



Baseline Assessment – Tunisia

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

2018
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

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
BCC	Behaviour change communication
CBO	Community based organization
CCM	Country Coordinating Mechanism
CD4	Cluster of differentiation 4
HIV	Human immunodeficiency virus
HTC	HIV testing and counselling
IPT	Isoniazid preventive therapy
LTFU	Lost to follow up
MDR-TB	Multi-drug-resistant tuberculosis
MoH	Ministry of Health
MTCT	Mother-to-child transmission
NGO	Non-governmental organization
NSP	Needle and syringe programme
OST	Opioid substitution therapy
PCR	Polymerase chain reaction
PHC	Primary health care
PMTCT	Prevention of mother-to-child transmission
SOP	Standard operating procedure
STI	Sexually transmitted infection
TB	Tuberculosis
TGF	The Global Fund
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	The United Nations Office on Drugs and Crime
VL	Viral load
WHO	World Health Organization
XDR TB	Extensively drug-resistant tuberculosis

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I. Executive Summary

Through its 2017-2022 strategy, the Global Fund is engaged in a major effort to expand investment in programs to remove rights-related barriers to health services in national responses to HIV, TB and malaria. Based on assessments of need, opportunity, capacity and partnerships, Tunisia was selected in April 2016 as one of 20 countries for intensive support to demonstrate feasibility and potential approaches for scaled up work to address rights-related barriers.

This Executive Summary covers findings from a baseline assessment conducted in Tunisia to provide data and analysis to help the country identify, apply for, and implement comprehensive programs to remove rights-related barriers to HIV services. Towards this end, the baseline assessment: (a) establishes a baseline concerning the present situation in Tunisia with regard to human rights-related barriers to HIV services and existing programs to remove them, (b) describes what comprehensive programs aimed at reducing these barriers would look like, and their costs, and (c) suggests opportunities regarding possible next steps in putting comprehensive programs in place.

Background

Located on the southern shores of the Mediterranean, Tunisia is a middle-income country of approximately 11.1 million people, with a relatively young population (median age 31) and a rich history and culture as a crossroads of trade and migration for Europe, the Middle East, and northern Africa. Tunisia had a 2016 per capita gross domestic income (GNI) of US\$ 11,100 and an overall Human Development Index rank of 97th of 188 countries.

Tunisia is a representative democratic republic. In January 2011, after a popular uprising toppled the dictatorship of president Ben Ali, Tunisians embarked on a process of reforming the country's legal and political structures to transition to a more pluralistic and inclusive system. After an initial October 2011 election of a constituent assembly, a new national constitution was adopted in January 2014, and elections of a parliament and a president took place in November 2014. The new 2014 Tunisian Constitution upholds many key civil, political, social, economic, and cultural rights and freedoms, including rights to free expression, assembly, association, right to a fair trial, right to privacy, and the right to health. The process of non-violent development of this constitution and an elected representative government earned four Tunisian NGOs a Nobel Peace Prize in 2015.

Tunisia has a small HIV epidemic, linked to epidemics elsewhere in Europe and North Africa, and concentrated within key populations and in urban coastal communities. According to UNAIDS data for 2016, approximately 2900 Tunisians are living with HIV, and fewer than 500 Tunisians become newly HIV-infected every year. Several key and vulnerable populations in Tunisia are at higher risk of HIV infection and HIV-related illness, and experience limited access to HIV-related services and systematic stigma and discrimination and other human rights violations. These populations include:

- People living with HIV
- Adolescent girls and young women
- Gay men and other men who have sex with men
- Transgender and other gender non-conforming people
- People who inject drugs

- Sex workers and other people engaged in transactional sex
- People detained in prisons
- Migrants

Summary of baseline HIV findings

Barriers to HIV services

The most significant human rights-related barriers impeding access to HIV services for key and vulnerable populations are:

- Laws that criminalise sexuality, sexual behaviour, and gender expression, criminalise drugs and drug use, and restrict the rights of migrants.
- Police practices that continue to be described as authoritarian, punitive, abusive, and without sufficient oversight or accountability, especially against people who use drugs, sex workers, gay men, and migrants from sub-Saharan Africa. Reported police practices included harassment, extortion, arbitrary arrests, and violence, including sexual violence.
- Prevailing gender norms and social attitudes about sex and sexuality, especially in more religious and socially conservative Tunisian communities, that make it difficult for Tunisian women, gay men and other men who have sex with men, and sex workers to seek sexual health services.
- Stigma about mental illness, addictions, and poverty, which adds to barriers faced by people living with HIV who experience these issues.
- HIV-related stigma, which causes people to fear being tested for HIV, deny that they may be HIV infected, be reluctant to use condoms or to disclose their HIV status to sexual partners or family, and refuse to seek HIV treatment.
- A poor national economy and high levels of unemployment in Tunisia, and dependence on subsidized health care through public clinics and hospitals in the country, which means vulnerability in cases of stigma, discrimination, breach of confidentiality or informed consent, rejection from services, or other rights violations in health settings.

Opportunities to address rights-related barriers to HIV services - from existing programs to comprehensive programs

UNAIDS and the Global Fund have set out seven Program Areas to assist in reducing human rights-related barriers to access to HIV services. They are set out in the Global Fund *HIV, Human Rights and Gender Equality Technical Brief*:¹

The following summarizes existing programming in Tunisia to remove human rights-related barriers to services under each key Program Area, as well as the proposed comprehensive program¹ that, if put in place, would to a great extent reduce such barriers to services.

Currently, several non-governmental and community-based organisations, as well as governmental entities, are working to address human rights-related barriers to HIV in Tunisia. These organisations are all small, the programs are being implemented at a very small scale and are largely unevaluated and significantly underfunded.

¹ Programs to remove human rights-related barriers to services are defined to be *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 and TB services.

Thus, these programs have had insufficient impact in reducing rights-related barriers to HIV services. Nevertheless, these organisations and programs form a basis for increased investment from the government and the Global Fund. The following summarizes existing or recent programs in Tunisia to overcome human rights-related barriers to HIV services, and potential programs that, if put in place, would to a great extent reduce rights-related barriers to HIV services for key and vulnerable populations.

PA 1: Programs to reduce stigma and discrimination for key and vulnerable populations

Existing programs: Approximately twenty organisations are working to address stigma and discrimination related to key and vulnerable populations, including programs targeted specifically to people living with HIV, adolescent girls and young women, gay men, other men who have sex with men, transgender and other gender non-conforming people, women and men engaged in sex work and transactional sex, people who inject drugs, and migrants. Most of these organisations work with minimal funding and a great deal of volunteered labour and face more needs than they can meet.

Comprehensive programming to reduce stigma and discrimination: A comprehensive approach to reducing stigma and discrimination for key and vulnerable populations would:

- Conduct regular national assessments to document and monitor stigma and discrimination experienced by people living with HIV and key and vulnerable populations, and the impact of stigma and discrimination on HIV service access and uptake.
- Systematically train public servants in key fields such as education, child and social services in each of Tunisia's 24 administrative areas to increase people's awareness and information and to encourage development of protocols and other standards and mechanisms of accountability to uphold human rights and reduce stigma and discrimination, including stigma associated with being a member of a key population.
- Fund key and vulnerable population organisations to hire community organizers and human rights and legal counsellors to engage key populations, community leaders, and opinion leaders (religious leaders, journalists, educators, health providers, and policy makers) in innovative programming to reduce stigma and discrimination, such as combinations of peer outreach and services, public media and social media communications, and projects in the arts and cultural realm that center on people's social identities, social networks, health and economic challenges, and experiences and ambitions

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

Existing programs: Existing trainings of health care workers are limited in rights-related content, are without follow up mentorship, monitoring, or enforcement, and are not specific to key or vulnerable populations or their specific rights-related barriers to HIV services.

Comprehensive program: A comprehensive approach would create model rights-affirming programs at major hospitals and create model programs in community settings to provide examples and lessons for health care providers, starting at Tunisia's largest public hospitals at Tunis, Sfax, Sousse, and Monastir where HIV treatment is provided and at leading non-governmental associations working with key and vulnerable populations, and then replicating and expanding to other sites and

organisations. In all of this work, the emphasis would be on attitudes and practices that reduce stigma and discrimination faced by members of people living with HIV and other key populations.

PA 3: Programs to sensitize law-makers and law enforcement agents

Existing programs: More than 30 organisations currently work in Tunisia to promote human rights and have been active in meeting with legislators and with law enforcement agencies (including the Ministry of Interior) about issues such as reducing violence against women, addressing addiction and drug use as a health issue and directing people into health care instead of incarceration, stopping arrests and prosecutions of gay men, improving conditions in prisons, and improving conditions and rights of migrants. However, this assessment heard about continuing challenges with police practices that are abusive, especially against people who use drugs, sex workers, gay men, and migrants from sub-Saharan Africa, with practices that include harassment, extortion, arbitrary arrests, and violence, including sexual violence. More than 7 governments ruled Tunisia in the last seven years. This situation has created a disruption in the implementation of several reforms. Numerous terrorist attacks have increased the popularity of authoritarian, conservative and populist leaders who were not supporting any improvement in police and judiciary practices and praising dictatorship era approaches.

Comprehensive program: A comprehensive approach to further measurably improve respect and fulfilment of rights by police forces and prison officials would include (1) international exchanges (including study visits) for law enforcement, (2) dialogues with justice officials and law enforcement, and (3) creation of community liaison committees for police departments. A central element of all of these activities should be the importance of instilling attitudes and practices that are respectful of the rights of people living with HIV and other key populations.

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

Existing programs: Tunisia’s 2011 revolution and development of a new 2014 national Constitution has increased popular awareness of civil, political, social, economic, and cultural rights and freedoms, including rights to free expression, assembly, association, right to a fair trial, right to privacy, and the right to health. The two free and fair elections that took place in 2011 and 2014 have included massive legal literacy campaigns from civil society organizations focusing on the right to vote, constitutional rights and other rights granted by the different international treaties and conventions Tunisia has signed after the revolution such as CEDAW and OPCAT.

Even after a long slow process of legal reform and a weak economy have dispirited some people about the ideals of the 2011 revolution, Tunisia’s political and social climate continues to spark dialogue in political, cultural and religious venues about human rights, the rule of law, and issues such as freedom from violence and rights of women. However, human rights educators and advocates say that more funding is needed for educational and community organising work to counter pessimism about progress on rights and authoritarian and discriminatory politics.

Comprehensive program: A comprehensive approach to further measurably improve legal literacy among key and vulnerable populations would be to fund a knowledge, attitudes and practices (KAP) study of legal literacy among key and vulnerable populations and then to fund follow up public education and dialogue in political, cultural and religious venues about human rights and the rule of law. Cities such as Tunis, Sfax, Sousse, Kairouan, Gabes, Bizerte, Gafsa, and Nabeul could be

targeted initially with gradual extension to the rest of Tunisia's administrative areas over time, and projects could include partnerships with local media, community dialogues, or projects in the arts and cultural sphere to increase legal literacy in relation to migrants, sex and gender identity, and other issues such as sexuality or drug use and addiction.

PA 5: HIV-related legal services

Existing programs: More than ten charitable NGOs and associations that are working with HIV-positive people and other key and vulnerable populations, including groups working with adolescent girls and young women, are able to link their clients to legal services. However this is limited: a total of only \$71,951 was identified as spent by the Tunisian National Program for the Fight Against AIDS (PNLS) or non-governmental organizations in 2016 for HIV-related legal services for key and vulnerable populations in all of Tunisia. Within the Association Tunisienne de lutte contre le Sida (ATL), a junior lawyer was on staff and led "l'Observatoire Éthique, droits humains et VIH, a watchdog that collected data on human rights abuses and other incidents Tunisian PLWHIV were subjected to. Most people were then referred to lawyers who provided pro-bono legal counsel.

Comprehensive program: A comprehensive approach to further measurably increase legal services for key and vulnerable populations, and thereby reduce barriers to HIV services, would be to increase legal service funding for the charitable NGOs and associations that are working with HIV-positive people and other key and vulnerable populations, including groups working with adolescent girls and young women, especially in larger cities such as Tunis, Sfax, Sousse, Kairouan, Gabes, Bizerte, Gafsa, and Nabeul.

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

Existing programs: As noted above, more than 30 organisations currently work in Tunisia to monitor and reform laws related to HIV. These groups have been active in meeting with legislators and with law enforcement agencies (including the Ministry of Interior) about laws and policies that can reduce violence against women, address addiction and drug use as a health issue and direct people into health care instead of incarceration, stop arrests and prosecutions of gay men, improve conditions in prisons, and improve conditions and rights of migrants. As noted earlier, collective advocacy has had an impact in the political realm, as demonstrated by the Tunisian parliament's recent enactment of several legal changes that have advanced the equality and rights of women in relation to marriage, divorce, child custody, workplace and wage discrimination, sexual harassment, and marital rape. Major reforms are still needed in Tunisian law and policies, especially related to laws and policies regarding sexuality, sexual behaviour, and gender expression, laws and policies regarding sex work, laws regarding drugs and drug use, and laws that do not separate public health aims and public health workers from policing and/or require public health workers to report patients to the police.

Comprehensive program: A comprehensive approach to monitor and reform laws in Tunisia, to specifically remove barriers to HIV services for key and vulnerable populations, would be to provide funding to national advocacy coalitions to:

- Advocate for changes recommended by the Legal Environment Assessment (to be carried out in early 2018), particularly related to the situation of sex work, drug use, LGBT rights, migrants and prisoners;
- Work with parliamentarians and civil society to build broad dialogue with many stakeholders and communities about repealing certain unjust laws and voting the

best possible laws to protect people from discrimination, promote human rights, and support access to HIV prevention and treatment;

- Engage and advocate in the Constitutional Court legal review process to encourage the best possible laws, and challenge the constitutionality of the unjust ones;
- Provide ongoing monitoring of enforcement of laws and policies and realization of people's rights;
- Due to unjust laws and police practices, advocate for the release of MSM, FSW and IDU while on abusive pre-trial detention and for a better due process for those who are unable to defend themselves or lack knowledge of their basic rights; and
- Create public awareness through media campaigns advocating for law reforms.

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

Existing programs: At least seven organisations are currently funded to provide HIV prevention education, HIV testing, and HIV treatment and care support for the 500 - 800 Tunisian women who are HIV-positive and the many thousands of women who may be at risk of acquiring HIV. However, these HIV-related services for women are not focused or mandated to address structural gender inequality and gender discrimination within HIV-related health services. This is mainly due to the lack of expertise in the gender dimension in the HIV epidemic among top leaders and decision makers including most of those of civil society. Further, women's community organizations that advocate for the equality and rights of women in relation to marriage, divorce, child custody, workplace and wage discrimination, sexual harassment, and marital rape have no interest or budgets dedicated to key populations, such as for women living with HIV, nor budgets for work specific to HIV or including HIV as a visible dimension of the work.

