

Delivering on SDG3: Strengthening and Integrating Comprehensive HIV Responses into Sustainable Health Systems for Universal Health Coverage

COUNTRY SUBMISSIONS

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INTRODUCTION

The Thematic Segment of the 44th UNAIDS Programme Coordinating Board (PCB) meeting will be held on the 27th of June 2019 and will focus on “*Delivering on SDG3: Strengthening and Integrating Comprehensive HIV Responses into Sustainable Health Systems for Universal Health Coverage (UHC)*”.

In the preparation for the Thematic Segment, UNAIDS issued a call for submission of examples of effective and innovative practices integrating HIV with UHC. A total of 24 good practice submissions were received, showcasing the wide range of efforts at integrating HIV and UHC services from African States, from Asian States, from Latin American and Caribbean States, from Western European and Other States, and cases which cover multiple countries or regions.

The submissions reflect the work of governments and civil society, as well as collaborative efforts. The case studies highlight different approaches in integrating HIV into health systems in the move towards UHC.

I. AFRICAN STATES

1. KENYA

TITLE OF THE PROGRAMME: Bridging the gap: Integrating HIV and SRH services among Female Sex Workers in Kilifi

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- **Programme is being implemented since:** 2016 - **End:** N/A
- **Responsible parties:** Government, Civil Society, UN or other inter-governmental organization
- **Population reached:** sex workers
- **Has the programme been evaluated/assessed?** No
- **Is the programme part of the National AIDS or Mental Health or Substance Abuse Prevention and Treatment Strategy?** Yes
- **Is the programme part of a national plan other than the National AIDS or Mental Health Strategy?** No

BACKGROUND

Female sex workers (FSW) in Kenya are a marginalized community, and have poor health, social and economic outcomes. They are among the most at risk groups for HIV in Kenya; Out of an estimated 133, 675 FSW in Kenya (NASCOP Mapping Consensus report, 2013), about 29.3% are HIV positive. This is about six times the national adult HIV prevalence (4.9%; Kenya HIV estimates report). Older sex workers are most infected although high rates of infection are currently reported for younger FSW; a study conducted by the International Center for Reproductive health among FSW in the coast (Whisper/Shout Clinical Trial) reported a prevalence of 34% among FSW aged 34 years and below (unpublished). In Kilifi county, estimated adult HIV prevalence is 3.9%. In addition to HIV, female sex workers also have very high unmet contraceptive needs, high unintended pregnancy rates and poor birth outcomes. Annually, we estimate that about 25% of FSW have an unintended pregnancy and majority of these pregnancies end in abortions (Luchters et al; 2016). Sex workers also experience high levels of gender-based violence, from both clients and law enforcers. Alcohol and drug use and food insecurity are also higher among this population than in general population women. FSW are emerging as a group at high-risk for non-communicable diseases. In addition to the poor

health outcomes, most sex workers get into sex work to overcome extreme poverty and to provide for themselves and their dependents. Many continue with sex work and have condomless sex for the same reasons. Sex work is also illegal in Kenya and FSW often experience violence from law enforcers and from the general community. When they experience this violence, it is hard to report, which perpetuates this vicious cycle of violence and marginalization. Stigma and discrimination around sex work also makes it difficult for FSW to seek key services and contributes to poor socio economic and health outcomes. Multiple interventions, over almost 20 years have targeted FSWs in many parts of Kenya, largely through peer education, specialist sex worker clinics, and antiretroviral treatment scale-up. HIV awareness has risen and risk behaviours declined over this period. Though significant progress has been made in creating an enabling environment for the provision of comprehensive sexual and reproductive health, several barriers still exist towards provision of FSW-friendly, stigma-free SRH services.

DESCRIPTION

The programme is a stand-alone Drop-In-Centre providing integrated HIV/SRH/GBV services to female sex using a variety of approaches: peer-led mobilization and risk reduction, outreach to services hotspots and in facility services. It is linked to the County and national health systems for reporting and supply of some commodities and supplies. Objectives: The program has four main aims: 1) Create demand for HIV/SRH services among FSW, 2) Scale-up SRH services provided to FSW, 3) Support structural interventions to improve HIV/STI programming among FSW 4) Provide evidence on best practices for HIV/STI prevention among FSW in Kenya. For demand creation, we aim to improve FSW knowledge and awareness on HIV/AIDS through a peer led approach and increase referrals for SRH services. For SRH service delivery, we aim to increase the number tested for HIV and linked to care and treatment, scale-up FP access, increase cervical cancer screening and treatment, and provide interventions to reduce alcohol and drug use. For structural interventions, we aim to support Kilifi County to reduce stigma and discrimination and marginalization of FSW in health facilities, and to establish a county-level technical working group (TWG) to advice the county's political leadership on FSW programming. We intend to create a center of excellence (learning site) for best practices in key population programs in Kenya by applying a program learning approach, designing research within the intervention and using program data for decision making. Implementer: The program is implemented by UNFPA through ICRH-K by supporting the Drop in centers in Mtwapa and Kilifi town which provide a safe space for the FSWs. This is achieved by use of the peer led system as recommended by NASCOP in running the KP programs in Kenya. The trained peer educators help in identification of FSWs at the hotspots and referral to the DICs for clinical services. A part from the identification and referral of FSWs, the peer educators also provide health education to the either through one on one or group sessions and dissemination of IEC materials; distribution of free condoms and lubricants The program currently has 30 peer educators, 10 in Kilifi and 20 in Mtwapa. The peer educators are supervised by an outreach worker who acts as a link between the outreach component and the program. The program provides free clinical services which include; Quarterly HIV testing and counseling, STI screening and treatment, family planning, cervical cancer screening, ARV provision and care, PrEP services, TB screening and referral, emergency contraception and SGBV services. The program is donor funded currently by UNFPA and Jilinde. ICRH continues to source for other donors to ensure sustainability of the program at the end of contracts with each partner. MOH continues to be a key partner in terms of support supervision and capacity building of the clinical staff, supply of drugs (ARVs, PrEP, FP and STI drugs) and test kits. This integration with the county health department is important for the sustainability of the program. While the MOH do

not currently have a comprehensive plan for specialized SRH interventions for FSW and other at-risk groups, and most of these interventions rely on donor-funded programs, this program continues to highlight the need for the MOH to investment in FSW programs and provides evidence on how to do so. By engaging the Country's and the county's political leadership through the technical working group, the project aims to advocate for increased revenue allocation for FSW interventions.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

The estimated FSW population in Kilifi County is 3,100. Every year, the program reaches about 2,984 of them with at least one service. 2,104 of these FSWs are consistently reached and receive HIV testing services at least once every three months as per the national KP Guidelines. This is achieved through the use of different strategies which include hotspot outreaches, creative activities at the drop-in center such as condom fashion shows, peers' day in-reach activities and clinic days at the hotspots. Between January and December 2018, 83 HIV cases were identified. Of these 80, were successfully linked to care and initiated immediate ART during this period. They were linked to various health facilities although most preferred to receive ART from the DIC. For HIV positive FSW, we also offer monthly psycho-social support group meetings to encourage bonding, provide psycho-social support and encourage adherence among those on ART. Among HIV negative sex workers, 215 have been initiated on oral pre-exposure prophylaxis (PrEP) for HIV prevention. PrEP is currently available in Kenya as part of combination HIV prevention. The DIC staff have been trained on provision of stigma free services to the FSWs which has helped in openness and trust with the patients resulting in frequent visits to the DICs for treatment and information and even peer referrals of new sex workers in town. The DICs contact monthly quality improvement meetings with representatives from the community to help identify and address any quality gaps in service delivery. The program is integrated into the county health service delivery system. ART, STI drugs and family planning drugs are provided through the respective county departments. Every month, the site provides a report to the county health department and health service data captured into DHIS2. We are also part of Kilifi county Key population technical working group (TWG). This comprises of: County AIDS/STD coordinator, other implementing partners, members of the KP community and representatives of other sectors. The TWG provides oversight to KP programming in the county and advises the county government on best practices. The program has also sensitized key people within the community on the importance of HIV/AIDS prevention programs among FSW. Among key community members sensitized are bar owners, police, chiefs and religious leaders. This has helped in reduction of stigma, discrimination and violence against the FSWs. This has also improved adherence to ART among HIV positive peers as they are no longer afraid to disclose their status for fear of stigma. This has in turn encouraged other FSW to test.

LESSONS LEARNED AND RECCOMENDATIONS

Peer led demand creation is very effective in providing HIV/STI education to FSW. Since peer educators are selected from among the FSW, they understand the dynamics of sex work at the hotspots and can effectively refer fellow FSW for SRH services. Hotspot outreaches and clinic days are key to reaching hard-to-reach FSW, especially those in confined environments such as sex dens and brothels. FSW operating in these two places are especially shy to leave the hotspots. Providing clinical services at the hotspots overcomes this challenge.

ANNEXES: N/A

2. SOUTH AFRICA

TITLE OF THE PROGRAMME : Low-Cost, Integrated Model for Sex Work Programming

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- **Programme is being implemented since** : 2017 – **End** (if applicable): N/A
- **Responsible Parties** : Government, civil society, UN or other inter-governmental organization
- **Population Group(s) reached** : Sex workers
- **Has the programme been evaluated/assessed ?** No
- **Is the programme part of the national aids strategy ?** Yes
- **Is the programme part of a national plan other than the national aids strategy ?**
Yes, National Sex Work HIV plan

BACKGROUND INFORMATION

South Africa, carries the largest burden of the HIV/AIDS pandemic globally, with an estimate of 13.1% of the population (7, 52 million people) being HIV positive. HIV prevalence among pregnant women has hovered around 30% since 2004 and more than 70% of new infections are among adolescent girls and young women. Although the epidemic is generalized, key populations have higher risk of HIV exposure such as sex workers and men who have sex with men. The Sex Workers Education and Advocacy Task-Force (SWEAT) in collaboration with United Nations Populations Fund (UNFPA) piloted a low-cost public health sector model aimed at providing comprehensive SRH and HIV services to sex workers in public health facilities. Traditionally, in South Africa sex workers are provided with HIV prevention and testing services through outreach models in selected sex work hot spots. This approach requires additional resources in terms of staff especially professional health care workers and it is not integrated within the main stream public health system, it also relies heavily on donor funding. Although, interventions targeting sex workers have shown to be effective, these have proven more expensive to deliver as they required separate specialised services to deliver integrated HIV prevention and SRH services. SA is classified as a middle-income country which means that the funds for service delivery have been reduced resulting in inadequate focus at grass roots or community level where more people need access to services. Against this background UNFPA and SWEAT piloted Low-Cost, Integrated Model to ensure that sex workers can access quality

integrated services. The model was implemented at district level to pilot and document lessons learned for adoption and scale up at provincial and national levels.

DESCRIPTION

The low cost integrated model is implemented in Chris-Hani district in the Eastern Cape in nine (9) health facilities. A package of services offered includes; family planning, cervical cancer screening, STI and TB screening, HTS, linkages to HIV treatment and GBV response. Before health facilities are selected, peer educators map sex work hot spots in the community and identifies health facilities that are located near the hot spots. The selected health facilities are then engaged and sensitised about service provision to sex workers. Peer educators are employed to provide day and night outreach as well as link sex workers to the health facilities. This intervention includes provision of condoms and lubricants, risk reduction workshops and support groups as well as building the capacity of health care workers in selected facilities to provide stigma free integrated SRH and HIV services to sex workers. The low-cost model is aligned to the South African national sex work HIV plan (2019-2016) which advocates for peer led approach.

RESULTS, OUTCOMES AND IMPACT OF THE PROGRAMME

From July 2017 – December 2018, nine public health facilities provided services to sex workers; • 4979 sex workers were reached, • 250 referred for HTS, 345 for ART services, • 595 screened for TB, 179 received contraceptives, • 672 screened for cervical cancer. • 24 workshops on risk reduction were held reaching 4085 sex workers. Impact of the program The model is continuing to ensure both universal access to for sex workers to sexual reproductive health and rights as well as contribute to achievement of the 90-90-90 targets. In addition, the model has improved knowledge about key populations as well as their SRHR needs as such health care workers are more sensitive to sex workers needs and provision of stigma free services. This model has been recognised by government and the South African National AIDS Council as the best practice in achieving the 90-90-90 and National HIV Sex Work HIV Plan targets.

LESSONS LEARNED AND RECOMMENDATIONS

This is a relatively low-cost model compared to stand alone outreach sites as it's reach depends on the public health system and it showed success in reaching sex workers. This is a low-cost model as additional funding is not required for health services. It is still critical to ensure allocation of resources for adequate training of health care workers, supporting staff (peer educators), mentoring and supporting staff at health facilities. Going forward the project will intensify collaboration with SANAC sex workers sector to advocate for scale up in other districts and document it as a good practice contributing to the National Sex Work Sector HIV plan.

3. UGANDA

4.1 TITLE OF THE PROGRAMME: Get up Speak out (GUSO)

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- **Programme is being implemented since:** 2016 - **End** (if applicable): 2020
- **Responsible party/parties:** ["Local government ", "Government", "Civil society", "Private sector", "Academic institution"]
- **Population group(s) reached:** ["Young people living with HIV ", "People living with HIV", "Sex workers", "Women and girls", "Young people"]
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy:** No
- **Is the programme part of a national plan other than the national aids strategy?** No

BACKGROUND

Get up Speak out (GUSO) is a 5 year (2016-2020) strategic partnership between the Netherlands MoFA and the GUSO consortium, it will building on UFBR/ASK achievements and lessons learned. The program will be designed and based on needs based Theory of Change that will serve as a reference for assessing the progress, and the contribution of this SRHR Partnership, towards the overall goals of the ToC(s), including the common strategic goals. It will be used as a point of reference to identify when adaptations to the strategies are required (e.g. by changing context, refuted assumptions). The program will operate on 4 key principles of Meaningful Youth Participation, Positive Rights Approach inclusion, Gender transformative approach and Multi-component approach, it will use the joint expertise to successfully link provision of sexuality education and information, provision of quality, youth-friendly SRH services and building support for youth SRHR, by addressing socio-cultural and political barriers in terms of practices, norms and policies.

DESCRIPTION

Uganda network of young people living with HIV is focusing on three objectives 1- OC 2 Empowering young people to voice their rights. 2- OC 4 Increase utilization of quality and youth friendly SRHR services that respond to the needs of all Young people 3-OC 5 Improve socio-cultural, political and legal environment for gender sensitive, youth friendly SRHR

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

17 peer buddies have been recruited. 8191 young people living with HIV have been reached with HIV/SRHR services and information.

LESSONS LEARNED AND RECOMMENDATIONS

The project has strengthen a good working relationship between young people living with HIV who are attached at the health center who are work as peer buddies

ANNEXES:

II. ASIAN STATES

4.1 BANGLADESH

TITLE OF THE PROGRAMME: Health Sector Response to Gender Based Violence

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- **Programme is being implemented since:** 2017 - **End** (if applicable): Continuing.
- **Responsible party/parties:** ["Government", "UN or other inter-governmental organization", "Academic institution"]
- **Population group(s) reached:** ["Sex workers", "Migrants, refugees or internally displaced people", "Men who have sex with men", "Children", "Women and girls", "Young people"]
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy**
No
- **Is the programme part of a national plan other than the national aids strategy?**
Yes
- **If yes, please specify:** Health Sector Response to Gender Based Violence is included in the operation plan of Health Economics and Financing, Health Economics Unit, Ministry of Health and Family Welfare.

BACKGROUND

Globally estimated 35% of women have experienced physical or sexual violence by a partner and/or sexual violence by a non-partner in their lifetime (WHO 2013). In Bangladesh 72.6% of ever married women experienced one or more such forms of violence by their husband at least once in their lifetime and 54.7% experienced violence during last 12 months (VAW 2015). There is a need for strengthening the health system to address the gender-based violence (GBV) in Bangladesh in accordance with global standard. As baseline a study is conducted with an aim to explore the perspectives of health care providers towards GBV survivors. A cross section study was performed in a randomly selected three districts named Jamalpur, Sherpur and Moulvibazar during August to October 2017. About 60% (26, n=44) of respondents did not have any experience and (or) exposure

to managing rape or sexual assault survivor as well as formal training covering all aspects of GBV services has not yet been delivered to any of the providers. According to response of 73% respondents, rape causes serious medical problem for the survivors, while 93% strongly agree that the child victim should be dealt with medical emergency. The study reflects the preparedness and service availability of primary and secondary level of health care delivery system for the GBV survivors. Capacity development of health care providers are essential to strengthen the overall service delivery for the GBV survivors. Currently Ministry of Women and Child Affairs with support from Denmark Government is implementing Multisectoral Programme on Violence Against Women. There are 9 One Stop Crisis Center in 9 Medical College Hospitals and 40 One Stop Crisis Cell in 40 district hospitals and 20 at Upazila Health Complexes. But this effort is not sufficient enough to cover the whole country.

DESCRIPTION

The specific objective is to strengthen the health system to provide medical care to all the survivors of GBV those who came to the health facilities at all level, specially district hospitals and Upazila Health Complexes (UHCs). Since 2017, UNFPA Bangladesh is providing technical and financial assistance to Gender, NGO and stakeholder participation unit (GNSPU) of Health Economic Unit, Ministry of health and Family Welfare (MOHFW) to develop a national protocol for the health service providers on health sector response to gender-based violence. A technical core group was formed and a series of technical meetings and workshops were organised to develop and finalise the protocol. HIV and Post Exposure Prophylaxis for the GBV survivor is the integral part of the protocol. The protocol was approved by MOHFW and disseminated among the relevant stakeholders. High Court of Bangladesh endorsed the protocol and directed to implement it throughout the country in a verdict while banning the two-finger test in April 2018. The programme is jointly managed, coordinated and financed by MOHFW and UNFPA.

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

Major Achievements: • National protocol on health sector response to GBV developed and endorsed by MOHFW • High Court of Bangladesh endorsed the protocol and directed to implement it throughout the country in a verdict while banning the two-finger test in April 2018. • Capacity building of 1334 health care providers (doctors, nurses, midwives, SACMO, Family Welfare Visitors, Community Health Care Providers) of 8 district has done. • Forms and formats including registers, informed consent form, referral slip etc for monitoring and evaluation are developed. • Standardised rape treatment kit named as 'Survivor Kit' is developed and distributed to all facilities. Anti-retro viral drugs for Post-Exposure Prophylaxis for prevention of HIV transmission are included in the list of medicines of Survivor Kits. • Residential Medical Officer of 16 disaster prone district hospitals also trained on Clinical Management of Rape and they are providing quality services with confidence. • A web based CMR training module in Bangla is at final stage of development. This module will help to develop the capacity of health service providers of different areas quickly even for the remote districts.

LESSONS LEARNED AND RECOMMENDATIONS

Lessons learnt and recommendation: • GBV data needs to be incorporated in the national MIS. • Capacity building of the services providers of all hospital at all level should be provided using this standard national protocol. • Survivor Kits need to be supplied to all the

facilities • Coordination, monitoring and supervision should be strong to implement the programme in 64 districts.

ANNEXES

National Protocol on Health Sector Response to Gender Based Violence.

4.2 BANGLADESH

TITLE OF THE PROGRAMME: Integrated and comprehensive SRH and HIV service programme for the brothel based female sex workers in Bangladesh.

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- **Programme is being implemented since:** 2018 - **End** (if applicable): We are continuing through 2019.
- **Responsible party/parties:** ["NGO, CBO", "Government", "UN or other inter-governmental organization"]
- **Population group(s) reached:** ["Sex workers", "Children", "Women and girls", "Young people"]
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy**
Yes
- **Is the programme part of a national plan other than the national aids strategy?**
Yes
- **If yes, please specify:** Brothel Based Female Sex Workers HIV intervention is included in the operational plan of AIDS STD Programme, Directorate General of Health Services, Ministry of Health and Family Welfare.

