission conducted an assessment to identify gender issues and to address gender inequalities in its programming (USAID). This assessment identified entry points for future USAID programming relating to HIV, including building on pilots of implementing partners to integrate gender and gender training into activities in community health and expand to other sites; developing different communication messages or using different communication channels for men and women (and adolescents, boys and girls); using both men and women to convey information about health practices; and targeting men to improve their experiences at clinics by offering appropriate incentives (USAID 2010). This assessment could not determine to what degree this programming was implemented, its follow up or impact.

The Violences sexuelles et mutilations génitales au Sénégal (VIMOS) project was implemented from 2014 to 2015 through ENDA Santé and San Acces in Ziguinchor, Sédhiou, and Kolda. (Santé 2018) The overall objective of the project was to contribute to the reduction of female genital cutting and sexual violence by influencing community dynamics through prevention and treatment actions as well as improved knowledge of reproductive health. The specific aims of this project were to review the situation of sexual violence and genital cutting; prevent early pregnancies, forced marriages, genital cutting and other types of sexual violence against adolescents and young people; improve access to legal, medical and psychosocial care for persons who are victims of sexual mutilation and/or sexual violence in areas of intervention; and develop the skills of youth and adolescents on leadership, gender and human rights incorporating information on STIs, HIV/AIDS and sexual violence as well as genital cutting in order to foster a sense of responsibility and improve their quality of life and interpersonal relationships. No evaluation of the program was found at the time of this assessment.

AJS conducts community-level sensitization activities that disseminate information about violence and abuse against women. AJS also organizes an awareness march to publicize the burden related to human rights violations and disrespect.

AWA has also implemented a program since 2006 that documents cases related to discrimination, violence, and stigmatization from service providers reported by female sex workers.

Limitations/Challenges

A representative from UNDP noted that in programs to reduce gender norms it is still difficult to conduct regular follow-up in cases of human rights violations.

Increasing Access to Education and Economic Empowerment opportunities

The only program found through this assessment that provides economic empowerment opportunities for women who are living with HIV or vulnerable to HIV infection was a program implemented by ENDA Santé with female sex workers (and men who have sex with men).

Limitations/Challenges

Few interventions exist to address gender disparities, especially in the context of economic vulnerability and education.

Strengthening the legal and policy environment to ensure that laws protect women and girls from gender inequality and violence

There is a CNLS department in charge of gender in order to efficiently support gender issues related to key and vulnerable populations (KII5). CNLS has also implemented a program since 2010 to create gender policies, install a gender focal point, and has conducted gender-training activities throughout the country (KII47). The key informant noted that the gender policy was a success, because there was a clear guide developed in conjunction with the policy. In addition, CNLS has organized workshops with key and vulnerable populations, the police, judicial, and religious leaders to discuss reduction of stigma and discrimination against women (KII47).

The Gender Policy Cell within the Ministry of Justice was created to ensure easier access to justice for women, increased attention was being given to female genital mutilation, and a nationwide survey was conducted to understand obstacles and barriers to the fight against this and other harmful practices. A multi-dimensional and holistic Plan of Action to Eliminate Gender-Based Violence was launched in cooperation with five United Nations agencies, including United Nations Women (CEDAW 2015).

Moving to more comprehensive programming

Programs to address gender inequality and gender-based violence as both causes and consequences of HIV infection should be supported in Senegal. It is proposed that these interventions be expanded and refined as follows, alongside the implementation of additional activities:

- Support CNLS program in updating gender policies related to HIV that integrate human rights information, skills-building and activities into gender training and activities throughout the country.
- Support efforts with Ministry of Justice to ensure easier access to justice for women in the context of gender based discrimination and violence, early marriage, property grabbing and custody disputes and the ending of other harmful gender practices, including female genital mutilation/cutting. Expand knowledge and training around a multi-dimensional and holistic Plan of Action to Eliminate Gender-Based Violence, ensuring that it fully incorporates HIV-related human rights aspects.
- Train service providers who provide gender-based violence services in the health care system in nondiscrimination, confidentiality and informed consent and other HIV related health concerns.