Comprehensive programming: A comprehensive approach to remove barriers to HIV services for all 500-800 Tunisian women who are HIV-positive and the many thousands of women who may be at risk of acquiring HIV would be to fund approximately three leading HIV and women's health organisations to take on projects such as:

- A study analyzing the social and legal barriers facing women in accessing HIV treatment and prevention services and providing recommendations.
- Advocacy for HIV services for adolescent girls and young women, as part of advocacy for their access to health services.
- Hiring adolescent girls and young women to provide counselling and support to their peers to promote health and rights, including health related to sex and drug use and addiction, rights to expression of gender and sexuality, and access to important HIV prevention and sexual and reproductive health interventions such as post-exposure prophylaxis and emergency contraception.

2016 investments and proposed HIV comprehensive program costs

An analysis of 2016 funding revealed the following allocations under each Program Area:

HIV Human Rights Barriers Program Area	2016 allocations
PA 1: Stigma and discrimination reduction for key populations	\$ 390,675
PA 2: Training for health care workers on human rights and medical ethics related to HIV	\$ 100,365
PA 3: Sensitization of law-makers and law enforcement agents	\$ 173,880
PA 4: Legal literacy (“know your rights”)	\$ 192,000
PA 5: HIV-related legal services	\$ 71,951
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	\$ 0
PA 7: Reducing discrimination against women in the context of HIV	\$ 72,520
Total	\$ 1,001,391

A full budget for the five-year comprehensive program is set out in the body of the report and in more detail in Annex 3. The five-year budget under each Program Area is set out below.

HIV Human Rights Barriers Program Area	5-year budget
PA 1: Stigma and discrimination reduction for key populations	\$3,253,899.20
PA 2: Training for health care workers on human rights and medical ethics related to HIV	\$421,979.79
PA 3: Sensitization of law-makers and law enforcement agents	\$1,069,122.15
PA 4: Legal literacy (“know your rights”)	\$815,252.61
PA 5: HIV-related legal services	\$1,180,572.45
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	\$878,183.10
PA 7: Reducing discrimination against women in the context of HIV	\$267,938.28
Total	\$7,886,947.58

II. Findings of the baseline assessment and costing

Introduction

Overview of the Global Fund Baseline Assessment Initiative

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 rights-related barriers to health services 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 services*” 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*”.²

The Global Fund has recognized 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 HIV, TB and malaria. They are indeed “critical enablers.”³ The Global Fund is working closely with countries, UNAIDS, WHO, UNDP, the Office of High Commissioner for Human Rights, the Stop TB Partnership, PEPFAR and other bilateral agencies and donors to operationalize this Strategic Objective.

Background and Rationale for Baseline Assessment in Tunisia

The Global Fund aims to support all countries to scale up programs to remove barriers to health services, and is starting by providing intensive support in 20 countries to demonstrate the feasibility and potential approaches for the work. Criteria for country selection were developed and considered during an international consultation convened by the Global Fund and partners in April 2016. Based on these criteria, a consultative process both across the Global Fund and with technical partners resulted in the list of 20 countries and disease focus within those countries. Tunisia was selected as one of the 20 countries based on the agreed criteria including need, opportunities, and capacity and partnerships in the country.

Purpose, objectives and expected outcomes of the assessment

The objectives of the baseline assessment for each country are to:

- Identify the key human rights-related barriers to health services;
- Describe existing programs to reduce such barriers, and their costs;
- Indicate what a comprehensive response to existing barriers would comprise in terms of the types of programs, their coverage and costs; and
- Identify the opportunities to bring these to scale over the period of the Global Fund Strategy.

The assessments will provide a baseline of the situation as of 2017 and will be followed up by similar assessments at mid- and end-points of the Global Fund strategy in order to assess the impact of scale-up of programs to remove barriers.

III. Methodology

Conceptual framework

The human rights-related barriers assessed in Tunisia are those that inhibit access, uptake and retention in HIV. There is ample evidence indicating that such barriers compromise efforts to fast track the response, affecting the prevention and treatment continuum². The theory of change envisages that through a comprehensive response that effectively reduces human rights-related barriers, access, uptake and retention across the prevention, testing and treatment continuum would be enhanced, and viral suppression achieved while improving quality of life.

The general categories of barriers interrogated in the assessment, as specified by the Global Fund, include those related to stigma and discrimination; poverty and economic and social inequality; punitive laws, policies, and practices; gender inequality and gender-based violence.

The focus populations for Tunisia are key and vulnerable populations using the following criteria stipulated by the Global Fund:

- Epidemiologically, the population 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;
- Access to relevant services is significantly lower for the population 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
- The population 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.

From the desk review carried out by APMG Health, the key and vulnerable populations identified in Tunisia include people living with HIV, adolescent girls and young women, gay men and other men who have sex with men, transgender and other gender non-conforming people, people who inject drugs, sex workers and other people engaged in transactional sex, people detained in prisons, and migrants.

Steps in the assessment process

In Tunisia, as for each selected country, research methods included:

- An initial desk review of existing peer-reviewed and grey literature and reports (conducted for Tunisia during August and September 2017);
- Data collection from people in each country, including key informant interviews, focus groups among key stakeholders, including persons affected by the diseases and among organizations implementing programs to remove barriers to services (conducted in Tunisia during October and November 2017);
- Data analysis, including analysis of the legal and policy environment relevant to the three diseases, analysis of the effectiveness of current programs in terms of their efficacy in removing barriers, and costing of existing programs to remove barriers to services (completed for Tunisia by December 2017).

² UNAIDS (2017). Confronting discrimination. Overcoming HIV-related stigma and discrimination in healthcare settings and beyond. http://www.unaids.org/sites/default/files/media_asset/confronting-discrimination_en.pdf

Desk review: Following the guidelines of the Global Fund and its partners for this baseline study, a comprehensive desk review was conducted to assess human rights barriers to HIV services for key and vulnerable populations in Tunisia. A literature review was first conducted during August 2017, using PubMed, Embase, and PopLine to identify peer-reviewed literature, and then Google Scholar to identify additional non-peer-reviewed (grey) literature. Supplemental searches were then made of websites of key organizations working in Tunisia to identify additional publicly available documents about key and vulnerable populations and human rights-related programming, including websites and documents of the Ministry of Public Health and National HIV/AIDS Program (PNLS), the Global Fund and UNAIDS, and key non-governmental organizations working in areas of health and rights in Tunisia. Key informants in Tunisia were then contacted by email and social media, provided with background about this research, and asked for additional information.

Data collection: During October and November 2017, researchers conducted key informant interviews and focus groups with key and vulnerable populations and related programs in Tunis, Sfax, Sousse, Nabeul, Sidi Bouzid and Kasserine. A total of 133 people were consulted (72 men, 4 trans, 57 women) in 10 focus groups and 25 interviews. All regions of the country were covered. Data was collected about:

- Human rights-related barriers to HIV services
- Key and vulnerable populations most affected by these barriers
- Programs 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
- Recommendations about what is needed to comprehensively address the most significant barriers for all groups most affected by these barriers
- Documented funding of all such programs (for 2016 financial years) and
- Costing of effective programs carried out presently or in the past.⁴

Data analysis: All interview and focus group reports were compiled and analysed during October and November 2017, in combination with compiled programmatic costs and findings from the desk review, to summarize a baseline situation: i.e., populations of concern; important rights-related barriers faced by these populations; and existing programs that address these rights-related barriers; and an outline of a proposed comprehensive response: i.e., priority rights-related interventions, perspectives on the most urgently needed and feasible pathways to bring those rights-related programming to scale in Tunisia, potential costs of that program implementation, and potential indicators of implementation, outcomes and impact.

This baseline report was then compiled using a standardized Country Report Outline and provided to the Global Fund for their work in:

- Establishing country-specific baselines against which progress can be measured in subsequent periods in terms of increasing investment in programs to remove human rights-related barriers and actually removing those barriers; and
- Assisting countries and the Global Fund to plan for and implement a comprehensive country-centred response to human rights-related barriers to access and use of HIV services for key and vulnerable populations.

Costing methodology: Three sets of costing processes were undertaken for this assessment:

First, all donors and funders who were discovered to have financed any activities in the 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 reach or coverage of funded activities.

Second, specific implementers were approached and information was gathered on costs involved in carrying out specific activities. This process followed the Retrospective Costing Guidelines that are part of the Costing Guidance developed specifically for the purposes of the Baseline Assessments (available from Global Fund on request).

Third, from the results of the first two processes, a Prospective Costing of the comprehensive program was carried out following the Prospective Costing Guidelines that are part of the Costing Guidance developed specifically for the purposes of the Baseline Assessments (available from Global Fund on request). The results of this process are provided in Annex 3. For each type of activity, an activity-level cost was assembled.

For activities that were new or had not been implemented in recent years, assumptions were made about the ways that these differed from activities whose costs are known. Such assumptions have been documented in Annex 2, to allow for replicability of method at mid-term and end-term assessments.

These costs were used to construct calculation tables (see HIV calculation tables in Annex 3). In these calculations, the number of services to be provided/people to be reached/trained were multiplied by the activity-level cost to provide an annual cost for each activity. Annual costs are required because some activities only take place every 2 years, such as use of the Stigma Index, and others require capacity building or other activities in the first year that are not needed in later years. Comments 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 (tab labeled 'HIV' in 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 in costing columns in Annex 3 and in the latter parts of this report.

Limitations

The costing component of the baseline assessment was a rapid investment analysis, therefore it should not be viewed as a full-fledged resource need estimation. The retrospective costing has informed the estimation of intervention-level costs, hence the limited data collected through the baseline assessment inherently affected the prospective costing.

The baseline assessment encountered certain limitations in the costing component both as pertaining to HIV programs aimed at removing human rights-related barriers:

- Certain key stakeholders were not able to take part in the data collection due to competing priorities. As a result, an important viewpoint on human rights barriers and on the effectiveness of current efforts to address them may be missing from the analysis. Stakeholders that could not participate also included a number of bilateral partners and, as a result, the description of current efforts to address and remove barriers may not include what these entities are currently funding or undertaking directly.

More specific limitations and challenges to the collection of financial data included:

- It appeared that a number of organizations felt that the information requested was too sensitive to share even though it was indicated in the invitation messages that the data would be consolidated and anonymized at the implementer level.
- Some organizations appeared to take the position that the benefit of completing the exercise was not worth the level of effort required, given other pressures on them.
- Most funders and intermediaries appeared to be unable to disaggregate their investments in combination prevention interventions to the level where funding for programmes addressing human rights barriers could be identified.
- Finally, as the analysis has noted there is a large gap in current and comprehensive quantitative data on a number of the human rights barriers identified by the assessment. As a result, there may be an over-reliance on individual or anecdotal accounts or perspectives which may not, in some cases, be an accurate reflection of an overall, country-wide trend.

The prospective costing of the comprehensive response to removing human rights-related barriers will inform the development of the five-year strategic plan and will therefore likely to change throughout the country-owned participatory plan development process.

IV. Baseline Findings

Context

Located on the southern shores of the Mediterranean, Tunisia is a middle-income country of approximately 11.1 million people, with a relatively young population (median age 31) and a rich history and culture as a crossroads of trade and migration for Europe, the Middle East, and northern Africa. Tunisia had a 2016 per capita gross domestic income (GNI) of US\$ 11,100 and an overall Human Development Index rank of 97th of 188 countries.^{5,6}

Tunisia is a representative democratic republic. In January 2011, after a popular uprising toppled the dictatorship of President Ben Ali, Tunisians embarked on a process of reforming the country's legal and political structures to transition to a more pluralistic and inclusive system. After an initial October 2011 election of a constituent assembly, a new national constitution was adopted in January 2014, and elections of a parliament and a president took place in November 2014.

The new 2014 Tunisian Constitution upholds many key civil, political, social, economic, and cultural rights and freedoms, including rights to free expression, assembly, association, right to a fair trial, right to privacy, and the right to health. The process of non-violent development of this constitution and an elected representative government earned four Tunisian NGOs a Nobel Peace Prize in 2015.

Tunisia's national commitment to health

The Tunisian Constitution's Article 38 defines a right to health, stating: "Health is a right for every person. The State shall guarantee preventative treatment and health care for every citizen and provide the necessary means to guarantee the safety and quality of health services. The State shall guarantee free health care for those without means and those with limited income. It shall guarantee the right to social assistance in accordance with the provisions set out by law".⁷

Tunisia's health services are provided through 57 tertiary hospitals - with the largest hospitals and greatest capacity in Tunis, Sousse, Monastir, Sfax – and 118 district hospitals, providing general medical services, general surgery, obstetrics, paediatrics, ophthalmology, and emergency care. Selected hospitals have dedicated clinics for sexual and reproductive health and adolescent health. Tunisia's public health system also includes 2091 primary health centres that have limited infrastructure, staffing, and hours of operation but a basic capacity for health assessments. In theory, 95 percent of the population lives within walking distance to a primary health care centre, which can provide a first point of care assessment and referral.

Tunisia's public health services are financed largely through a combination of employment-based health insurance, direct out-of-pocket patient expenditures and government subsidy. At least one million Tunisians lack employment-based health insurance and have incomes below Tunisia's US\$ 2,400 per annum minimum wage, making them dependent on government-subsidized health care.

The Tunisian government has a history of contracting with non-governmental community organizations to provide specialized health education and services for specific populations, such as education and services for adolescent health, perinatal and reproductive health, and HIV and STI prevention and education. Health services are also provided by physicians operating in the

private sector. Although private providers are usually more expensive than the public option and are not accessible to everyone, private health care providers operate throughout the country, with 80 inpatient clinics and over 3,000 physician offices operating as of 2016. As HIV/AIDS drugs are only available in 4 public hospitals and is solely under the care of infectious disease doctors, it is rare that PLWHIV go and seek care at a private practice. There is no data regarding the number of Tunisians treated at private practice. During the latest GF country dialogue, private sector infectious disease doctors reported treating patients from Libya and few wealthy patients who are willing to pay in order to avoid hospitals lack of anonymity, stigma and discrimination. There is no process of quality assurance for the HIV services provided in Tunisia.

Because of Tunisia's history of national investments in health, the country has seen steady progress on several core health measures, including increases in life expectancy (now over 76 years), coverage of infant and child immunizations, access to family planning and perinatal care, and reductions in infant and maternal mortality. Tunisia's broadest health challenges are beginning to resemble those of Europe, as increasingly, non-communicable diseases related to diet, exercise, tobacco, and aging.⁸

A context of ongoing social and economic challenges

Tunisia is also facing serious social and economic challenges that will affect national politics and public health in the foreseeable future. These challenges are interrelated and include economic stagnation, income inequality, gender inequality and perceptions of inefficient and ineffective governments.