BACKGROUND

An estimated 100,000 women and teenage girls work in Bangladesh's sex industry. More than 3,856 female sex workers (FSWs) are residing in 11 brothels in 9 districts of Bangladesh. Sex-workers in Bangladesh are perceived as criminals as soliciting in public and running a brothel are illegal. Only few workers have license and provide service in registered brothels. These Sex workers remain confined in the brothels and have little access to health services at their need. HIV and other health programme for the brothel-based sex workers were supported by 3rd sector programme, HPNSDP, 2011-2016 of Ministry of Health and Family Welfare (MOHFW). Since November 2015, brothel based female sex workers are not covered by any other funded

programs due to completion of the projects and unavailability of fund. Other female sex workers (street, residence and hotel based female sex workers) are covered by Global fund. Currently 4th sector programme (HNPSP, 2017-2022) is implementing in Bangladesh and brothel-based sex workers package is included in the operation plan of AIDS STD Programme, Directorate General of Health Services, MOHFW. But till today the project did not come to the light. Understanding the overall situation, in January 2018, with support from UBRAF, UNFPA has engaged Light House, a local NGO to conduct a situation analysis in the brothels. The report revealed that no public, private or NGOs are providing any sorts of services in 10 brothels except Daulatdia brothel where BRAC has a service center nearer to the brothel and the FSWs are receiving health services from there. Other findings are: • No supply of condoms in any brothels • They are not aware of dual protection of condom, but majority of them know how HIV or STIs are transmitted. They use vaginal douching for keeping themselves free of HIV or STI. • FSWs practicing unprotected sex because of the unwillingness of the clients in using condom and they offer more money that fuels the practice of having sex without condom. • FSWs are not willing to go to the public hospitals for their health needs due to stigma and discriminations. Even conflict exists between the pick hour of their business and opening hour of outdoors in the public hospitals. • No HIV or SRH services are available for them and they used to purchase drugs from the nearby pharmacies without any prescription. • Many FSWs are using injectable family planning methods from government field staffs but numbers of induced abortion, menstrual regulation, etc. are also very high. • House rent within the brothel is very high that pushed them to have sex without condom. • Majority of the FSWs are teenage girls and young women but certain number of FSWs became old and they rarely get any client and struggling to earn money for their livelihood. • Small girls are using or forced to use hormonal tablet to make them attractive. Drug abuse revealed as concern in all brothels. • Sometimes bonded FSWs are forced to have sex during their menstrual period. • Community Based Organization (CBOs)/ Self-help groups exists in all brothels but they do not have resources and sometimes they became leader of the brothel.

DESCRIPTION

Since March 2018, UNFPA and UNICEF jointly engaged Light House with support from UBRAF Country Envelope (2018) to implement an integrated and comprehensive SRH, HIV and PMTCT programme in Mymensingh and Tangail brothels for one year based on the situation analysis done in January 2018. It was not possible to cover all the brothels with this small funding. The programme is jointly coordinated by UNAIDS Country office, UNFPA and UNICEF. The brothel residents mainly targeted for the project which includes adolescent sex workers (MARA aged 10-19), adult and active sex workers (aged 20-45 years) and old aged in-active sex workers (aged 45+ years and above). The project has designed to cover 520 brothel residents with essential services to address SRH, PMTCT, HIV and human rights issues. The goal was to enhance access to comprehensive, high-quality, effective, efficient, and sustainable SRH, HIV/AIDS and PMTCT services for Brothel based sex workers. Four strategies were adopted for this project: Strategy 1: Empowerment of brothel residents and their self-help groups/CBOs Strategy 2: Facilitate enabling environment within local communities through participation, networking & advocacy Strategy 3: Create access to integrated and comprehensive SRH, HIV and PMTCT services by establishing two Comprehensive Service Centre at Tangail and Mymensingh Brothels. The project adopted a rights-based approach and the key theme of the project is “community for community” to protect own rights”. Major activities: Peer based Education: The project assigned age specific peer educator (including MARA) and they worked as a “Change Agent”. Change Agents were trained and they are engaged in awareness raising among the age specific sex workers for SRH service utilisation, condom promotion, gender based violence, etc. Appropriate BCC and training materials are used to support them.

Comprehensive Service Centre: Two Comprehensive Service Centre (CSC) are established, one in each brothel. A CSC Manager and a Female Medical Assistant are recruited and trained for each CSC. Both CSCs were well equipped with all logistics, supplies and medicines required for the sex workers. The Female Medical Assistant specially trained on SRH, HIV and PMTCT which includes; antenatal care, postnatal care, sexually transmitted infections, screening of cervical cancer by visual inspection by acetic acid (VIA test), self-examination of breast for screening of carcinoma breast, HIV abs TB testing, general ailments for the sex workers and their children, Capacity Building: Developed capacity of the project staffs and existing self-help associations/community based organisations (CBO) in terms of skills, resources and experience to understand and respond effectively in addressing unmet needs. Referral Linkages: The project developed strong referral linkages with public hospitals for the complicated case. They also developed linkage with police, law enforcement department, district women and child department, district administrators etc. Community Engagement through activity/strategic Partnership: This projects established partnership with community based organisation (CBO)/Self-help group (SHG), sex worker's networks for meaningful involvement of brothel residents and communities, community organisations and networks, in advocacy, crisis management, social marketing of condom, developing future service volunteer, planning and implementing . Social Marketing Initiative (SMI) for Condom Promotion and Health Products: This project promoted Social Marketing of Condom, sanitary napkins and other products as suitable and available. Community Squad – a crisis management initiative: The project developed a community squad led by sex worker's network, the CBO/self-help group leaders to address their own needs while local muscle power tries to put greater harm towards brothel and brothel residents.

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

Strategy 1: • 150 adolescent FSWs received life skills training. • 20 Change Agents received peer education training. • One month duration beautification and sewing training provided to 20 FSWs and 4 of them are involved in IGA. • CBO leaders helped i) 3 aged FSWs to receive government social safety-net support and ii) able to reduce harassment of the FSWs by the Law Enforcement Agencies. • Community Squad managed 11 GBV cases, resolved conflict between FSWs and Babus (lover) and torture by Masi/ house owners. • 5 meetings held in both CSCs with law enforcement agencies, NGOs, lawyers, human rights activist, and CBO leaders, etc. Sixteen members of the legal system were present in the meeting. Harassment from the Law enforcement agencies has reduced and they became supportive. • A total of 169,500 condoms, 653 packet of napkins, 160 ORS and 150 Paracetamol sold under social marketing initiative (SMI). Strategy 2: • 62 Peer groups formed comprising 589 FSWs. • Till March 2019, a total of 261 education sessions conducted with 589 participants. • Strengthened the capacity of FSWs leaders to manage GBV and other issues. • Observed World Aids Day, Human Rights Day, International Day to End Violence Against Sex Workers, and International Women Days. • 4 advocacy meetings held in two brothels under the leadership of CBOs, aiming to strengthen referral linkage. Representatives from district Social Service, Medical college and hospital, district Women & Children Affairs, law enforcement agencies; media, district Family Planning, one stop crisis center (OCC), NGOs and ward counsellor, etc. were participated. Strategy 3: • Two Comprehensive Service Centers are functional. • IEC materials: 7,390 brochures distributed • 473 beneficiaries participated in education session by Medical Assistants. • 6 monthly health screening: 429 FSWs in 2 quarters and 526 in 3rd quarter. • Menstrual Regulation: 2 • Ca cervix screening: done for 772 FSWs, 45 found positive. referred to Tangail and Mymensingh Medical Colleges for confirmation and found negatives. • 628 FSWs received hands on training on Self-examination of breast cancer • 45 referral made to public hospitals. • 19 FSWs received ANC care and 20 received PNC care; 18 received immunisation, ensured 9

facility delivery. • 924 FSWs and their children received treatment for general ailments. • Total 458 FSWs screened for TB by Xene-Expert till March 2019. 2 referred for microscopy test. • 10 Old FSWs were involved in SMI. • 670 FSWs were tested for HIV. Found one positive but the project missed the case because she left the brothel. • 511 FSWs tested and treated for STIs until March 2019. • Project received TA support from clinicians to manage 41 complicated cases.

LESSONS LEARNED AND RECOMMENDATIONS

Major lessons learnt and recommendations are: • Awareness building and motivational change for development of a community led programme for ensuring sustainability. It needs an integrated approach with resource and political commitment for long duration. • These sex workers are day earner. It is difficult to make them motivated for the small premium for insurance. When they realize a handsome amount is available in the common fund, they want their money back. • Frequent turnover of the health service providers is another challenge. Once they are trained and posted in a brothel of a remote district, they quickly quit because of stigma and discrimination. It comes from family and society. Even the government health service providers denied attending health camps inside the brothels. Once they are trained, they are picked up by other organization with higher remuneration. • Drug abuse among the female sex workers is another challenge. Sometimes local people and assailants are involved with it. • Livelihood of the middle and old aged female sex workers is another challenge. The young sex workers who have very good earning do not have any back account and failed to invest for old age. To achieve the Universal Health Coverage: living no one behind, reaching the most vulnerable, hard to reach who are stigmatized and discriminated, a community led integrated SRH and HIV service programme is essential for its sustainability. A long-term joint investment by involving the government, UN agencies, CBOs and other stakeholders needed. In 2019, UNFPA expanded the area of intervention from 2 brothels to all 11 brothels in Bangladesh by adding its regular resources with the UBRAF Country Envelop.

ANNEXES

1. Mapping study and size estimation of Key population, 2015-2016, MOHFW. 2. Situation Assessment in brothels.

5. CHINA

TITLE OF THE PROGRAMME: The Chinese Practices of HIV/AIDS Prevention and Control

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- **Programme is being implemented since:** long term - **End** (if applicable):
- **Responsible party/parties:** ["Government"]
- **Population group(s) reached:** ["People living with HIV", "People who use or inject drugs", "Prisoners", "Sex workers", "Migrants, refugees or internally displaced people", "Men who have sex with men", "Children", "Women and girls", "Young people"]
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy**
Yes
- **Is the programme part of a national plan other than the national aids strategy?**
No
- **If yes, please specify:**

BACKGROUND

The Chinese government has been committed to the HIV prevention and control over many years, and is currently working to leverage the ongoing health care reform and Healthy China Initiative to continue the strong momentum of HIV response. To that end, China has strengthened laws and regulations, built work mechanisms, increased funding support, carried out prevention and control strategies, enhanced institutional arrangements, explored new models of work, and secured implementation. By using these multi-pronged approaches, the Chinese government has achieved full-service coverage, curbed further spread of HIV, and put in place a pro-HIV social environment.

DESCRIPTION

A. Strong commitment from the Chinese leadership and an overarching design for health
China's head of state and government leaders have all attached great importance to HIV/AIDS prevention and control for a long time. In particular since 2012, Chinese President Xi Jinping, Premier Li Keqiang, Vice-premiers responsible for disease prevention and control have paid multiple visits to show their support to the frontline healthcare professionals, grassroots working staff, social organizations and volunteers, and contributed their guidance and strategies for deploying resources. During one National Health Conference, President Xi Jinping stated, "Without universal health, we would never be able to achieve a well-off life for all. We shall beef up efforts to build a healthy China and strive toward a multi-faceted and full life-cycle approach to secure health for the general public." The Chinese government developed the "Healthy China 2030 Program" and implemented a healthy China strategy. By incorporating HIV/AIDS and other major infectious diseases into the Program as an essential part, China put focus on prevention and stressed importance of combining prevention and control in order to secure a life-cycle health for all. So far China has passed Regulations on HIV/AIDS Prevention and Treatment, developed and implemented four Five-year Action Plans for Curbing, Preventing and Controlling HIV/AIDS. Multiple sectors have carried out policies, ranging from prevention to treatment, from participation by social organizations to social assistance, from institutional building to service delivery and have taken measures at the appropriate time to prepare and modify all relevant technical guidelines and standards. Therefore, a policy framework suited to the Chinese context has already taken place. In addition, local government has implemented policies in line with local needs and included HIV response into the universal health coverage.

B. Strengthened work mechanism and increased funding support
A full coverage of HIV prevention and treatment services requires a solid and sound service delivery system. The Chinese government has set up a mechanism in which the government agencies lead and organize, each sector performs its own duties and social forces engage and participate. By doing this all stakeholders can work jointly to achieve synergized prevention and control. At the national level, the State Council AIDS Working Committee has convened on a regular basis while multiple sectors have strengthened supervision and inspection to guide local HIV actions. All provinces have set up a multi-sector coordination and consultation mechanism. All prefectures and counties have set up a government leadership accountability system. In the high prevalence areas, the Number One leader will be held accountable and expected to enhance roles by the sectors and local jurisdictions. Relevant HIV targets are broken down across different levels of the bureaucracy and incorporated into the corresponding government performance assessment system subject to supervision and inspection. Enabling policies have been developed to support social organizations, businesses and volunteers to participate in this journey. As a result, social participation has significantly improved, activities have enriched and diversified, and coverage of beneficiaries has expanded. A full HIV service coverage requires adequate funding support. The different levels of government have continued to increase investment in this regard. The central government alone has increased funding from 2.36 billion yuan in 2010 to 5.83 billion in 2018. The same trend also occurred among the local governments. Meanwhile, China continued its international cooperation, mobilized all societal actors to contribute in kind and cash, and thus secured a smooth and prompt HIV response.

C. Enhanced specialized institutions and teams, and improved service networks.
To provide universal access to health require

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

The Chinese HIV response has produced significant effects. Transmissions through intravenous drug use, blood(blood transmission almost nearing zero in the scale of reporting system),and mother-to-child pathways were put under effective control; the detection rate of people living

with HIV and AIDS patients remarkably increased; mortality rate dropped noticeably; the steep upward trend of transmission in the key areas was basically curbed; the overall national epidemic was successfully controlled within the low prevalence band and the people affected with HIV continued to see their living standard improving with reduced social discrimination. All those safeguarded the physical and mental health of the general public.

LESSONS LEARNED AND RECOMMENDATIONS

China has been a responsible powerhouse in this area and is determined to forge ahead despite the stark challenges.

ANNEXES

6. GEORGIA

TITLE OF THE PROGRAMME: Online training module for service providers on “HIV Prevention and Sexual reproductive health and rights service standards for key populations” for Health Professionals, Social Workers and Outreach Workers

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- **Programme is being implemented since:** 2019 - **End** (if applicable): ongoing
- **Responsible party/parties:** ["Government", "Academic institution"]
- **Population group(s) reached:** ["Health professionals, Social Workers, Outreach Workers"]
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy**
Yes
- **Is the programme part of a national plan other than the national aids strategy?**
Yes
- **If yes, please specify:** Georgia Transition and Sustainability Plan (2016) and Georgia HIV/AIDS National Strategic Plan 2019-2022 clearly identified the need to strengthen human resources for quality HIV/AIDS service delivery. It states, that there is no policy for production/training of health professionals, non-medical staff, in particular for CSOs personnel. In addition, transition preparedness emphasizes that training activities that have been fully covered by the external sources for the last decade have not been institutionalized in the formal education system, which increases sustainability risk. In 2018, UNFPA provided technical assistance and in partnership with Academia and Government responded to the needs of strengthening capacity of service providers in SHR/HIV

BACKGROUND

Georgia is one of those countries in the region where the steady increase (25%) in HIV incidence has been observed during the recent years. National efforts to halt a spread of HIV showed some positive results, though the outcomes have not yet provided an adequate ground to conclude that the country is effectively addressing the evolving epidemic. For the UNAIDS

90-90-90 Fast Track targets Georgia is well positioned for last two, but is behind for the first 90 target. By the end of 2017 only 53% of estimated PLHIV knew their status, while 75% of them were enrolled in ART and in 81% the VL suppression was achieved. HIV epidemic continues to disproportionately affect key populations at higher risk of HIV – MSM, SWs, PWID. Despite the important positive developments achieved in HIV control, Georgia continues to face a number of serious challenges that need to be addressed through strengthening the health system, capacity development, the application of patient-centered approaches with appropriate patient support, with adequate funding and strengthened governance. Global Fund is gradually downsizing the support and eventually exiting from the country, which makes maintenance of prevention interventions increasingly challenging. Due to the limited resources there is a significant implication on the range and types of high-quality HIV and SRHR services available for key populations, including for young key population. Limited role and capacity of primary care providers in delivering SRH and HIV preventive services poses significant challenge as this impedes health system's capacity to timely detect those needing referral to HIV diagnostic services. Furthermore, a focus that reduces the HIV response to primarily testing and treatment will not make any impact on these highly marginalized young people, who are not covered by mainstream adolescent and youth programming and have a wide range of needs. Lack of well-defined national standards including competencies, roles and responsibilities for service providers engaged in provision of SRH and HIV preventive services to key populations is significant challenge in HIV response. There is no requirement for a specific accredited training on SRH and HIV prevention for service providers and outreach workers, engaged in reaching the communities and key populations to ensure provision of SRH and HIV prevention services.

DESCRIPTION

Addressing the needs of institutions and support capacity development of service provided involved in SRHR/HIV prevention service provision with focus on key populations. UNFPA has been consistent to promote new policies and procedures and build institutional capacity for their enforcement and compliance. One of the most remarkable achievements of UNFPA is successful partnership with the Ministry of Health (MoH) and Tbilisi State Medical University (TSMU) to develop, introduce and promote e-learning platform to support professional development and capacity building in SRHR and HIV prevention. In 2018, UNFPA in cooperation with National Center for Disease Control (NCDC), National Aids Center, Tbilisi State Medical University (TSMU) supported development of the online training module for service providers on "HIV Prevention and SRH Service Standards for Key Population" for provision of quality SRHR and HIV preventive services targeted at key populations including YKPs. The training module capacitates service providers (health professionals, social workers, outreach) to provide quality SRHR, FP and HIV services. TSMU was selected as the strategic partner, as the only Higher Education Institution in medical field with the online training platform, developed in partnership with UNFPA in 2017. Moreover, TSMU is uniquely positioned, and the accreditation process of the online module and its integration in the national Continuous Medical Education (CME) system; thus, each service provider working with key populations and their partners will have access the course and be able to obtain certificates. The accredited course has been endorsed and approved by the Professional Development Committee under the Ministry of Health. After endorsement, the course is fully managed by the NCDC and TSMU, which is financially sustainable.

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

As the course has been launched since April, 2019, therefore it is early to discuss the above details, though we can report that the course is already very popular among service providers,

as it has been promoted among the service providers. Moreover, within the frame of Cluster Evaluation Exercise of the UNFPA country programme, the online module development initiative has been evaluated as very successful and highly sustainable, and that UNFPA contribution was remarkable in supporting professional development through creation of web-based training IT platform and development of accredited online training modules to improve national capacity for delivering quality reproductive health, family planning and HIV prevention services.

LESSONS LEARNED AND RECOMMENDATIONS

UNFPA through its work has contributed to building resilient health system that involves strengthening human resources. UNFPA has a role and capacity to be positioned as the major partner of MoH and NCDC with regard to the policy development on HIV prevention for key populations including YKPs, regulations and guidelines to address issues affecting access to HIV services, ensure that the tools (SWIT, MSMIT, IDUIT) are embedded within transition and sustainability plans, and support sustainable capacity development of service providers, while GFAMT is gradually downsizing the support and eventually exiting from the country. UNFPA contribution was remarkable in supporting professional development through creation of web-based training IT platform and development of accredited online training modules to improve national capacity for delivering quality reproductive health, family planning and HIV prevention services. The UNFPA contribution is expected to be critical enabling factor to improve the access to quality SRH services. As a result of the UNFPA advocacy efforts, online training courses in SHRH/HIV prevention became the first ones among few training courses accredited by the TSMU and acknowledged by the MoH. More advocacy is recommended to make these courses mandatory for service providers.

ANNEXES

Link of the Online Platform: <http://sms.tsmu.edu/ssms/cme/?ena=eng>

7. INDIA

TITLE OF THE PROGRAMME: Avahan III (2014-2018); Taaras and Invest for Wellness subsequently

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- **Programme is being implemented since:** 2014 – **End** (if applicable): currently ongoing
- **Responsible party/parties:** ["community organisations", "Civil society", "Private sector"]
- **Population group(s) reached:** ["transgender persons", "People living with HIV", "Sex workers", "Men who have sex with men", "Children"]
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy**
No
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

The Avahan India AIDS Initiative began in 2003 and was implemented in three phases in the last 14 years. It has averted 600,000 new HIV infections (during its Phase I and II), and there has been substantial reversal in the HIV infection trends in the states covered under this initiative. Started as a biomedical intervention in Phase I, Avahan progressed into a more effective behavioural change programme at the end of Phase II. Two key components were added; (a) strengthening community systems through community mobilisation and establishing Community Organisations (COs); and (b) addressing vulnerabilities that affect key populations to adopt safe behaviours (particularly violence reduction). Studies showed significant differential impact on HIV infection trends following this strategy over the stand-alone core HIV programme. Post Phase II, as a part of its sustainability strategy, BMGF transitioned successfully the programme to the Government. While the core HIV intervention components of the programme continued, the other critical components of strengthening community systems and support to reduction of key vulnerabilities did not continue as envisaged. This challenged the sustainability of the impact created and potential increase in the HIV infection trends (as the differential impact was largely due to the additional components of community systems strengthening and vulnerability reduction). It was therefore important to empower communities and strengthen their

institutions to own and progress the agenda of vulnerability reduction and HIV risk reduction, so that they are able to engage with government and other stakeholders to access services and realise their rights. Avahan Phase III was envisaged keeping this agenda in mind. It aimed at sustaining the impact of HIV prevention efforts among key population in five states of India by reducing their key vulnerabilities and empower and enable them to adopt behaviours and services to protect themselves from HIV. Access to financial services, social protection and violence reduction are critical support to reduce vulnerabilities. Combining this with strong relationships and interplay between communities and ecosystem is essential to sustain safe behaviour. Sensitizing the ecosystem and simultaneously empowering communities to advocate for their rights and leverage support are critical, for which long and constant engagement with both communities and ecosystem is necessary. Building strong, democratic, and financially sustainable COs to drive this agenda and processes is key to sustaining this, irrespective of any external support. As funding for Phase III concluded in 2017-18, the sustainability plan has expanded to ensuring strong community organisations continue to facilitate a range of services including primary care services (in addition to HIV and STI), delivered through a financial institution, supported by a community coalition and resource organisations.