- Recruit, train and supervise peer human rights educators and paralegals among women and girls and adolescents for HIV-related human rights and legal literacy and legal services.
- Develop, post and disseminate patients' rights materials for women in maternal and child health facilities and clinics to reduce mother to child transmission of HIV.
- Engage, sensitize and support religious and traditional leaders to reduce harmful gender norms and gender-based violence at community level; resolve disputes around property, custody and inheritance; and work against gender-based discrimination and inequality.

2.5 Investments to date and costs for a comprehensive response to human rights-related barriers to HIV

In 2016, a total of around USD \$.. was invested in Senegal to reduce human rights-related barriers to HIV services. Major funders and allocated amounts for reduction of human rights barriers to HIV services in 2016 were as follows:

Funding source	2016 allocation
Global Fund	
USAID	
Austrian Development Cooperation	
Government of Luxembourg	
Government of Senegal	
Total	

** Not including funds allocated for reduction of human rights related barriers to HIV for 2015*

Although several funders stated that they were unable to provide exact figures for the amounts allocated to each program area, the assessment team calculated the likely split between program areas by acquiring expenditure data from the funded organizations and matching these to activities under each program area. This gave the following split of funding across program areas to remove human rights-related barriers to services:

HIV Human Rights Barriers Program Area	2016
PA 1: Stigma and discrimination reduction for key populations	
PA 2: Training for health care workers on human rights and medical ethics related to HIV	
PA 3: Sensitization of law-makers and law enforcement agents	
PA 4: Legal literacy (“know your rights”)	
PA 5: HIV-related legal services	
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	
PA 7: Reducing discrimination against women in the context of HIV	
PA8: Relevant activities but which cannot be classified elsewhere	

Total	
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* We were unable to obtain details on funds allocated for reduction of human rights related barriers to HIV services for 2015.

Costing of a 5-year comprehensive HIV program

Estimated costs for the recommended interventions for the five-year comprehensive program set out are set out in the table below. Detailed intervention areas and costs are set out in Appendix 3.

HIV Human Rights Barriers Program Area	Year 1**	Year 2**	Year 3**	Year 4**	Year 5**	Total**
PA 1: Stigma and discrimination reduction for key and vulnerable populations						
PA 2: Training for health care workers on human rights and medical ethics related to HIV						
PA 3: Sensitization of law-makers and law enforcement agents						
PA 4: Legal literacy (“know your rights”)						
PA 5: HIV-related legal services						

PA 6: Monitoring and reforming laws, regulations and policies relating to HIV						
PA 7: Reducing discrimination against women in the context of HIV						
Management						
Monitoring and Evaluation						
Research						
Total						

***Pending finalization of activities and prospective costing*

3. Limitations, measurement approach, and next steps

Limitations

Given the rapid nature of this assessment, it is possible that some programs or interventions, particularly those that occurred at the local level and those that have less of an online presence, have been missed. Furthermore, because fieldwork took place in the regional cities, it is possible that programming in more remote or rural regions of the country has been missed. However, the inclusion of several stakeholder meetings, such as the inception meeting and multi-stakeholder meeting, as part of the assessment provided opportunities for program implementers and funding agencies to share documentation about programs that were missing from the review. Interventions to reduce human rights-related barriers are often times integrated in service provision or broader programs focused on structural enablers or community strengthening more generally. Discerning the interventions and associated costs geared at reducing human rights-related barriers has been a challenge, and assumptions have been used to inform the costing component.

Measurement approach

Qualitative Assessment

In the midpoint and endpoint assessments planned, in order to understand how the comprehensive response is addressing human rights-related barriers to HIV services, it will be critical to conduct qualitative assessments that capture the experience of those affected by human rights-related barriers to services. Such assessments will provide perceptions of changes in levels of access to HIV services due to the various approaches being implemented. Qualitative assessments could also shed light on new programs that have not been previously implemented in Senegal.