The first challenge has been a weak economy. Tunisia's economy is dependent on tourism and exports to Europe, and has lagged since the 2011 revolution, in part hurt by weak European economies, by regulations and business practices that inhibit international investment and creation of new companies, and in part because disruptions caused by the 2011 revolution and a large 2015 terrorist attack which created (largely unfounded) fears by potential tourists about Tunisia's stability and safety.

The result of the weak economy has been high unemployment, which at a national level surpassed 15 percent in 2017 with 626,000 Tunisians unemployed.⁹ Unemployment is affecting people in both rural and urban areas, and people across all educational levels. Over one in four university graduates is unemployed and the country's largest metropolitan region of Greater Tunis, encompassing Tunis, Ben Arous, Ariana and Manouba, had a 17 percent unemployment rate in 2017, with 191,000 jobless individuals. As a reflection of the lack of formal employment opportunities, a recent 2016 study suggests that some 1.1 million people are working in the informal sector, which equates to 32 percent of the working population.¹⁰ Among young working people under the age of 40, a calculated 60 percent of young men and 83 percent of young women are informally employed. These high rates of unemployment and informal employment have an impact on health services, in part because people who are unemployed or informally employed have lower incomes and no health insurance, meaning that they are dependent on government subsidies for health care in the public health system.

This economic situation is creating social and political frustration about the inability of the 2011 revolution and successive governments to create improved prospects for a better future. Three years after the 2014 enactment of a new constitution and first national election of a new parliament, Tunisia ranks only 90th among other countries for per capita income, lower than countries such as Algeria, Lebanon and Turkey, and remains only 58th among 113 countries in the Rule of Law index (including 62nd of 113 for fundamental rights, 71st for civil justice, 60th for

absence of corruption, and 64th for regulatory enforcement).^{11,12} Tunisian governments continue to struggle to demonstrate the potential of the revolution's promise for positive change, especially on issues of economic opportunity, political and social unity, and a change from old bureaucratic or authoritarian cultures in key government agencies.

Overview of epidemiological context and focus populations

HIV in Tunisia

Tunisia has a small HIV epidemic, linked to epidemics elsewhere in Europe and North Africa, and concentrated within key populations and in urban coastal communities. According to UNAIDS data for 2016, approximately 2900 Tunisians are living with HIV, and fewer than 500 Tunisians become newly HIV-infected every year.¹³ Previous studies by the Tunisian Ministry of Public Health (MSP) and National Program for the Fight against AIDS and Sexually Transmitted Diseases (PNLS) suggested these numbers might be higher, at approximately 3400-4000 Tunisians living with HIV and 650-850 Tunisians becoming newly HIV-infected every year, but still these numbers indicate a relatively small epidemic with a national prevalence among adults aged 15-49 of below 0.1 percent.^{14,15} Early in Tunisia's HIV epidemic, 75 percent of all HIV cases were among men, presumably acquired from unsafe sex and/or injection drug use between men, and national statistics continue to suggest a 2:1 or 3:1 male-female ratio in total adult HIV cases.

HIV is concentrated among key populations (discussed in detail below) and in urban coastal areas, according to available data from national reporting and three bio-behavioural studies conducted in 2009, 2011 and 2014. The geographic distribution reflects the overall demographics of the country, but also reflects the migration of key populations to the more tolerant and anonymous settings of larger cities, the increased likelihood for multiple unsafe sexual and drug use encounters in cities, and a higher historical background HIV prevalence which increases the likelihood of HIV being transmitted during an unsafe sexual or drug-related encounter. It is also very likely that key populations in rural regions might be traveling to urban coastal locations for confidential HIV testing, care and treatment.

Most Tunisians living with HIV do not know that they have HIV, or if they know, they are not seeking health care through a provider that reports data to the national agencies. For example, in 2013, Tunisia recorded a total of only 1,440 people diagnosed with HIV and 92 of these individuals were newly-diagnosed, which indicates that formal health systems reporting is capturing fewer than half of all HIV cases in the country.¹⁶ Tunisia routinely tests all blood and organ donations and through its national HIV strategy, has a national policy to routinely offer HIV testing to people with TB, people in sero-discordant couples, and, through the national PMTCT program, pregnant women. This means that the undiagnosed and unreported HIV is likely in key populations.

Most Tunisians living with HIV are not treated for HIV. As of 2015, 850 HIV-positive Tunisians had been prescribed HIV treatment`. This is less than half of all people who are diagnosed and less than a third of all people estimated to be living with HIV.^{17,18} Rates of HIV treatment retention and viral suppression are unclear, although a 2013 study of 68 people starting ART showed that 96 percent were continuing to take their treatment after one year and 87 percent were continuing after two years. HIV treatment is officially free, along with HIV care at public hospitals, under a 2001 Decision Number 16-2001 of the Tunisian Ministry of Public Health.

Tunisia's HIV response is governed by a National AIDS Program (PNLS), a National AIDS Committee (CNLS), and a Country Coordinating Mechanism (CCM), all constituted under the authority and supervision of the Ministry of Public Health (MSP). Tunisia's HIV response is also

guided by national strategic plans, the most recent plans covering 2012-2016, then 2014-2017, and now 2015-2018.¹⁹ The Tunisian government currently invests approximately \$10 million each year in HIV services, with the Global Fund contributing an additional \$2.5-3.5 million and households and employers also spending funds through insurance and health care fees.²⁰

Key and vulnerable populations in the HIV response in Tunisia

Several key and vulnerable populations in Tunisia are at higher risk of HIV infection and HIV-related illness, experience limited access to HIV-related services and systematic stigma and discrimination. Their increased and sustained involvement and leadership is key to the HIV response in Tunisia. The following section summarizes available HIV-related data about these populations.

People living with HIV

As noted above, approximately 2900 Tunisians are living with HIV. They are subject to stigma and discrimination related to HIV or key populations (described below) and most face systematic challenges in accessing to HIV-related health services, including limited economic means or lack of health insurance, lack of peer support for accessing health care, and distance from HIV health providers. Given gender inequality in Tunisia, adolescent girls and young women living with HIV may face particular barriers and therefore are included separately, below, as a key and vulnerable population. Tunisia has five charitable non-governmental organizations and associations are working with HIV-positive people and other key and vulnerable populations to reduce stigma and discrimination related to HIV and other sexually transmitted infections. These organizations include the Tunisian Association for the Fight Against HIV and STIs (ATL/MST/SIDA), the Tunisian Association for Information and Education About HIV and Addiction (ATIOST), the Tunisian Association for the Prevention of Addiction (ATUPRET), the Tunisian Association for the Fight Against Risk Behaviors (ATLCR), and the Tunisian Association for Positive Prevention (ATP+).

Adolescent girls and young women

According to the Tunisian PNLs, limited data suggest that between 500 to 800 Tunisian women are living with HIV, and perhaps many thousands of women may be at risk of acquiring HIV.^{21,22} The lead Tunisian organization led by an HIV-positive woman is the Association Tunisienne de Prévention Positive (ATP+). National data and anecdotal evidence from interviews with health care providers and community organizations indicate a diversity of demographics and possible HIV risks among Tunisian women who are newly diagnosed with HIV. Common themes are reported about the HIV-related vulnerability of adolescent girls and young women, including undiagnosed or undisclosed HIV among men, male sexuality norms that encourage multiple concurrent sexual relationships and age-disparate sexual relationships with younger women. Women's lack of economic independence and prevalent norms and expectations about marriage, childbearing and intimate partner violence are also contributors to vulnerability. In addition, health care providers report high levels of self-stigma among women and stigma against women in relation to STIs, including HIV, which lead to low levels of testing and late diagnosis of HIV and other STIs.

Gay men and other men who have sex with men

An estimated 29,000 Tunisian men have sex with other men, although the true number could be many times higher – 100,000 to 150,000 men – if patterns in Tunisia society are similar to what is found elsewhere in societies throughout the world.^{23,24,25} Tunisia's Mode of Transmission studies and three waves of integrated bio-behavioural surveys (IBBS) using respondent driven sampling (RDS) in 2009, 2011 and 2014 suggest that over 80 percent of new HIV infections result

from sex between men, which would mean that over 2,000 of Tunisia's 2900 people living with HIV are gay men and other MSM, and that most of country's 500-850 new HIV infections each year are among gay men and other MSM. This aligns with available data from the IBBS research, which suggest that 9 percent of MSM are living with HIV, with higher HIV prevalence seen in the north-western coastal cities of Tunis, Sousse, Nabeul and Bizerte.²⁶ Preliminary results from the IBBS of 2017-18 indicate HIV prevalence of 11.2%, an estimated 8.2% among men under 25 years and 13.1% among those 25 and older.²⁷ This survey also estimated that 35% of these men used condoms during their last sexual encounter with a man. Because of stigma and criminalization of sex between men, men rarely self-report homosexual activity and so prevalence statistics from outside of Tunis and other cities are prone to inaccuracies and under-reporting. This geographic concentration of HIV among gay men and other MSM in major cities would be consistent with what is seen in other countries.

Transgender and other gender non-conforming people

There is little information on the situation of transgender people in Tunisia, and a literature review found no data about the size, demographics or epidemiology of HIV or other health problems among transgender or gender non-conforming populations in Tunisia.²⁸ If the Tunisian population is similar to European populations, Tunisia would have 10,000 to 20,000 people who would self-identify as transgender, with several hundred trans people living with HIV and several hundred more at risk for contracting HIV from unprotected receptive anal sex.²⁹ These numbers of transgender people at risk for HIV likely overlap with statistics about MSM because of the similar mode of HIV transmission, and also because men who might potentially identify as trans women also often self-identify for political action and social change with broader LGBTI³⁰ coalitions, despite the fact that populations marginalized because of gender identity are different from those marginalized because of sexuality.

People who inject drugs

The number of Tunisians who inject drugs is estimated to be between 8,000 and 18,000, with the largest number of people who inject being in Tunis and other coastal cities. Drugs injected are primarily heroin, morphine, buprenorphine, and cocaine.^{31,32,33} National IBBS studies in 2009, 2011, and 2014 indicate that approximately 400-600 of Tunisia's 2900 people living with HIV acquired HIV through injecting drug use.³⁴ Preliminary results from the 2017 IBBS, which did not seek to estimate the size of the population of people who inject drugs, indicate a doubling of HIV prevalence in this population from the 3 percent estimated in earlier surveys to 6 percent, with the largest increase in Greater Tunis.³⁵ Prevalence of hepatitis C infection was estimated at 29%, about the same as in earlier surveys.³⁶ In the 2017 survey, about 91 percent of people reported that they did not share injection equipment in their last usage, significantly improved from earlier surveys; not knowing where to get sterile equipment was a significant correlate of sharing. The Tunisian government has authorized harm reduction programming, and research among active injectors in Tunis has indicated high levels of access to buprenorphine and sterile injection equipment, with most people injecting drugs at home and many injecting alone.

The 2017 IBBS found that 77% of people who inject drugs had been in prison at some time,³⁷ a worrisome figure given the scarcity of harm reduction services in prisons. An earlier study found that 16 percent of injectors had exchanged money or drugs for sex.,³⁸ the same figure estimated in the 2017 IBBS. The recent IBBS also found significant deficits in HIV knowledge in this population and estimated that only 20.6 percent of people who inject drugs had sought an HIV test in the previous year.³⁹ Generally there are very limited health services to provide people with counselling, substitution therapy or residential treatment to overcome addiction to illicit drugs. Further, people who use drugs are subject to social stigma, punitive policing, and other rights violations as described throughout this report. For these reasons, HIV-related services (or other

health services such as HCV treatment) are denied to or are discriminatory against people actively using drugs, and are generally unavailable, inaccessible, or non-accepting for most people who use drugs in Tunisia.

Sex workers and other people engaged in transactional sex

An estimated 25,500 women and an unknown number of men engage in sex work in Tunisia.⁴⁰ In the 2014 IBBS research in a sample of 960 female sex workers based in Tunis, Sousse, and Sfax found that most female sex workers were younger than 25 years of age, many had no other employment and many were unmarried. Nearly all had been sexually active since teenage years, 72 percent had four or more male partners during the previous week, 55 percent had used condoms with a recent client and only 27 percent had used condoms consistently in all sexual encounters of the previous month. In non-representative samples of sex workers, HIV prevalence among female sex workers was estimated to be 0.61 percent in 2011⁴¹ and 0.94 percent in 2014, which would translate to approximately 250 sex workers living with HIV.⁴² Preliminary results from the 2017 IBBS, however, suggest an estimated HIV prevalence among sex workers of 1.2 percent, and 1.8 percent among those under the age of 25 years.⁴³ In the 2017 survey, 58 percent of sex workers reported condom use with the last client, not greatly changed from earlier surveys. Studies also show that only one quarter of sex workers reports having had an HIV test and only one in six have been tested for HIV during the previous year.⁴⁴ Studies of STIs rates among sex workers in Tunis have shown extremely high rates of STIs other than HIV, including half of 188 sex workers in Tunis having chlamydia and/or herpes simplex (HSV-2).⁴⁵

People detained in jails and prisons

Tunisia has a relatively high per-capita number of people in detention, with 128,446 Tunisian citizens arrested in 2015. Approximately 20,000-27,000 people are held in jails and prisons and more than half of all these people are held in a situation of preventive or pre-trial detention.^{46,47} Most detainees are men, under the age of 30 with only primary school education. More than one in four detainees – over 8,000 people - are held for crimes relating to drug use.^{48,49} As noted in the previous text about drug users, there is an overlap with migration to and from Europe, with several thousand Tunisians (more than 2,000 in Italy alone) currently imprisoned in Europe for drug-related charges and likely to be deported to Tunisia at the end of their punishment.⁵⁰ Only a small number of prisoners have been diagnosed with HIV. HIV testing conducted among 9,292 prisoners between May 2010 and November 2014 by the organization ATIOST (Tunisian Organization for Information and Guidance on Aids and Drug Addiction) identified only 18 people with HIV. HIV care and treatment are not available in any of Tunisia's 28 prisons, meaning that people living with HIV are untreated and not virally suppressed. Mental health and substance use treatment services are also not available. Although opioid substitution therapy (OST) is provided in one prison, there are no syringe access programs in prisons. Prisoners do report to researchers that drugs are injected inside Tunisian prisons and male prisoners are having unprotected sex with each other, which indicates the potential for HIV transmission inside prisons. Upon release from prison, people face social stigma and discrimination from their families and communities and, because people are required to have a clean record in order to join the civil service or to access certain other private professions, former prisoners face high rates of unemployment and recidivism.