DESCRIPTION

Phase III of Avahan India AIDS Initiative was implemented by Swasti along with its sister organizations, Vrutti and Catalyst Management Services, across five high HIV prevalence states of India (Andhra Pradesh, Maharashtra, Karnataka, Tamil Nadu and Telangana). The programme was implemented across 45 districts covering 632 towns, cities and villages. The programme has worked with 84 community organizations over a period of 3.5 years and has reached more than 1,31,000+ Women in sex work (WSW, Men who have sex with men (MSM) and Transgender persons (TG). From 2014 to 2017 was funded by BMGF with a no-cost extension until end Dec 2018. During 2014-2017, district level mentors worked with Community Organisations as well as with Stakeholders to work on the 4 pillars of the programme namely - 1) Safety, Security and Justice 2) Institutional Development Support 3) Financial Security and 4) Social Protection. Community Organisations received sub-grants to maintain a team and ensure each of the members (key population and PLHIV) were linked to and access appropriate services. One of the significant achievements of the program is to work with and track a cohort of key populations, obtain their status with respect to their possession of civic identity, social entitlements, financial status, their engagement with COs, their understanding and experience of violence, coping strategies. The program used a tool called 'Member Engagement and Communication (MEC)' and later this information was brought into the 'Taaras' Android app, the technology solution to assist in community engagement and services facilitation during outreach. This helped to deliver KP-specific focused support based on their needs and priorities. This was a very significant decision by the program to go for this approach, as the data sets available at the time of starting phase III was at aggregate level and did not have individual records. Within the overall coverage, it was important to prioritize the KPs who are more vulnerable than others - with a view to 'leave no one behind' and 'put the most vulnerable in front of the line'. The levels of vulnerability change from time to time. The program developed a 'vulnerability index' using a set of indicators and continuously assessed the level of vulnerability and prioritized services to those members. The program had undertaken sample surveys of KPs called 'outcome monitoring (OM)' covering 15,000 members across all COs. Owing to the focussed efforts augmented with KP-specific data, the percentage of the most vulnerable members has significantly decreased from 15% during 2015 to 7% in September 2017. Apart from this, to ensure inclusion of hidden key populations, the program developed and implemented new methodologies to reach and continuously engage them. Various mechanisms like membership drives, mapping using the MECT, network enrolment which leverages the

power of networks of the members on the field and tracking using technology have been used. Owing to these mechanisms, 31,947 new members have been brought under the ambit of the program. Network enrolment has led to 78% year on year increase in number of new members engaged. Since September 2018, the funding has been provided by the Ashraya Hastha Trust, a private family philanthropy in Bangalore, India. The level of funding is significantly lower than the funding from BMGF and so a phased approach of support has been followed where approximately 20 Community Organisations are provided an expanded range of services across all pillars mentioned earlier while the remaining 40 are focused on linkage and follow up working through volunteers.

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

Primary goal of Avahan III investment was to ensure that HIV prevalence rates, which were reduced in earlier phases, remain low and do not increase. While the data sharing arrangement with NACO/ SACS has been accepted, the data on the status of HIV prevalence for the states/ locations in the program has not been shared to date. The delay in data sharing agreement also affected the roll out of the external impact evaluation by Population Council, and hence the progress against the impact indicators could not be tracked. However, the overall prevalence rates in the five states of Avahan, at a macro level, continue to go down according to recent surveillance reports of NACO. Outcomes - 2014-2017

- 1) Safety, Security and Justice: Over the period of three years, there is 30% decrease in number of members facing violence in the last 6 months. Overall reporting of incidents has increased by 2.63 times from 18% in 2015 to 69% in 2017. In order to simplify the field processes, tracking of each incident over a period of time was introduced. Based on the data over time, we see that with system strengthening during the initial years of the program, there is decline in incidence, incidents and increased reporting and resolution. With continued work on legal literacy and engagement with stakeholders, there is an increase in incidence and incidents which has been our previous experience as well - as people who have previously been victimized become assertive and demanding, there is backlash. The decline in reporting and reporting to CO is explained by the increased capacities at individual level where situations are resolved independently, without seeking support from Programme (28%).
- 2) Social Protection: Formal identity and citizenship documents is the basis for asserting their rights and entitlements. Therefore, work on access to civic identities and social protection schemes was an important strategy of the program. Access to at least one civic identity has increased from 89% to 98% and to two civic identities has increased from 84% to 94% (see graph below). This has helped leave no one behind and ensure the poor and vulnerable get access to citizen rights. This was the gateway for access to a variety of social protection schemes. Access to schemes has increased from 37% to 81% over a period of three years.
- 3) Financial Security: There has been 20 times increase in access to insurance and almost 3 times increase in opening of savings account during the program period. Currently, 87% of the members have reported to have access to saving account which is higher than the national average of 54%. Percentage of members with functional saving account has increased from 55% to 95% which is very high as compared to the national and South Asia average. Insurance worth INR 7,975 Million (USD 122 Million) has been facilitated for the members and their families in the program. For both social protection and financial security, the program has leveraged the Government of India's schemes such as Aadhar and financial inclusion through schemes like Jan Dhan Yojana, Pradhan Mantri Suraksha Bima Yojana, MUDRA, etc. to accelerate access and benefit to the KPs. The capacities of the CO staff was built to engage with government departments and to leverage it for facilitating these services for our members through UHD. Owing to these efforts, economic benefits worth INR 3,150 Million (USD 48.5 Million) has been raised in the hands of community.
- 4) Building Institutional Capacity of COs: The program was initiated with 87 community organizations but due to non-performance and

unwillingness of the COs to continue, only 69 COs continued till September 2017. Alternative arrangements were done to continue services 18 CO areas. Overall, the program has significantly improved the institutional capacity of these 69 COs towards sustainability.

LESSONS LEARNED AND RECOMMENDATIONS

a) Vulnerability must be addressed to sustain risk reduction: The HIV prevention strategy has worked effectively in the Targeted Intervention space over the past decade. However, the programmes are still focussed on health as outputs and not on the determinants which affect the outcome of HIV prevention. Through the Avahan III program, a distinct positive association has been established between service delivery aimed at vulnerability reduction and accelerated outcomes to risk reduction. The vulnerability reduction interventions are relatively cheaper than the positive prevention services and can be easily integrated with the national programme to reach vision 90-90-90. b) The community agenda is not over; the issues are inter-generational; and it is not realistic to expect any one donor or government to solve the issues; there is need for a natural owner to move this forward: The need of the organizations and the members transcends funding. A forum/movement is needed for the members to take up what really matters to them and work towards it irrespective of the funding and the funder. This requires ownership at multiple levels with full support of external facilitators. c) Churning and continuous engagement at community level is essential: The nature of sex work has changed but differentiation and definitions in most current programmes have not. They are still implemented with a target based approach and this causes considerable fatigue in the field. Additionally, as the country moves towards Digital India, a variety of mechanisms exist (interaction over phone, WhatsApp etc. which are explored by the individuals and used within their networks) but remain to be tapped in by the programme for strategic outreach. Remaining closely connected to the realities of the community, in their work and lives, is essential for programmes to remain relevant to them. Through the Avahan III, we developed some tools and methodologies that have allowed us to understand and therefore engage with the community. d) Multi-levels of support systems: Tiering of support is critical for continual services on the field for members. Having a CO to engage with stakeholders is not sufficient unless there are volunteers and field workers to engage with individual members as well. e) Constant support, motivation and capacity building at COs is needed: The COs have had different evolutionary paths across the states and work in complex environments with extremely vulnerable and marginalized communities. The Board of these organizations changes every 2 years; investment in their capacities is crucial for them to remain relevant to their members. Employees of the COs are available only when resources (grants are available) and this has ebbs and flows, during the year as well as over time. Institutional memory and capacity are constraints at the CO level. Avahan III has invested in strengthening the COs but without continuation of a minimal level of inputs, the COs will face challenges. The type of support needed by the COs varies based on their context and maturity as well as current capacities.

ANNEXES

Annex A Network mapping , Annex B New Engagement model , Annex C Lead by communities, Annex D Community based testing and treatment , Annex E Focus on risk and vulnerability, Annex F Artificial Intelligence , Annex G Health Bank , Annex H Primary care , Annex I Integrated Prevention and treatment , Annex J Technology enabled cohort tracking tool

8. INDONESIA

TITLE OF THE PROGRAMME: Lessons learned from efforts to integrate HIV and community-led responses into Universal Health Coverage agenda in Indonesia

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- **Programme is being implemented since:** 2017 - **End** (if applicable): On-going
- **Responsible party/parties:** ["Government", "Civil society", "UN or other inter-governmental organization"]
- **Population group(s) reached:** ["People living with HIV", "People who use or inject drugs", "Prisoners", "Sex workers", "Men who have sex with men", "Children", "Women and girls", "Young people"]
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy**
Yes
- **Is the programme part of a national plan other than the national aids strategy?**
Yes
- **If yes, please specify:** Ensuring CSO engagement in HIV sustainability and transition and integration of HIV in UHC

BACKGROUND

Indonesia's national response has relied heavily on external contributions with the exception of government support of HIV diagnostics and first line ARV treatment for PLHIV. The Global Fund and PEPFAR remains the two largest funders of HIV prevention, community outreach, and comprehensive support to MoH implementation of national test and treat program. However, in 2018, as Indonesia reached Upper-Middle Income status, donors including GF and PEPFAR have initiated discussions on withdrawing support to Indonesia. While Indonesia remains eligible for GF and PEPFAR funding for the time being, it is crucial that national stakeholders including CSOs initiate now transition planning for the eventual termination of external funding for the national HIV program. The main concern about the roll out of UHC in Indonesia is that with limited domestic health budgets, UHC will be hard to fulfil and that meagre resources will be spread even more thinly across a wide variety of health priorities, threatening the availability and

quality of comprehensive health and HIV and AIDS services. It might also leave marginalized groups behind and endanger the critical role of the community response to HIV. In the context of Indonesia, the budget allocation for the health sector was only 5% of the Indonesian Government budget, a percentage that is very low compared to the health budget proportion in other Asian countries. The budget breakdown is not specified, so it is not clear how much of that 5% budget is allocated for medication, logistics and other items outside the allocation for civil servants' salary. If not done strategically and carefully, the critical successes achieved in the HIV and AIDS response in the past decades risk being reversed if the response is not integrated into national UHC plans in a way that builds on these successes.

DESCRIPTION

In 2017, CSOs engaged in a number of initiatives such as (1) SHIFT: Sustainable HIV Financing in Transition; (2) PITCH: Partnership to Inspire, Transform and Connect the HIV response; (3) Multi-Donor Trust Fund to pilot social contracting for community-led responses (World Bank, Bappenas and IAC); (4) Review of ARV pricing and procurement practice to ensure sustained, affordable, high quality ARVs for PLHIV; (5) Advocacy to ensure key populations are part of the Standard Minimum Package of Services for HIV at district level. All these initiatives aimed to ensure rights-based and community-centered integration of HIV into the Universal Health Coverage agenda.

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

1. Improved capacity of local CSOs to assess and analyze local contexts in regard to HIV financing, policy review and development, CSO access to state funding, CSO engagement in decision-making process, and advocacy to accessibility, affordability and availability of high-quality health commodities, particularly ARVs, condoms and needles/syringes. 2. Through these programs, CSO managed to secure space to engage and be consulted on the way forward for sustainability and transition. Local CSOs are now strengthened to play role as community watchdog to ensure accountability. 3. CSO engaged and successfully influenced the inclusion of all PLHIV and key/priority populations (SW, PWUD, MSM, TG, prisoners, mobile populations) in the Standard Minimum Package of Services for HIV at district level

LESSONS LEARNED AND RECOMMENDATIONS

- Decentralization poses enormous challenges to ensure consistent and uniform implementation of high standard services (e.g. Test and Treat All; condom procurement and distribution; viral test and suppression). Full implementation of the Standard Minimum Package Services for HIV will address this challenge. However, this requires full cooperation and commitment from local authorities (Ministry of Internal Affairs).
- While AIDS is unfinished, there is too many competing priorities at all levels (national, provincial, and district). In areas where local government has provided attention to HIV, the issues were linked to other health and social programs to clearly state the case for action. To ensure HIV integration in UHC, more efforts must be made to convince local leaders that this is important to the economic and social development of their communities.

9. ISLAMIC REPUBLIC OF IRAN

TITLE OF THE PROGRAMME: Promotion of mobile HIV/STI Services for Most at risk and affected women by HIV and linking them to dedicated services and facilities

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- **Programme is being implemented since:** January, 2017 CDC (Ministry of Medical Education and Health) ordered this project and , Iranian Research Center for HIV/AIDS (IRCHA) implemented. - **End** (if applicable): June ,2018 then the project expanded in national program.
- **Responsible party/parties:** ["Government", "Civil society", "Academic institution"]
- **Population group(s) reached:** ["most at risk and affected women by HIV and their clients ", "Sex workers"]
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy**
Yes
- **Is the programme part of a national plan other than the national aids strategy?**
Yes
- **If yes, please specify:** The program was in line of 3 strategies of HIV/AIDS National Strategic Plan: 1- HIV case detection in MARPs and link to care and treatment, 2- Harm Reduction, 3- STI prevention, Diagnosis, care and treatment

BACKGROUND

Iran has made a commitment to end the AIDS epidemic by 2030 and accordingly incorporated the 90-90-90 targets into the 4th HIV/AIDS national strategic plan. In order to achieve these ambitious goals, however, the national AIDS program needs to bridge significant gaps in testing and treatment. The Iranian research center for HIV/AIDS has also

initiated mobile services for most at risk and affected women by HIV within an operation research setting. At pilot phase we looked at a static model of service delivery for this group: in 15 eight-hour night shifts, 186 women (average age 36, mostly homeless and of low literacy) received PIT, HIV prevention and STD management, of whom 12 tested positive for HIV. Of these 10 were linked to care, one migrated away from the area, and one died because of advanced HIV disease. Although this intervention falls under the overall rubric of HIV / STI services for most at risk and affected women by HIV it is a standalone intervention in that explores the feasibility and acceptability of HIV/ STI services based on mobile services delivery. Although there are counseling and harm reduction centers for most at risk and affected women by HIV to HIV/AIDS in Iran but some part of our high risk population are not refer to these centers. The center for disease control reports the results of the project as an effective intervention program in coordination sessions with organizations and senior management levels in deputy of social affairs and deputy of health of ministry of health and education. The outcome of the meeting was expansion and continuation of the program.

DESCRIPTION

This program includes:) Clinical and support services to reduce STI/HIV prevalence: - Providing council and comfort to most at risk and affected women by HIV and if possible, persuade them to contact and convince their partners to reach out appropriate testing and consulting settings. - Providing Rapid Tests and referring patients to the nearest consulting center; voluntary counseling and testing center at Imam Khomeini Hospital was set as the default setting for referring our patients - Reducing STI prevalence and performing cervical cancer tests for 270 suspicious and 208 confirmed patients. - Availability of first-line STD medications; first-line STI medications were prescribed for 158 patients along with 159 confirmed STI patients. - Complete documentation and monitoring of referred patients - Distribution of condoms, syringes, needles and related paraphernalia; a total number of 6000 of above-mentioned has been distributed among most at risk population.) Empowerment of most at risk and affected women by HIV - Providing adequate reproductive health education and related equipment such as condoms; - Promoting medication and safe sex adherence and encouraging patients to avert from alcohol and various drug abuses. - Electing a group of 20 individuals from high risk locations across Tehran as a peer.) Increasing access to health and social services for most at risk and affected women by HIV - Identify and Access to high risk hot spot through Mapping - Introducing free of charge health care services and their providers. (VCT, MMT) - Introducing telephone counseling and visiting charts - Free HIV and pap smear point care patient testing - Identify and refer positive and suspicious individuals to voluntary counseling testing centers - Creating a safe haven for referring women to rehab and counseling centers) Capacity development for the development , Monitoring and implementation of services - Develop and use a personal performance-review checklist as a job aide. - Assess staff knowledge, skills and competencies in relationship to key responsibilities of the job and develop a personal capacity building plan, including needs and opportunities for training, re-training, mentoring and coaching in order to address areas that are deemed to be important for good job performance. - Work with managers, supervisors, and/or peers to learn new skills or refine existing skills. - Obtain training (on-the-job, off-the-job, short-term and/or long-term) - Assess knowledge attitude and practice of most at risk and affected women by HIV women and clients and plan educational activity - Obtain train-the-trainer instruction to enhance their own presentation skills as a formal or informal trainer or communicator on M&E issues. - Remain up-to-date on specific test and counseling methods, Last consulting guidelines - Obtain an in-depth understanding of the most recent standardized protocols, tools and

guidelines to be able to design, conduct and/or critically review activities. - Obtaining consent and evaluation forms } Promote inter – and intra– sectoral coordination for referral of most at risk and affected women by HIV - Introducing women's health clinic, government hospitals and rehab centers } Adopt family –centered approach and provide integrated child services (where relevant) - Providing services to high risk children (8 cases) and pregnant women (5 cases) - Providing information on mother to fetus HIV transmission and its related treatments and prevention methods - } Identify and train peer education /outreach works from among service users annex 1(further information)

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

} 12 cases of confirmed HIV were diagnosed, 10 of them linked to care and treatment center } 5 cases with Epithelial cell abnormalities. } 2 case (ASC-US) } 1 case Low grade squamous intra-epithelization (LSIL) with HPV cytopathic features } Of a total 270 examined patients, 119 had healthy results and 151 demonstrated signs of STIs and Vaginitis. Further information and detailed result(table) find in the annex 2 } Pap smear tests were obtained from 208 patients, 78 were excluded due to the use of lubricants or a recent intercourse of less than 48 hours; it is noteworthy to consider the following results as six patients demonstrated suspicious results in their pap smear tests - For All cases provision of condom and educated condom negotiation Provision of basic antimicrobial care (syndromic approach, as per national protocol) Provision of HIV counselling and testing, psychosocial support Rapid HIV testing Substance use history Sexual history Provision of basic HIV prevention services (condoms, needle – syringes) Educational material Needles- syringes, alcohol pads for all cases Better understanding of parameters that affect the accessibility and acceptability of mobile HIV / STI services For improved accessibility to mobile clinic services, a week advanced notice is mandatory Client satisfaction questionnaire Monitoring of diurnal variation in client usage Improved method for delivering mobile HIV/ STI services After the end of the pilot phase, the scheme continued every other night and 15 shifts per month. According to the plan, HIV and STI tests were performed and positive people were referred. Distribution of condoms, syringes and needles was done, and the consequences of joint injections were taught. Pap smear was performed and patients were advised to receive a response on the next referral date. Also, the diagnosis of the disease, if any, and symptomatic treatment were performed with the drug administration process. STI line drugs were approved by the AIDS office and coordinated by the AIDS Office of the Tehran Medical Sciences Academy. Also, based on the requirement, multivitamin (10 pills) and iron (30 pills) were given at each visit and ways of contraception were taught by the midwife. Referral of the patients with introduction letters to the STI/HIV services at governmental hospital facilities was carried out. The questionnaires were also completed. The executive director monitored the accuracy of the information and randomly participated in the night shift. Every month's hangout planning was updated by the project manager and replaced by new questionnaires, due to the change of the hangouts of that month. In mid-March, a joint meeting was also held on the agenda for serving vulnerable women clients. The second phase ended with the problem of referral and requesting services at centers such clinics. } Results: In total 334 clients were recruited, most clients (n=97) were categorized as illiterate while 3 of them had university degrees (Master or higher). Among clients, 51.5% reported history of homelessness (at least 10 nights) during the recent year. Considering marital status, most clients (39.5%) were married and 7.56% of them had remarried. about 13.7% of participants had experienced temporary marriage once. Of all clients, 35.2% lived alone, about 42.2% lived with their permanent spouse and 16.9% of the clients lived with their temporary spouse. 3.61% of participants reported to have provided sexual services in

exchange for money, drugs or food in the recent month. Most clients (82.8%) did not take care of a particular person, 73.5% had not used the services available at most at risk women by HIV 's centers or some similar centers as they were not informed about it.11% used condom services and 1.2% used the sterile syringe had been offered at women support centers. 4.1% used the center's counseling services, further information in Annex 2

LESSONS LEARNED AND RECOMMENDATIONS

According to our project we found that main issues in FSW mobile clinic is the service delivery time schedule. All the services should be in middle night when the female sex workers are in shift work. Services should be comprehensive and Health care providers(HCP) should delivery the services friendly and according to the culture. We find new hot spots just with peers. So working peers in mobile clinic who know about FSW hot spots and role of FSW hot spots and polices is very important. All HCP would know about communication skills and manager of mobile clinic should select HCPs among someone's who have a lot of experience for working with FSWs. Each mobile services should supported by vulnerable clinic. Gynecological services should provide for them and all mobile clinics should link with Harm reduction centers and general Hospital. For access to health package mobile clinic is better way for distribute them. Most of FSW do not know about vulnerable center of free of charge health services, so mobile clinic can increase knowledge of FSW about this subjects.