Quantitative Assessment

While it may not be possible to quantitatively evaluate all of the programs implemented as part of the comprehensive response, Senegal should consider quantitatively evaluating selected interventions. For example, it will be important to determine if the stigma and human rights pre-service training for healthcare workers leads to increased utilization of healthcare services for men who have sex with men, people who inject drugs, sex workers, and people with disabilities. Likewise, it would be important to evaluate the influence of informational materials developed in local languages and adapted to provide information to individuals with limited literacy. In addition to evaluations of specific programs, the impact of the comprehensive response can be assessed with several outcome and impact-level indicators, most of which are already being collected in Senegal as part of the national monitoring system for HIV. The indicators, baseline values (where possible), data sources and proposed level of disaggregation are described in Annex 5. Data sources included: the 2012 *PLHIV Stigma Index* and the Stigma Index 2.0; indicators reported to UNAIDS as part of Global AIDS Monitoring (GAM) and used to inform Spectrum modelling and estimations; the 2016 Senegal DHS. Outcome indicators are proposed for people living with HIV, key populations, the general population, healthcare workers, institutions and financing.

Measurement Limitations

It will not be possible to directly attribute key outcome and impact level change to the activities supported under the comprehensive response. However, comparison of baseline values with

values collected at midpoint and endline, and examination of the findings of the repeated qualitative assessments will provide a sense of how the addition or expansion of efforts to remove human rights-related barriers to HIV services has contributed to Senegal's progress towards reaching the 90-90-90 targets for HIV.

Next steps

This baseline assessment will be used as the basis for dialogue and action with country stakeholders, technical partners and other donors to scale up to comprehensive programs to remove human rights-related barriers to HIV services. Toward this end, the Global Fund will arrange a multi-stakeholder meeting in country where the findings of this assessment will be presented for consideration and discussion towards using existing opportunities to include and expand programs to remove human rights-related barriers to HIV services.

4. Setting priorities for scaling up interventions to reduce human rights-related barriers to HIV and services

There is an urgent need to improve stigma and discrimination within the health care facilities in order to improve uptake and quality of services for key and vulnerable populations. Therefore, it is important to update existing training curricula and ensure that training on human rights and medical ethics is rolled out to a majority of health care workers providing HIV-related treatment and to key administrative personnel and management in the facilities. Such training should be rolled out in priority districts where there are particular challenges with treatment and retention rates. To be able to evaluate these efforts, measurement of stigma and discrimination among health care personnel in some facilities should be conducted prior to the training and after.

An additional priority is to expand legal literacy and legal support for key and vulnerable populations through the recruitment, training, supervision and support of peer human rights educators and peer paralegals for each key and vulnerable population, including women and adolescent girls. Peer educators and peer paralegals can be recruited from existing community outreach health workers and/or mediators. The peer paralegals can be less in number but should have access to a few lawyers who will supervise and support them and are dedicated to serving marginalized populations. The work of these should not only be to support individual knowledge and legal needs but to help the networks and associations of the populations strategize and mobilize around concrete human rights and legal issues to improve their situation.

Other priorities include coordination and facilitation of relationships between law enforcement and sex worker associations to monitor police practice and implement joint activities to improve treatment of sex workers; development of organizational alliances with religious leaders toward the elaboration of messages that support a more protective environment for key populations; and the reestablishment of the Observatoire de la réponse au VIH/SIDA au Sénégal.

Supporting and strengthening existing individual key population association networks and facilitating coordination and capacity strengthening around human rights for key population associations and between key population networks is recommended as a priority and an

approach that would contribute to the effectiveness of other programs recommend in this report.

Given the limited information available on transgender women, another priority would be to gather representative data on the population size, HIV prevalence, uptake of HIV prevention and treatment services, and human right related barriers to health services for this population. These data should lead to advocacy for the expansion of services for transgender women based on their specific needs, the inclusion of transgender women in the national definition of key populations and the roll out of human rights programs for them. In the meantime, steps should be taken to incorporate transgender women into HIV and human right programs.

Linked with the scale-up of training activities, mid-term efforts should focus on developing and implementing appropriate monitoring tools for impact of training. Efforts in end years of implementation should focus on adapting training based on lessons learned from monitoring and evaluation. Programs should incorporate sustainability efforts through finalization of tools, curricula, and support mechanisms.

List of annexes

Annex 1: Chart – Comprehensive programs to reduce human rights-related barriers to HIV services

Annex 2: Calculations for retrospective costing of programs to remove human rights-related barriers to HIV services.

Annex 3: Calculations for costing the comprehensive response

Annex 4: Costing considerations

Annex 5: Baseline indicators and values for comprehensive response

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