Migrants

Approximately 2 million Libyan migrants and several thousand migrants from other countries, mostly from sub-Saharan Africa, are living in Tunisia. Among these migrants, 253 people with HIV were reported in 2013, 327 reported in 2014, and 189 reported in 2015. Approximately two-thirds of these people living with HIV are non-resident Libyan immigrants who come to Tunisia to receive HIV-related medical care, usually from private medical providers. One in three – 60 to

100 people - are migrants, residents and students from sub-Saharan Africa. Most of these migrants do not have access to HIV treatment or care in the public sector and are relying for their care and treatment on physicians in private practice and on charity organizations such as ATL/MST/SIDA, mainly in the two major cities of Tunis and Sfax. Officials at the Ministry of Public Health estimate that 500 to 600 Libyan nationals living with HIV are treated in Tunisia by infectious disease specialists in private practice.⁵¹ Information about the health needs and other needs of migrant populations in Tunisia can be improved, and the National AIDS Program (PNLS) is about to launch a study co-sponsored by the International Organization for Migration and other partners to analyse migrant needs and the best ways to provide health information and health care of these populations.

Human rights barriers to access, uptake and retention in HIV services

Introduction and theory of change

Because of high levels of unemployment in Tunisia, many people, including key and vulnerable populations related to HIV, depend on subsidized health care through public clinics and hospitals in the country. This means that key and vulnerable populations depend on the quality and accessibility of HIV-related services at hospitals and public health centres and can be highly vulnerable if they are confronted by stigma, discrimination, breach of confidentiality or informed consent, rejection from services or other rights violations. There is ample evidence indicating that such barriers compromise efforts to fast-track the HIV response, affecting prevention services, reducing likelihood of people getting tested and knowing their status, and further exacerbating losses throughout the treatment cascade.³ The theory of change envisages that through a comprehensive response that effectively reduces human rights-related barriers, access, uptake and retention across the prevention, testing and treatment continuum would be enhanced, and viral suppression achieved while improving quality of services.

Key and vulnerable populations experience a range of rights-related barriers in accessing HIV-related health services. These are set out below.

Barriers related to stigma and discrimination

Tunisia has clear laws against discrimination, including a 1992 law that states that medical treatment and health education and prevention should be provided without discrimination, including discrimination on the basis of race, colour, sex, language, religion, political or other opinion, national or social origin, property or age. Further, Tunisia has a national communications plan and campaign to reduce HIV-related stigma and discrimination and to improve people's access to legal services and justice in cases of discrimination.⁵²

Surveys of people living with HIV reveal a high level of concern about HIV-related stigma and discrimination, and because of this fear, people living with HIV report not disclosing their HIV status to sexual partners, not taking HIV medicines in public and not participating in HIV-related public events. A research study of adolescents found that nearly one in three agreed with the statement, "AIDS is a punishment from God" for the sin of having had sex or having used drugs.⁵³

³ UNAIDS (2017). Confronting discrimination. Overcoming HIV-related stigma and discrimination in healthcare settings and beyond. http://www.unaids.org/sites/default/files/media_asset/confronting-discrimination_en.pdf

Key informant interviews and focus groups with health care providers and key and vulnerable populations revealed repeatedly that people fear that a diagnosis of HIV will threaten their marriages and families, their livelihoods, their place in the community, their access to health care and justice and would possibly result in ostracism and violence. As a consequence, people fear getting tested for HIV, and if they receive a positive test result, may deny that they are HIV infected, may decide not to use condoms, may be reluctant to disclose their HIV status to sexual partners or family, and may fear seeking HIV treatment - all because it may reveal to others that they are living with HIV.

Tunisian women living with HIV are reported to experience an added layer of discrimination because of prevailing gender norms in many Tunisia communities, including expectations of sex only within marriage, expectations of childbearing and economic dependence on husbands and expected loyalty to husbands even in case of domestic violence. Tunisian women who are unmarried and who contract STIs or who become pregnant experience rejection by families and health care providers, including verbal abuse and denial of services by health workers.^{54,55} Some evidence shows that this stigma and discrimination have become worse since the 2011 revolution, with greater expression of religious conservatism in some health care settings.⁵⁶

Furthermore, as in other countries, many people in Tunisia hold and experience stigmatizing attitudes about a range of issues, including health conditions and disabilities (including mental health and addiction), poverty, literacy, vocation, marital status, age and gender, expressions of gender and sexuality. As in other countries, these attitudes are influenced by prevailing social, cultural, political and economic forces, including norms expressed by families and communities, local governments, law enforcement, religious institutions, service providers and public media.⁵⁷

Stigmatizing attitudes about sex and sexuality especially affect gay men and other men who have sex with men, sex workers and unmarried women. As an example, in 2012 Tunisia's prime minister for human rights, Samir Dilou, attacked the existence of an online gay magazine called Gayday Magazine, saying, "freedom of expression has limits. [LGBT people] live as citizens but they must respect the red lines set up by our religion, heritage and civilization," and further stating that homosexuality is a "sexual perversion" that needs to be "treated medically."⁵⁸ This kind of opinion is shared by a large number of people in Tunisia even now and creates an environment in which men face rejection and discrimination if they are perceived to be gay.

Norms about perceptions of appropriate gender roles in Tunisian society affect transgender women and other transgender and gender non-conforming people. There are no laws to define or prohibit any forms of gender expression, but trans people face discrimination in public venues and face harassment and arrest by police under Article 226 of the Penal Code, which criminalizes "disgraces to the public morality".⁵⁹

People who are battling addictions and people caught up by police and the criminal justice system (two overlapping populations in Tunisia) also face social stigma and discrimination in families, communities and potential employment. For example, even though Tunisia has one of the highest rates of detention in Africa and the Middle East, people are required to have a clean record in order to join the civil service or to access certain other private professions.⁶⁰ This leads to high unemployment and recidivism among key and vulnerable populations at risk for HIV.

Stigmatizing attitudes about national origin, race, and language affect migrants in Tunisia. People report discriminatory treatment by police and health care workers based on perceived nationality due to language or skin colour. Some migrants in the focus groups also reported self-stigma about

HIV and HIV disclosure, due to their vulnerability as foreigners in Tunisia, lack of peer support, and fears that they would not be supported by Tunisian health services.

Ultimately, for all key and vulnerable populations related to HIV, stigma and discrimination carries a strong potential for less access to health services and poorer health outcomes, due to self-stigma and isolation, lack of visible peers for support, disconnection and dislocation from families and communities, mistrust of health systems and discrimination experienced in health services.⁶¹

Barriers related to fulfilment of human rights within the health care system

There are many positive Tunisian laws and policies to protect and respect people's human rights in health care settings. These include:

- The National Constitution's Article 24, which states: "The State shall protect the right to a private life, sanctity of domiciles, confidentiality of correspondence and communications and personal information." In the case of HIV, this personal information includes information about the health status of individuals, including their HIV status.
- Article 254 of the National Penal Code, which obliges professionals, doctors, medical staff and anyone who has access to another person's medical records to maintain the confidentiality of patient's medical information, including any medical conditions or transmissible infections.⁶²
- Law Number 2004-63 of 2004, which describes patients' medical information as private, requires protection of this personal health data, and authorizes a National Commission of Personal Data to monitor health facilities and health care providers for compliance with this law and enforce standards of confidentiality with legal penalties.⁶³
- Tunisia's national HIV strategy, which:
 - Prohibits mandatory or forced HIV testing against people's will or without their knowledge
 - Instructs health providers to allow people to opt out of HIV testing if they prefer
 - Commits to promoting migrants' access to HIV testing, treatment, and care even if individuals do not have asylum status or a residence permit.⁶⁴

For key and vulnerable populations, the Tunisian government also augments the services provided in hospitals and public health centres with public health education, testing and referrals provided by charitable non-government associations such as ATL/MST/SIDA, ATIOST and ATUPRET.

Despite these laws, policies and programs, interviews and focus groups with Tunisian health care providers and with key populations described four major challenges to rights-based health care in the country:

- Stigma and discrimination remain common in health care settings, especially stigma and discrimination related to HIV and STIs and related to issues such as extramarital sex, homosexuality, drug use and addictions, and origin from sub-Saharan Africa. Health care workers are reported to show lack of respect for those vulnerable to or affected by HIV, provide judgmental or disparaging treatment and sometimes either denial of care or creation of needless delays in access to care.
- Health care workers are not seen as different from other government workers, and thus are seen by gay men and other men who have sex with men, drug users, sex workers and undocumented migrants as likely to report them to police for arrest and prosecution.

- Hospital and clinic staff report that they lack adequate resources for training and supervision to ensure achievement of national rights-based standards.
- Staff at charitable non-government associations such as ATL/MST/SIDA, ATIOST, and ATUPRET report that limited funding restricts their ability to provide services at sufficient scale, which limits their availability and benefit for all who are in need of them.

Barriers related to knowledge, attitudes and practices of law-makers and law enforcement agents

Interviews and focus groups repeatedly revealed descriptions of police practices as authoritarian, punitive and abusive, especially against people who use drugs, sex workers, gay men and other men who have sex with men, and migrants from sub-Saharan Africa. Reported abusive police practices included harassment, extortion, arbitrary arrests and violence, including sexual violence.

- Gay men talked about a police practice of rounding up men at venues perceived to be frequented by gay men, with police then bringing the detained men to a forensic examiner for a rectal examination for presence of rectal STIs or semen, with judges using rectal STIs or the refusal of men to undergo forensic examination as evidence of sex with other men.
- Sex workers spoke of harassment, arbitrary arrests, bribes and extortion, sexual violence and the use of condoms in their possession as evidence of sex work.
- People who use drugs and outreach workers talked about being arrested at harm reduction service sites, and being framed with drugs planted as evidence and extorted for money. Advocates for harm reduction programming spoke of an urgent need to sensitize the Ministry of Interior and police about addiction and drug use as a health issue and the need to direct people into health care and drug treatment and thereby reduce incidence of crime and violence.
- Migrants from Cameroon, Côte d'Ivoire, Niger and Senegal described harassment by police because of their skin colour or the language they were speaking to friends.
- Staff at charitable community-based organisations working in prisons also told of people in police custody and prisons being denied access to life-saving medicines.

In general, key informants noted the new 2014 national Constitution and the progress made at the highest level in Tunisia toward dignity and respect for all persons but said that local law enforcement and frontline police officers still operated as they had under the old system, without sufficient oversight or accountability. The result has been to push key and vulnerable populations underground and away from police protection or health services.

Barriers related to legal literacy among key and vulnerable populations

Tunisia's 2011 revolution and development of a new 2014 national Constitution have increased popular awareness of civil, political, social, economic, and cultural rights and freedoms. These include rights to free expression, assembly, association, a fair trial, privacy and health. Even though a long, slow process of legal reform and a weak economy has dispirited some people about the ideals of the 2011 revolution, Tunisia's political and social climate continues to spark dialogue in political, cultural and religious venues about human rights, the rule of law and issues such as freedom from violence and the rights of women.

However, key informants and focus group participants were careful to emphasize the unevenness of progress and the extent of the need. People noted that large parts of Tunisian society hold very conservative views about gender roles and sexual behaviour and that racism against sub-Saharan Africans is more widespread than publicly admitted.

Staff at progressive HIV-focused charitable associations described the ongoing work needed among colleagues and clients, even in the supposedly liberal city of Tunis. This involved building awareness of gender roles and gender inequality, sexual consent and sexual violence, and peer literacy about health and laws, including health services and laws related to sexual health and sexual violence, drug use and addiction, and rights to expression of gender and sexuality.

Overall, the message from key informants was that more resources are needed for legal literacy work to be conducted, directed not only towards clients and communities in stereotypically rural, conservative, “illiterate” locations, but also throughout the country towards all staff at charitable non-governmental organizations and associations that are working with people living with HIV and other key and vulnerable populations, including groups working with adolescent girls and young women.

Barriers related to availability and accessibility of HIV-related legal services

All of the charitable non-governmental organizations and associations that are working with key and vulnerable populations who were interviewed for this baseline assessment described efforts to link their clients to legal services, including paralegal advice and counselling and pro-bono or contracted attorney representation.

However, respondents in interviews and focus groups repeatedly said that the extent of these legal services was insufficient to meet the current need, and that legal services related to HIV and key populations are unavailable, unaffordable, and/or inaccessible, and not always trusted by key populations.

- Hundreds of people living with HIV are in need of help in cases of discrimination or rejection in health services, employment, and housing.
- Many thousands of women are in need of help, including legal assistance in cases of intimate partner violence, rape, divorce, and child custody.
- Gay men and other men who have sex with men are experiencing arrests and extortion by police, and prosecution and potential incarceration based on sexual orientation.
- Prisoners need legal help in challenging denial of services in prison and pre-trial detention.
- Sex workers, people who use drugs and undocumented migrants are seeking legal help after being arrested, and migrants in Tunisia additionally need legal help in seeking asylum, residency or other formal legal status.

Ultimately, a vast scale-up of legal information, advice and referrals and legal services is needed for HIV key and vulnerable populations, including adolescent girls and young women, as well as a coordinated national effort to monitor police stations, jails and prisons for people who may need legal information, advice and representation, and HIV service provision.

Barriers related to laws and policies and HIV

2017 has been an important time of change in laws and policies related to HIV in Tunisia. Following the enactment of the new 2014 national Constitution, Tunisia is in the process of

creating a Constitutional Court, a body that will have the power to strike down laws that are not in harmony with the 2014 constitution, including laws related to the equality of women in the public and private sphere and laws related to free expression, assembly, association, right to a fair trial, and right to privacy.

The members of the new Tunisian parliament, elected in 2011 and 2014, have already enacted several legal changes that advance human rights. Most recently, in July and September 2017, the Tunisian legislature passed laws that advanced the equality and rights of women in relation to marriage, divorce, child custody, workplace and wage discrimination, sexual harassment and marital rape.

This positive momentum is encouraging and during interviews and focus groups, key informants described several areas of law reform still needed in the country. In relation to access to HIV services, the greatest barriers are laws about sex, drugs and migrants:

Laws about sexuality, sexual behaviour, and gender expression

For people who self-identify as lesbian, gay, bisexual, or transgender (LGBT), Tunisia is the only country along the southern coast of the Mediterranean that has legalized LGBT rights associations. Major cities in Tunisia, along with cities in Morocco and Lebanon, are relatively tolerant places compared to many other places in the Arab world.