ANNEXES

Annex 1 (detailed description) Annex 2 (table and detailed results)

10. KYRGYZSTAN

TITLE OF THE PROGRAMME: Strengthening institutional capacity of both NGO and healthcare settings to provide integrated SRH and HIV services to key populations

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- **Programme is being implemented since:** 2012 - **End** (if applicable): n/a
- **Responsible party/parties:** ["Government", "Civil society", "UN or other inter-governmental organization"]
- **Population group(s) reached:** ["People living with HIV", "Sex workers", "Men who have sex with men", "Young people"]
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy**
Yes
- **Is the programme part of a national plan other than the national aids strategy?**
Yes
- **If yes, please specify:** New health strategy for 2019–2030 tagged “Healthy person – prosperous country” aims to protect health, ensure access to essential quality services, strengthen primary health care and decrease financial hardship for all people and communities, in pursuit of universal health coverage (UHC) by 2030.

BACKGROUND

Kyrgyzstan is a lower-middle income country, with a Human Development Index of 0.672 (http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/KGZ.pdf). In 2017, 25.6 per cent of the population lived below the national poverty line and 0.7 per cent in extreme poverty (National Statistics Committee, Poverty rate in Kyrgyz Republic in 2017, <http://www.stat.kg/media/publicationarchive/e6b6504b-fbdc-4699-9cf5-1f13d0eafaa1.pdf>). The economy is vulnerable to external shocks, with many households dependent on remittances. The total population is 6.1 million, with two-thirds living in rural areas. In 2015, the population growth rate was 2.1 per cent and life expectancy at birth was 66.7 years for men and 74.8 years for women. Young people aged 14-28 years comprise 30.2 per cent of the population. The

unemployment rate stood at 6.9 per cent in 2017 (National Statistics Committee). The country experienced two government turnovers in 2005 and 2010, and inter-ethnic clashes in June 2010. This affected economic growth and the development of institutional systems. The 2010 Constitution ushered in government reform and led to a change from a presidential system to a parliamentary republic. Kyrgyzstan is vulnerable to numerous natural disasters including earthquakes, landslides, mudflows, avalanches, mountain lake spills and flooding. Seventy five per cent of the population live in areas at risk of earthquakes exceeding nine on the Richter scale. The country faces the additional threat from Soviet-era industrial and nuclear waste which poses serious environmental and health risks. Services to promote sexual and reproductive health and reproductive rights, including HIV prevention, are unsatisfactory. Those affected are primarily women and young people, particularly those from vulnerable and marginalized groups. The 2017 maternal mortality ratio was 31.9 per 100,000 live births, one of the highest in the region (National Statistics Committee, <http://www.stat.kg/ru/opendata/category/142/>). The contraceptive prevalence rate is 42, while unmet need for family planning is 19 per cent. Despite a fall in the abortion rate from 1.55 to 0.7, abortion continues to be an over-utilized method of family planning and its true rate is likely to be underreported (National Statistics Committee). The country is ranked 67th on the Gender Inequality Index, with a score of 0.353. Gender stereotypes, customs and practices lie at the heart of gender inequality and violence against women. The Government is creating a multi-sectoral prevention and response programme for gender-based violence; however, it is limited and uncoordinated. Women and young people with inadequate access to sexual and reproductive care, education and information are at greater risk of violence. Sexual and reproductive health inequalities are connected to gender inequality. Addressing gender inequality is the key for women and young people to attain the highest achievable standards of sexual and reproductive health and reproductive rights. Young people face institutional and cultural barriers in accessing sexual and reproductive health and HIV information and services. Despite the low incidence of HIV infection (0.16 per cent), HIV prevalence is growing. Although injecting drug use is the main mode of HIV transmission, infection through sexual transmission has grown rapidly from 33 per cent to 66 per cent. According to the data provided by the National AIDS Center, as of 1 April 2019, there are 9,010 officially registered cases of HIV infection. Most of the people living with HIV are able-bodied and of reproductive age. There are more women and young people getting affected by the epidemic.

DESCRIPTION

As there has been a tendency of growing sexual transmission of HIV infection in the country for the last few years, UNFPA Country Office in Kyrgyzstan has been providing technical assistance to the Government in strengthening linkages between SRH and HIV and their integration into the work of both healthcare institutions and NGOs working with key populations to better address the epidemic in the context of combination prevention. The main objective is to reduce sexual transmission of HIV in the country. Thus, there have been two specific thematic national clinical guidelines developed: 1) Support of sexual and reproductive health for people living with HIV, and 2) Support of SRH sexual and reproductive health for key populations. The guidelines has served as a basis for further capacity building of healthcare providers on provision of integrated SRH and HIV services to key populations. Besides, specifically for key populations, there was a manual on support of SRH of key populations and people living with HIV developed. The manual can be used by NGOs working with key populations to build capacity of their clients on SRH issues, including contraceptive choice, STIs, reproductive health diseases, etc. Strengthening linkages between SRH and HIV has been implemented in partnership with the National AIDS Center and civil society organizations. SRH and HIV services will be integrated into the daily routine of PHCs and NGOs and be provided to key

populations respectively.

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

In 2018, under leadership of the National AIDS Center, a wide range of stakeholders decided to identify healthcare settings at the primary healthcare level that will serve as pilot/model settings to provide integrated SRH and HIV services to key populations. The focus was made on the geographical areas most affected by HIV and included Bishkek city, Chuy, Jalalabad and Osh oblasts. As a result, from each of these areas, there were two healthcare settings identified with participation of Oblast level Healthcare Coordinators, Oblast level AIDS Centers, PHCs and most importantly with community members of key populations. In partnership with Kyrgyz State Medical Institute of Continuous Education, there have been institutional capacity of four of the selected PHCs built to date. The training program includes description and identification of each key population groups and their specificities, counselling and providing services based on specific needs of each group, including HIV testing services, contraceptive choice, addressing gender-based violence, prevention, diagnosis and treatment of STIs, viral hepatitis, anal health, male and female infertility, pregnancy, delivery and post-delivery care in key populations, prevention and early diagnosis of tumor of reproductive system, elimination of stigma and discrimination towards key populations etc. Besides, community leaders and outreach workers of NGOs working with key populations were trained based on the manual on support of SRH of key populations and people living with HIV developed and use it in their daily outreach work and capacity building work. To ensure institutionalization of capacity building of PHCs, UNFPA provided technical assistance in development of a training program for healthcare providers on provision of integrated SRH and HIV services with key populations and people living with HIV of the Kyrgyz State Medical Institute on Continuous Education and will be used further to build capacity of healthcare specialists. The Institute approved the program. This also included development of educational methodological package/program on integrated SRH and HIV services for key populations for faculties of the Institute. 22 Professors of the various Faculties of the Institute improved their knowledge and skills on this newly developed training program. The Institute's Family Medicine Faculty will provide its technical assistance to the healthcare providers of the PHCs that built their institutional capacity in managing clients from key population groups based on online ZOOM platform. This implies that based upon request of healthcare specialists from PHCs the Faculty brings together relevant experts/specialists, including from key populations depending on the subject of the issues related to management of clients from key populations. It will be a part of continuous education and capacity building of the medical personnel. Because of the institutional capacity building of healthcare settings, there was a change in the attitudes of medical personnel towards key populations and people living with HIV. This is the most significant part in providing quality services, as reluctance to provide the services triggered by stigma and discrimination results in further growth of HIV epidemic. As the program on integration of the services into PHC level started in 2018 only, at this point of time it is still early to show the number of people reached by the services. However, it is expected that at least 50% of those reached by HIV prevention programs funded by GFATM in Kyrgyzstan i.e. sex workers – 3932, men who have sex with men – 5,754, drug users – 19,627, and people on antiretroviral therapy – 3,237 (The Global Fund data explorer, Results on Kyrgyzstan, 2017, <https://data.theglobalfund.org/results/KGZ>) will benefit from receiving integrated SRH and HIV services that will result in decrease of HIV epidemic in the country and improved sexual and reproductive health of key populations.

LESSONS LEARNED AND RECOMMENDATIONS

Throughout this whole period of strengthening linkages between SRH and HIV services to be provided to key populations, the role of community members, including people living with HIV was critical. As such, community members have been involved and were an equal part of all processes including from development of guidelines, manuals, identifying PHCs to provide integrated SRH and HIV services and significantly building capacity of healthcare professionals. The latter shows the result of community empowerment and treating community members as equal partners and implementing HIV and SRH programmes with key populations and not for key populations. Involvement of key populations at all stages has been a key success factor. Therefore, it is strongly recommended to not only engage, but also provide space for meaningful participation to key populations in all processes. Widespread stigma and discrimination to key populations and people living with HIV is still a challenging problem in the country. There is high level of stigma and discrimination in the society, as well as among healthcare providers. Therefore, providing exhaustive information to healthcare providers on each key population group is of utmost importance, as it helps to change negative attitude, eliminate stigma and discrimination that will result in provision of friendly and quality services based on the specific needs of each group. Leadership and ownership of national partners and the Government of the sexual and reproductive health and HIV programs is crucial to ensure sustainability of the programs.

ANNEXES

11. MALAYSIA

TITLE OF THE PROGRAMME: CARAM Asia Project “Integrated Services of Safe Migration, HIV Prevention and Care for Migrant Workers and Families – (Phase-II)” funded by Robert Carr Fund (RCF) for Civil Society Networks

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- **Programme is being implemented since:** January 2016 - **End** (if applicable): December 2018, however a similar project has been started in 2019 until 2021
- **Responsible party/parties:** ["Civil society"]
- **Population group(s) reached:** ["Migrants, refugees or internally displaced people"]
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy**
No
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

South Asia and Southeast Asia are comprised of many heavily populous, low-income and developing countries, with tendency to export manpower to earn foreign exchange in form of remittances. Migrant's health is an area of concern; especially migrant workers in informal economy are particularly vulnerable as they face many challenges in accessing healthcare and services. Migrants are often exposed to exceptional occupational hazards, face social exclusion and discrimination, language barriers, and interpersonal challenges of migrating that all affect their ability to access health services. Social, economic and political factors in origin and destination countries influence the risk of HIV infection of international labour migrants. These include separation from spouses, families and familiar social and cultural norms, substandard living conditions, and exploitative working conditions. The resulting isolation and stress may lead migrant workers to engage in behaviours which increase HIV risk. In destination countries the Policies and Laws regulating in-migration are chaotic where migrants' health is neglected. Policies are built on the concept of a short-term remedy for

labour shortage problems. Failure on the part of policymakers to recognize critical contribution of migrant workers over the longer term, results in absence of a comprehensive policy on in-migration as an integral part of national strategies. The policies mostly are comprised of Single Entry policy, No sex, No Pregnancy, No Marriage and No children. Thus, CARAM Asia advocates for the formulation of migrant-friendly national policies that are yet far from concrete results at national level. CARAM and member organizations engage with other relevant sectors to influence on migrant's accessibility and affordability of health services and focus on empowering migrants on prevention to reduce risk behaviour and new HIV infections.

DESCRIPTION

CARAM Asia is advocates for protection of migrant worker's health rights with focus on HIV, AIDS and SRHR issues. Based on lessons learned from project implementation and requirements of various stakeholders involved in migration, directly or indirectly as well as identified needs and gaps in the field of migration and HIV, the interventions under this program were to strengthen the overall services for migrant workers by integrating awareness and HIV prevention programs at government policy and practice level and improve the situation for migrants themselves. Working closely with various government departments enhances engagement with new and very relevant people to bring durable changes by adopting recommendations from project partners. The project aimed at raising awareness at larger scale at migrant's community level to significantly contribute in reducing stigma, enhancing PLHV's access to health services and engage large number of new groups into the program. Stigma and discrimination at community level and among staff members at government hospitals is a big obstacle for HIV positive migrants to access health services. Secondly, based on experience from ongoing project most of the positive migrants and their spouses are not economically sound. They have to spend much more money for the nutritious food. Those who are able to take ART from government but they have to bear other diagnostic costs which are expensive. Their livelihood opportunities are very limited. Employer normally does not allow them to work. Therefore this project focused on reducing stigma and discrimination by conducting trainings with hospital staff with expectations to help in increasing positive migrant's access to health services. This project also aimed at facilitating positive migrants to provide livelihood support for their economic reintegration to reduce their poverty and improve their lives with better financial opportunities to access health care. The project focused on developing coordination among private and public hospitals and clinics as well as PLHIV networks to overall enhance positive migrants' access to health. Key objectives: 1. To enhance migrants accessibility to HIV services, prevention, treatment, care and support, by reducing stigma and discrimination and developing coordination among health service providers, NGOs working on HIV issues, HIV networks, government departments and by providing referral and counselling services in project duration and beyond. 2. To advocate for prioritizing positive migrant workers issues in the formulation and implementation of HIV and AIDS policy frameworks at regional and national level as well as protection of HIV positive migrant's human rights, by building capacity of government sectors and sensitizing policy makers gradually by approaching bottom to top hierarchy in three years and beyond project duration. 3. To build the capacity of relevant actors from government and private sectors to enhance effective HIV response in project duration. This regional project was implemented by five CARAM Asia member organizations in five countries in South and Southeast Asia. The list of countries and members is given below: 1- Bangladesh - Oribashi Karmi Unnayan Program (OKUP) 2- Cambodia - CARAM Cambodia 3- Pakistan – SPEAK Foundation (Formerly known as AMAL Human Development Network) 4- Philippines – ACHIEVE (Inc.)

5- Sri Lanka – Community Development Services (CDS)

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

Under CARAM Asia project “Integrated Services of Safe Migration, HIV Prevention and Care for Migrant Workers and Families – (Phase-II),” supported by RCNF Roughly around 9800 people benefited from the activities in three years including 2529 stakeholders comprised of national level institutions including National AIDS Authority (NAA) and National Center for HIV/AIDS, Dermatology and STD (NCHADS) and representatives from various departments and institutions, NGOs and community networks, Parliamentarians, Media, government officers at the Divisional Secretariat (DS) level, hospital staff, ministers of health & foreign affairs. Around 7271 Inadequately Served Populations (ISPs) including, potential migrants, returnee migrants, women migrant’s entertainment workers, HIV positive migrants their spouses and family members. Massive awareness was raised via Television Programs and via celebrating International AIDS day. The project activities enabled CARAM Asia and all partners to strengthen existing collaborations and establish new partnerships with government institutes, communities, other CSOs working on similar issues which resulted in to a step forward in advocacy and capacity building. The sensitization trainings for hospital staff and government officers were conducted in Bangladesh, Cambodia, Pakistan and Sri Lanka. The objective of the Sensitization Workshops was to Eradicate Stigma and Discrimination about HIV/AIDS with hospital staff, and to increase access to services for HIV positive migrants. After the trainings were organised, feedback was obtained from migrant PLHIVs who were referred to health services, and from officers and hospital staff who participated in trainings. Migrants reported that overall stigma and discriminatory practices have been reduced at health services. For instance, now “hospital staff’s behaviour is better than before and they are using appropriate language with female migrant workers who go for medical check-up and STI treatment”. In Bangladesh, staff used to hang a name card on the bed for hospitalized patients with the patient’s name and HIV positive status as a caution for others to be careful. This practice was stigmatizing and shameful for HIV positive patients. Now this practice has been stopped and HIV positive patients are treated as other patients, which has encouraged them to increasingly seek treatment. In Sri Lanka, STI clinic staff have realized that migrants are at high risk of contracting HIV while abroad and have incorporated HIV prevention programs targeting migrants and advocated with STI clinics in Colombo to provide HIV testing programs for returnee migrants. Trained Sri Lankan government officers have also changed their attitude towards PLHIV from fear to compassion, and are standing up for their rights by educating other staff and communities in their areas. The partners organized sessions at community level to raise awareness on HIV prevention and risk behaviors and provided counseling to returnee migrants. After training, one migrant said “I have been living with the HIV virus for the last 10 years. How long should I keep secret my status when I am fine and leading a normal life? The training has increased my boldness - I have revealed my HIV status with people in my village”. Policy Changes: Progress has been made in ensuring that migrant workers have access to preventive information and health services for HIV and AIDS through the recognition of HIV positive migrants as a Key Population Group and Vulnerable Group under the National HIV policies of two countries - Bangladesh and Pakistan. Last year, in both countries, CARAM members were involved in dialogue with relevant ministers working on policy documents. Now, policy documents are finalized with the inclusion of migrants - an improved step in protecting HIV positive migrant workers’ health rights.

LESSONS LEARNED AND RECOMMENDATIONS

Generally, CARAM members under the project worked closely with respective governments as part of our advocacy for recognition of migrant workers as an “at-risk-group” for HIV. Most national policies focus on injecting drug users, sex workers, MSM and transgenders to provide HIV prevention information and health services, but migrants are neglected. Due to advocacy, relevant Ministries have shown a willingness to accept recommendations from NGOs, migrants’ groups and PLHIV Networks to include migrants into the National Policy on HIV & AIDS. In this regard, the National Policy was drafted in Bangladesh and CARAM member OKUP was one of the core group members to provide inputs for the Policy. The draft has been finalized and policy is in place. Similarly, in Pakistan, CARAM member SPEAK formerly known as AMAL was invited by the Ministry of Overseas Pakistanis and Human Resource Development, to take part in policy development for migrants. The Ministry specifically asked SPEAK to work on the HIV section with focus on HIV services for migrants, returnees and deported migrants. Additionally, in Sri Lanka, a CARAM member started working on data dis-aggregation tools for migrants. The Ministry of Health/National STD/AIDS Control Program has taken proposed data for migrant workers and included it into their data collection mechanism with additional dis-aggregated information, which will be useful for advocacy and effective management of counselling & health care for HIV positive migrants. Another Lesson Learned: Empowering HIV positive migrants with knowledge, information and support to work with CSOs at community level with migrants their spouses and other family members and also to work together when have meetings with stakeholders, develop their case studies to share and encourage them to be together for sensitization workshops with health services providers and even for the meetings with government officials. According to experience it becomes a touching moments emotionally when an HIV positive migrant comes in front and tell about his/her experience. It makes difference when people meet HIV positive people in reality and realize that there is no difference between them and HIV positive person. It helps in reducing reluctance in other HIV positive migrants to come forward and seek support. Throughout CARAM Asia projects funded by RCNF the partners trained and empowered many HIV positive returnee workers to go to the community and talk about their rights. In the Philippines the program staff was a returnee HIV positive migrant. It makes difference and help in gaining communities’ trust.

ANNEXES

Research Report: A Review of HIV Policy Progression and Migrant’s Health Rights in Five Origin Countries

III. LATIN AMERICAN AND CARIBBEAN STATES

12. BRAZIL

TITLE OF THE PROGRAMME: Department of Surveillance, Prevention and Control of Sexually Transmitted Infections, HIV/AIDS and Viral Hepatitis, of the Secretariat for Health Surveillance, of the Ministry of Health of Brazil

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- **Programme is being implemented since:** 1986 - **End** (if applicable):
- **Responsible party/parties:** ["Government"]
- **Population group(s) reached:** ["People living with HIV"]
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy**
Yes
- **Is the programme part of a national plan other than the national aids strategy?**
Yes
- **If yes, please specify:** Multi-Annual Government Plan (PPA) and National Health Plan (PNS).