However, Tunisia has a legal norm – Article 230 of the Penal Code – that subjects people, mostly men, to up to three years for homosexuality or consensual same-sex conduct. Article 230 is interpreted and enforced by police and courts as applying not only to behaviour but also to identity and orientation and thus violates human rights principles of rights to privacy and freedom of thought. Under Article 230, police are not required to have caught people in the act or have witnesses, but instead have arrested people who are suspected of either same-sex attraction or same-sex conduct.

During 2017, advocates focused public attention on the police practice of bringing men who they suspected of same-sex conduct to a medical forensic examiner to undergo a forensic rectal examination to test for presence of STIs or semen, and treating any refusal of men to undergo this test is accepted by some Tunisian judges as evidence of homosexuality or history of homosexual acts. The police practice of rounding up men and bringing them to a forensic examiner for a rectal exam was condemned by human rights groups as a violation of rights against cruel or degrading treatment. The threat of being brought to a forensic examiner for a rectal exam and potentially being diagnosed positive for an STI meant that men who are arrested by police for suspected homosexuality were reluctant to contest the charges. In September 2017, the Tunisian Minister for Human Rights committed to advocate against this practice, although at the time of this baseline assessment in September 2017, advocates were sceptical about the speed at which practices of police and judges would change⁶⁵.

People who self-identify as lesbian, gay, bisexual, or transgender (LGBT) in Tunisia report many negative effects of these punitive laws and policies, including exclusion from education and employment, vulnerability to violence, and lack of protection from police.⁶⁶ In the 2014 HIV IBBS research, 27 percent of men who self-identified as gay or as men having sex with men reported that they had experienced violence at school, work or in public places.⁶⁷ The overall effect on access to HIV services is that the Tunisian population at highest risk of HIV, encompassing at least 2000 of Tunisia's 2900 people living with HIV, are less likely to come forward to clinics and

organizations to reveal HIV risks, seek HIV testing or access HIV-related prevention, treatment and support.^{68,69}

For transgender women and other transgender and gender non-conforming people, Tunisia has no formal laws that define or prohibit gender expression but, Article 226 of the Penal Code, provides for six months imprisonment and a fine for anyone who is found guilty of “public indecency” or “public infringement of morality or public morals by gesture or speech”. This law is used by police to threaten, harass and arrest people who are perceived to not conform to appropriate gender norms and gives an excuse to businesses to exclude transgender people from employment or patronage.⁷⁰

With regard to sex work, Tunisian law distinguishes between two different situations in sex work. It permits and regulates the activity of registered sex workers, while criminalizing other women who engage in sex work or transactional sex. The laws allowing registered brothels and sex work date back to 1942 and created a regulated and taxed business in which women are licensed but controlled in relation to where they work, live and travel. However, since the 2011 revolution, conservative politics have caused many brothels to close and have induced police to stop issuing licenses, thus shrinking this legalized sex work sector.⁷¹ Criminalization of other women who engage in sex work is under Article 231 of the Criminal Code which prohibits and punishes women who “incite to debauchery” or “by gesture or by word expose themselves to the public gaze or engage in prostitution, even on an occasional basis”. In practice, Tunisian courts use evidence of intent to solicit money and evidence of recurrent solicitation as grounds for conviction. Notably, only women are subject to arrest and prosecution for prostitution. Male customers are considered by law to be only an accomplice. The effect of these laws, law enforcement practices and judicial practices is that Tunisian women who engage in sex work and transactional sex, estimated by the government to number 25,500 women, are vulnerable to violence and lack of protection from police and are less likely to come forward to clinics and organizations to reveal HIV risks, seek HIV testing or access HIV-related prevention, treatment and support.

Laws regarding drugs and drug use

Cannabis is included as a prohibited drug in Law 52, even though it is widely used. As of December 2015, 28 percent of the total prison and jail population in Tunisia - nearly 7,500 people (7,350 men and 150 women) were being held on drug-related offences and 70 percent of these people – over 5,000 people – were being held on charges related to cannabis. In April 2017, an amendment to Law 52 was adopted by the Tunisian parliament to allow magistrates to take into account extenuating circumstances in sentencing, and thus avoid imprisonment in some cases. Consequently, the media has reported a major drop in the number of prisoners from approximately 25,000 people down to approximately 20,000 people over a period of just a few months.⁷² Nevertheless, thousands of people are still detained. The effect of these laws, law enforcement practices and judicial practices is to push drug use into the shadows, inhibiting people from seeking health care and drug treatment and increasing their risk of violence and rights violations.

For people who inject drugs, Chapter IV of Tunisian Law 52 provides a legal pathway to drug treatment by which a person can voluntarily notify a public health centre of their addiction and need for medical treatment without fear of prosecution. First-time drug offenders can be referred to drug treatment in lieu of charges and imprisonment. However, the 1992 Law Number 92-52, amended in 1995, 1998, 2008 and 2017, still defines punishment of incarceration and a fine for anyone who is convicted of “consuming or holding” narcotics or “knowingly visiting a place affected and equipped for the use of narcotics”. People convicted of drug use, drug possession or of being in

a place for drug use can also be prohibited from working as a public employee or from obtaining a passport or traveling abroad.

Laws restricting rights of migrants

For migrants, Tunisian law grants the right to seek asylum or citizenship, but also, under Law 1968-7, allows for deportation of any non-citizen who is perceived to be a threat to public order, which can be interpreted to include a threat to public health. In the event of a deportation decision, the residence permit is withdrawn from the migrant and he or she must then leave Tunisia within eight days. This effectively rules out time for any legal action to challenge the decision.⁷³ For migrants, including the two million Libyans and several thousand people from other countries who are in Tunisia to study, work or take refuge from instability and threats in their home countries, public health care, aside from HIV, is not accessible without asylum status or a residence permit. As described above on page 18, stigmatizing attitudes about national origin, race, and language affect migrants in Tunisia. People report discriminatory treatment by police and health care workers based on perceived nationality due to language or skin colour. Some migrants in the focus groups also reported self-stigma about HIV and HIV disclosure, due to their vulnerability as foreigners in Tunisia, lack of peer support, and fears that they would not be supported by Tunisian health services.

Barriers related to gender norms and gender-related vulnerabilities related to HIV

National Tunisian data suggest that between 500 to 800 Tunisian women are living with HIV, and perhaps many thousands of women may be at risk of acquiring HIV, with HIV-related vulnerability of adolescent girls and young women linked to many factors. Factors of vulnerability include women's lack of economic independence, and prevalent norms and expectations about marriage, childbearing, economic dependence on husbands, and expected loyalty to husbands even in case of domestic violence.^{74,75}

In addition, health care providers report high levels of self-stigma among women about sexually transmitted infections, including HIV, and reports describe Tunisian women who are unmarried and who contract sexually-transmitted infections or HIV, or who become pregnant, experiencing rejection by families and health care providers, including verbal abuse and denial of services by health workers.^{76 77} Some evidence shows that this stigma and discrimination has become worse since the 2011 revolution, with greater expression of religious conservatism in some health care settings.⁷⁸

Ongoing barriers to HIV prevention, testing, treatment, and care related to gender norms and gender inequality include:

- Women's access to education, employment and economic independence
- Social norms about marriage and childbearing
- Norms within marriage about sexual consent, violence, and decision-making about contraceptives
- Prevalent norms about gender roles, sexual consent and sexual violence
- HIV stigma among men, which leads to men having undiagnosed or undisclosed HIV and putting their wives or other sexual partners at risk.
- Concepts of male sexuality that encourage men to have multiple concurrent sexual relationships and age-disparate sexual relationships with younger women.

- Lack of peer support among adolescent girls and young women to promote health and rights, including health related to sex and drug use and addiction and rights to expression of gender and sexuality.

Existing interventions, ongoing gaps and insufficiencies, and suggested comprehensive approach

PA 1: Programs to reduce stigma and discrimination for key and vulnerable populations

Existing interventions

In Tunisia, five charitable non-governmental organizations and associations are working with HIV-positive people and other key and vulnerable populations to reduce stigma and discrimination related to HIV and other sexually transmitted infections. These organizations include groups working specifically on HIV, such as ATL/MST/SIDA, ATIOST, ATUPRET, ATLCR, and Association Tunisienne de Prévention Positive (ATP+), and also groups working with the National Office on Family and Population to inform adolescent girls and young women about sexual and reproductive health and link them to services, such as Groupe Tawhida, Association Tunisienne des Femmes Démocrates (ATFD), and IPPF-Tunis.⁷⁹

Name	Geographical locations	Estimate of the number of people served
ATL/MST/SIDA ⁸⁰	Sfax, Gabes, Djerba, Tunis, Sousse	5000-10000
ATIOST	Tunis, 24 Prisons	1000-5000
ATUPRET	Sfax	100-200
ATP+	Sousse, Mahdia, Tunis, Bizerte	1000-5000
ATLCR	Nabeul	<100
ATL Tunis	Gafsa, Kasserine, Tunis, Nabeul, Sousse	5000-10000
ATSR	20 cities ⁸¹	5000-10000
ATFD	Tunis	100 -1000
Groupe Tawhida Be Cheikh	Tunis	<100

Eight organizations are working specifically to reduce stigma and discrimination among and against gay men, other men who have sex with men, transgender and other gender non-conforming people, and women and men engaged in sex work and transactional sex. These groups work in greater Tunis, as well as Sfax, Sousse, Gabès, Bizerte, and Nabeul and include ATL/MST/SIDA, ATP+, ADLI, and Maison Sidi Bou Said and several LGBT organizations such as Damj (also known as Tunisian Association for Justice and Equality), Mawjoudin, Chouf, and Shams.^{82 83 84 85}

Name	Geographical location	Type of intervention
ADLI	Tunis	Legal reviews and advocacy for legal reforms
Damj	Tunis	Psycho-social support and legal counselling (100-500 beneficiaries) – Advocacy
Maison Sidi Bousaid	Tunis	Shelter <100 beneficiaries

Mawjoudine	Tunis	Psycho-social support – documentation of human rights abuses – Advocacy for legal reforms (100-500 beneficiaries)
Chouf	Tunis	Advocacy for Lesbians rights
Shams	Tunis	Advocacy- health promotion – psycho-scoail support (100- 500).

In relation to people who inject drugs, ATL/MST/SIDA works in partnership with Drosos in the Greater Tunis, Nabeul, Kasserine and Gafsa regions to reduce stigma and discrimination against drug users. They also provide socio-medical, psychological, psychiatric, occupational therapy and legal services to reduce the risks associated with injecting drug use and the spread of HIV and HCV. In Sfax, ATUPRET and the MoH operate a centre for the care and treatment of people who inject drugs, and also occasionally conduct public education about drug use, addiction and harm reduction.^{86 87 88} The organization ATIOST also works with drug users through a rehabilitation clinic in Tunis. The regional network MENAHRA also has a program operating in Tunisia, mostly in the North, to promote harm reduction and understanding related to addiction and drug use.

NGOs	Geographical locations	Interventions	Number of beneficiaries
ATL/MST/SIDA	Sfax, Kasserine,, Nabeul, Tunis, Gafsa, , Sidi bouzid	Seringe exchange, psycho-social interventions	500 - 1000
ATUPRET	Sfax	Rehabilitation	100-500
ATIOST	Tunis	Seringe exchange, psycho-social intervention	500 -1000

Seven organizations are working in Tunisia to reduce social discrimination against migrants and to improve connection and access to health services, especially for migrants from sub-Saharan Africa who do not speak French or Arabic. According to stakeholders interviews, It is estimated that less than a 1000 migrants are benefitting from these services. Examples include Médecins du Monde, ATP+, the Red Crescent Society, Maison du Droit et des Migrations, Terre d’Asile, and ATL/MST/SIDA. These organizations have a presence in migrant hotspots such as Tunis, Sfax, Mednine, Jerba and Tataouine.

In total, analysis of all of the programming described above found that approximately twenty organisations are working to address stigma and discrimination related to key and vulnerable populations. Most of these organisations work with minimal funding and a great deal of volunteered labour, and their total allocated costs for work related specific to HIV and key and vulnerable populations totalled \$410,675 in 2016.

Proposal for a comprehensive program

Reduction of stigma and discrimination requires involvement of many sectors, including local community leaders, governments, law enforcement, religious institutions, private employers, service providers, and public media.⁸⁹ A comprehensive approach to further measurably reduce stigma and discrimination for key and vulnerable populations, and thereby reduce barriers to HIV services, could be centred on three strategies: (1) measuring and monitoring stigma and

discrimination, (2) training public service employees, and (3) supporting community-level associations to innovate in locally-adapted education, communication and dialogue.

Measure and monitor stigma and discrimination: Tunisia does not currently have a national coordinated system to generate regular data to adequately monitor stigma and discrimination experienced by people living with HIV and key and vulnerable populations, or the impact of stigma and discrimination on HIV service access and uptake. Using innovative research tools and methods⁹⁰, the Tunisian PNLs could sponsor a regular national assessment, conducted every two years, of the drivers, types and level of stigma and discrimination experienced by key and vulnerable populations in health care settings, in specific communities and in key employment sectors such as health care and tourism. It could also assess policies, practices and laws that undermine confidentiality and privacy with respect to HIV status. This regular assessment could provide the basis for monitoring the success of local anti-stigma programming, and design of improvements in remedial policies and programs.

Train Tunisia's public service employees: A comprehensive approach could recruit and retain the time of a lead trainer and resource person in each of Tunisia's 24 administrative areas who have an understanding of the rights-related barriers experienced by key populations, approaches to empowering key populations to overcome stigma and discrimination, and existing and potential mechanisms of redress and accountability to uphold standards of rights-affirming practices. These individuals in each region would be responsible for training at least 20 public servants in key fields such as education, child and social services about human rights and issues related to access by key and vulnerable populations, and would serve as a liaison for key and vulnerable populations as they seek to navigate access to services and overcome stigma and discrimination. These individuals would also serve as a resource for programmes in developing organisational protocols to reduce rights-related barriers for key populations. A total initial cost of this effort focused on stigma and discrimination could be an average of \$2,000 in training fees and costs for each of 24 administrative areas in the first year, assuming complementary funds for other activities are also available through other program areas, below), to reach more than 200 officials and leaders with a total national cost over a five-year period of \$360,878.

Fund local community organisations to innovate in education and dialogues to reduce stigma and discrimination at a structural level, institutional level, and community and individual level: People interviewed for this assessment repeatedly stated that isolation, lack of support, and lack of resources for their organizations and associations were major problems to be addressed. International research suggests that programming against stigma and discrimination should apply a combination of interventions, including peer support in marginalized communities and support of local community organizations.^{91,92} These community programs are best centred not on HIV, key population identities, or HIV-related health behaviours, but rather on the fully expressed social identities, social networks, health and economic challenges, and experiences and ambitions of the individuals and communities of concern.^{93 94,95} On this basis, the Tunisian PNLs could strengthen key and vulnerable population organizations to hire community organizers and human rights and legal counsellors to engage key populations, community leaders, and opinion leaders (religious leaders, journalists, educators, health providers, and policy makers) in innovative programming to reduce stigma and discrimination. A comprehensive approach could start by funding six community organizers and four human rights and legal counsellors at organisations in Tunis, Sousse and Sfax, and then scale up to Bizerte, Medenine, Nabeul, Tozeur and other cities. This innovative programming could also underwrite small costs of projects in the arts and cultural sphere, and with local media and community dialogues, to raise issues related to HIV and related to religion, ethnicity and national origin, sex and gender identity, and other issues such as sexuality or drug use and addiction, and to encourage people to publicly embrace difference and diversity as positive attributes for society, and

encourage people to respect each other, reject stereotypes, and confront discrimination in all settings. A total initial cost of this effort focused on stigma and discrimination could be \$30,700 in the first year (assuming costs for organisers and counsellors are also covered by other program areas such as recommended under legal literacy, below) with a cost over a five-year period of \$153,500.

PA 2: Training for health care workers on human rights related to HIV

Existing interventions

As noted above, Tunisia has existing laws and trainings against discrimination in medical treatment and health education, including discrimination on the basis of race, colour, sex, language, religion, political or other opinion, national or social origin, property, or age. For key and vulnerable populations at risk of HIV, the Tunisian government also augments trainings within hospitals and public health centres with trainings offered by charitable non-government associations.

- Groups such as ATL/MST/SIDA, ATIOST, ATUPRET, and ATP+ train clinicians and other health care personnel ⁹⁶in public hospitals and penitentiary health services about non-discriminatory care for people living with HIV, LGBT people, sex workers, and migrants.
- For adolescent girls and young women who are vulnerable to HIV, organisations such as the Association Tunisienne des Femmes Démocrates (ATFD), Groupe Tawhida, and IPPF-Tunisia have trained health providers about appropriate counselling, advice and support for women seeking access to sexual and reproductive health services in public clinics.
- Tunisia also has harm reduction and syringe access programs for people who inject drugs, and these programs have staff and clients who have trained clinicians and other health care workers⁹⁷ about addictions and related harms and harm reduction, including substitution therapy, residential treatment, and integrated mental health care and social support.

In total, analysis of all of the programming described above found that around ten organisations are working to educate health care workers and improve respect and fulfilment of rights in health care settings in relation to HIV and key and vulnerable populations. The total identified budget for this work in 2016 was minimal and totalled \$35,365.

Proposal for a comprehensive program

In-country interviews suggest that the main challenge in health care systems is adequate resources for training and supervision to ensure achievement of national rights-based standards. A comprehensive approach to further measurably improve respect and fulfilment of rights in health care settings for key and vulnerable populations, and thereby reduce barriers to HIV services, could include (1) projects to create model programs at major hospitals, and (2) projects to create model programs in community settings that can provide examples and lessons for health care providers. In all of this work, the emphasis would be on attitudes and practices that reduce stigma and discrimination faced by members of people living with HIV and other key populations.

Create model programs at leading public hospitals: Starting with Tunisia's largest public hospitals at Tunis, Sfax, Sousse, and Monastir, where HIV treatment is provided, and then expanding to public hospitals in locations such as Nabeul, Bizerte, Kairouan, Gabes, and Gafsa, provide funding to the Ministry of Health to assess potential structural changes to improve patient experience of rights-related issues in health care settings.

- Structural improvement projects could start with an assessment of patient experience of rights-related issues in health care settings, such as perceptions of stigma or discrimination, capacity for informed consent, confidentiality and privacy, patient-centred care, patient rights and workers' rights and meaningful participation of both the patient and health care workers in decision-making about care.
- Projects could then define a deliberate series of steps to train health care staff and to improve patient scheduling and referrals, protocols for counselling, peer mentoring, patient support groups, and patient follow up. Trainings could contain content about issues such as gender and gender identity, gender equality, gender-based violence, sexual health, addiction and mental health, and laws, policies and legal service options that exist to protect people's access to care. Trainings could also include content about ensuring the rights and protections of health care workers, to fully apply and integrate human rights standards in the workplace. They could be co-led by organisations that represent patients, such as organisations representing people living with HIV and members of other key and vulnerable populations including adolescents and young women.
- Follow-up monitoring and assessment could then collect patient feedback through surveys, interviews and comment boxes at each facility to ask about patients' perception of ease of scheduling and access to care, perceptions of provider respect and competency, and overall quality of care. Knowledge and competency of health care workers could also be tracked as part of ongoing clinical supervision and recertification/relicensing processes.
- A final step would be to rotate health care providers from other locations through these programs to allow health care providers from other parts of Tunisia to have direct experience of models of rights-affirming health care.

Create model programs in community settings that can provide examples and lessons for health care providers: Starting with leading non-governmental associations such as ATL/MST/SIDA, ATP+, Mawjoudine, Damj, Groupe Tawhida, and IPPF-Tunisia, provide funding in the form of a contract or award to offer expanded community-based health screenings, referrals, and patient accompaniment and case management to increase accessibility of care and address rights violations that are barriers to HIV care. Awards could focus on creating model rights-affirming programs for key and vulnerable populations in mental health and addiction services, reproductive health services or other specific health service specialties, examining the resulting impact on uptake and success of HIV testing, treatment and care. Community-based associations could then document these models of care and meet with health officials to discuss how rights-based approaches can be integrated into hospital and clinic settings with accountability mechanisms at health facility level and broader referrals to legal services and mechanisms of redress for patients whose rights have been violated.

PA 3: Programs to sensitise law-makers and law enforcement agents

Existing interventions

More than 30 organisations currently work in Tunisia to promote human rights in public communications, campaigns and legislative processes. These organisations include the groups advocating for rights related to HIV, such as ATL/MST/SIDA, ATIOST, ATUPRET, and ATP+. There are also groups advocating for rights related to gender equality and sexual and reproductive health such as Groupe Tawhida, Tunisian Association of Democratic Women (ATFD) and IPPF-Tunis and groups advocating for rights related to sexual orientation and gender identity such as Damj (also known as Tunisian Association for Justice and Equality), Mawjoudin, and Shams. Many of these organisations are part of broader coalitions that work collectively to promote and

defend the rights of all vulnerable populations, including prisoners and migrants. These coalitions include the Tunisian League of Human Rights (LTDH), the Tunisian Forum for Economic and Social Rights, Citizenship and Freedoms Association, Tunisian Association for the Defense of Individual Freedoms (ADLI), Committee for the Respect of Freedoms and Human Rights, Tunisian Organization of Social Justice and Solidarity, and the Tunisian Association for the Right to Health (ATDS).

These coalitions have been active in meeting with legislators and with law enforcement agencies (including the Ministry of Interior) about issues such as reducing violence against women, addressing addiction and drug use as a health issue. They also advocate for directing people into health care instead of incarceration, stopping arrests and prosecution of gay men, improving conditions in prisons and improving conditions and rights of migrants. Analysis of the costs of this programming finds total identified budgets for this work at \$108,880 in 2016.

As noted earlier, this collective advocacy has had an impact in the political realm, as demonstrated by the Tunisian parliament's recent enactment of several legal changes that have advanced the equality and rights of women in relation to marriage, divorce, child custody, workplace and wage discrimination, sexual harassment and marital rape.

The main challenge heard from interviews and focus groups is concern about a lingering authoritarian culture within law enforcement agencies, in which police are not accountable to local communities, and are abusive, especially towards people who use drugs, sex workers, gay men, and migrants from sub-Saharan Africa. Practices include harassment, extortion, arbitrary arrests, and violence, including sexual violence. Efforts to address this challenge are underfunded but are underway, and are described in the preceding paragraphs and included advocacy about laws, systematic law enforcement practices, and case-by-case advocacy in cases of rights violations.

Proposal for a comprehensive program

A comprehensive approach to further measurably improve respect and fulfilment of rights by police forces and prison officials would include (1) international exchanges for law enforcement, (2) dialogues with justice officials and law enforcement, and (3) creation of community liaison committees for police departments. A central element of all of these activities should be the importance of instilling attitudes and practices that are respectful of the rights of people living with HIV and other key populations.

In partnership with UNODC and other international agencies, sponsor dialogue and exchange of experience between police forces, prison officials and international experts from key Mediterranean countries (e.g. Spain, Italy, France, Morocco, Algeria, Libya and Lebanon) to review policing practices and prison policies related to key and vulnerable populations. This should start with a focus on women prisoners (a small and politically sympathetic population) and engage at least 30 law enforcement officials and officers from six Tunisian cities in dialogue about how to reduce incarceration of women, ensure best practice in prisons. It should also investigate how to fund local community organisations to create post-prison social reintegration that encompasses housing, economic support and health care, with the ultimate aim to build knowledge and support in Tunisia for rights-affirming practices.

Engage criminal justice officials in dialogue: Starting in the major population centres such as Tunis, Sfax, and Sousse, and then replicating successful models to other locations, create dialogue sessions and trainings that engage at least 240 judges, prosecutors, police, and key and vulnerable

populations in a regular conversation about key and vulnerable populations, HIV and human rights, to literacy about human rights standards in policing and to foster policing practices that reflect respect for people's constitutional rights.

Fund community liaison committees for police departments: Work with police departments and local members of human rights coalitions such as the Tunisian Association for the Right to Health (ATDS), Tunisian Association for the Defense of Individual Freedoms (ADLI), Committee for the Respect of Freedoms and Human Rights (CRLDHT), the Tunisian Forum for Economic and Social Rights (FTDES), Tunisian League of Human Rights (LTDH), the Citizenship and Freedoms Association, and the Tunisian Organization of Social Justice and Solidarity, to fund the establishment, training and meeting costs of community human rights committees that provide advice, support and oversight to police departments.

Some of the international police exchange costs for this strategy could be raised from external sources and much of the meeting space could be covered by existing agency budgets.

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

Existing interventions

Several of the charitable non-governmental organizations and associations that are working with HIV-positive people and other key and vulnerable populations, including groups working with adolescent girls and young women, have carried out interventions to educate their employees and clients about human rights to improve legal literacy⁹⁸. This education is typically integrated into programs for community mobilisation, legal services and support, and HIV prevention and treatment information.

These community-based legal literacy programs are limited in their scale and reach. Interviews with leading HIV associations and other community rights-based groups suggest that total budgets for public education and promotion of civil, political, social, economic, and cultural rights and freedoms were \$192,000 for all of Tunisia. Human rights educators and advocates say that more funding is needed for educational and community organising work to counter pessimism about progress on rights and authoritarian and discriminatory politics.

Proposal for a comprehensive program

A comprehensive approach to further measurably improve legal literacy among key and vulnerable populations would be to fund a knowledge, attitudes and practices (KAP) study of legal literacy among key and vulnerable populations and then to fund follow up public education and dialogue in political, cultural and religious venues about human rights and the rule of law.

KAP research could be integrated into existing research such as the IBBS, or could be conducted as a series of dedicated studies tailored to specific populations or regions. Studies could focus on a sequence of themes (such as awareness and literacy about laws about sexual consent and sexual violence; laws about drug use and addiction; laws about expression of gender and sexuality; and laws and rights related to migrants).

Building from the findings of the KAP research, leading charitable non-governmental organizations and associations could be funded to conduct public education. Cities such as Tunis, Sfax, Sousse, Kairouan, Gabes, Bizerte, Gafsa, and Nabeul could be targeted initially, but training should be extended to the rest of Tunisia's administrative areas. The messages developed could

be promoted through partnerships with local media, community dialogues or projects in the arts and cultural spheres. Projects could aim to increase legal literacy in relation to migrants, sex and gender identity and other issues such as sexuality, drug use and addiction.

PA 5: HIV-related legal services

Existing interventions

More than ten charitable non-governmental organisations and associations that are working with people living with HIV and other key and vulnerable populations, including groups working with adolescent girls and young women, are able to link their clients to legal services. These legal services include paralegal advice and counselling and pro-bono or contracted attorney representation⁴ to help people in cases such as: arrest or prosecution for homosexuality, prostitution, or public indecency; denial of services in prison and pre-trial detention; violence against women, including intimate partner violence and rape; illegal police behaviour involving harassment, arbitrary arrest and violence; or discrimination or rejection in health services, employment, housing and property and custody rights. Within the Association Tunisienne de lutte contre le Sida (ATL), a junior lawyer was on staff and led “l’Observatoire Éthique, droits humains et VIH, a watchdog that collected data on human rights abuses and other incidents Tunisian PLWHIV were subjected to. Most people were then referred to lawyers who provided pro-bono legal counsel.

Non-governmental organizations described limited budgets to pay for legal services. A total of only \$71,951 was identified as allocated by the PNLIS or non-governmental organizations in 2016 for HIV-related legal services for key and vulnerable populations across Tunisia. Presumably there was additional unquantified spending by individuals and also pro-bono time contributed by lawyers and paralegals. However, in total, limited resources and resulting limited capacity has translated to legal services being largely unavailable, unaffordable, and/or inaccessible, and not always trusted by key populations.

Proposal for a comprehensive program

A comprehensive approach to further measurably increase legal services for key and vulnerable populations, and thereby reduce barriers to HIV services, would be to increase legal service funding for the charitable non-governmental organizations and associations that are working with people living with HIV and other key and vulnerable populations, including groups working with adolescent girls and young women. This could focus first in larger cities such as Tunis, Sfax, Sousse, Kairouan, Gabes, Bizerte, Gafsa, and Nabeul. As legal services are made available, affordable, and accessible to key populations, further research could be funded to identify underserved populations and address barriers still faced those populations.

Funding could be on a lump sum legal service fee for the services comprising experienced attorneys and paralegals, who would be tasked with:

- Setting up a hotline and in-person consultation to provide as-needed legal information, advice and referrals for key and vulnerable populations at risk for HIV, including adolescent girls and young women.
- Monitoring police stations, jails, and prisons for people who may need legal information, advice and representation.

⁴ Civil society has established a coalition for the protection of personal freedoms. This coalition includes a number of pro-bono lawyers and para legals who volunteer most of the time to defend and document any human rights abuses.

- Providing legal representation and case litigation.
- Training other lawyers to increase their knowledge on the legal context of HIV in Tunisia.

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

Existing interventions

As noted above, more than 30 organisations currently work in Tunisia to monitor and reform laws related to HIV. Many of these organisations are part of broader coalitions that work collectively to promote and defend the rights of all vulnerable populations, including prisoners and migrants.