BACKGROUND

I would like to start by providing the historical context of the proposed topic in order to properly respond to the demand of the 44th Meeting of the UNAIDS Programme Coordination Board (PCB) and, then, try to bring the focus of the discussion back to the contribution of the Brazilian experience with the Unified Health System (SUS), in particular the Brazilian response to the HIV/AIDS epidemic, which was consolidated as a significant element of the movement that gave rise to this system. It is not my intention to reduce the complexity of the proposed topic – subject of a global discussion – to a specific experience. Rather, I would like to state that each specific condition may help us see, from various points of view, the paths to be pursued in order to reach universal coverage and the reduction of health inequalities. This debate around the issue of universal coverage and

universal healthcare systems has drawn the attention of several social players and national authorities from the health sector. Mainly, the debate has led to different concepts and understandings about the ideal health system and how it may best meet current demands, in a context of demographic and epidemiologic transitions, as well as the persistent health situations and conditions associated with poverty. Within these contexts, I must admit that there is a consensus around the need to scale up coverage and ensure that it is equally distributed. From my point of view, the issue lies in the model proposed for the problem, separating the notion of universal coverage from universal public healthcare systems. This implies in reformulating welfare options and benefits for society as a whole. This separation compromises one of the most valued healthcare principles, which states that health is a universal right, ratified in 1948 by the Universal Declaration of Human Rights and WHO's directing principles. Therefore, I tend to view the debate around universal coverage as an inseparable element of another debate: universal health systems versus stratified models of care. In general, the main characteristic of a universal health system is the right to health based on social justice and free access, viewed as the pillars of social security and social welfare. However, many of these systems face structural barriers, such as regional imbalances, inequality in the distribution of equipment and healthcare services, and unequal access, as a result of a person's socio-economic condition. On the other hand, stratified models of care, many of which are built around a selected portfolio of services based on an evaluation of a patient's health risk category, with limited access and coverage of services, are costly and more complex, compromising families' income. In general, this model attempts to compensate unequal access by offering a specific set of health care therapies, following the logic that it is necessary to provide customized coverage. In brief, I believe that the Brazilian response has benefitted from a universal healthcare model, such as SUS, with all its contradictions. If the option had been the stratified health care model, we would not have ensured universal access to treatment and prevention.

DESCRIPTION

The Brazilian experience is the result of a historical context of political reforms, which culminated in the 1988 Federal Constitution, responsible for creating the Unified Health System (SUS). The response to the HIV epidemic was built in consonance with the principles of SUS: universality, integrality, tripartite single command, and social participation through a structure that ensures equal and democratic representation of users, healthcare professionals and managers. In the beginning of the HIV epidemic, the Brazilian response introduced one of the core elements of the discussion about universal health systems and universal coverage, "solidarity", a key element to strengthen a democratic society. This was possible because the Brazilian society organized itself and gave rise, in an autonomous manner, to the construction of solidarity through prevention measures and provision of services to support people living with HIV/AIDS (PLHIV). This community-based experience is the main pillar of the Brazilian response. Without social participation and their interventions in the political arena, it would not have reached universal access to treatment and the full right to health. From the constitutional point of view, social participation is an innovation of the Brazilian democracy. Before it was formally consolidated as a public policy, the Brazilian response was built as a social movement, capable of mobilizing different players: academia, healthcare professionals, PLHIV, popular movements, networks of young people, and mainly, most-affected populations (MSM, trans people, sex workers, and people who use drugs). There is another significant aspect of the Brazilian response that must be highlighted in the debate of "universal coverage", which was the reaction of the Brazilian response to the World Bank's strategy. The World Bank, in the 1970's, established the separation between prevention and assistance in the repertoire of measures to face the

HIV epidemic, fostering the need for specific strategies, as registered in the publication “Confronting AIDS: public priorities in a global epidemic.” The Brazilian response thus followed another path by adopting the indivisibility between prevention and comprehensive care, well before international recommendations. Furthermore, instead of an approach centered on individual risk, the country adopted the concept of programmatic, social, and individual vulnerability, as defined by Jonathan Mann. In this context, a new element is introduced to counterbalance the idea of universal coverage: indivisibility between prevention and integral healthcare supposes universal access to treatment of all people who need universal access to prevention. The third point I would highlight is the approach to health as a right, that is, as a fundamental human right. This approach has consolidated the basis of the Brazilian response, because it focuses on respecting human rights and fighting stigma and discrimination. The issue of health as a right opposes the stance that views health as a business or even as a battlefield for the market’s interests, as it protects the citizen while granting the State the role of health promoter and regulator. As a result, the Brazilian response has gained importance as it included human rights as a reference to design prevention and comprehensive healthcare actions. By adopting this position, it has been possible to repeal initiatives such as the “criminalization of HIV transmission”, “compulsory testing”, “breach of confidentiality”, and even prevention measures based on “abstinence”. It is important not to restrict the universal coverage debate exclusively to the supply and demand of health services, as there are many barriers related to discrimination, structural violence and social inequalities. The Brazilian response is an important experience for a developing country that pursues a public healthcare system based on the principle of universality.

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

Having as reference the pillars of social participation and solidarity, and the indivisibility between prevention and healthcare assistance as a fundamental right of every citizen, I would like to describe some of the results and their impacts on the discussion about universal coverage. First, the most relevant result has been ensuring that all people living with AIDS have access to treatment, and guaranteeing that everyone has access to prevention and diagnostic supplies, including condoms, rapid tests, and clinical monitoring tests. This approach has advanced over the years, allowing the incorporation of innovative technologies and the adoption of protection measures, resulting in the timely adoption of treatment policies for all. This includes offering post-exposure prophylaxis for people at risk of HIV, STIs and viral hepatitis infections, as well as pre-exposure prophylaxis to reduce the risk of HIV infection – a combination of strategies for universal access, universal coverage and targeted actions, while still taking into account the notion of the right to health. Graph 1 presents a historical series of the growing number of people on antiretroviral treatment in Brazil. Graph 2 shows the AIDS mortality coefficient in Brazil, since the beginning of the HIV epidemic. The decline in mortality, in different historical moments, is attributed to the offer of free-of-charge antiretroviral treatment in 1996, and the adoption of treatment for everyone living with HIV, in 2014. The second contribution lies in the construction of a solidarity network, based on the historic experience of social participation in the Brazilian response to the epidemic. I point out the Brazilian experience in this regard, because I do not normally find, in current discussions and documents related to “universal coverage”, any reference to the strategies developed by community-based organizations. This omission, from my point of view, is a mistake and compromises access and coverage, especially when we consider that the populations we deal with suffer stigma and segregation. Community-based social participation is important and may guide decision-making processes related to health policies, in a more solidary and fair manner. Finally, I point to the need to reaffirm the

experience of keeping alive the flame of health as a fundamental right for all and, through this, to seek a healthier, more solidary and less unequal society.

LESSONS LEARNED AND RECOMMENDATIONS

In general, I would like to highlight the arguments previously presented in regard to the Brazilian response, that is, the indivisibility between prevention and assistance, which may also be translated into indivisibility between access and universal coverage; direct participation of community-based organizations in the formulation of health policies; and the advances of discussing health as a fundamental human right.

ANNEXES

Graph 01: Number of people living with HIV who started and were on ART. Brazil, 2000-2018. Graph 02: AIDS Mortality Coefficient. Brazil 1980-2017.

IV. WESTERN EUROPEAN AND OTHER STATES

13. ALBANIA

TITLE OF THE PROGRAMME: Voluntary Counseling Testing services in prison settings – a comprehensive response to reduce HIV prevalence in low resource settings.

CONTACT PERSON

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- **Programme is being implemented since:** 2012 - **End** (if applicable):
- **Responsible party/parties:** ["Government"]
- **Population group(s) reached:** ["Prisoners"]
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy**
Yes
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

Albania is a low HIV prevalence country where the epidemic is driven due to sexual contacts (80% heterosexual and 10% homo/bisexual). HIV prevention programmes in prisons are small in scale and rarely comprehensive in nature. A programme supported by UNFPA/Albania under the leadership of government institutions and in strong partnership with civil society organizations has been implemented and consists in establishment of voluntary counseling and testing (VCT) centers, guidelines development, and strengthening of leadership and management capacities in prison settings.

DESCRIPTION

Nine VCT centers are established in prisons (8 male and 1 female) followed by training of socio-health and security prison staff. Guidelines on HIV management and surveillance reporting forms were also developed. Advocacy and consultative meetings at both political and technical level were carried out. A Bio-BSS survey was carried out covering 11 prisons and 210 prisoners. Prison administration provides management of this initiative and thanks to political

and institutional support and commitment we consider this programme a sustainable one. Prison administration, civil society organizations as well as Ministry of Health and Social Protection and Institute of Public Health are the main partners in this process.

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

- VCT network in prison settings completed (9 VCT centers) where testing is available and results are given in real time (15 minutes); - Eight advocacy meetings were carried out with General Prison Administration representatives; - Risk reduction activities with prisoners organized. The aim of these activities was to inform prisoners about HIV/AIDS prevention, safer sex, substance abuse and practicing healthy behaviors during and after prison time; - More than 800 prisoners attended IEC activities (male and female prisons) attended the information activities; - National workshops organized with prison socio-health: medical staff and social staff (social workers, psychologists and educators); - Framework Guideline for Successful Transition of Young People with Mental or Substance Use Disorders from Jail/Prison to community, developed; - Engagement and action among key actors at country level, to fully address rights and needs of young key populations in policies, programmes, strategies and services, focusing in prison community, strengthened

LESSONS LEARNED AND RECOMMENDATIONS

- Political and institutional support and commitment in establishment of VCT system in prison settings ensures / guarantees programme sustainability and continuation; - Engaging beneficiaries in early phase of programme (start-up and implementation) ensures great success in achieving programme outcomes / results; - Prevention programs for vulnerable groups should be tailored and gender oriented, and services should be provided based on their needs; - Collaboration and fruitful partnerships among key stakeholders / actors becomes critical in a successful implementation of the programme.

ANNEXES:

14. ESTONIA

TITLE OF THE PROGRAMME: National HIV Action Plan

CONTACT PERSON

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- **Programme is being implemented since:** 2003 - **End** (if applicable): 2007
- **Responsible party/parties:** ["Government", "Civil society", "UN or other inter-governmental organization"]
- **Population group(s) reached:** ["People living with HIV", "People who use or inject drugs", "Sex workers", "Men who have sex with men"]
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy**
Yes
- **Is the programme part of a national plan other than the national aids strategy?**
Yes
- **If yes, please specify:** National Health Plan

BACKGROUND

HIV started to spread rapidly in Estonia in the beginning of the 2000s, when the number of new HIV cases registered per year more than tripled in 2001 reaching 108 cases per 100 000 population. Since then, the number of new HIV cases has been stably decreasing over the years. Among key affected populations, HIV prevalence is the highest among people who inject drugs (PWID) (in the range of 48–66%) and lowest among men who have sex with men (MSM) (between 2 and 4%). Among other key affected populations (sex workers and people in detention facilities), the prevalence is lower than 16%. Although the spread of the virus has for many years mostly been related to injecting drug use, in recent years, new HIV cases have mostly been related to heterosexual intercourse. In 2017, 219 new HIV cases were registered, with over 70% occurring in people aged over 30. The main route of transmission was heterosexual intercourse (39.7% of new HIV cases). Homosexual intercourse accounted for 6.8% of the cases and 6.4% were related to injecting drug use.

DESCRIPTION

Since the end of Global Fund financing (the program lasted from 2003 to 2007) Estonia has established a sustainable financing for the service package intended to reduce the incidence of HIV, from which many services were initiated during the Global Fund financing period. All the services (including ART and other treatment services) are provided free of charge for all Estonian residents regardless of their citizenship and health insurance status. The financing scheme includes broadly three pillars. Health care services, such as ART, infectious disease specialist services, and HIV testing are financed through Estonian Health Insurance Fund, who reimburses these services for people with health insurance. The Ministry of Social Affairs of Estonia reimburses the same service package to people without health insurance, and Estonian National Institute for Health Development finances specialized services for key affected populations that are essential in HIV response. These services include amongst other case management, voluntary counselling and testing, opioid substitution therapy, low threshold services where at-risk people can get counselling, HIV rapid test and other necessary services (e.g. harm reduction centres for people who use drugs and counselling centres for people involved in prostitution), prevention campaigns and training of specialists in order to reduce stigma.

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

Altogether 7 770 people have been diagnosed with HIV in Estonia (during the period of 2000-2017), from whom 5 939 were alive as of 2017. In 2017, 4 109 (70%) of them received antiretroviral treatment (ART) from whom 87.3% had an undetectable viral load (<200 copies/mL). Based on HERMETIC mathematical modelling there are approximately 916 people living with HIV, who are not aware of their diagnosis. Thus, approximately 85% of people living with HIV in Estonia are aware of their diagnosis.

LESSONS LEARNED AND RECOMMENDATIONS

Although in some areas of Estonian HIV response the capacity is still low (e.g. there is a need for scaling up integrated services and services for people who use drugs and men who have sex with men), there are several examples that can be brought out as good practices:

- 1) Treatment coupled with case management service In Estonia four out of five HIV treatment centres offer case management to people living with HIV, which includes different types of counselling provided by specialized nurse, social worker, psychologist and peer counsellor. The latter is a representative of community and is an important member of this team. Service has several purposes that largely depend on the patients' needs. Case management specialists help patients to cope with their diagnosis and get over the initial shock that may accompany the diagnosis. They also help to identify people possibly exposed to the infection (e.g. sexual partners of diagnosed people) and encourage them to take up HIV test. Case management team has an important role linking vulnerable patients to other healthcare and social services by assisting on booking appointments, facilitating meetings with local social services etc. They also seek out patients that have discontinued their treatment in order to increase retention in care. The latter is mainly carried out by peer counsellors and includes cooperation with harm reduction services if patients lost for follows up are actively using drugs. Case management is provided as an integral part of the treatment and it is a good example of integrated service model, where healthcare services are coupled with social services, which is especially important when many of the patients belong to vulnerable population groups such as people who use drugs. As of 2017, 397 patients initiated ART for the first time in their life and 334 of them received counselling from case management specialists. 322 patients restarted ART and from them 52 were sought

out by peer councillors, who motivated them to continue the treatment. 2) Integrated service for ART and opioid substitution treatment To improve retention in ART as well as opioid substitution treatment, one HIV treatment centre offers an integrated service, where both treatments are delivered by infectious disease specialist. This service i

ANNEXES:

15. POLAND

TITLE OF THE PROGRAMME: National Programme for Preventing HIV Infections and Combating AIDS.

CONTACT PERSON

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- **Programme is being implemented since: 2001 - End** (if applicable): No
- **Responsible party/parties:** ["Government", "UN or other inter-governmental organization"] Government
- **Population group(s) reached:** ["People living with HIV", "People who use or inject drugs", "Prisoners" etc] Prisoners
- **Has the programme been evaluated/assessed:** Yes, In accordance with the national regulations, health care programmes run in prisons are subject to annual monitoring
- **Is the programme part of the national aids strategy:** Yes. The program is part of the National Programme for Preventing HIV Infections and Combating AIDS. The current edition of the program concerns years 2017-2021.
- **Is the programme part of a national plan other than the national aids strategy?** No

BACKGROUND

Since 2001, the Penitentiary Service implements the Antiretroviral treatment of persons living with HIV in Poland program, financed by the Minister of Health. In alignment with WHO guidelines, this program allows prisoners full access to free-of-charge ART and provides same services those as offered to people living with HIV outside the penitentiary system. As of 1 July 2015, OST programme financed by the Ministry of Justice has been made available to all those in need in all 155 penitentiary units in the country. The National AIDS Centre, from the MoH budget, subsidizes and monitors HIV prevention and health promotion activities implemented by Polish NGOs and CSOs, based on the Schedule for implementation of the national programme for preventing HIV infections and combating AIDS. These activities aim to address the needs of the general population, people living with HIV and key populations, including people who inject drugs, prisoners and MSM. At present, among incarcerated persons who are HIV positive, 70% report being people who inject drugs; thus, treatment efforts are being directed towards this group.

DESCRIPTION

Each year, the Ministry of Health allocates funding to ensure the procurement of ARVs, tests and vaccines for children (in 2018 approx. 60 million EUR). The National AIDS Centre developed the system of purchasing ARVs and monitoring drug management optimize the use of funds and streamline drug distribution in the country, including among key populations. ART and OST programmes in Poland are fully funded by the Ministry of Health and Ministry of Justice, respectively. Both programmes are implemented by medical and social staff working in the prison service. In accordance with the national regulations, health care programmes run in prisons are subject to annual monitoring. National Programme for Preventing HIV Infections and Combating AIDS for 2017-2021 assumes undertaking activities in five areas: prevention of HIV infections within the entire society, prevention of HIV infections among persons with higher levels of risky behavior, support and healthcare for HIV positive persons and persons suffering from AIDS, international cooperation, monitoring.

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

In 2008, OST was only an option for inmates who had been receiving OST prior to incarceration. In 2008, 87 inmates were receiving OST and OST programmes were running in 19 penitentiary units in five cities in Poland. As a national strategy on OST was lacking, it was difficult to provide continuous OST during referral from one institution to another or between the penal system and re-entry to the community. As of 1 July 2015, OST has been made available to all those in need in all penitentiary units in the country. ART and OST programmes are available to all inmates who need and want to join them. A large emphasis is placed on involving inmates in educational programmes organized in prisons, including for health.

LESSONS LEARNED AND RECOMMENDATIONS

It would not be possible to effectively implement both ART and OST program in prisons without close and good cooperation between all entities responsible and interested in their implementation. This good practice is the direct result of a strong relationship between the National AIDS Centre (Ministry of Health) and the Central Board of Prison Service (Ministry of Justice).

ANNEXES

No

16.1. UKRAINE

TITLE OF THE PROGRAMME: Capacity building of law enforcement representatives and judges on Human Rights and HIV/AIDS

CONTACT PERSON

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- **Programme is being implemented since:** 2017 - **End** (if applicable):
- **Responsible party/parties:** ["Government", "UN or other inter-governmental organization"]
- **Population group(s) reached:** ["People living with HIV", "People who use or inject drugs", "Prisoners"]
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy**
No
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

Ukraine still faces the second highest HIV epidemic in Eastern Europe and Central Asia. Even though new HIV cases are decreasing globally, Ukraine continues to experience an increase in HIV incidence, especially among key populations at higher risk of HIV. The findings demonstrate that stigma, discrimination and human rights violations of people living with HIV/AIDS are widely spread in Ukraine. Despite implementation of the plan for the transition to complete state financing of services related to HIV and tuberculosis previously funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria, and overall improvements in both the health care and human rights environments relevant to HIV and TB in Ukraine, certain barriers to service provision persist. Law enforcement officials are seen globally as key actors in the prevention of disease, among which HIV and TB are leading pandemics. Due to the specificity of their work, police officers maintain constant contact with key populations vulnerable to HIV. Police should be in the process of preventing any violation of human rights of people living with HIV, people who use drugs and other categories that, due to their marginalization, are not able to effectively counteract illegal actions or protect and restore their own rights in the case of a violation. As a part of its mandate, UNDP actively collaborates with the law enforcement representative to combat the HIV and TB epidemics in Ukraine.

DESCRIPTION

As part of UNDP's HIV/TB response and support for the rights of key populations, and in partnership with the Ministry of Internal Affairs, UNDP held three trainings on HIV and human rights for law enforcement officers from Kyiv, Odesa, and Sievierodonetsk cities in September 2017. The trainings covered HIV, human rights, gender-based violence, and how to provide gender-responsive services for most-at-risk populations. Following this activity, and in partnership with the National Police of Ukraine, UNDP Ukraine developed the Training of Trainers (TOT) Guide for the National Police on "Human Rights and HIV/AIDS" and piloted it in Kyiv city. The main goal was to provide guidelines for the capacity building of law enforcement representatives related to ensuring the rights of people living with HIV and key populations in the context of HIV/AIDS response, development of the tolerant attitude and prevention of stigma and discrimination against people living with HIV and key populations. The Guide is comprised of 6 modules to be delivered either as a part of the curriculum for the on-job trainings for law enforcement or in a two-day training format. The theoretical and practical elements of the ToT Guide build law enforcement's capacity to address HIV/AIDS challenges by revealing the relationship between human rights and HIV/AIDS as a behavioral illness, sharing international standards and national legislation that regulates the rights of people affected by HIV/AIDS and practicing the skills of responding to the crimes committed by persons with special needs (ART, SMT) in the context of the HIV/AIDS response. The ToT Guide applies interactive teaching methods on HIV and human rights and provides instruction on how to evaluate the training. In addition to work with the National Police, UNDP established a communication platform with judges on HIV, TB, and human rights issues, identifying the role of judges in reducing stigma and discrimination.