These coalitions have been active in meeting with legislators and with law enforcement agencies (including the Ministry of Interior) about laws and policies that impede access to rights and services. An analysis of the total allocation for this work estimated that around \$108,000 was spent in 2016.

Proposal for a comprehensive program⁹⁹

A comprehensive approach to monitor and reform laws and policies to specifically remove barriers to HIV services for key and vulnerable population would include funding of national advocacy coalitions such as the Tunisian Association for the Right to Health (ATDS), Tunisian Association for the Defense of Individual Freedoms (ADLI), Committee for the Respect of Freedoms and Human Rights (CRLDHT), the Tunisian Forum for Economic and Social Rights (FTDES), Tunisian League of Human Rights (LTDH), the Citizenship and Freedoms Association, and the Tunisian Organization of Social Justice and Solidarity, to:

- Advocate for changes recommended by the Legal Environment Assessment (to be carried out in early 2018), particularly related to the situation of sex work, drug use, LGBT rights, migrants and prisoners;
- Work with parliamentarians and civil society to build broad dialogue with many stakeholders and communities about repealing certain unjust laws and enacting laws that protect people from discrimination, promote human rights and support access to HIV prevention and treatment;
- Engage and advocate in the Constitutional Court legal review process to encourage the best possible laws and challenge the constitutionality of the punitive ones.
- Provide ongoing monitoring of enforcement of laws and policies and realization of people's rights.
- Advocate on behalf of people who are incarcerated due to unjust laws and police practices.
- Create public awareness through media campaigns advocating for law reform.

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

Existing interventions

As described previously, health care workers involved in HIV testing and treatment centres and women's health and rights organizations are working to challenge and remove ongoing barriers to HIV prevention, testing, treatment, and care for the 500 - 800 Tunisian women who are HIV-positive and the many thousands of women who may be at risk of acquiring HIV. These include organizations such as ATL/MST/SIDA, ATIOST, ATUPRET, Association Tunisienne de

Prévention Positive (ATP+), Groupe Tawhida, Association Tunisienne des Femmes Démocrates (ATFD), and IPPF-Tunis.

Analysis found that most work funded as HIV-related services for women is not focused on promotion of human rights – no specific budgets were identified specifically targeted or structured to ensure gender equality within HIV-related health services. Further, outreach to women’s community organizations that advocate for the equality and rights of women in relation to marriage, divorce, child custody, workplace and wage discrimination, sexual harassment and marital rape found no targeted budgets dedicated to key populations, such as for women living with HIV, nor budgets for work specific to HIV or including HIV as a visible dimension of the work.

Proposal for a comprehensive program

A comprehensive approach to remove barriers to HIV services for all 500-800 Tunisian women who are HIV-positive and the many thousands of women who may be at risk of acquiring HIV would be to fund leading HIV and women’s health organisations to expand individual case management and systematic advocacy for women’s health and rights, especially in larger cities such as Tunis, Sfax, Sousse, Kairouan, Gabes, Bizerte, Gafsa, and Nabeul. Specific goals could include:

- Location-specific studies to collect testimony and stories from HIV-positive women about their lives and barriers in accessing services, and an accompanying policy and communications effort to use these stories for advocacy with policy-makers and with the public.
- Advocacy for adolescent girls and young women’s access to health, education, employment and economic independence.
- Advocacy for HIV-positive adolescent girls and young women as they navigate issues of marriage, pregnancy and childbearing, and decision-making about contraceptives.
- Hiring adolescent girls and young women to provide counselling and support to their peers to promote health and rights, including health related to sex and drug use and addiction, rights to expression of gender and sexuality, and access to important HIV prevention and sexual and reproductive health interventions such as post-exposure prophylaxis and emergency contraception.

To the extent that the activities listed above are health services, they can be included as part of the comprehensive integrated services already funded by the Government of Tunisia and other sources. However, supplemental funding could be allocated toward the non-service advocacy work, especially to elevate and address the needs of key and vulnerable populations such as women battling addiction, transgender women, and women migrants.

2016 investments and proposed HIV comprehensive program costs

An analysis of 2016 funding revealed the following allocations under each Program Area:

HIV Human Rights Barriers Program Area	2016 allocations
PA 1: Stigma and discrimination reduction for key populations	\$ 390,675

PA 2: Training for health care workers on human rights and medical ethics related to HIV	\$ 100,365
PA 3: Sensitization of law-makers and law enforcement agents	\$ 173,880
PA 4: Legal literacy (“know your rights”)	\$ 192,000
PA 5: HIV-related legal services	\$ 71,951
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	\$ 0
PA 7: Reducing discrimination against women in the context of HIV	\$ 72,520
Total	\$ 1,001,391

A proposed budget for the 5-year program is presented in the following table. Detailed intervention costs and costing assumptions are contained in Appendix 2.

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 populations	\$633,116.06	\$602,737.52	\$653,042.06	\$675,061.52	\$689,942.06	\$3,253,899.20
PA 2: Training for health care workers on human rights and medical ethics related to HIV	\$111,146.49	\$68,689.35	\$111,146.49	\$68,689.35	\$62,308.11	\$421,979.79
PA 3: Sensitization of law-makers and law enforcement agents	\$194,365.83	\$243,012.33	\$194,365.83	\$243,012.33	\$194,365.83	\$1,069,122.15
PA 4: Legal literacy (“know your rights”)	\$165,901.17	\$137,307.36	\$177,036.36	\$157,971.36	\$177,036.36	\$815,252.61
PA 5: HIV-related legal services	\$161,330.49	\$203,150.49	\$244,970.49	\$272,030.49	\$299,090.49	\$1,180,572.45
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	\$170,323.02	\$170,323.02	\$170,323.02	\$183,607.02	\$183,607.02	\$878,183.10
PA 7: Reducing discrimination against women in the context of HIV	\$35,726.58	\$42,671.16	\$51,933.06	\$59,209.74	\$78,397.74	\$267,938.28
Total	\$1,471,909.64	\$1,467,891.23	\$1,602,817.31	\$1,659,581.81	\$1,684,747.61	\$7,886,947.58

V. Gaps, challenges and opportunities

The picture that emerges from the data collected by this assessment is of a unique and timely opportunity to support human rights-based HIV programming in an Arab country. Tunisia's current process of legal reforms and accompanying political debates, along with Tunisia's civil society engagement in favor of human rights constitute crucial enabling factors that are rare in the MENA region.

In the last years, an amazing transformation of civil society, allowed the establishment of organizations led and managed by key populations. The incredible commitment of the key populations leaders to defend their rights allowed them to benefit from international support, gain valuable advocacy skills, reach out to officials and the public about their struggle and get a significant amount of recognition.

This breakthrough in a country that still criminalizes same sex relations, drug use and sex work needs to be supported in order to demonstrate feasibility and potential approaches for scaled up work to address rights-related barriers.

The women's movement is particularly strong in Tunisia, both in terms of civil society's ability to deliver services but also to advocate at higher spheres for legal reforms. The law on violence against women is a great example of this ability to bring change. If these organizations were to embrace the AIDS work through Global Fund money, the current landscape would quickly change and long-awaited results could see the light of day.

Post-revolution Tunisia has also seen an increased number of international collaboration between ministries and other public-sector institutions with international organizations and sponsors. Ministry of the Interior (Police) or the Ministry of justice (prisons) could potentially get GF funding to initiate change on the ground.

One major challenge, could be a repetition of the political paralysis that affected the current GF grant roll out. In 2019, will have an election year and a new government will take over amidst an ongoing financial crisis. This crisis could potentially be an opportunity to see some results out of the ongoing advocacy but more likely, it will reduce the government eagerness to develop and offer better HIV services and reduce opportunities for civil society to get funding and political support on the local level. Compared to other countries, National AIDS Program is barely staffed and lacks the technical expertise to manage a disease that does not seem to gather political weight. This situation is likely to last in the foreseeable future and will definitely hinder any ambitious plan to achieve the 90-90-90 goals.

The over representation of Tunis and other coastal cities in any political and programmatic decision could also be a challenge for the implementation of nationwide programming aiming at improving the quality of HIV services and at removing Human Rights related obstacles.

With Libya's turmoil continuing, Tunisia should expect higher numbers of migrants going through its borders. In theory, they should be entitled to HIV services as everyone else but in practice, it seems that they have huge problems accessing health services. If their number was to expand and stay to last longer, this can pose a real threat to the current HIV response and an exponential transmission of HIV should be expected.

ANNEX 1: BASELINE INDICATORS AND VALUES – TUNISIA

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 services. Towards this end, the Global Fund will arrange a multi-stakeholder meeting in-country to which it will present a summary of the key points of this assessment for consideration and discussion towards using existing opportunities to include and expand programs to remove human rights-related barriers to HIV services.

The Global Fund will also use the assessment as a basis to support country partners to develop a 5-year strategy to move from the current level of programming to remove barriers to comprehensive programs to remove barriers. In this five-year strategy, it is envisioned that the country will set priorities as well as engage other donors to fully fund the comprehensive programs involved.

Finally, in order to build the evidence base regarding programs to reduce barriers to HIV services, the Global Fund will commission follow up studies at mid- and end-points of the Strategy to assess the impact on access to HIV services of the expanded programs put in place under the five-year plan.

Due to the broad range of barriers, key populations and suggested components of the comprehensive approach, it will be necessary for the performance framework to rely on a range of qualitative indicators and data collection methods. Though there are outputs that can be measured in numerical terms, success in removing barriers to access to services is likely to be best measured by examining the experiences of key and vulnerable populations and, in the longer term, in changes to the testing and HIV treatment cascade.

Barriers to HIV services

	2016	2019	2021
% PLHIV expressing reluctance to disclose HIV status	>90% (anecdotal)		
% of women in key populations (e.g sex workers, female prisoners, women living with HIV) reporting experience of gender inequality, gender-based discrimination, and sexual and gender-based violence	>90% (anecdotal)		
# health care workers comprehensively trained about human rights related to key and vulnerable populations and HIV, including standards for informed consent, confidentiality and privacy, patient-centred care, patient rights and workers' rights, and meaningful participation of both the patient and the health care worker in decision-making about care.	<5% (anecdotal)		
# judges, prosecutors, and police engaged in regular review of arrests of key populations and reports of abusive policing, and engaged in training and dialogue about practices that reflect respect for people's rights.	<5% (anecdotal)		
# of people from key and vulnerable populations trained about their legal rights and legal resources to call upon to realise their rights and seek recourse in case of rights violations	<200 (anecdotal)		

# of attorneys providing HIV-related legal services to key and vulnerable populations, including adolescent girls and young women, about their legal rights and legal resources to call upon to realise their rights, and assistance in seeking legal recourse in case of rights violations, including sexual and gender-based violence	<20 (anecdotal)		
# of policy advocates working full-time to address national laws related to sex work, drug use and addiction, homosexuality, or transgender identity.	<5 (anecdotal)		
# of policy advocates working full-time to monitor, document, and advocate about failures of laws and the legal justice system to protect, respect and fulfil people's rights in relation to HIV and key populations	<5 (anecdotal)		
# of openly HIV-positive women working at women's rights advocacy organisations with a mandate to promote gender equality and women's access to education, employment, services and justice.	0		
# of women in key populations (e.g. sex workers, female prisoners, women living with HIV) receiving services to address gender inequality, gender-based discrimination, and sexual and gender-based violence	<500 (anecdotal)		

Quantitative Assessment

From the assessment, the following key numerical indicators are recommended:

- a) Number of Tunisian cities and Tunisia's 24 administrative areas in which an assessment is conducted of key and vulnerable populations' experience of rights-related barriers to HIV services, with subsequent processes to address those barriers.
- b) % PLHIV expressing reluctance to disclose HIV status
- c) % of women in key populations (e.g. sex workers, female prisoners, women living with HIV) reporting experience of gender inequality, gender-based discrimination, and sexual and gender-based violence
- d) # of women in key populations (e.g. sex workers, female prisoners, women living with HIV) receiving services to address gender inequality, gender-based discrimination, and sexual and gender-based violence
- e) Number of women's groups deploying community organizers and educators engaging people in promoting gender awareness and equality in services related to HIV.
- f) # of openly HIV-positive women working at women's rights advocacy organisations with a mandate to promote gender equality and women's access to education, employment, services and justice.
- g) # health care workers comprehensively trained about human rights related to key and vulnerable populations and HIV, including standards for informed consent, confidentiality and privacy, patient-centred care, patient rights and workers' rights, and meaningful participation of both the patient and the health care worker in decision-making about care.
- h) Number of hospitals participating in an assessment of patient experiences and perceptions of stigma and discrimination in health care settings, and then a subsequent process to improve practices for informed consent, confidentiality and privacy, patient-centred care, patient rights and workers' rights, and meaningful participation of both the patient and health care workers in decision-making about care.

- i) # judges, prosecutors, and police engaged in regular review of arrests of key populations and reports of abusive policing, and engaged in training and dialogue about practices that reflect respect for people's rights.
- j) # of people from key and vulnerable populations trained about their legal rights and legal resources to call upon to realise their rights and seek recourse in case of rights violations
- k) # of attorneys providing HIV-related legal services to key and vulnerable populations, including adolescent girls and young women, about their legal rights and legal resources to call upon to realise their rights, and assistance in seeking legal recourse in case of rights violations, including sexual and gender-based violence
- l) # of policy advocates working full-time to address national laws related to sex work, drug use and addiction, homosexuality, or transgender identity.
- m) # of policy advocates working full-time to monitor, document, and advocate about failures of laws and the legal justice system to protect, respect and fulfil people's rights in relation to HIV and key populations

Qualitative Assessment

Each assessment should include a scan of the legal environment and an overview of the social and political environment, with an analysis of any (changed) factors that are enabling or hindering access to HIV services. Each assessment should include the major steps of this Baseline Assessment, including an updated desk review, key informant interviews and focus groups with key and affected populations:

- a) The desk reviews should particularly concentrate on evaluations of any programs considered for or implemented as part of comprehensive programs, as well as updating the epidemiology of HIV, checking that no changes have occurred in the key and vulnerable populations most affected by the two diseases, and updating with the findings of the Legal Environment Assessment planned for 2018 and any research published on HIV human rights barriers in Tunisia.
- b) Key informant interviews should focus on changes in the legal, social, political and programmatic environment since the previous assessment, as well as capturing key informants' views on how the comprehensive programs are being implemented, indicating strengths and weaknesses.
- c) Measurement of stigma and discrimination should be carried out by examining annual human rights reports, evaluations of law enforcement and prisons, and any measurements done in health care settings.
- d) Focus groups of key populations should emphasize the following questions:
 - Is it now easier to access HIV services than two years ago for each key population? Different for men, women, transgender people, adolescents and young people?
 - Have you found that attitudes and behaviour of health care providers towards your community have improved or worsened in the past two years? Different for men, women, transgender people?
 - Have illegal police practices (e.g. harassment, extortion, arbitrary arrest or detention, violence, rape) against your community increased or decreased over the past two years? Different for men, women, transgender people?
 - Has general stigma or discrimination against your community increased or decreased during the past two years? Different for men, women, transgender people?
 - Has violence (other than police violence) against your community increased or decreased during the past two years? Different for men, women, transgender people?
 - (Showing the comprehensive programs) Have you accessed any of these services? How useful were they? Different for men, women, transgender people, adolescents and young people?