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

The Guide was piloted as part of the training for trainers in Kyiv in September 2018. As a result of the training, 23 trainers, who were representatives of the Ministry of Internal Affairs (MIA) from different regions of Ukraine, shared their newly developed knowledge and skills in their respective regions by conducting similar trainings for students of police academies. To date, more than 100 students of police academies have benefited from this initiative. The Guide is currently undergoing revision in the MIA and once it gets final approval, it will be recommended by the MIA to be included in the national curriculum of the police academies, which will increase geographic coverage and the number of people reached by this activity. Regarding the work with the judges, more than 14 judges from different judicial levels, including the Supreme Court, joined a UNDP Human Rights Breakfast in November 2018 to share their experiences and discuss challenges related to their work. UNDP maintains communication with them, engages them in national and international events, and forwards them pertinent literature and other materials related to the HIV/TB and human rights response to raise their awareness and contribute to a zero-discrimination attitude.

LESSONS LEARNED AND RECOMMENDATIONS

Facilitating ToTs for non-health state actors (law enforcement representatives) cascades capacity-building efforts to prevent stigma and discrimination that ultimately affect key populations' health. Key populations tend to face stigma and discrimination acutely from law enforcement and the judicial system. This results in mistrust with and marginalization from public institutions, while exacerbating the inaccessibility of services. Building the capacity of front-line law enforcement and judicial decision-makers shifts the culture of mistrust and heals

relationships between key population communities and the state. This intervention contributes to achieving UHC by ensuring that the social determinants of health are structurally addressed and demonstrates that the health system is responsive to the on-the-ground reality of key populations. The ToT model empowers law enforcement's ownership of a vision for inclusivity and cascades a shift in culture from police for police through its incorporation into the police academy's curriculum. Maintaining a communication platform with judges makes 'passive' capacity-building possible within their tight schedules and sets the foundation for more intensive future collaboration.

ANNEXES

16.2. UKRAINE

TITLE OF THE PROGRAMME: Implementation of the Legal Environmental Assessment for Tuberculosis in Ukraine

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- **Responsible party/parties:** ["Government", "Civil society", "UN or other inter-governmental organization"]
- **Population group(s) reached:** ["people affected by TB", "People living with HIV", "Migrants, refugees or internally displaced people"]
- **Has the programme been evaluated/assessed:** No
- **Is the programme part of the national aids strategy?**
No
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

Ukraine still faces the second highest HIV epidemic in Eastern Europe and Central Asia. In addition, Ukraine is among the 30 MDR-TB burden countries in the world and WHO states that the TB epidemic in Ukraine is characterized by widespread multi-drug resistant (MDR) and extensively drug resistant (XDR) tuberculosis (TB), high mortality from untreated or inappropriately treated TB, and increasing TB/HIV co-infection rates. The socio-economic hardship has been aggravated by political crisis and war in the East of Ukraine with more than one million Internally Displaced Persons (IDPs) throughout the country who need emergency assistance including TB and TB/HIV care. Under the signed Association Agreement with the European Union, Ukraine takes measures to comply with the European regulatory requirements and the development of a public health approach, including measures for epidemiological surveillance, HIV, tuberculosis and other communicable diseases infection control, prevention of substance abuse, expansion of harm reduction programs, introduction of modern technologies for the donation of blood or other tissues and organs, as well as the development of primary health care. Despite the adoption of the Stop TB Strategy by the National TB Programme (NTP), components of the Strategy have not been sufficiently implemented and while there have

been improvements in both the health care and human rights environments relevant to HIV and TB in Ukraine, certain barriers to service provision persist.

DESCRIPTION

To address the complicated epidemiological situation, UNDP Ukraine and Stop TB partnership conducted an assessment of Ukraine's national legal and regulatory framework regarding TB legislation. The primary aim of the Legal environment assessment for Tuberculosis in Ukraine (TB LEA) was to identify and review TB, HIV, health and any other related laws, regulations and policies and practices that have an impact on the national response to TB. A range of laws (not just health laws) were implicated because TB is not just a health/medical issue, but also an issue that requires deep inquiry into the structural factors of inequality, power, personal and social dynamics. The TB LEA included a range of laws affecting TB key populations, such as: children's laws that set out children's rights; family, marriage and inheritance laws providing information on the rights of women to own and inherit property; criminal laws that affect people with TB (e.g., laws that criminalize non-adherence to TB medication or call for the solitary confinement of people with TB and MDR-TB); laws that criminalize the behaviour of key populations at risk for TB including people who inject drugs; intellectual property laws that restrict or promote access to TB medications; correctional service laws that determine access to services for prisoners; citizenship, immigration/migration and/or refugee laws that determine access to services for non-citizens; employment laws that set out the rights of people with TB in the workplace, and necessitate non-discrimination and compensation; and disability laws that set out the rights of people with disabilities. The report was released in 2018 and presented at the 49th Union World Conference on Lung Health in October 2018 jointly with the Public Health Center of the Ministry of Health (MOH) of Ukraine. The outcome of the TB LEA was a set of recommendations proposed to strengthen the legal environment, including through law review, reform, and programmes to increase awareness of the right to legal services. In consideration of the epidemiological variation throughout the country, recommendations were prioritized through stakeholders' consultations using a bottom-up approach from the local to the national level.

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

The stakeholders' consultations were held in 3 districts of Ukraine (Dnipro, Ivano-Frankivsk and Poltava oblasts) and resulted in the development of 3 local action plans based on TB LEA key recommendations for the TB response that were endorsed by the local Country Coordinating Mechanism (CCM) committees for further implementation. Based on this experience, the national consolidated action plan was also developed and further incorporated in the Strategic Plan for a comprehensive response to human rights barriers for access to HIV and TB prevention and treatment by 2030. In addition, UNDP and the Public Health Centre of the Ministry of health of Ukraine initiated a stakeholders' platform to facilitate an action-oriented dialogue to explore how cooperation at the national level can contribute to the implementation of the TB LEA recommendations at all levels. Key partners and stakeholders from different ministries, government institutions, NGOs, UN agencies, international organizations, as well as patient groups and professional organizations contributed to the discussion and agreed on the next steps. It was agreed that the Public Health Center of the Ministry of Health of Ukraine will lead, coordinate and monitor the implementation of the plan.

LESSONS LEARNED AND RECOMMENDATIONS

Identifying specific legal barriers to health access and effective epidemic response using a

human rights framework catalyses global partnership and local action on law reform for key populations. TB LEA has provided a specific road map of obstacles impeding an effective HIV and TB response. The report also indirectly addresses the legal challenges of incorporating HIV and TB response within a sustainable health system for UHC and galvanizes political will to meet global calls such as 90-90-90 targets and Agenda 2030. As the TB epidemic in Ukraine requires a joint integrated response, the bottom-up approach in the implementation of the TB LEA recommendations enables coordination and cooperation between local and national stakeholders to overcome the social and economic problems caused by TB, protecting and respecting the rights of people affected by TB in order to achieve the Sustainable Development Goals. Country-specific and area-based LEAs for Universal Health Coverage (UHC) would provide explicit lists of legal barriers and gaps for stakeholders to coordinate their efforts on. This can speed up decision-making for both local and national actors and provide a clear evidence base for global support. Assessing the specific legal barriers that key populations face accessing UHC and engaging all stakeholders in addressing these issues is critical for equitable and inclusive UHC.

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17. UNITED KINGDOM

TITLE OF THE PROGRAMME: Call to Action: Civil Society working on HIV engaging effectively in UHC

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- **Programme is being implemented since:** 2018 - **End** (if applicable): 2020
- **Responsible party/parties:** ["Civil society"]
- **Population group(s) reached:** ["People living with HIV", "People who use or inject drugs", "Sex workers", "Men who have sex with men", "Women and girls", "Young people"]
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy**
No
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

Civil Society organisations working on HIV have a weak understanding of universal health coverage. Organisations did not have the knowledge or tools to engage with other civil society organisations and governments regarding UHC. Organisations needed to prepare for engagement at national, regional and global level on UHC. Key principles of engagement and advocacy plans and implementation were needed. It was necessary to identify the tools that CSO and community lead groups needed for more effective engagement with the UHC agenda.

DESCRIPTION

-Increase knowledge of CSO of UHC -Share information on key country contexts -Define an action plan -Create tools to facilitate CSO involvement with UHC The UHC: Call to Action workshop brought together 45 participants from 37 organizations working on HIV, 24 countries, from 5 continents. It included representatives of key populations networks. It was organised and financed by SCDI, Frontline AIDS, Aidsfonds, and the Partnership to Inspire, Transform and Connect the HIV response (PITCH). This initial workshop had the following results: Deeper understanding of the UHC and the global agenda Sense of urgency was generated and a

commitment to be involved in the UHC agenda. Deeper understanding on what is happening in terms of UHC implementation in different countries. Understand what UHC really means in practice and providing participants with a better knowledge around the three dimensions of UHC: 1) Understanding who is covered, 2) which services are covered and 3) proportion of the costs covered. Reducing the resistance to the UHC agenda. "Some participants have moved from being UHC-resistant, or UHC-sceptic to becoming UHC-enthusiastic as a result of the workshop. Many other have moved "from not knowing to knowing, from not understanding to understanding, from doing nothing to being ready to take action" – as one put it. " Common agreement on key Principles for UHC were define: the right to health at the centre; prioritizing and ensuring political and financial support to community responses for health; ensuring accountability and multisectoral platforms for UHC; key focus on the most marginalised, and ensuring meaningful involvement of key populations and continue to push for decriminalization; building partnerships within health and beyond (social movements and human rights movement, economic justice, social cohesion, ministries of finance...); build on existing experiences and learning from the HIV response. Concrete action plan was defined at the level of their institution, their countries, or their regions. Further capacity development needs identified especially in terms of health financing. Many spoke of concrete actions to be taken – at the level of their institution, their countries, or their regions. · There are big concerns about UHC leaving key populations behind. · There was a common sense for an increased engagement with UHC debates, while at the same time ensuring (advocating for) specific approaches to HIV services (vertical approach, within and outside UHC debates), particularly in specific countries, areas and populations. So, it is not UHC versus HIV but both should exist and build on each other. · Risks, opportunities and challenges to integrate HIV within UHC. Community mobilization and community systems strengthening are necessary to ensure no one is left behind. Most of the opportunities referred to getting more support to community responses, advocating for the right to health and for more resources for health, including from domestic governments. Many concerns about how the UHC debates are going on, with little engagement from CSOs, no human rights approach etc. The biggest identified risk was about undermining all the progress done on HIV worldwide or diluting the HIV approaches in the language of broader health. Implementation of UHC plans -National and regional CSO meetings have taken place by PITCH project. -Participation and support to young leaders to participate in UHC consultations --Africa Health Agenda International Conference - Rwanda Participation in the Multisectoral meeting in preparation of UHC HLM - support to Young leaders and CSO representatives with the support of the READY movement. Social media presence and support from READY movement Pre conference meeting prior to IAS HIV Scientific Conference with support from GF. Social media presence Frontline AIDS Discussion guide on UHC financing produced and shared with technical teams of CSO engaging on UHC.

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

39 organisations increased knowledge of UHC and have action plans on UHC 14 organisations are engaging actively in the discussions on UHC Active presence in social media of young people living with HIV in regional and global consultations -- Discussion Guide: How to finance UHC-- document produced and shared at multisectoral meeting on UHC HLM.

LESSONS LEARNED AND RECOMMENDATIONS

-UHC literacy and understanding of budget frameworks is necessary for effective engagement with this agenda. We need to engage with financing for health discussions. -Understanding process countries are following to achieve universal health coverage is essential. Very few

countries make the processes they are following public. PITCH project has collected data from various countries that has been essential for advocacy efforts. -Engagement and dialogue with government is essential. Donors are able to push governments to make information available on their UHC processes: definition of essential package of services, what is covered by primary health care, how things were costed finances. They can push governments to make budget process public and criteria or process used to prioritise services public. -Guttmacher Lancet Accelerate Progress -SRHR May 2018 provides an excellent gold standard for Primary Health Care package -- knowing where each country is regarding UHC is essential and a useful tool for advocacy -CSO working on HIV need to have deeper understanding of budget frameworks. - UHC is country specific. UHC and HIV programmes must not be seen as either/or. UHC does not mean the HIV programme will be dismantled. However, the question of how to deliver good services around one disease will have to be re-thought and negotiated. It is essential that agreement is reached on what the essential intervention package should look like and how to ensure that the necessary medicines and commodities are available and that services are accessibility and accountable. Meaningful community engagement is critical for the achievement of UHC, as is strengthening and improving the actual capacity of the community to effectively do so. The priority for civil society in its engagement with UHC is to ensure that all marginalized population are included and 'No one is left behind'. It is essential to prioritize those who are excluded, to listen to hitherto unheard voices, to ensure that UHC really leads to the Right to Health. Equity must be an integral part of the process of achieving UHC. Civil society has a key role in checking progress towards UHC, and ensuring that governments and other service providers are held accountable. Civil society must educate itself and others on what UHC ensure that the lessons are learnt from the HIV experiences.

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Discussion Guide on UHC

18. UNITED STATES OF AMERICA

TITLE OF THE PROGRAMME: Fenway Health (Fenway Community Health Center)

CONTACT PERSON

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- **Programme is being implemented since:** Fenway Health has been providing HIV care since the early 1980s - **End** (if applicable):
- **Responsible party/parties:** ["Health center"]
- **Population group(s) reached:** ["LGBT people", "People living with HIV", "People who use or inject drugs", "Men who have sex with men", "Women and girls", "Young people"]
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy**
Yes
- **Is the programme part of a national plan other than the national aids strategy?**
Yes
- **If yes, please specify:** We work closely with US government agencies and local government to prevent, screen for, reduce HIV/STIs especially among LGBT people, and to promote affirming health care, including behavioral health care, for LGBT people.

BACKGROUND

A growing body of research has documented lesbian, gay, bisexual, transgender (LGBT) health disparities in health and disease outcomes, risk behaviors and factors, rates of insurance coverage, access to preventive care, and access to culturally competent, affirming care. Anti-LGBT discrimination in health care correlates with poorer health and well-being for LGBT people, and can cause LGBT people to not access health care. Poverty, stigma, lack of health insurance, and medical mistrust are factors in Black gay and bisexual men not being engaged in regular health care. Transgender women, especially Black and Latina transgender women, are disproportionately vulnerable to HIV infection, but they are less likely than other populations to receive regular medical care and adhere to their HIV medications due to similar factors affecting Black gay and bisexual men.

DESCRIPTION

Fenway Health offers an integrated model of care in which behavioral health is integrated into primary medical care. We serve 32,000 patients from the Greater Boston area. About half are LGBT, 2200 are people living with HIV, 3000 are transgender, and 1000 are gender nonbinary. Fenway uses a trauma informed approach to care and collects sexual orientation and gender identity data from patients to inform decision support and preventive screenings and to improve quality of care.

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

Since its founding in 1971, Fenway Health has provided culturally competent, affirming health care for LGBT patients. This is essential to keeping LGBT people retained in care. We also offer family medicine--including assisted insemination, pediatrics, optical and dental care.

LESSONS LEARNED AND RECOMMENDATIONS

Train all staff in the unique needs and experiences of LGBT patients across the life course age spectrum. Highlight the particular experiences of LGBT people who are racial/ethnic minorities, people living with disabilities, youth or elders, living in rural areas, immigrants and/or who are not proficient in English. Collect sexual orientation and gender identity data and use it to improve quality of care.

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Mayer K. et al., The Evolution of the Fenway Community Health model, American Journal of Public Health, 2001; Cahill S, Baker K, Deutsch M, Keatley J, Makadon H. (2016). Inclusion of sexual orientation and gender identity in Stage 3 Meaningful Use guidelines a huge step forward for LGBT health. LGBT Health. 2016 Apr;3(2):100-2. Cahill S, Taylor SW, Elsesser SA, Mena L, Hickson D, Mayer KH (2017). Stigma, medical mistrust, and perceived racism may affect PrEP awareness and uptake in Black compared to White gay and bisexual men in Jackson, Mississippi and Boston, Massachusetts. AIDS Care. 29(11): 1351–1358. Cahill S, Mayer K, & Boswell S (2015). The Ryan White HIV/AIDS Program in the age of health care reform. American Journal of Public Health. 105(6): 1078-1085. Volpi C, Cahill S (2018, April). Retaining transgender women in HIV care: Best practices in the field. Boston: The Fenway Institute.

V. MULTIPLE COUNTRIES

19. GLOBAL

TITLE OF THE PROGRAMME: HEALTH FOR ALL: Position Statement and Recommendations to Member States regarding Universal Health Coverage

CONTACT PERSON

Name: Michaela Clayton

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Organisation: UNAIDS HIV and Human Rights Reference Group

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- **Programme is being implemented since:** 2001 - **End (if applicable):**
- **Responsible party/parties:** UNAIDS and Independent Human Rights Experts
- **Population group(s) reached:** Key populations, people living with HIV, UNAIDS and cosponsors, policy makers, community groups, governments, donors.
- **Has the programme been evaluated/assessed:** N/A
- **Is the programme part of the national aids strategy:** N/A
- **Is the programme part of a national plan other than the national aids strategy?** N/A
- **If yes, please specify:**

BACKGROUND

The HIV pandemic has demonstrated powerfully the fundamental importance of attention to human rights in the ongoing effort, at global and country levels, to achieve universal access to health. It is essential that the UHC agenda be informed by these lessons. It is equally essential that the response to HIV that has been mobilized, internationally and at country level, not be weakened or diluted in efforts to achieve UHC, and indeed should be strengthened not only to achieve the HIV-related Sustainable Development Goal in Agenda 2030 but as a necessary element of achieving the broader UHC goal that has been adopted by the international community.

As an international advisory body with expertise on HIV and human rights, the UNAIDS Reference Group on HIV and Human Rights therefore takes this opportunity to highlight key

factors for consideration by Members States and others in crafting the Political Declaration to be adopted later this year — including principles and outcomes that must, as a matter of consistency with Member States' human rights obligations, guide the way forward toward achieving UHC.

DESCRIPTION

The UNAIDS Reference Group on HIV and Human Rights was established in 2002 to advise the Joint United Nations Programme on HIV/AIDS on all matters relating to HIV and human rights. As an international advisory body with expertise on HIV and human rights, the UNAIDS Reference Group on HIV and Human Rights therefore takes this opportunity to highlight key factors for consideration by Members States and others in crafting the Political Declaration to be adopted later this year — including principles and outcomes that must, as a matter of consistency with Member States' human rights obligations, guide the way forward toward achieving UHC.

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

Defining the agenda for achieving UHC is a key opportunity to advance the needs and rights of people living with and affected by HIV at all ages and to reach the goal of eliminating AIDS as a public health threat by 2030, another of the SDG goals. It is also an opportunity to reflect, strengthen and apply, on a broader scale, the principles and strategies upon which the HIV response has been built: people-centered, rights-based, gender-transformative approaches towards the elimination of health disparities to truly leave no one behind. The world's experience of the HIV pandemic, and of the failures and successes of our ongoing collective response, must inform the UHC 2030 agenda.

To this end, the Political Declaration that will help define the UHC agenda must reflect the understanding that it is essential to remove structural barriers to universal health coverage and promote social enablers that are critical for achieving universal coverage and sustainability — including community and political mobilization, treatment literacy, law and policy reform, monitoring of the equity and quality of program access, reduction of stigma and discrimination, and the defence and promotion of human rights for all, and in particular for those most marginalized and whose rights are regularly violated.

The Reference Group therefore presents below, in relation to four key themes, 10 recommendations to Members States and others (including UNAIDS and other UN entities) regarding the UHC 2030 process, including the Political Declaration, and the implementation of the UHC agenda.

Themes:

1. Member States must address key barriers to equitable and affordable access to health care.
2. Member States should ensure that sexual and reproductive health services, as well as programmes for and protections against gender-based violence and services that are accessible to young people, are included within UHC priorities.
3. Member States should dedicate at least six percent of all global health resources to addressing social enablers to achieve UHC.