ANNEX 2: CHART - COMPREHENSIVE PROGRAMS TO REDUCE HUMAN RIGHTS-RELATED BARRIERS TO HIV SERVICES IN TUNISIA

Intervention	Specific Activities	Coverage/ Location	Expected results/ Comments
Program Area 1: Stigma and Discrimination Reduction			
Generate information on levels of access to services by key and vulnerable populations and determinants of barriers to access	Expand research to (a) document and measure the types and level of HIV-related stigma and discrimination experienced by key and vulnerable populations in health care settings and in specific communities, and (b) assess policies, practices and laws that undermine confidentiality and privacy and increase HIV-related stigma and discrimination.	National	New rights-related HIV-related data generated from national population and health surveys, with measures of stigma and discrimination related to HIV status, other disabling health conditions such as mental illness or addiction, poverty, illiteracy, certain professions such as sex work, or bias against adolescent girls and women based of their marital status, age, reproductive choices, or expressions of gender and sexuality.
Training of public service employees in education, child and social services sectors	Conduct at least one training for teachers, child protection officers, and social service agencies in each of Tunisia's 24 administrative areas in dialogue about stigma and discrimination related to HIV and key and vulnerable populations.	200 officials and leaders in 24 administrative areas of Tunisia.	Increased official literacy about evidence of stigma and discrimination, model policies and programmes to combat stigma and discrimination, and how to educate and advocate to combat stigma and discrimination.

Community mobilisation dialogues, trainings, and meetings	Scale up work by key and vulnerable population organisations on stigma and discrimination, first in Tunis, Sousse and Sfax, and then extending outward to engage at least forty community members in each of at least seven other cities.	400 people from key and vulnerable populations in least 10 cities in Tunisia.	Increased community literacy about evidence of stigma and discrimination, model policies and programmes to combat stigma and discrimination, and how to educate and advocate to combat stigma and discrimination.
Continue currently funded activities	See Baseline Assessment Report	National	

Intervention	Specific Activities	Coverage/ Location	Expected results/ Comments
Program Area 2: Training for health care workers (HCW) on human rights and medical ethics related to HIV			
Create model rights-affirming programmes at leading hospitals	Incentive funding for hospitals in Tunis, Sfax, Sousse, and Monastir, and then in Nabeul, Bizerte, Kairouan, Gabes, and Gafsa, to (1) assess patient experience of rights-related issues in health care settings, (2) improve protocols and train health workers, (3) conduct ongoing patient surveys and monitor and support competency of health care workers, and (4) invite rotations of visiting providers to successful programmes to provide direct experience of models of rights-affirming health care	Ten hospitals, starting with largest HIV programmes	Improved experience of all of the 2900 HIV-positive patients currently seen in healthcare facilities in Tunisia. Increased health care worker competency on human rights and medical ethics issues related to HIV and key and vulnerable populations in all of Tunisia's major hospitals,

Create model rights-affirming programmes in community settings	Incentive funding for community-based organisations to pilot and document innovative rights-affirming health consultations, screenings, referrals, and accompaniment and case management that measurably increases accessibility of care and addresses rights violations of key populations.	Six locations in Tunisia, including the largest cities of Tunis, Sfax, and Sousse	Health care administrators and workers learn about innovative model rights-affirming programmes for key and vulnerable populations, sited in mental health and addiction services, reproductive health services, or other specific health services or social services.
Continue currently funded activities	See Baseline Assessment Report	National	

Intervention	Specific Activities	Coverage/ Location	Expected results/ Comments
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Program Area 3: Sensitization of law-makers and law enforcement agents

Sponsor international dialogue and exchange of experience between police forces, prison officials and international experts across multiple Mediterranean countries.	Provide opportunities for Tunisian police to learn from police forces, prison officials and international experts from other Mediterranean countries (e.g. Spain, Italy, France, Morocco, Algeria, Libya and Lebanon) to review policing practices and prison policies related to key and vulnerable populations, starting with a focus on women.	Law enforcement agencies from six cities including Tunis, Sfax, and Sousse	At least 30 Tunisian law enforcement engaged in dialogue about how to reduce incarceration of women, ensure best practice in prisons, and how to fund local community organisations to create post-prison social reintegration that encompasses housing, economic support, and health care, with the ultimate aim to build knowledge and support in Tunisia for rights-affirming practices.
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Engage judges, prosecutors, police, and local politicians in a dialogue about human rights and justice issues as factors in HIV risks and barriers to HIV services.	Trainings would focus on human rights and justice-related factors in HIV risks and barriers to HIV services for key or vulnerable populations, including issues of arbitrary arrests and detentions by police, gender-based	Starting in the major population centres such as Tunis, Sfax, and Sousse, and then replicating successful models to other locations.	240 local magistrates, prosecutors, police, and local politicians engaged and trained across at least six of Tunisia’s cities.
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	discrimination and violence, and poverty.		
Fund community liaison committees for police departments	Work with local police departments and local members of human rights coalitions such as ATDS, ADLI, CRLDHT, FTDES, and LTDH to fund the formation, training, and meeting costs of community human rights committees for police departments.	Starting in the major population centres such as Tunis, Sfax, and Sousse, and then replicating successful models to other locations.	Police departments gain functional human rights liaison committees that are dedicated to providing supportive trainings, case reviews, and advice.
Continue currently funded activities	See Baseline Assessment Report	National	

Intervention	Specific Activities	Coverage/ Location	Expected results/ Comments
Program Area 4: Legal literacy (“know your rights”)			
Fund a knowledge, attitudes and practices (KAP) study of legal literacy among key and vulnerable populations and then fund follow-up public education and dialogue in political, cultural and religious venues about human rights and the rule of law.	Fund KAP research in a sequence of locations, populations, or themes, to examine awareness and literacy about laws and rights related to issues such as sexual consent and sexual violence; drug use and addiction; expression of gender and sexuality; and immigration and migrants, and then fund education and community dialogue in partnerships with local media, community	Start in ten cities, such as in Tunis, Sfax, Sousse, Kairouan, Gabes, Bizerte, Gafsa, and Nabeul	At least 1000 women and men from key and vulnerable populations are reached in at least 20 high-burden locations across all 14 districts in Tunisia

	dialogues, or projects in the arts and cultural sphere.		
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Intervention	Specific Activities	Coverage/ Location	Expected results/ Comments
Program Area 5: HIV-related legal services			
Subsidize legal services for key and vulnerable populations.	Provide funding for associations working with key and vulnerable populations to subsidize legal services for clients, to be provided alongside existing support services from community organisations, and requiring some pro-bono time contributed by lawyers and paralegals.	At least six of the largest cities in Tunisia, including Tunis, Sfax and Sousse.	Legal advice and services are accessible to all key and vulnerable populations in at least six of Tunisia's largest cities
Continue currently funded activities (legal services budgets at HIV associations and key population organisations)	See Baseline Report	Multiple locations, see Baseline Report	

Intervention	Specific Activities	Coverage/ Location	Expected results/ Comments
Program Area 6: Monitoring and reforming laws, regulations and policies relating to HIV			
Building upon the findings of the Legal Environment Assessment, conduct policy research to define barriers, assess feasibility and potential impact of reform, and build coalitions for reform.	Offer funding for policy analysts and advocates at key and vulnerable population organisations and allied legal advocacy groups to: (1) conduct operational research to assess and quantify the impact and cost of specific sets of laws, policies and law enforcement practices that are potential barriers to	National	Policy analyses, advocacy strategies, and advocacy coalitions are developed in relation to a number of topics, including national laws related to sex work, homosexuality, transgender identity, and prison health, drug use and addiction (including drug criminalization laws, laws preventing opioid substitution therapy, syringe access programmes and other harm reduction programming), gender equality (including laws related to women's access to education, employment and economic independence, and women's rights in marriage and related to intimate partner violence), and laws or policies

	HIV services; (2) assess the relative feasibility and potential impact of reforming any of these laws, regulations, policies, and practices, (3) build, convene, inform, and mobilise coalitions to engage policy-makers for reform of laws and policies in line with existing Constitutional prohibitions against discrimination and commitments to human rights.		that impact accessibility of services for adolescents in schools and out of school.
Continue currently funded activities	See Baseline Assessment Report	National	

Intervention	Specific Activities	Coverage/ Location	Expected results/ Comments
Program Area 7: Reducing discrimination against women in the context of HIV			
Fund women's organisations to promote gender awareness and equality in services related to HIV	Women's organisations such as ATFD or IPPF would (1) hire women living with HIV to become vocal advocates about gender-related barriers to health services, (2) facilitate safe space and psychosocial support for adolescent girls and young women build capacity and peer support for health including sexual health.	National, with a focus on Tunis, Sfax, and Sousse	Tunisia's 500-800 HIV+ women and other women at risk of HIV, such as women battling addiction, transgender women, and women migrants, would gain support from leading women's rights advocacy organisations in advocating for improved accessibility of health services
Support key and vulnerable population networks in Tunisia to integrate and promote awareness of gender roles and gender inequality in their work.	Key and vulnerable population networks in Tunisia integrate and promote awareness of gender roles and gender inequality in their work, including education of staff and clients about	National, with a focus on Tunis, Sfax, and Sousse	All key and vulnerable population groups funded by PNLs conduct gender-related sensitivity training.

	issues of sexual consent and intimate partner violence, and issues that contribute to women's vulnerability to HIV in Tunisia, including women's access to education, employment and economic independence; norms about marriage, childbearing and intimate partner violence; and concepts of male sexuality and male health that encourage men to have multiple concurrent sexual relationships or to avoid use of condoms or regular testing for HIV and other STIs..		
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- ² *The Global Fund Strategy 2017-2022: Investing to End Epidemics*. GF/B35/02
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- ¹⁴ Tunisian Ministry of Public Health, Report of Activity in the HIV Response in Tunisia. Pp 40-43.
- ¹⁵ From the two methods used by the PNLs to estimate prevalence and incidence, a Modes of Transmission method estimated 3413 HIV-positive Tunisians and 837 Tunisians newly infected in 2011, and an Estimation and Projection Package (EPP)/Spectrum methodology estimated 3991 HIV-positive Tunisians and 669 Tunisians newly infected in 2013.
- ¹⁶ Tunisian Ministry of Public Health, Report of Activity in the HIV Response in Tunisia. Pp 40-43.
- ¹⁷ UNAIDS. Data Book 2017.
- ¹⁸ Note that the Global Fund website says that the number of people on HIV treatment has jumped from 710 people in 2015 to 4200 in 2016. 4200 is more people than are reported to have HIV in Tunisia, so this statistic needs correction or an explanation.
- ¹⁹ Le Plan Stratégique National 2015-2018 en Tunisie, [http://www.leaders.com.tn/uploads/FCK_files/PSN%20\(1\)%20\(1\)2015-2018%20version%20finale.pdf](http://www.leaders.com.tn/uploads/FCK_files/PSN%20(1)%20(1)2015-2018%20version%20finale.pdf)
- ²⁰ Tunisian Concept Note to the Global Fund, 2015. <https://www.theglobalfund.org/en/portfolio/country/?k=c34c5b40-98a0-4aa2-9501-f9290181a671&loc=TUN>
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- ²² WHO HIV Surveillance in the Eastern Mediterranean Region, 2013.
- ²³ Tunisian Concept Note to the Global Fund, 2015. 2014 Global AIDS Response Progress Reporting (GARPR) data based on 2011 surveys.
- ²⁴ WHO. HIV Surveillance in the Eastern Mediterranean Region. 2013. Page 56.
- ²⁵ International studies suggest that the proportion of the male population engaging in anal sex with other males in MENA seems to be consistent with reported global levels of very roughly 2%–3%, which translates to approximately 100,000-150,000 men in Tunisia .
- ²⁶ Bozicevic I, Riedner G, Calleja JMG. HIV surveillance in MENA: recent developments and results. *Sex Transm Infect* 2013;89:iii11-iii16. {Intervention-HIV}
- ²⁷ Integrated Bio-Behavioral Survey (IBBS) – Tunisia, 2017-18, preliminary results (on file with Global Fund).
- ²⁸ Transgender is a term used to refer to individuals whose gender does not (fully/constantly) match their sex assigned at birth. Trans individuals might have a binary concept of gender and feel they belong to the other gender (i.e., trans women, trans men) or might feel they belong to both or neither genders recognized by mainstream society (i.e., male and female gender), and thus have a non-binary concept of gender (e.g., queer).
- ²⁹ Eyssel J, Koehler A, Dekker A, et al. Needs and concerns of transgender individuals regarding interdisciplinary transgender healthcare: A non-clinical online survey. *PLOS One*, 2017.
- ³⁰ People in Tunisia use many terms and concepts to self-identify their sexual orientations and gender identities, using several languages and drawing from European, Arab, and North African cultures. This paper uses the acronym LGBT and related terms to refer to that full range.
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- ³² Mumtaz, G. R., Weiss, H. A., Thomas, S. L., Riome, S., Setayesh, H., Riedner, G., ... Abu-Raddad, L. J. (2014). HIV among People Who Inject Drugs in the Middle East and North Africa: Systematic Review and Data Synthesis. *PLoS Medicine*, 11(6), e1001663. <https://doi.org/10.1371/journal.pmed.1001663> {Population-HIV}
- ³³ Sellami R et al. The Profile of Drug Users in Tunisia: Implications for Prevention. 2016.
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⁹⁰ Existing tools which can be adapted and used in Tunisia to measure HIV-related stigma and discrimination include The People Living with HIV Index, The GAM indicator on discriminatory attitudes in general population and its NCPI, The PLHV-friendly Achievement Checklist for health care settings by the Population Council, and the IBBS module on S&D experienced by key populations. Real-time community-based programme monitoring methods could also be adopted; examples of these include the ITPC community observatories operating in West Africa, the iMonitor phone app in Asia, community monitoring of stockouts and S&D in Malawi, and use of REACT for CBM elsewhere in Africa.

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⁹⁹ A Legal Environment Assessment (LEA) is planned for 2018, which will build on the findings of this baseline assessment and develop recommendations for law and policy reform. The content of this section should therefore be updated upon completion of that Legal Environment Assessment.