4. The UHC 2030 agenda should institutionalize community engagement across all dimensions of health: needs assessment, service delivery, research, monitoring and evaluation, and governance.

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Position paper from HIV and Human Rights Reference Group:

<http://www.hivhumanrights.org/statements/health-for-all-position-statement-and-recommendations-to-member-states-regarding-universal-health-coverage/>

20. INDONESIA, KENYA, UGANDA AND UKRAINE

TITLE OF THE PROGRAMME: Towards Transformative Integration of HIV/AIDS Response Into Universal Health Coverage - Building on the Strengths and Successes of the HIV/AIDS Response

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- **Programme is being implemented since:** 2018 - **End** (if applicable): December 2018
- **Responsible party/parties:** ["Civil society", "Academic institution"]
- **Population group(s) reached:** ["People living with HIV", "People who use or inject drugs", "Sex workers", "Men who have sex with men", "Women and girls", "Young people"]
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy**
No
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

We submit to this call the findings of a collaborative research study between the Partnership to Inspire, Connect and Transform the HIV response (PITCH) and the London School of Hygiene and Tropical Medicine, summarised in the policy report, "Towards transformative integration of the HIV and AIDS response into Universal Health Coverage: Building on the strengths and successes of the HIV and AIDS response". PITCH is a strategic partnership between Aidsfonds, Frontline AIDS and the Ministry of Foreign Affairs of the Netherlands. To better understand how HIV is being integrated into UHC in-country and to assess whether this integration is possible without major deterioration of the strengths and advances of the HIV and AIDS response, a multi-country assessment was carried out in Indonesia, Kenya, Uganda and Ukraine. These four low- and middle-income countries were selected as case studies from the PITCH programme. The researchers carried out desk reviews and key informant interviews with representatives from government, civil society, and development partners in each country to elicit their views on the main risks and opportunities of integrating HIV into UHC. The study aimed to clarify whether

such integration is possible without jeopardising the key strengths contributing to the success of the HIV and AIDS response. The global policy report is available from: https://frontlineaids.org/wp-content/uploads/2019/03/0034-PITCH_Global-Report_WEB.pdf and <https://aidsfonds.org/resource/integrating-the-hiv-response-into-universal-health-coverage>.

DESCRIPTION

The research report is part of the five-year Partnership to Inspire, Transform and Connect the HIV response (PITCH) programme. The aim of the research is to inform national and global debates around UHC implementation to ensure UHC takes a rights-based approach and includes comprehensive and equitable health services for people living with HIV (PLHIV), key populations and all who need them, building on the successes and lessons of the HIV and AIDS response. The research was led by Gorik Ooms, Professor at the London School of Hygiene and Tropical Medicine (LSHTM) with the support from PITCH global and country policy staff. As a programme, PITCH is focused both on building the capacity of civil society organisations (CSOs) to advocate for equal access to HIV-related services, sexual and reproductive health and rights for those most affected by HIV, and equal and full rights for key populations (KPs). KPs most affected by HIV and engaged by PITCH are lesbian, gay, bisexual and transgender people (LGBT), including men who have sex with men (MSM), sex workers (SW), people who use drugs (PUD), and adolescent girls and young women (AGYW). PITCH is a strategic partnership between Aidsfonds, Frontline AIDS and the Dutch Ministry of Foreign Affairs (MoFA), and is funded through the Ministry's Dialogue and Dissent strategic partnership programme. It focuses on nine countries: Indonesia, Kenya, Mozambique, Myanmar, Nigeria, Uganda, Ukraine, Vietnam, and Zimbabwe. The programme also features global policy and regional programme components (in Southern Africa and Eastern Europe and Central Asia).

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

The aim of the research study was to verify whether some key strengths of the HIV/AIDS response are present in country, these strengths being: matching political commitment with the mobilisation of resources; efforts to include everyone; involvement of civil society and communities in the provision of services; and inclusion of civil society and communities in essential decision-making processes. The study found that integration of HIV/AIDS into UHC has the potential to make the response more sustainable, and UHC more inclusive and rights-based. This was reflected in the following findings: i. Increased sustainability due to limited dependency on unpredictable and short-term donor funding cycles that have been typical in the HIV/AIDS response. ii. More equitable resource use and distribution across the health sector. iii. Reduced fragmentation of health systems leading to improved healthcare access for PLHIV and key populations in integrated settings that address multiple health needs, and consider PLHIV holistically as patients with multiple health needs beyond those that are HIV-specific. iv. Stigma reduction against PLHIV and key populations by addressing HIV as a more 'mainstream' health issue among many other health issues. v. Engaging of people living with HIV and key populations in broader health decision-making in a more inclusive and meaningful way, thereby increasing inclusion and acceptance of these groups. However, there were five main challenges identified for integration of HIV into UHC, as follows: 1. Declining international support for HIV and health poses a major risk for the effective integration of the HIV and AIDS response into UHC. Domestic resources may not be sufficient to achieve UHC in the foreseeable future and already limited resources will be spread even more thinly across competing health priorities. Even where governments can fund their own HIV and AIDS response, they are not always willing to ensure comprehensive HIV and health services for everyone. 2. Domestic funding mechanisms for UHC come with their limitations for HIV services and key populations. In all four

study countries, whether HIV services will be included in National Health Insurance Schemes is still undecided. The risks with NHIS are that they frequently exclude the informal sector and marginalised populations from enrolment and thus access to services. 3. Legal barriers and prohibitive laws risk leaving key populations behind in UHC. Development partners have historically been key players in challenging restrictive or discriminatory laws that target marginalised populations, but there is a risk that this influence will diminish as domestic financing and control over finances increases. 4. The risk of collapse of the community response to HIV and AIDS. An increase in domestic funding could risk the sustainability of key population services which, within the HIV/AIDS response, have previously been provided through local CBOs, with international funding, and subsequently also mean a loss of non-medical services such as prevention, social protection. 5. Lack of meaningful civil society participation in UHC decision-making processes at country-level. There is limited involvement of civil society in UHC planning and monitoring processes in all four study countries. Most key informants interviewed for the study are cautious supporters of integrating the HIV and AIDS response into UHC. But this is caveated with successful integration needing to ensure a gradual transition to integration and gradual replacement of donor funding with domestic resources. Meaningful civil society and community engagement is also emphasised as paramount to ensuring that community voices are fully taken on board. Safeguarding the human rights aspect of HIV/AIDS advocacy & programming (and funding this) was also seen as critical, alongside the need for UHC plans to include all HIV and AIDS services (including ART, a prevention budget and community response

LESSONS LEARNED AND RECOMMENDATIONS

The study identified both challenges and opportunities for integration of HIV/AIDS into UHC. Key learnings are illustrated below through some country examples, which are further explored in the report. Matching political commitment to resource mobilisation: In all four countries, domestic health financing is insufficient for the HIV response: a falling budget allocation to health in Uganda; a heavy reliance on external funding for the HIV response in Kenya; exclusion of key populations in Indonesia's national health insurance scheme due to the requirement of registration via a family health card; and transition of activities and funding away from Global Fund NGO principal recipients to the new national Public Health Centre rising to 80% of the national budget by 2020. Efforts to include everyone: In all four study countries, criminalisation, stigma and social discrimination present major barriers to key populations accessing HIV and health services. On the positive side though, human rights advocacy – which has been a critical component of the HIV and AIDS response – continues. There are concrete results in Kenya, where 'Comprehensive Care Centres' are sensitising and training health workers to increase awareness on less stigmatising and discriminatory behaviour and in Indonesia, where a strong civil society is mobilising around human rights advocacy and for multi-stakeholder engagement with the government. . The continuation and increase of international funding for human rights advocacy within UHC is critical to ensure key populations are not left behind. Involve civil society and communities in service provision: Community responses to HIV and AIDS are the cornerstone of effective, equitable and sustainable HIV and AIDS services, delivering non-medical services (such as HIV prevention), and advocating for the right to health. But this work is currently underfunded by donors, and the community response risks being diluted when HIV is integrated into UHC. Two strong examples where this isn't the case: in Ukraine CSOs working with the Public Health Centre are expanding the scope of their work successfully, beyond HIV and AIDS, rooting key populations in Ukraine's public health strategy; and Ugandan HIV and AIDS services are well integrated with other services, with key populations interventions included through the 'MARP initiative'. Include civil society and communities in decision-making: Similarly, the successes of the HIV and AIDS response would not have been achieved without

the inclusion of people living with HIV in decision-making (under the ‘nothing about us without us’ principle). At present, there are no clear national UHC mechanisms in place in the study countries, and a possibility of HIV and AIDS engagement mechanisms being dissolved with GF withdrawal. Where there is strong engagement in HIV and AIDS decision-making via well-functioning platforms, such as the Global Fund Country Coordinating Mechanisms in Ukraine, there is potential for these to become national UHC engagement platforms. In Kenya, civil society involvement in decision-making is already an embedded way of working, and has continued in the new ‘UHC Benefits Package Advisory Panel’, directly transferring this approach to UHC engagement. The global policy report makes key recommendations to governments, to international development actors, and to local civil society. These are summarised below, but can be read in full in the policy report. Recommendations to governments I. Prioritise general tax-based financing to strengthen the public health system, negotiating with development partners to fill gaps. II. Negotiate transition plans and financial support required to meet UHC and HIV and AIDS goals. III. Create legally and socially enabling environments for all people to access health care without discrimination. IV. Implement enforcement mechanisms for local and regional governments to follow national guidance and policies;

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The global policy report is available from: https://frontlineaids.org/wp-content/uploads/2019/03/0034-PITCH_Global-Report_WEB.pdf and <https://aidsfonds.org/resource/integrating-the-hiv-response-into-universal-health-coverage>.

21. KAZAKHSTAN, KYRGYZSTAN, TAJIKISTAN

TITLE OF THE PROGRAMME: Improving Retention in HIV Care and Treatment through Nurse-led, Home-based Care in Central Asia

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- **Programme is being implemented since:** 2011 - **End** (if applicable):
- **Responsible party/parties:** ["Government", "Civil society"]
- **Population group(s) reached:** ["People living with HIV", "People who use or inject drugs", "Sex workers", "Men who have sex with men", "Women and girls"]
- **Has the programme been evaluated/assessed:** Yes
- **Is the programme part of the national aids strategy**
Yes
- **Is the programme part of a national plan other than the national aids strategy?**
No

BACKGROUND

HIV incidence continues to rise in Central Asia and Eastern Europe. Between 2010 and 2015, there was an estimated 57 percent increase in new infections each year. By 2015, there were 1.5 million people living with HIV in the region, only 20 percent of whom were accessing antiretroviral therapy (ART). Access to ART and retention in care is particularly low among key populations facing high levels of stigma and discrimination, such as people who inject drugs, sex workers, and men who have sex with men. Challenges to retention and adherence include stigma, discrimination, lack of family support, and the opportunity costs related to health care (travel time and costs, clinic wait times, income loss, etc.). Increasing retention in care and adherence to ART requires people-centered services that are organized around the health needs and preferences of people living with HIV. Home-based care is an intervention that has the potential to reduce many of these barriers to sustained HIV care and treatment. Nurses often have the most direct contact with patients and have proven to be the most effective home-based caregivers. The Home Visiting Nurse Program, which began in 2015, is being

implemented at all 20 ICAP-supported health facilities in Kazakhstan, Kyrgyzstan, and Tajikistan. The program is being implemented in close partnership with the ministries of health and the Republican AIDS Centers in each country, as well as local health education institutions. To date, ICAP's support has included training home visiting nurses in comprehensive HIV management, providing mentorship and clinical supervision to home visiting nurses, creating linkages to other services for people living with HIV, and institutionalizing the identification of treatment supporters. The Home Visiting Nurse Program is part of ICAP's broader work in the region, which includes the revision of national clinical protocols in the three republics, strengthening HIV management nursing curricula, providing regional training on the clinical management of HIV and TB/HIV co-infection, and supporting adherence counseling, data analysis, disease monitoring, laboratory activities, the development and roll-out of an electronic HIV case management system, and medication assisted therapy and risk reduction programming for people who inject drugs.

DESCRIPTION

Targeting the Most At-Risk Patients for Home-based Care: Using data extracted from the electronic HIV case management system, clinic HIV care and treatment supervisors identified and prioritized patients with whom home visiting nurses should connect. The aim was to reach patients most at risk of falling out of care and those who had already discontinued treatment or were no longer in contact with the clinic. To maximize the impact of the home visits, patients who had previously initiated ART were prioritized for home-based visits. **Developing a Cadre of Well-Trained Nurses Equipped with HIV Management Skills:** ICAP found that a considerable number of nurses in clinical departments were unable to perform basic HIV management tasks, such as adherence assessments. Nursing schools in the region offer little in the way of HIV clinical management training, leaving most graduates ill-equipped to take on more than basic clinical roles. Most nurses are not included in HIV capacity building programs and receive little or no formal, HIV-specific postgraduate training. ICAP's wider program in the region focuses on addressing this training gap in a number of ways, including through curriculum development, training, and clinical mentoring support. The new home visiting nurses were included in many of the national and on-the-job HIV trainings ICAP was providing in Kazakhstan, Kyrgyzstan, and Tajikistan. This included receiving general HIV training and targeted training on ART adherence, tuberculosis (TB) symptom screening, opioid substitution therapy, and homebased care. **Task Shifting:** Physicians in the region are often overburdened and ensuring that nurses are properly trained can help alleviate some of their workload. ICAP supported clinical supervisors to review which tasks could be transferred to the home visiting nurses, which freed up physicians' time to see additional patients in the clinic. As part of this task-shifting, home visiting nurses in Kazakhstan now conduct TB symptom screening and adherence monitoring, tasks that were previously done by physicians. **Embracing a Holistic View of Adherence Barriers:** ICAP encouraged nurses to use home visits as an opportunity to understand patients' living situation and apply that knowledge to improve patient care. For example, home visiting nurses can get a first-hand look at patients' routines and support systems, working with them to address adherence challenges and tailoring their ART regimen if needed. Similarly, nurses can see if stigma is a cause of non-adherence and work with patients to develop strategies to minimize stigmatizing circumstances in the future. **Ensuring Robust Supervision of Home Visiting Nurses** ICAP developed quality improvement tools that helped health facility managers oversee the day-to-day management of home visiting nurses, including helping them determine which patients the nurses should visit and to delegate specific tasks to nurses based on indicators and problem areas (e.g., increase adherence work, provide ART education, refer for CD4 count or viral load testing). ICAP also built the capacity of health facility managers to effectively monitor and evaluate the work of home visiting nurses, providing monthly mentorship and support visits

to each facility as well as additional support when needed. Identifying Treatment: To enhance the Home Visiting Nurse Program, ICAP introduced the practice of identifying treatment supporters to help patients follow their care and treatment plan. Once identified, the treatment supporter signs a mutual support agreement with the patient, promising to take on support responsibilities, such as reminding the patient to take his or her medications and to attend scheduled clinic appointments.

RESULTS OUTCOMES AND IMPACT OF THE PROGRAMME

The following key achievements resulted from the support ICAP provided to local partners in Kazakhstan, Kyrgyzstan, and Tajikistan in 2015 and 2016: • Increased the proportion of people living with HIV still on treatment 12 months after starting ART: - In Kazakhstan's East-Kazakhstan Oblast, the proportion increased from 54 percent to 72 percent - In Kyrgyzstan, the proportion increased from 55 percent to 82 percent • Trained 39 home visiting nurses • Conducted over 15,230 home visits • Conducted 49 facility-based mentorship visits • Developed and introduced a training manual/curriculum for nursing schools at postgraduate universities in Kazakhstan and Kyrgyzstan • Assisted 163 people living with HIV to restart ART • Provided HIV counseling to 340 sexual partners and tested 166 • Re-engaged 134 previously lost-to-follow-up patients in treatment

LESSONS LEARNED AND RECOMMENDATIONS

The following lessons were learned during the implementation of the Home Visiting Nurse Program: Nurses need targeted training to enable them to manage HIV care and treatment effectively. Care from home visiting nurses can improve patient retention in care and adherence to treatment. Home visiting nurses spent significant time with patients, often more than would be the case in a clinic environment. As such, they had a unique opportunity to gain a more complete understanding of the patient's needs, discuss a wider spectrum of issues related to the patient's health, and improve patient retention in care and adherence to treatment. Home visits can reduce care delays and interruptions by bringing services directly to patients' homes. Social stigma can be overcome through home-based care. Patients affected by social stigma demonstrated improved adherence to medication when provided with health services in the privacy of their own homes. Well-functioning health facilities are needed for successful home-based care. The home-based care model is not effective if home visiting nurses cannot refer patients to health facilities that are functional for needed follow-up testing and care. This includes clinics that can provide speedy CD4 and viral load tests and are well-stocked with HIV test kits and needed medications. Home visiting nurses require support. Providing HIV care is demanding and emotionally exhausting work. It is important that home visiting nurses be linked to support services to ensure that they have the continued energy and capacity to provide quality care to people living with HIV in the community.

ANNEXES

https://icap.columbia.edu/wp-content/uploads/Central-Asia_Home-Visiting-Nurses-Brief_ENGLISH.LR_single_27Feb17.pdf

22. TANZANIA, UGANDA

TITLE OF THE PROGRAMME Integrating Legal Empowerment and Social Accountability for Quality HIV Health Services for Adolescent Girls and Young Women

CONTACT PERSON

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- **Population group(s) reached:** Children, Women and girls and Young people
- **Programme is being implemented since (indicated start year):** November 2016 to November 2018
- **Responsible Party/Parties:** Civil Society, UN or other inter-governmental organization
- **Has the Programme Been Evaluated/Assessed?** Yes
- **Is the Programme part of the National AIDS strategy?** Yes
- **Is the programme part of a national plan other than the national aids strategy?** Yes
- **If yes, which:** PEPFAR country operational plans

BACKGROUND

In sub-Saharan Africa, three out of four new HIV infections among 15–19-year-olds are among adolescent girls and young women (AGYW) (UNAIDS 'Women and Girls and HIV', 2018). AGYW are more vulnerable to HIV because they are often subjected to a range of gender and age-based biases, discrimination and violence, including sexual assault, forced marriages and trafficking. Both AGYW and their communities often lack economic, social and cultural support and resources to assert their rights and bring about their own protection and well-being.

Despite growing HIV-related responses, AGYW and their communities most often do not have the capacity, voice and power to hold service providers accountable for improved delivery of quality HIV-related services. Even when information is available, it does not enable AGYW and their communities to act. Furthermore, AGYW and their communities do not have the tools to demand improved HIV-related responses, including clear processes to access remedies and stronger structures to compel quality services.

While legal empowerment (LE) and social accountability (SA) strategies have evolved separately, they share common aims and overriding principles. Both promote human rights and social justice and provide knowledge and skills to individuals and communities to act and seek solutions to problems through grassroots education, mobilization and empowerment. Further,

they help strengthen participatory decision making and power-sharing between poor and marginalized communities and state authorities.

Globally, the integrated use of legal empowerment and social accountability (LE+SA) strategies has been successfully utilized with respect to health and HIV programming. However, use of LE+SA within a cohesive and multipronged intervention for HIV prevention programming among AGYW is an innovative and unique approach in this field. Using these approaches in combination can address weaknesses in one approach through strengths of the other.

DESCRIPTION

Project Goal: To reduce new HIV infections among AGYW by strengthening demands for quality HIV prevention services while increasing capacity of service providers and government actors to use rights-based local engagement and feedback processes for improving HIV prevention service delivery for all.

Project Objectives

The program relied on a blend of legal empowerment and social accountability efforts to maximize results, focusing on three components:

1. Empowering AGYW and their communities to demand quality HIV-related service delivery for AGYW, including protection against GBV and discrimination;
2. Enhancing local health committees and service providers' capacity to develop and use rights-based local engagement and feedback processes for improving HIV-related AGYW service delivery; and
3. Improving policy debates on HIV-related service delivery for AGYW through evidence-based monitoring.

Project Outputs

1.1. Paralegal pools established and prepared for community capacity development on HIV-related AGYW services, including on legal, health and gender frameworks, AGYW rights and gender-based violence (GBV) support systems;

1.2. AGYW knowledge and skills on HIV-related services (including on GBV) and their rights increased;

1.3. Community knowledge and skills on HIV-related services for, and rights of, AGYW increased;

2.1. Paralegal pool trained in developing and implementing legal empowerment and social accountability tools;

2.2. Increased local/ village health committees' capacity and influence to hold HIV service providers accountable;

2.3. Local grievance and justice processes established or strengthened;

3.1. Increased capacity of health service providers, police and other justice actors on legal aspects of HIV service delivery, gender and rights of AGYW and their communities;

3.2. Lines of feedback and process for integration into policy established with the Ministry of Health (MOH) / National AIDS Program (NAP) and Ministry of Justice (MOJ)/police;

3.3. Legal aid services utilised to address individual and/or collective rights violations relating to access, providing and fulfilling HIV services for AGYW, including GBV cases; and

3.4. Lessons generated at National and Regional level for replication and scale up.

Project Implementing Partners

In Tanzania: The Legal and Human Rights Centre (LHRC); and

In Uganda: The Centre for Health, Human Rights & Development (CEHURD).

Project Beneficiaries

AGYW in the targeted Districts; AGYW peer educators; Paralegals in community-based organisation in each District; Members of the AGYW communities (e.g. partners, spouses, children, parents, family members, community leaders) and Community-based organisations in each District.

The project was funded by ViiV Healthcare through the Positive Action for Women and Girls program. The project was part of the DREAMS Innovation Challenge - an expansive partnership aimed at reducing new HIV infections among sub-Saharan African AGYW.

The project was implemented alongside the IDLO project 'Building Sustainable Approaches to Reduce Discrimination and Advance Access to Justice for People Living with HIV and Other Key Affected Populations ('Law Schools Project'), also in Tanzania and Uganda.

Results Outcomes and impact of the programme:

[The number of people reached and geographic coverage. What has the programme achieved in terms of integration of HIV responses into sustainable health services for UHC, increased quality of care, integration, changes in laws, policies, practices, and attitudes, etc. Please provide information or references for any evaluations carried out]

The IDLO project focused on empowering AGYW and their communities by building knowledge and skills in the community in a sustainable way. To this end, AGYW project beneficiaries were involved in every step of the project life cycle to integrate their perspectives throughout implementation of all activities.

With a view to enhance legal empowerment and social accountability skills and knowledge of targeted groups in both Tanzania and Uganda, implementing partners CEHURD and LHRC, with support from IDLO, developed manuals and delivered trainings involving over 550 participants from among AGYW community advocates, health providers, representatives of village health committees and justice sector professionals in the targeted districts.

To strengthen legal empowerment at the community level, the project conducted awareness raising through media and communication campaigns, as well as community engagement meetings including dialogues with AGYW, their parents, local community leaders and government officials. Over 200 among AGYW community advocates and representatives from community-based organizations trained by the project in both countries were involved in legal aid support activities, with the aim to enhance peer-to-peer learning and reach AGYW and communities in the four districts targeted. Overall, AGYW community advocates engaged with 3,214 AGYW in Uganda through 11 safe spaces provided by DREAMS partners. In Tanzania, 9,240 AGYW were reached through 161 safe spaces.

At the policy level, national dialogues were held with the aim to establish lines of feedback and advocate for policy reform with the Ministry of Health and National AIDS Program and the

Ministry of Justice. Finally, a legal fund to support legal-related costs for AGYW was developed in both countries and managed by implementing partners with IDLO support.

Through implementing partners, IDLO also worked with service providers, including healthcare professionals from district and village health facilities, justice sector professionals, local government officials and village health committee representatives, to build their capacity and understanding of the legal aspects of HIV service delivery. Gender sensitive training was provided to raise awareness among service providers of the rights and needs of AGYW and their communities. In Tanzania, 66 health and legal service providers, 77 village health committee members, and 50 justice sector professionals were trained. In Uganda, 100 among health and legal service providers and village health committee members were trained as well as 70 justice sector professionals.

In addition to these trainings, social accountability mechanisms such as new lines of communication allowing community members to give feedback to legal and healthcare providers were also introduced so that AGYW and their families can hold providers to account when their rights are not being realized. Specifically, community dialogues were conducted by IDLO and implementing partners, as a mechanism to administer community scorecards on experiences with HIV health and justice service provision. Existing village health committees were also strengthened through training on their role and responsibilities in channeling complaints from community members and holding health service providers accountable.

Programme Evaluation

An independent program evaluation will be completed by mid-2019. Contact IDLO for more information.

LESSONS LEARNED AND RECOMMENDATIONS

The combined use of LE and SA approaches in health-related interventions is evolving. These approaches have been integrated in various ways to advance development goals. IDLO's programming represents another step forward for LE+SA with respect to HIV prevention programming. As outlined in preceding sections, the choice of and implementation of mutually reinforcing LE and SA interventions and strategies as a cohesive integration from the outset has led to significant progress in ensuring AGYW have access to effective HIV prevention information and services in the focus districts, in both Tanzania and Uganda. Based on the foregoing sections, the key lessons and opportunities identified are summarized as follows.

Lesson 1: Adopt LE+SA programming to reinforce strategies and address gaps

IDLO's programming shows that if designed in a coherent and integrated fashion from the start, the benefits of programs combining LE and SA approaches in the context of HIV prevention interventions targeting marginalized groups are twofold: SA and LE reinforce each other's seminal elements and characteristics; and they complement gaps left by single approach interventions.

Commonly, both approaches rely on capacity building to provide knowledge and skills to both service providers, on delivering on their duties in accordance with human rights and gender equality, and individuals and communities, to empower action and contribute to broader awareness raising, education and mobilization. Moreover, they promote a rights-based approach to health service delivery and access to justice, focusing on human rights and avenues to redress violations. Finally, they are both targeted at influencing high level decision-

making, albeit through the use of different tools and approaches. Both LE and SA also have inherent weaknesses that may prevent programming from achieving objectives and ensuring a long-term positive impact on the lives of those affected. Therefore, it worked to ensure that the strengths of one approach were used to reinforce the other in a complementary way throughout the entire project life cycle.

While SA approaches can be effectively utilized to collectively address identified problems, they often fail to consider the specific interests and needs of the vulnerable and marginalized.

Moreover, SA alone does not provide avenues for redress with respect to identified issues, which is central to achieving meaningful change. LE interventions can fill this gap by promoting structural policy and legal reform through multiple strategies such as high-level advocacy, judicial precedent setting, and communication campaigns to mobilize media and generate broader public support. Moreover, LE focuses on removing barriers to redress and access to justice in individual and collective cases, using legal frameworks as a basis for action, and strategies to reach the most marginalized, ensuring that their rights are upheld.

Similarly, SA includes information interventions that help increase knowledge and awareness of community members, empowering claims to rights and better services. However, SA information interventions are primarily aimed at enhancing transparency or service delivery and decision-making processes. It is also necessary to consider answerability mechanisms, compelling service providers and power-holders to recognize their responsibilities and account for their actions, leading to greater compliance with legal standards and collectively agreed norms or objectives. Indeed, SA tools such as the community scorecard, participatory budgeting, social audits and citizen report cards enable communities to access timely information and use it as the basis for formulating enforceable demands.

Finally, while LE approaches are contingent on individual or community initiative for interventions to proceed, SA tools - such as the community scorecard - allow the institutionalization of long-term monitoring, while others, such as village health committees, enable continuous feedback between service providers and users, ultimately leading to the maintenance or improvement of services' quality.

Given this understanding, IDLO integrated elements from both approaches into the design stage and throughout project implementation, adapting activities to emerging needs and contextual dynamics. This included comprehensive capacity building, the parallel implementation of LE and SA strategies, as well as the combination of the two approaches into single activities or processes, as with the community scorecard. Additionally, a fit for purpose, comprehensive monitoring, evaluation, research and learning (MERL) framework, integrating complementary methods and tools allowed for monitoring LE and SA interventions jointly, building on a clearly defined theory of change. This implies consistent and constant monitoring through the use of both traditional and technical tools, as well as user-friendly community-owned monitoring tools such as the case tracker and the community scorecard action plans.

In particular, a multi-stage participatory tool such as the community scorecard, allowed a combined approach by establishing a participatory social accountability process at the community level, while at the same time bringing legal empowerment to life through providing the community with a forum to learn about their legal entitlements in relation to HIV, voice their needs and identify violations of their rights.

In fact, beyond creating accountability channels for HIV prevention services, the process served to enliven core human rights tenets highlighted in the context of the LE interventions, as discussions reaffirmed HIV related rights of communities (entitlements) and the corresponding set of responsibilities and obligations for the state (e.g. the principle of accountability of government to people). As community awareness of service entitlements and knowledge of applicable HIV prevention related laws and regulations was strengthened, AGYW and other marginalized individuals were empowered to voice their needs.

Moreover, the community scorecard also helped reinforce coordination and cohesion among different community constituencies, bringing additional value to the project through an integrated monitoring framework. As previously noted, action plans will be used by selected community focal points to ascertain the extent to which results at different government levels are being achieved, what lessons are emerging from the context, and how these should inform future programming.

Lesson 2: Implement an overarching, tailored-to-context programming strategy

Adopting a multi-faceted approach is essential for a comprehensive, tailored-to-context LE+SA intervention. The first step is to understand intricacies of the local context. This means identifying the issues, who needs to be engaged to address them, the avenues, forums and strategies that are useful to do so, and is contingent on credible evidence drawn from both primary and secondary sources of data.

IDLO's approach was phased as first, a review of secondary data collected by partners for preliminary context analysis; and second, targeted needs assessment and community mapping studies in project focus districts. Primary research in the inception phase of the project provided insights on specific contextual issues instrumental in guiding the design, implementation and monitoring of LE+SA strategies. More specifically, it enabled the project to map existing HIV health services for AGYW and assess the capacity of community organizations, village health committees and existing local grievance and justice delivery systems to support AGYW in claiming their right to health and accessing quality HIV services, including in SGBV cases. To ensure the success of LE+SA initiatives, a number of contextual factors had to be considered and needed further efforts to be addressed. IDLO's initial context analysis was used to identify core considerations such as imbalanced gendered power structures, technical capacity gaps of justice actors and health workers, poverty prevalence in certain areas, and illiteracy in some instances. In particular, where interventions are intended to primarily benefit AGYW, it is important to take cognizance of structural gender inequality and strengthen their agency through a rights-based and gender-responsive approach. This meant building interventions based on continuous consultations with AGYW and acting on identified needs and priorities.

The needs assessment and community mapping studies were also instrumental in identifying partners working on different issues, such as poverty reduction strategies and health services. Strengthening coordination among DREAMS partners facilitated joint implementation of initiatives targeting multiple groups of beneficiaries. In particular, it may be possible, through partnerships, to identify and reach new categories of beneficiaries that play a central role in perpetuating gender inequality and risky behaviors or violence, such as parents, adolescent boys and young men (ABYM), and schools. Focusing on AGYW may raise questions on why ABYM are not benefiting from similar interventions. This makes it important to consider partnership with institutions that have a track record of deconstructing negative masculinities in ways that lend themselves to addressing unequal power relations that contribute to HIV prevalence and incidence amongst AGYW.

Finally, this type of contextual collaboration with other DREAMS partners was essential to identify different areas of expertise and increase the mobilization of resources. Coordinated efforts among multiple partners led to joint implementation of initiatives contributing to the overall attainment of the DREAMS partnership goal. This included the identification of AGYW to work alongside and the use of DREAMS partners' safe spaces as forums where AGYW community advocates could engage their peers on LE+SA interventions.

Lesson 3: Divide roles and responsibilities strategically

Assembling a program team whose expertise lends itself to the attainment of project results is necessary both with respect to the lead and implementing partners. In the case of a community-based intervention such as the DREAMS partnership, this entails a team comprised of persons with knowledge of LE+SA from a conceptual stand-point, expertise in legal, health, girls' and women's rights and hands-on experience in community engagement, among others.

For this purpose, identifying implementing partners strategically is crucial to ensure that the necessary competencies and networks can be leveraged both in understanding the context and enhancing ownership of the project during implementation. This is especially important for structured in-country presence in the program areas.

IDLO engaged in various efforts geared towards identifying implementing partners as well as additional key local actors during the design and inception phase. These included network scanning and in-person missions to assess partner competencies first-hand. Selection criteria was based on the expertise and capacity of partners, as well as their networks, presence, and relationships with state and non-state actors at national and local levels. To enhance coordination among partners, it was critical to formally define roles and responsibilities through sub-grant agreements from the outset, in line with identified roles and responsibilities.

Additionally, for other local partners, the needs assessment and community mapping studies identified critical actors such as community-based organizations and DREAMS partners, their focus and assessed their capacity to engage in LE+SA and community mobilization. This was crucial to reach beneficiary groups, identify potential areas of complementarity, gaps and priority areas for improvement in HIV service delivery for AGYW.

Finally, in community-based and multi-pronged interventions of this nature, regular provision of technical support when required by implementing partners is crucial, as it allows issues identified to be dealt with expeditiously. IDLO provided regular support and guidance remotely as well as directly in country, through both informal and formal interactions, including progress meetings and workshops for implementing partners. Moreover, technical support was leveraged with respect to the knowledge produced throughout project, including the development of legal manuals and the conceptualization of advocacy mechanisms such as the national dialogue processes and the combination of LE and SA approaches through initiatives such as the community scorecard.

However, while dividing roles presents multiple benefits, one of the lessons emerging from the project is the need to envisage technical support and regular field presence to provide for unexpected capacity gaps. Indeed, in multidisciplinary projects of this nature, partners might have specific expertise and strengths in some areas, but they might need extensive guidance and support in others. Further lessons and areas for improvement will continue to emerge through the cross-cutting analysis of findings resulting from the present study, impact monitoring reports, as well as the final evaluation of the project.

Lesson 4: Build and embed local ownership for sustainability

IDLO's strategy in this sense was two-fold. The first focused on linking key stakeholders at country level. The second was building ownership in the project. Both are crucial to facilitating long-term collaboration with state and non-state actors who are central to the sustainability of the project.

In the inception phase of the project, buy-in from key stakeholders in the HIV sector at national level including the Ministries of Health and National AIDS Commissions was obtained through preliminary country missions as well as the signing of memoranda of understanding between the implementing partners and community-based organizations, and local government

authorities. This facilitated the identification of AGYW to involve in the project and of complementary initiatives by other actors around HIV prevention.

Given the initial lack of coordination between multiple DREAMS partners working in the similar or complementary areas, IDLO focused on ensuring coordination of activities between implementing partners and DREAMS partners in the field, and between the former and local and national government actors. This included the establishment of quarterly progress meetings in both Uganda and Tanzania, where DREAMS partners provided status updates on their individual projects, as well as regular national dialogues with local and national administrations around HIV prevention.

Indeed, post-project sustainability will be determined by the successful institutionalization of multi-actor initiatives such as the national dialogues, and LE and SA mechanisms such as the safe spaces for paralegal and awareness raising activities and the One-Stop Center. Ownership of the project at community and national levels is also central to the sustainability of implemented LE+SA interventions. Avenues for building local ownership include the engagement of influential opinion leaders or authorities such as village chiefs, local governments, national AIDS commissions, and community-based organizations. This contributes to the legitimization of project initiatives and facilitates direct involvement of beneficiaries in interventions both at national and community levels.

In this regard, the One-Stop Centre in Kahama-Tanzania is a mechanism that enables central access to health and justice sector related HIV prevention services and is a sustainable avenue for engaging AGYW community advocates, providing a space where they can exercise knowledge and skills gained from the project. If fully operationalized, the Centre may serve to build experience with practical aspects of providing centralized HIV prevention information and services for AGYW and replicate it beyond the district.

Institutionalization of the LE+SA approach by implementing partners vis-à-vis HIV prevention among AGYW is an opportunity to build on work commenced in the project so that momentum derived is maintained. As previously outlined, partner integration of programming into strategic plans is a positive step as is use of project-developed community actions plans to hold leaders to account for commitments made, building on the goodwill leveraged by health workers and justice sector professionals for continued engagement vis-à-vis HIV prevention services for AGYW. This includes exploring ways to mainstream the community scorecard process into government operations.

Another crucial aspect for sustainability of LE+SA interventions is community ownership of LE+SA tools. Extensive time and resources went into LE efforts for duty bearers and rights holders. Moreover, handbooks, manuals, communication and awareness raising tools, and community scorecard templates were developed, which can be easily harnessed for future programming by implementing partners or other local organizations. With the information imparted, these actors should be able to provide quality services, and the AGYW and their communities to hold service providers accountable.

As multiple stakeholders participated in the community scorecard process and related training, including health and justice service providers and community-based organizations, opportunities to institutionalize SA processes and bring about policy and legal reform arose from multiple sides. Despite a relatively short project implementation period, continued cooperation among project partners through the formulation of joint action plans aims to build on existent cooperation among DREAMS partners to help understand the extent to which LE+SA interventions are contributing to the overall reduction in HIV incidence in both focus countries in the long term.

Finally, the financial sustainability of LE+SA intervention beyond the project life cycle is another crucial aspect. Legal Aids Funds established in the IDLO project helped ensure AGYW received justice for SGBV related complaints. Indeed, interventions of a similar nature may work best when an expansive view of access to justice is adopted whereby funds can support the holistic

needs of SGBV survivors such as costs related to legal proceedings, travel costs, psychosocial support, reconstructive surgery, or other similar areas.

However, the sustainability of these funds comes into question due to the short-term nature of LE+SA projects compared to the general length of criminal proceedings. In order to overcome this, it is important that SA systems are in place for use by the community to effectively hold governments accountable for an accessible and efficient justice system. In particular this may mean ensuring government funded legal aid mechanisms and social amenities, such as counselling services for AGYW and post-GBV care systems, availability of shelters, proximity of courts in remote areas, and other similar efforts.

Ultimately, LE+SA projects should support the establishment of effective and sustainable systems and processes in targeted countries in order to minimize the need for non-state actor managed or supported legal aid funds.

Lesson 5: Program with adaptive strategies and continuous learning

IDLO's approach placed a strong focus on learning, from the inception phase and context analysis, throughout project implementation and monitoring. To this end, data collection efforts were undertaken in the context of final monitoring as well as for this report, to gather feedback on project activities and understand areas for improvement.

In particular, AGYW and partner organizations detailed ideas to expand and improve capacity building and awareness raising activities by implementing partners. This included improvements to the communication tools and materials; ways to ensure institutionalization and sustainability of legal aid services and health committees at the community level; avenues for future funding of SGBV-related disputes; and entry points for greater engagement of other community members such as ABYM, parents and girls and women of other age groups through strategic partnerships. Moreover, internal learning within implementing partners was encouraged through dedicated sessions for staff held at different intervals of the project cycle to strengthen understanding of the LE+SA approach, discuss emerging issues and exchange solutions, and continuously learn from implementation.

An illustration of IDLO's adaptive approach to programming is provided by the integration of capacity building activities of media actors. The latter, through consultations with AGYW, were identified as contributing to the fear of stigmatization and social isolation associated with GBV, thus contributing to the low rate of prosecution of GBV cases. To address these issues, IDLO developed training on ethics in communicating GBV and HIV issues, as well as awareness raising initiatives on LE+SA for quality HIV health services to AGYW, targeted to radio and newspaper reporters.

In Tanzania, increased coordination between partners resulted in the implementation of a One-Stop Centre to centralize access to HIV prevention information and services linked to post-SGBV care for AGYW. Interactions with beneficiaries and contextual analysis pointed to the need to provide a single space for easy access to multiple services related to HIV, ensuring privacy, safety, and accessibility for AGYW. This included health and legal services such as PEP, child protection and social welfare services.

Ultimately, if fully operationalized, the One-Stop Centre will not only ensure centralized access to health and justice services related to HIV prevention for AGYW, but also allow trained AGYW community advocates to be integrated in the Center and continue to safely exercise knowledge and skills gained from the project. This initiative provides a successful model to learn from and replicate in other project areas, building on the momentum for joint action and coordinated interventions between DREAMS partners.

Finally, the community scorecard is another important consultative mechanism in terms of continuous learning and monitoring of LE+SA interventions. The success of community-based

LE+SA HIV prevention strategies for AGYW in the context of a multi-district and country project rests on having a robust MERL system in place. This entails consistent and constant monitoring including through participatory tools such as the community scorecard, allowing for the identification of lessons emerging from the context and agreement on how these should inform future programming. As a tool, the community scorecard identified issues and gaps directly by community members through discussions focused on mediating conflicting views of different groups and reaching consensus, resulting in forward looking, community owned action plans that provide a basis for institutionalized monitoring of LE+SA interventions.

Recommendation for Universal Health Coverage

The LE+SA approach should be explored in other contexts to address structural barriers, including stigma and discrimination, in access to health services.

ANNEXES

1. ***Protection Against Gender Based Violence and Litigation on HIV Related Rights: A Handbook for Lawyers and Activists*** (Legal and Human Rights Centre, Tanzania, 2018) <https://www.humanrights.or.tz/assets/attachments/1548317024.pdf>
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